CHAPTER 180. MONITORING AND ENFORCEMENT

SUBCHAPTER: A. GENERAL RULES FOR ENFORCEMENT

§180.1. Definitions.

The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Abusive practice – a practice that:

(A) does not meet professionally recognized standards for health care or insurance claims adjusting; or

(B) does not meet standards required by the Act, rules, or previous notification to system participant; or

(C) is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) unnecessary system costs or in reimbursement for services that are not medically necessary; or
(ii) improper reduction or increase of benefits.

(2) Accident Prevention Services Inspection – an inspection under Chapter 166 under this title (relating to Workers' Health and Safety – Accident Prevention Services) that focuses on carrier's duties to provide accident prevention services under Texas Labor Code Chapter 411, Subchapter E and Commission Rule.

(3) Act – the Texas Workers' Compensation Act, Texas Labor Code Title V, Subtitle A.

(4) Administrative Law Judge – an administrative law judge (ALJ) designated by the State Office of Administrative Hearings (SOAH) to preside over the hearing, or a hearing officer of a state or federal tribunal which would include commission hearing officers and appeals panel judges.

(5) Audit Violations – violations discovered through a census or statistical sampling of the alleged violator. Audit Violations are representative of overall compliance in the audited Compliance Category(s).

(6) Agent – a person or entity that a system participant (insurance carrier, health care provider, employer, employee, or attorney) contracts with or utilizes for the purpose of providing claims service or fulfilling duties under the Act and Rules. The system participant that the agent works on behalf of is responsible for the acts and omissions of that agent executed in performance of services for the participant.

(7) Charged Person (also Alleged Violator)– the system participant who is charged with an administrative violation or wrongful act. As used in these Rules, charged person includes both person(s) initially charged and those found guilty of an administrative violation(s).

(8) Compliance – a system participant is in compliance if the system participant timely and accurately fulfills his duties under the Act and Rules in the form and manner required (does not commit a violation by an act of omission or commission) and if the system participant does not commit an act which is prohibited.

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

(10) Compliance Category – a group of related duties under the Act and/or Rules.

(11) Compliance Rate – The percentage of duties that are met by a system participant, as reported by or on behalf of the system participant, or as validated by the commission. Compliance rates are validated using censuses or statistical sampling.

(12) Compliance Standard – a rate of compliance that a system participant is minimally expected to meet.

(13) Continued Noncompliance (also Active Noncompliance)– a system participant is in "continued noncompliance" if the system participant has committed a violation of the Act or Rules and has yet to take action to come into full compliance. For example, a system participant who fails to file a required report (or who files an incomplete report) would be in "continued noncompliance." The system participant could come into compliance by filing a properly completed report (although, doing so would not eliminate the existence of a violation for failing to timely file a complete report in the first place).

(14) Controlled substances – "controlled substance" as defined by the Texas Controlled Substances Act (Texas Civil Acts, Article 4476-15) or its successor and the Federal Controlled Substances Act (21 USCA §8.01 et seq.) or its successor.

(15) Conviction or convicted –

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

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

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

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

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

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

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

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

(ii) an appeal is pending;

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

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

(16) Demonstrable Harm - significant physical or emotional harm to an injured employee or significant economic harm to a system participant.

(17) Emergency – as defined in §133.1 of this Title (relating to Definitions for Chapter 133).

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

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

(20) Intentionally – a system participant acts intentionally with respect to the nature of his conduct or to a result of his conduct when it is his conscious objective or desire to engage in the conduct or cause the result.

(21) Knowingly – a system participant acts knowingly with respect to the nature of his conduct or to circumstances surrounding his conduct when he is aware of the nature of his conduct or that the circumstances exist. A system participant acts knowingly with respect to a result of his conduct when he is aware that his conduct is reasonably certain to cause the result.

(22) Matter of Practice – This term is synonymous with Pattern of Practice, as defined in this section.

(23) Noncompliance or Noncompliant Act – a violation of the Act or Rules.

(24) Notice of Intent (NOI) – a notice issued by the commission to a system participant who it appears has committed a violation that allows the system participant to provide feedback so that the commission can make a final decision regarding the possible violation. The NOI is issued prior to the commission taking formal enforcement action through the issuance of a Notice of Violation or Warning Letter.

(25) Notice of Violation (NOV) – a formal notice issued to a system participant by the commission under Texas Labor Code §415.032 when the commission has found that the system participant has committed an administrative violation and the commission seeks to assess an administrative penalty.

(26) Pattern of Practice – the acts or omissions of a participant in the workers' compensation system which are repeated. This term is synonymous with similar terms such as "business practice," "pattern of conduct," "matter of practice," "practices or patterns," and "practices and patterns."

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

(28) Referral Violations – violations discovered outside of a Compliance Audit of the violator. These violations may or may not be representative of overall performance.

(29) Representative Violation – a violation may be considered "representative" if it is indicative of an overall performance problem.

(A) A violation caused by a procedural or programming error on the part of the violator may be considered representative.

(B) Audit findings using censuses or statistical sampling are representative of overall performance in the audited category(s).

(30) Rules – the commission's Rules adopted under this Act.

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

(32) Significant Violation – a violation which:

(A) arises from an action or inaction where the violator has demonstrated unwillingness or has alleged an inability to take corrective measures to avoid committing the same violation in the future;

(B) resulted or was likely to result in significant physical or emotional harm to an injured employee;

(C) resulted or was likely to result in significant economic harm to a system participant;

(D) was fraudulent in nature;

(E) involved a violation of an agreement or commission decision or order; or

(F) was either willfully committed or which is part of an uncorrected pattern of practice.

(33) SOAH – the State Office of Administrative Hearings.

(34) System Participant – a person or entity required to comply with the Act and Rules. This will generally be an insurance carrier (carrier), employer, health care provider (provider or HCP), attorney, injured employee (employee) or other claimant.

(35) Uncorrected Pattern of Practice – a pattern of practice which continues even after the commission provides written notice to the system participant committing the violation(s)of the noncompliance.

(36) Violation – a failure to comply with a duty established under the Act or Rules or commission of an act prohibited by the Act or Rules which can involve failing to timely fulfill a duty or failing to fulfill the duty in the manner required (whether timely or not).

(37) Violation Review – a review of an allegation of noncompliance conducted outside the context of a Compliance Audit. Violation Reviews are conducted upon receipt of an allegation of noncompliance (violation referral) that was made or forwarded to the commission.

(38) Violator – a system participant found to have committed an administrative violation or another offense.

(39) Warning Letter – a formal notice issued to a violator when the commission has found an administrative violation for which the commission does not plan to assess an administrative penalty or other sanction.

(40) Willfully – intentionally or knowingly. Also, continuing conduct after being notified by the commission or other regulatory authority. NOTE –"wilful " and " wilfully " as used in the Act are the same as "willful " and "willfully," respectively.

The provisions of this §180.1 adopted to be effective September 14, 2003, 28 Tex Reg 7746.

§180.2. Referrals.

Any person may make a referral to the commission: for fraudulent acts or omissions by any system participant; for failure of a health care provider to provide reasonable and necessary health care; for failure of an insurance carrier to ensure that all and only reasonable and necessary health care is approved and reimbursed in accordance with the Statute and Rules; or for other violations of the Statute or Rules by any system participant.

The provisions of this §180.2 adopted to be effective July 29, 1991, 16 TexReg 3940; amended to be effective March 14, 2002; 27 TexReg 1817

§180.3. Compliance Audits.

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

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

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

(1) be in writing;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) The auditee shall submit payment by check, made payable to the order of the commission, for the expenses within 25 days after receipt of the bill. Payment may be delivered in person or by mail to the commission in Austin.

The provisions of this §180.3 adopted to be effective September 14, 2003, 28 Tex Reg 7748.

§180.5. Access to Workers' Compensation Related Records.

(a) Upon written request from the commission, any person subject to monitoring or review by the commission shall provide access to all records and information held by that person related to issues being reviewed or investigated.

(b) The request will identify the information or documents to be produced, and will provide a specific, reasonable date to produce the information.

The provisions of this §180.5 adopted to be effective July 29, 1991, 16 TexReg 3941.

§180.6. Evidence of Patterns of Practice.

For purposes of enforcement of the portions of the Texas Workers' Compensation Act (Act) pertaining to wrongful acts, administrative violations, and sanctions, the following guidelines apply:

(1) A pattern of practice is established upon the first conviction by a court for a criminal act that constitutes a violation of the Act or the rules of the commission.

(2) A pattern of practice may be established by at least three administrative violations of the same provision of the Act or commission rule.

(3) A pattern of practice is established by a system participant continuing to engage in acts after the commission has issued a written warning of the prohibited nature and consequences of the act.

The provisions of this §180.6 adopted to be effective September 14, 2003, 28 Tex Reg 7711.

§180.7. Date Violation Deemed to Have Occurred; Establishing Willful Violations.

(a) A violation is deemed to have occurred:

(1) on the date a noncompliant action is taken; or

(2) when no action is taken by the close of business on the date that the Statute or Rules requires an action to be taken.

(b) A violation may be deemed to be “willful” if the person who committed the violation:

(1) did so knowingly or intentionally;

(2) remains in continued noncompliance seven or more days after the date the commission brought the violation to the attention of the violator; or

(3) after previously being notified by the commission that a given action or inaction violates the Statute or Rules, repeats the same action or inaction.

The provisions of this §180.7 adopted to be effective July 29, 1991, 16 TexReg 3941; amended to be effective March 14, 2002, 27 TexReg 1817.

§180.8. Notices of Violation, Warning Letters, and Notices of Intent.

(a) A notice of violation (NOV) is a formal notice issued to a system participant by the commission under Texas Labor Code §415.032 when the commission has found that the system participant has committed an administrative violation and the commission seeks to assess an administrative penalty.

(b) A NOV shall include:

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

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

(3) a description of the sanction (such as an administrative penalty) that the commission intends to assess in accordance with the Act and this Chapter; and

(4) information about the rights, obligations, and procedures for the charged system participant to file a written answer or request a hearing.

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

(d) Failure to respond to a NOV in 20 days, absent good cause, is deemed consent to the penalty.

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

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

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

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

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

(g) Prior to issuing a NOV or Warning Letter, the commission may issue a Notice of Intent (NOI) that allows a system participant, who it appears has committed a violation, to provide feedback so the commission can make a final decision regarding the possible violation. The NOI:

(1) shall be accompanied by a copy of the commission's penalty calculation worksheet and shall include a summary of the duty that the commission believes that the charged system participant failed to fulfill or timely fulfill.

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

(3) may offer the system participant the opportunity to enter into a settlement agreement.

(h) The commission may, at its discretion, enter into a settlement agreement with the violator. A settlement agreement may be entered into before or after issuance of a NOV. The settlement agreement shall require the violator to:

(1) waive the right to appeal either the commission's violation finding or the commission's use of the finding to increase penalty amounts of other similar violations;

(2) come into compliance on the violation (if the commission alleges that there was continued noncompliance);

(3) agree to review the causes of the violation and take action as necessary to improve compliance; and

(4) pay one-half the penalty calculated in accordance with this chapter.

The provisions of this §180.8 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.10. Duration and Extent of Noncompliance.

(a) Upon determination by the commission that a violation of the Act or Rule has occurred, the commission shall determine the duration and or extent of noncompliance.

(b) The duration of violations shall be measured by the number of days of noncompliance. If a violation occurred, there is at least one day of noncompliance.

(1) The first day of noncompliance is:

(A) the first day that the violator took a noncompliant action(s); or

(B) the first day after the last day that the violator had to comply with a requirement under the Act or Rules but failed to do so.

(2) The last day of noncompliance is the day that the violator came into compliance by either discontinuing his noncompliant action(s) or taking the action(s) necessary to correct the noncompliance by completing his duty under the Act or Rules (such as making an owed payment plus applicable interest or correcting an improperly filed form).

(3) In counting the number of days of noncompliance, both the first day of noncompliance and the last day of noncompliance are included in the count unless they are the same day.

(c) When a system participant commits what appear to be separate violations, they may be grouped together and treated as a single violation if they:

(1) involved multiple instances of the same basic duty;

(2) constituted actions or inactions occurring on the same day; and

(3) involved actions or inactions due on the same day.

(d) Actions or inactions that involve more than one duty or prohibition, occurring on separate days, or those involving separate due dates shall be treated as separate violations.

(e) The following examples illustrate the concepts described in subsections (c) and (d) of this section:

(1) If three weeks of indemnity benefits are all due on the same day but the carrier paid the benefits four days late, each of the three weeks is considered part of the same violation, because they were all due on the same day. This is referred to as "stacking" (because the three weeks of benefits "stacked up" into one payment) and is treated as a single violation.

(2) If three weeks of indemnity benefits were due on the same day but the carrier paid them late on three different days, each week of benefits paid late is considered an individual violation, because they were due on the same day and the carrier paid each separately (representing three individual actions). This is referred to as "unstacking" (because a "stack" of three weeks of benefits that were due on the same day was unstacked) and is treated as separate violations.

(3) If a carrier is late making a payment one week (i.e., makes a payment a few days late) and then continues to pay every seven days thereafter, only the first week is counted as late. This type of violation is called the start of a "series" of late payments. As long as the carrier stays in the series (making the payments every seven days), there is only one violation. However, if the carrier breaks the series by paying more than seven days after the prior payment in the series, then this payment would be a separate violation.

(4) If a carrier underpaid a week of indemnity benefits and continued to underpay the benefits each week thereafter, the weeks of benefits included in the initial payment constitute one violation and each separate, subsequent week of benefits that was underpaid is a separate violation (because each represents a separate instance where benefits were to be accurately paid but were not).

The provisions of this §180.10 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.11. Compliance Categories.

(a) This section defines various categories in which duties under the Act and/or Rules can be categorized for purposes of identifying administrative violations and calculating administrative penalties. If a duty (or violation of that duty) seems to fit into more than one category, the more specific category applies.

(b) The Compliance Categories are:

(1) Communication – includes all duties relating to timely filing complete/correct reports, filings, notices, or other communications required under the Act or Rules (not just required reports on commission forms) as well as providing documentation when and as required.

(A) Common examples of these duties include:

(i) employers filing Employer's First Reports of Injury, Wage Statements, and Supplemental Reports of Injury;

(ii) doctors filing Work Status Reports and Reports of Medical Evaluation; and

(iii) carriers filing notifications of coverage or notices of initiation of benefits, and providing a List of Policyholder accounts prior to an Accident Prevention Services Inspection.

(B) Common violations relating to these duties include:

(i) failure to timely file a report;

(ii) providing incorrect information on a report; and

(iii) failure to file a complete report in the form and manner prescribed by the commission (such as failing to file electronically if required, using the wrong form, or failing to provide all information required by the form).

(2) General Benefit Delivery – includes insurance carrier duties relating to compensability and indemnity benefits (income or death benefits). Although attorney fees are not indemnity benefits, duties relating to payment of attorney fees are included within this category. Duties relating to payment of burial benefits are also included in this category. Common violations relating to these duties include:

(A) failure to timely pay or dispute indemnity benefits/attorney fees/burial benefits;

(B) failure to properly pay interest on accrued but unpaid income benefits;

(C) failure to pay indemnity benefits, attorney fees, or burial benefits at the correct rate; and

(D) denial, suspension, or reduction of compensability, indemnity benefits, attorney fees or burial benefits without providing a sufficient explanation.

(3) Seeking Medical Reimbursement – includes all administrative duties relating to the proper submission of medical bills, requests for reconsideration, requests for refunds, and requests for medical dispute resolution for payment (i.e., does not include issues of medical judgment/quality of care). Common violations relating to these duties include:

(A) failure to use the correct medical billing forms;

(B) failure to use appropriate billing codes required by rule;

(C) failure to provide documentation required by rule;

(D) improper filing of requests for reconsideration;

(E) failure to request refunds in the form and manner prescribed by the commission;

(F) failure to exhaust administrative remedies before pursuing reimbursement in civil court; and

(G) improper pursuit of a private claim against a claimant.

(4) Medical Bill/Refund Processing – includes all duties relating to the processing and payment/denial of medical bills, requests for reconsideration, refund requests, and participating in the medical dispute resolution process. The category also includes processing claimant requests for travel reimbursements. Common violations relating to these duties include:

(A) improper return of a medical bill, travel reimbursement, or a request for reconsideration;

(B) failure to timely take final action on a properly completed medical bill, travel reimbursement, or reconsideration request;

(C) failure to properly pay interest when owed;

(D) failure to make payment in accordance with the Act and Rules; and

(E) reduction or denial of medical benefits without providing a sufficient explanation.

(5) Requesting Preauthorization or Concurrent Review – includes all administrative duties relating to requesting preauthorization or concurrent review, requests for reconsideration, and requests for medical dispute resolution (i.e., does not include issues of medical judgment/quality of care). Common violations relating to these duties include:

(A) submitting incomplete requests;

(B) submitting improper re-requests (i.e., not utilizing the reconsideration or dispute resolution processes); and

(C) improper filing of requests for reconsideration.

(6) Processing Requests for Preauthorization, Concurrent Review and Medical Dispute Resolution – includes all carrier duties relating to processing and responding to requests for preauthorization, concurrent review, requests for reconsideration and participating in the medical dispute resolution process. Common violations relating to these duties include failure to:

(A) timely respond to a request;

(B) provide the requestor a reasonable opportunity to discuss the request prior to issuing a denial; and

(C) provide a sufficient explanation for not approving a request (such as approving part of the request and not providing a reason for not approving the entire request).

(7) Data Submission Accuracy – includes duties relating to the accuracy of data submitted to the commission (whether electronically or otherwise) in the format required. Though data submission is generally a "report" or a "filing," this category is separate from the Communication category because Data Submission Accuracy has a different Compliance Standard (as identified in §180.12 of this title (relating to Compliance Standards and Compliance Rates)).

(8) Accident Prevention Services – includes duties relating to providing required accident prevention services to employers. However, issues relating to communication and data submission accuracy are included in those respective compliance categories rather than in Accident Prevention Services. Common violations relating to these duties include:

(A) failure to provide an onsite visit or other appropriate services as required by rule;

(B) failure to make an onsite inspection within three days of a report of a fatality; and

(C) utilization of unqualified staff to provide services.

(9) Attendance – includes duties relating to attending benefit review conferences, contested case hearings, and required medical examinations (which would also include attending designated doctor examinations).

(10) Record-Keeping – includes duties relating to maintaining all required records in the form and manner and for the period prescribed by the commission.

The provisions of this §180.11 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.12. Compliance Standards and Compliance Rates.

(a) This section identifies:

(1) the Compliance Standards that system participants are minimally expected to meet in each Compliance Category;

(2) how the commission will identify a system participant's Compliance Rate; and

(3) how the commission will validate a system participant's Compliance Rate to determine whether a Compliance Standard has been met.

(b) Nothing in this section, chapter, or title is to be interpreted as endorsing noncompliance or encouraging or condoning violation of the Act or Rules. Though the section identifies minimal Compliance Standards and though achieving these standards may result in reduced enforcement action for noncompliance, no such consideration or reduction shall take place if the noncompliance involved a significant violation.

(c) Unless otherwise noted by the Rules, the Compliance Standard for all duties under the Act and Rules is 95%. However, because accurate data is critical to the commission's ability to monitor system compliance, the Compliance Standard for the Data Submission Accuracy Category is 98%.

(d) The commission will initially identify a system participant's Compliance Rate for a particular duty or Compliance Category by monitoring and evaluating the relevant data submitted to the commission by or on behalf of the system participant. To validate the Compliance Rate indicated by the system participant's data, the commission will conduct a Compliance Audit of the system participant's Compliance Rate using, in its discretion, either a census or a statistical sampling.

(1) When a census is used, the Compliance Rate is the proportion (percentage) of duties met by the system participant compared to the number of all reviewed transactions and/or data for the specific time period under review.

(2) When a statistical sampling is used, the Compliance Rate is calculated by subtracting the margin of error of the statistical sampling (calculated based upon 95.00% confidence) from the proportion (percentage) of duties in the sample that were met by the system participant. The Compliance Rate based upon a sample is also called the Least Likely Compliance Rate.

The provisions of this §180.12 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.13. Warning Letter Criteria; Relevant Time Period.

(a) This section outlines the commission's general criteria for the issuance of a Warning Letter instead of an administrative penalty or other sanction.

(b) The commission may, in its discretion, issue a Warning Letter instead of an administrative penalty (penalty) or other sanction if:

(1) the violation involved no more than one day of noncompliance;

(2) the violator is not in continued noncompliance;

(3) the conduct was not a significant violation; and

(4) Depending on whether the violation is a Referral Violation or an Audit Violation:

(A) For a Referral Violation, the violator had not been previously notified of a compliance problem in the same Compliance Category in the one year prior to the first day of noncompliance for the current violation or

(B) For an Audit Violation in a given Compliance Category, the violator met or exceeded the Compliance Standard for the Compliance Category or the commission only identified one violation in that category.

(c) The commission will not initiate enforcement action for Referral Violations against a violator if the violation was reported to the commission more than one year after the last day of noncompliance, except in the cases of significant or recurring violations or cases of continuing noncompliance. However, this subsection does not apply to Audit Violations.

The provisions of this §180.13 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.14. General Provisions for Penalty Calculations.

(a) This section identifies the basic process for calculating penalty amounts referencing other rules that are involved in the final calculations.

(b) If a violation falls into a Compliance Category, the administrative penalty (penalty) to be assessed for that violation is determined by multiplying the appropriate Base Penalty calculated in §180.15 of this title (relating to Base Penalties) by the appropriate modifiers based upon whether the violation was discovered as part of an audit or not.

(1) Review Modifiers, as calculated in §180.16 of this title (relating to Review Modifiers), are used to modify a penalty being issued in response to a violation discovered through a Violation Review or other investigation. Review Modifiers adjust penalties based upon:

(A) aggravating and mitigating circumstances surrounding the violation; and

(B) prior history.

(2) Audit Modifiers, as calculated in §180.17 of this title (relating to Audit Modifiers), are used to modify a penalty being issued in response to a violation discovered through a Compliance Audit of the violator. Audit Modifiers adjust penalties based upon:

(A) the Compliance Rate achieved in the applicable Compliance Category;

(B) prior history; and

(C) the proportion of the violator's universe that was reviewed in the audit.

(c) Notwithstanding any other provision of this subchapter, the following provisions apply:

(1) the commission shall issue the maximum administrative penalty allowed by the Act if the commission is alleging that a violation was committed willfully or intentionally;

(2) penalties involving failure to comply with an order or decision of the commission shall be calculated based upon the Compliance Category in which the underlying duty is contained and then doubled;

(3) penalties may not exceed the maximum administrative penalty allowed by the Act for that violation; and

(4) penalties shall be rounded down to the nearest dollar after all modifiers are applied.

(d) If a violation does not fall into a Compliance Category, the commission shall calculate the penalty in accordance with Texas Labor Code §415.021(c).

The provisions of this §180.14 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.15. Base Penalties.

(a) Each Compliance Category as described in §180.11 of this title (relating to Compliance Categories) has its own Base Penalty formula as outlined in this section to be used to calculate penalties for violations of duties in those categories.

(b) Base Penalty formulae include a limit on how high the Base Penalty may go. This is a limit on the Base Penalty only. With the exception of the penalties set out in (2)(A), the Base Penalty can then exceed that amount by multiplying it by the applicable modifiers as outlined in subsection §180.14 of this title (relating to General Provisions for Penalty Calculations) and contained in §§180.16 and 180.17 (relating to Review Modifiers and Audit Modifiers, respectively).

(1) Communication Violations – The Base Penalty is dependent on the maximum penalty allowed by the Act (statutory maximum) and is calculated as follows:

(A) $1,000 plus $200 per day of noncompliance, not to exceed $5,000 for a Class A administrative violation or a penalty to be issued under Texas Labor Code §415.021(b);

(B) $500 plus $100 per day of noncompliance, not to exceed $2,500 for a Class B administrative violation;

(C) $100 plus $20 per day of noncompliance, not to exceed $500 for a Class C administrative violation; or

(D) $50 plus $10 per day of noncompliance, not to exceed $250 for a Class D administrative violation.

(2) General Benefit Delivery Violations –

(A) The Base Penalty for failure to either timely initiate temporary income benefits or file a notice of refusal to pay equals $500 if the carrier initiates compensation or files a notice of refusal within five working days of the date required by the Act; $1,500 if the carrier initiates compensation or files a notice of refusal more than five and less than 16 working days of the date required by the Act; $2,500 if the carrier initiates compensation or files a notice of refusal more than 15 and less than 31 working days of the date required by the Act; $5,000 if the carrier initiates compensation or files a notice of refusal more than 30 working days of the date required by the Act.

(B) The Base Penalty for all other General Benefit Delivery Violations equals $350 plus $25 per day of noncompliance for up to three days of noncompliance plus $50 per day of noncompliance over three days, the total of which is not to exceed the greater of $5,000 or twice the dollar value of the affected amount (which includes any owed interest), not to exceed $5000 per day of noncompliance.

(i) If the violation involves more than one benefit period (which includes attorney fee payments), each additional benefit period increases the Base Penalty by 25% (note this subsection does not apply if the additional benefit periods are separate violations as described in §180.10 of this title (relating to Duration and Extent of Noncompliance). Examples:

(I) Carrier initiates and pays two weeks of accrued benefits seven days late making the Base Penalty amount equal to ($350 plus $25 for the first three days of noncompliance plus $50 per day of noncompliance over three days) × 1.25, which is $781 (after rounding down); however

(II) if the carrier initiates benefits seven days late but the late initiation only affects one week of benefits, the Base Penalty amount would equal to ($350 plus $25 for the first three days of noncompliance plus $50 per day of noncompliance over three days), which is $625.

(ii) If the violation involves only a failure to pay the correct amount of benefits, the Base Penalty shall be reduced as follows:

(I) by 75% if the underpayment was less than or equal to 5% of the amount due;

(II) by 50% if the underpayment was more than 5% of the amount due but less than or equal to 20% of the amount due; or

(III) not at all if the underpayment was more than 20% of the amount due.

(iii) If the violation involves a payment that was reduced by post-injury earnings (PIE), the Base Penalty is reduced by multiplying the Base Penalty by the PIE and then dividing by the Average Weekly Wage (AWW). Mathematically, this formula reads (Base Penalty × PIE) ÷ AWW.

(iv) If the violation involves monthly rather than weekly benefit periods, the Base Penalty shall be multiplied by 4.34821 (which is the average number of weeks in a month) up to a maximum of the greater of $21,741.00 ($5000 × 4.34821) or twice the amount affected.

(3) Seeking Medical Reimbursement Violations – The Base Penalty equals:

(A) for improperly pursuing a private claim against a claimant or pursuing a claim in civil court prior to exhausting administrative remedies at the commission is two times the amount of the claim being pursued (not to exceed $5,000); or

(B) for other billing violations and refund requests $25 plus the following amounts depending on the types and number of billing/refund requesting errors committed (the total of which shall not exceed $200 unless the improper billing/refund request caused an improper payment):

(i) $1 per identified error related to basic identification information (e.g., name of the injured employee, the provider of the care, or the place care was provided);

(ii) $1 per identified error related to submitting treatment/billing information (e.g., procedure codes or modifiers) in accordance with commission rules and fee guidelines;

(iii) $25 for not attaching required documentation;

(iv) $25 per other procedural violation (e.g., not using the correct forms or not providing explanations documenting reasons for requests for reconsideration or Medical Dispute Resolution) associated with medical billing/refund requesting; and

(v) twice the amount that was improperly paid if the improper billing resulted in failure to pay the correct amount.

(4) Medical Bill/Refund Processing Violations – The Base Penalty equals 10% of the amount affected plus $10 per day of noncompliance, not to exceed the lesser of $10,000 or twice the dollar value of the amount affected.

(A) If the violation only involved failure to pay the correct amount of medical benefits, the Base Penalty may be reduced as follows:

(i) by 75% if there was an underpayment that was less than or equal to 5% of the benefits affected;

(ii) by 50% if there was an underpayment that was more than 5% of the amount due but less than or equal to 20% of the benefits affected; or

(iii) not at all if there was an underpayment that was more than 20% of the benefits affected.

(B) For the purposes of this subsection "benefits affected" includes owed interest and the lesser of:

(i) the maximum allowable reimbursement under the Act and Rules; or

(ii) the amount billed by the provider.

(5) Requesting Preauthorization/Concurrent Review Violations – The Base Penalty equals $50 plus the following amounts depending on the types and number of errors committed (the total of which shall not exceed $400):

(A) $2 per identified error related to basic identification information (e.g., name of the injured employee, the provider of the care, or the place care is to be provided); and

(B) $50 per other procedural violation (e.g., not using the correct forms or not providing explanations documenting reasons for requests for reconsideration or Medical Dispute Resolution) associated with Preauthorization/Concurrent Request Violations.

(6) Processing Requests for Preauthorization/Concurrent Review Violations – The Base Penalty equals $100 plus $100 per day of noncompliance, not to exceed $10,000. If the violation involves only an administrative issue associated with the manner in which the carrier's response to the request was made (i.e., not responding in writing to a request or not providing the approved specific health care in the response), the Base Penalty shall be reduced in half.

(7) The Data Submission Accuracy Violations – The Base Penalty is dependent on the types and number of data elements in the data submission that were not accurately submitted to the commission. Each record that contains errors is a separate violation.

(A) The Base Penalty is $25 plus the following amounts depending on the types and number of billing errors committed (the total of which shall not exceed $250):

(i) $1 per identified inaccuracy related to basic identification information (e.g., injured employee, the employer, health care provider);

(ii) $1 per identified inaccuracy related to benefit information (e.g., benefit amounts, benefit periods, medical procedure coding, modifiers); and

(iii) $25 per identified inaccuracy associated with a duty of the system participant making the submission (e.g., a carrier incorrectly submitting the date a bill or notice of an injury was received or the date payment or dispute made).

(B) For the purposes of this section, "record" refers to each individual record contained in a data submission not the batch transmission itself (e.g., a medical bill or an electronic data interchange transmission). For example, if a carrier submits a batch of 2000 medical bills and 12 of the bills contain errors then there would be a total of 12 violations (one for each of the 12 records that had errors).

(8) Accident Prevention Services Violations – The Base Penalty is:

(A) calculated by rounding the premium (as defined in §166.1 of this title (relating to Definitions of Terms)) amount for the policyholder that did not receive timely or appropriate accident prevention services up to the nearest $5,000 and then multiplying by 2%; or

(B) $250 plus $250 per policy serviced that policy year by an unqualified Field Safety Representative not to exceed $5,000.

(9) Attendance Violations – The Base Penalty equals $100 per violation.

(10) Record-Keeping Violations – The Base Penalty equals:

(A) $25 per record; or

(B) if the violator's record-keeping violation prevents the commission from verifying that another violation occurred, the Base Penalty equals the lesser of:

(i) the maximum penalty allowable under this section for the type of violation that cannot be verified due to violator's failure to maintain required documentation; or

(ii) $10,000.

(c) The following table summarizes the base penalties described in subsection (b) of this section. With the exception of the penalties set out in subsection (b)(2)(A), these base penalties can be increased or decreased based on certain additional factors described in §§180.16 and 180.17 of this title (relating to Review Modifiers and Audit Modifiers, respectively), if applicable.

Communication Violations (e.g., TWCC-1s, TWCC-3s, TWCC-6s, TWCC-69s and TWCC-73s)	
Class A	$1,000 plus $200 per day of noncompliance (not to exceed $5,000)
Class B	$500 plus $100 per day of noncompliance (not to exceed $2,500)
Class C	$100 plus $20 per day of noncompliance (not to exceed $500)
Class D	$50 plus $10 per day of noncompliance (not to exceed $250)

General Benefit Delivery Violations (Initial TIBs Only)	
1 to 5 Working Days Late	$500
6 to 15 Working Days Late	$1,500
16 to 30 Working Days Late	$2,500
More than 30 Working Days Late	$5,000

General Benefit Delivery Violations (e.g., TIBs , IIBs, SIBs, DBs and LIBs payments)			
Timeliness of Income Benefits (including attorney fee payments)	$350 plus $25 per day of noncompliance for up to three days; plus $50 per day of noncompliance over three days (not to exceed the greater of $5,000 or twice the dollar value of the affected amount, including any owed interest, and not to exceed $5,000 per day of noncompliance).	If the violation involves more than one benefit period:	Each additional benefit period increases the base penalty by 25%.
		If the violation involves **only** a failure to pay the correct benefit amount:	AND the underpayment is less than or equal to 5% of amount due – the base penalty is reduced by 75%.
			AND the underpayment is more than 5% but less than or equal to 20% of amount due – the base penalty is reduced by 50%.
			AND the underpayment is greater than 20% of amount due – the base penalty is not reduced.
		If the violation involves a payment reduced by post injury earnings (PIE):	The base penalty is reduced by multiplying the base penalty by the PIE and then dividing by the AWW.
		If the violation involves monthly rather than weekly benefit periods:	The base penalty is multiplied by 4.34821 (up to a maximum of the greater of $21,741 or twice the amount affected).

Seeking Medical Reimbursement Violations	
Pursuing a Private Claim or pursuing a claim in civil court prior to exhausting administrative remedies	The base penalty is 2X the amount of the claim being pursued (not to exceed $5,000).
Billing and Refund Requests	The base penalty is $25 plus $1 per basic identification error or treatment/billing information error; plus $25 for failure to attach required documentation; plus $25 per other procedural violation; plus 2X the amount improperly paid (not to exceed $200).

Medical Bill/Refund Processing Violations		
10 percent of the amount affected plus $10 per day of noncompliance, not to exceed the lesser of $10,000 or twice the dollar value of the amount affected.	If the violation involves **only** a failure to pay the correct medical benefit amount:	AND the underpayment is less than or equal to 5% of amount due – the base penalty is reduced by 75%.
		AND the underpayment is more than 5% but less than or equal to 20% of amount due – the base penalty is reduced by 50%.
		AND the underpayment is greater than 20% of amount due – the base penalty is not reduced.

Requesting Preauthorization/Concurrent Review Violations
The base penalty is $50 plus $2 per basic identification error; plus $50 per other procedural violation (not to exceed $400)

Processing Requests for Preauthorization/Concurrent Review Violations	
$100 plus $100 per day of noncompliance (not to exceed $10,000)	If the violation involves **only** an administrative issue regarding the manner in which the response was made – the base penalty is reduced by 50%.
	If the violation involves more than an administrative issue regarding the manner in which the response was made – the base penalty is not reduced.

Data Submission Accuracy Violations
The base penalty is $25 per record plus $1 per basic identification error or benefit information error; plus $25 per system participant duty inaccuracy (not to exceed $250).

Accident Prevention Services Violations	
Not Receiving Timely or Appropriate Service	The base penalty is the policy premium rounded up to the nearest $5,000 and then multiplied by 2 percent.
Unqualified Field Safety Representative	The base penalty is $250 plus $250 per policy serviced (not to exceed $5,000).

Attendance Violations (e.g., BRCs, CCHs, RME Exams and Designated Doctor Exams)
The base penalty is $100 per violation.

Record-Keeping Violations	
General Record-Keeping Violation	The base penalty is $25 per record.
Unverifiable Violation Due To Record-Keeping Failure	The base penalty is the maximum penalty allowable for the violation that cannot be verified or $10,000 (whichever is less).

The provisions of this §180.15 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.16. Review Modifiers.

(a) With the exception of penalties issued for failure to either timely initiate temporary income benefits or file a notice of refusal to pay, the modifiers in this section apply to penalties being issued for violations discovered either as a result of the commission's review of an alleged violation (Violation Review) or as a result of a commission audit (Compliance Audit) of a system participant other than the auditee. They do not apply to penalties being issued for violations discovered through a commission audit of the auditee.

(b) The Base Penalty may be increased based upon aggravating circumstances or decreased based upon mitigating circumstances surrounding the violation.

(1) The commission may multiply the Base Penalty by a 1.5 modifier if another person had previously notified the violator of the noncompliance but the noncompliance was corrected only after the violator was contacted by the commission.

(2) The commission may multiply the Base Penalty by a 2 modifier if the commission determines that the violation was a representative violation.

(3) The commission may multiply the Base Penalty by a 2 modifier if the violation resulted in demonstrable harm to the affected party(s) and the violator failed to take actions to rectify the consequences of the violation prior to the commission issuing a Notice of Violation under §180.8 of this title (relating to Notices of Violation, Warning Letters, and Notices of Intent).

(4) The commission may multiply the Base Penalty by a .5 modifier if the noncompliance was corrected prior to contact by another person related to the violation. This modifier does not apply to a violation involving a late action because the violation has already occurred.

(c) A Review History Modifier is used to increase penalties based upon the violator's past experience of committing similar violations (violations that fall into the same Compliance Category), as evidenced by prior notice to the violator (prior violations).

(1) To calculate this modifier, the commission shall determine for the current violation the number of similar violations which the commission has previously notified the violator. This number of prior violations is then used to calculate the modifier under subsection (c)(6) if the Review History Modifier is to be used.

(2) Except as otherwise provided, the History Period for a violation is the two years prior to the first day of noncompliance for the current violation.

(3) Except as otherwise provided, the Review History Modifier shall be used if the number of prior violations in the first year of the history period is more than four and greater than or equal to the number of prior violations in the second year of the history period. The first year of the history period is the year immediately preceding the first day of noncompliance for the current violation; the second year of the history period is the year immediately preceding the first year of the history period.

(4) Notwithstanding this subsection, the Review History Modifier is always used if the commission is alleging that the violation is part of a pattern of practice and the commission may extend the History Period as appropriate to demonstrate the pattern.

(5) Notwithstanding subsections (c)(2) and (c)(3), the prior violations used to calculate the Review History Modifier for violations discovered during an Accident Prevention Services Inspection provided for under Texas Labor Code §411.064 and Chapter 166 of this title (relating to Workers' Health and Safety – Accident Prevention Services) shall include all prior violations from the prior two inspections.

(6) The Review History Modifier for:

(A) Communication Violations is 1 plus .05 per prior violation;

(B) General Benefit Delivery Violations is 1 plus .025 per prior violation;

(C) Seeking Medical Reimbursement Violations is 1 plus .025 per prior violation;

(D) Medical Bill/Refund Processing Violations is 1 plus .025 per prior violation;

(E) Requesting Preauthorization or Concurrent Review Violations is 1 plus .1 per prior violation;

(F) Processing Requests for Preauthorization, Concurrent Review and Medical Dispute Resolution Violations is 1 plus .1 per prior violation;

(G) Data Submission Accuracy Violations is 1 plus .025 per prior violation;

(H) Accident Prevention Services Violations is 1 plus .05 per prior violation;

(I) Attendance Violations is 1 plus .5 per prior violation; and

(J) Record-Keeping Violations is 1 plus .05 per violation.

The provisions of this §180.16 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.17. Audit Modifiers.

(a) With the exception of penalties issued for failure to either timely initiate temporary income benefits or file a notice of refusal to pay, the modifiers in this section only apply to penalties being issued for violations discovered through a Compliance Audit of the violator that used either a census or a statistical sampling.

(b) An Audit Modifier shall be used to increase or decrease penalties issued in response to a Compliance Audit based upon the verified Compliance Rate(s) compared to the Compliance Standard, as provided in §180.12 of this title (relating to Compliance Standards and Compliance Rates). If the Compliance Rate is:

(1) 0 to 5.00 percentage points below the Compliance Standard, the Audit Modifier is .5;

(2) 5.01 to 10.00 percentage points below the Compliance Standard, the Audit Modifier is 1;

(3) 10.01 to 15.00 percentage points below the Compliance Standard, the Audit Modifier is 1.5;

(4) 15.01 to 20.00 percentage points below the Compliance Standard, the Audit Modifier is 2;

(5) 20.01 to 25.00 percentage points below the Compliance Standard, the Audit Modifier is 2.5;

(6) 25.01 to 30.00 percentage points below the Compliance Standard, the Audit Modifier is 3;

(7) 30.01 to 35.00 percentage points below the Compliance Standard, the Audit Modifier is 3.5; or

(8) 35.01 or greater percentage points below the Compliance Standard, the Audit Modifier is 4.

(c) Audit History Modifiers are used to increase penalties based upon the violator's past experience of committing similar violations (violations that fall into the same Compliance Category) as evidenced by the Compliance Rate(s) of a prior comparable audit. The Audit History Modifier involves comparing the Compliance Rate(s) of the current audit to the Compliance Rate(s) for the same Compliance Category(s) of the prior audit. If the current Compliance Rate is**:**

(1) 30.00 or greater percentage points higher than the prior audit, the Audit History Modifier is .25;

(2) 20.00 to 29.99 percentage points higher than the prior audit, the Audit History Modifier is .5;

(3) 10.00 to 19.99 percentage points higher than the prior audit, the Audit History Modifier is .75;

(4) 0 to 9.99 percentage points higher than the prior audit, the Audit History Modifier is 1;

(5) 0 to 5 percentage points less than the prior audit, the Audit History Modifier is 1.25;

(6) 5.01 to 9.99 percentage points less than the prior audit, the Audit History Modifier is 1.5; or

(7) 10 or greater percentage points less than the prior audit, the Audit History Modifier is 2.

(d) A Sampling Modifier is used to modify penalties issued in response to violations discovered in a Compliance Audit that used a statistical sampling rather than a census. The modifier is used to adjust penalty amounts on discovered violations based upon the violations that the sample predicts occurred.

(1) The Sampling Modifier is used if the violator is more than 10 percentage points below the Compliance Standard on an initial audit or more than 5 percentage points below the Compliance Standard on a subsequent audit.

(2) Rather than issue a separate penalty for each "projected violation," the penalty amounts for the identified violations discovered shall be raised to account for the fact that the commission is 95% certain that the violator has committed additional, similar violations.

(3) The Sampling Modifier is equal to one-half the size of the universe from which the sample was selected divided by the sample size, up to a maximum of four.

(e) If the violator objects to the use of sampling to measure compliance or believes that the sample size was too small to produce sufficiently accurate results, the violator can offer to have the sample size expanded (even into a census) if the violator enters into a binding agreement to pay the additional costs associated with the audit, which could include hiring outside contract auditors. The commission will then take enforcement action based upon all violations identified in those Compliance Categories for which the expanded sample or census finds that the violator did not meet or exceed the Compliance Standard.

The provisions of this §180.17 adopted to be effective September 14, 2003, 28 Tex Reg 7711

§180.18. Applicability.

§180.3 (relating to Compliance Audits), §180.8 (relating to Notices of Violations, Warning Letters, and Notices of Intent), §180.10 (relating to Duration and Extent of Noncompliance), §180.11 (relating to Compliance Categories), §180.12 (relating to Compliance Standards and Compliance Rates), §180.13 (relating to Warning Letter Criteria; Relevant Time Period), §180.14 (relating to General Provisions for Penalty Calculations), §180.15 (relating to Base Penalties), §180.16 (relating to Review Modifiers) and §180.17 (Audit Modifiers) shall apply to compliance audits initiated and allegations of noncompliance received on or after October 1, 2003.

The provisions of this §180.18 adopted to be effective September 14, 2003, 28 Tex Reg 7711.

§180.19. Incentives

(a) The purpose of this section is to develop incentives and emphasize performance-based oversight to regulatory outcomes. Regulatory outcomes are assessed for the following key regulatory goals:

(1) provide timely and accurate income and medical benefits;

(2) increase timely and accurate communications among system participants;

(3) encourage safe and timely return of injured employees to productive roles;

(4) promote safe and healthy workplaces;

(5) ensure each injured employee shall have access to prompt, high-quality, cost-effective medical care; and

(6) limit disputes to those appropriate and necessary.

(b) At least once every biennium, the Division shall assess the performance of insurance carriers and health care providers based on the key regulatory goals stated in subsection (a)(1)-(6).

(c) Insurance carriers and health care providers who are assessed will be placed into one of the following regulatory tiers based upon their level of compliance with the Labor Code and related rules and their performance in meeting the key regulatory goals in §180.19(a) relative to the performance of all other assessed insurance carriers and health care providers:

(1) high performers;

(2) average performers; or

(3) poor performers.

(d) Incentives will be based on the regulatory tier into which the insurance carrier or health care provider was placed after being assessed on the key regulatory goals.

(e) In granting incentives, the Commissioner may also consider any other factors that the Commissioner finds relevant which leads to overall compliance or which may adversely impact the workers' compensation system.

(f) Incentives for insurance carriers and health care providers placed into the high performer regulatory tier are:

(1) public recognition, and

(2) use of that designation as a marketing tool.

(g) Other incentives for insurance carriers and health care providers placed into a regulatory tier may include:

(1) limited audit exemption for insurance carriers and health care providers placed in the average and high performers regulatory tiers, while reserving the Division's discretion to audit an average or high performer if deemed necessary;

(2) penalties which may be lower than normally assessed for insurance carriers and health care providers who have been placed in the high performer regulatory tier;

(3) penalties which may be reduced for insurance carriers and health care providers in any regulatory tier who self-disclose non-compliance;

(4) flexibility for audits and inspections based on performance and placement in any regulatory tier; and

(5) any other incentive the Commissioner may deem appropriate.

The provisions of this §180.19 adopted to be effective January 16, 2008, 33 TexReg 428

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SUBCHAPTER B. MEDICAL BENEFIT REGULATION

§180.20. Commission Approved Doctor List.

(a) This section governs the commission's approved doctor list (ADL). Except in an emergency, as defined in §133.1 of this title (relating to Definitions For Chapter 133) or for the immediate post-injury medical care, as defined in §180.1 of this title (relating to Definitions) injured employees (employees) shall receive health care from a doctor on the ADL:

(1) The ADL established by the statute and commission rules as it exists on August 31, 2003 is null and void as of September 1, 2003. Any doctor on the ADL prior to September 1, 2003 who does not reapply to be on the ADL or whose application is not approved will not be on the ADL as of September 1, 2003.

(2) On or after September 1, 2003, doctors who provide any functions in the Texas workers' compensation system are required to be on the ADL.

(b) Until September 1, 2003, unless deleted from the list by the commission, the ADL includes all doctors licensed in Texas on or after January 1, 1993, and doctors licensed in other jurisdictions who have been added to the list by the commission. Doctors licensed in other jurisdictions may ask to be added to the list by submitting a written request containing information prescribed by the commission. Doctors on the ADL on or after September 1, 2003, whether licensed in Texas or licensed by another jurisdiction, shall have:

(1) successfully completed the training required by §180.23(h) of this title (relating to Commission Required Training for Doctors/Certificate of Registration Levels);

(2) applied for a Certificate of Registration with the commission in the form and manner prescribed by the commission; and

(3) disclosed financial interests as required by Texas Labor Code §413.041 and §180.24 of this title (relating to Financial Disclosure) with the application.

(c) An incomplete application for registration to be admitted to the ADL pursuant to this section shall be rejected and shall not be processed. A complete application shall include:

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

(2) the training module taken and date completed;

(3) Impairment Rating Skills Examination score, if applicable;

(4) verification of licensure;

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

(6) an agreement that the doctor will comply with the Statute and Rules, including but not limited to, cooperating with commission monitoring and review efforts such as audits by the commission and paying audit bills when required by Statute or Rule;

(7) if the doctor applying for the ADL is not licensed in this state but wishes to perform utilization review and/or peer reviews for an insurance carrier or its agent, the applicant must certify that the reviews will be performed under the direction of a doctor who is licensed in this state and has an ADL Level 2 Certificate of Registration (as provided in §180.23 of this title). The carrier requesting such a review must ensure that the work was performed under the direction of an appropriate in-state doctor, and, upon request, must

identify the in-state doctor and present documentation that the review was performed under the direction of that doctor; and

(8) if the doctor is applying for a Level 1 Certificate of Registration with a Non-Medical Management designation as provided in §180.23(c)(1)(D) of this title, the doctor must indicate in the appropriate place on the application that the doctor's practice does not include ongoing medical management, including pain management, of injured employees.

(d) The commission may utilize members of the Medical Quality Review Panel for evaluating ADL applications and making recommendations to the Medical Advisor to approve, approve with condition(s) or restriction(s), or deny admission to the ADL.

(e) The commission may grant a temporary exception to the requirement to be on the ADL to ensure that employees have access to health care pending commission action on a doctor's application. A doctor with a temporary exception must meet all the requirements that doctors on the ADL must meet. A temporary exception does not constitute "being on the ADL," "approval to be on the ADL," or "denial of an application to be on the ADL."

(f) Doctors shall be denied admission to the ADL or admitted with condition(s) or restriction(s) for:

(1) failing to complete required training;

(2) having relevant restriction(s) on their practice (including, but not limited to, prior deletion from the ADL); or

(3) other activities which warrant application denial or restriction such as grounds that would require or allow 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 the Statute and Rules.

(g) The commission shall notify a doctor of the commission's approval, approval with condition(s) or restriction(s), or denial of the doctor's application to the ADL.

(1) Denials or approvals with condition(s) or restriction(s) shall include the reason(s) for the action.

(2) Within 15 days after receiving the notice, the doctor may file a response which addresses the reason(s) given for the denial or admission with condition(s) or restriction(s).

(A) If a response is not received by the 15th 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 commission shall review the response and shall notify the doctor of the commission's final decision. If the final decision is not an unrestricted approval, the commission's final notice shall provide the reason(s) why the doctor's response did not convince the commission to grant the doctor an unrestricted admission to the ADL. The denial or admission with condition(s) or restriction(s) shall be effective the day following the date the doctor receives notice of the final decision unless otherwise specified in the notice.

(3) Notwithstanding other provisions of this subsection, for denials pursuant to §180.20(f)(1) of this title (relating to Commission Approved Doctor List), and for denials pursuant to §180.20(f)(3) of this title wherein the subsection of §180.26 of this title relied upon is subsection (b), and within five working days (as defined by §102.3(b) of this title (relating to Computation of Time)) after receiving the notice, the doctor may 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 commission shall review the response and shall notify the doctor of the commission's final decision. A final decision denying the doctor admission to the ADL shall provide the reason(s) why the doctor's response did not convince the commission to grant the doctor admission to the ADL. 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).

(5) The fact that the commission did not take action to deny admission to a doctor or admit a doctor with condition(s) or restriction(s) to the ADL does not waive the commission's right to review or further review a doctor and take action at a later date.

(h) Chapter 133 of this title (relating to Benefits - Medical Benefits) applies to all medical bills, including those from doctors who were not on the ADL at the time the health care was rendered.

(1) All licensed doctors, whether on the ADL or not, are entitled to reimbursement in accordance with the Statute and Rules for providing reasonable and necessary emergency or immediate post-injury medical care.

(2) A doctor is entitled to reimbursement in accordance with the doctor's level of Certificate of Registration and the Statute and Rules for directly or indirectly providing reasonable and necessary health care (other than emergency or immediate post-injury medical care) or other medical services (such as peer reviews or other evaluations) if:

(A) the doctor was on the ADL at the time the service was provided;

(B) the doctor was granted a temporary exception to the requirement to be on the ADL at the time the service was provided; or

(C) the doctor has been granted an exception on a case-by-case basis as provided in §180.23(b) of this title, and the claim for which the doctor is billing is one for which the doctor has been granted an exception.

(3) A doctor who is entitled to reimbursement based on paragraph (2)(A) and (B) of this subsection may perform medical services and bill for those services only after notification of such entitlement from the commission.

(4) A carrier who receives a bill from a doctor who is not entitled to reimbursement pursuant to paragraph (2) of this subsection shall deny the medical bill and send the required explanation of benefits (EOB) with the appropriate payment exception code.

(5) Notwithstanding this subsection, a doctor's entitlement to direct or indirect reimbursement for health care or medical opinions directly or indirectly provided (other than for emergency or immediate post-injury medical care) may be limited by sanction imposed by the commission.

(i) The commission shall make available through its Internet website the names, licensure and other identification information, and ADL or ADL exception status of:

(1) doctors who are not on the ADL because their applications were denied;

(2) doctors on the ADL (including a description of any privileges, conditions or restrictions placed on the doctor by the commission);

(3) doctors deleted or suspended from the ADL or otherwise sanctioned by the commission (including a description of the sanction);

(4) doctors reinstated to the ADL or whose sanctions were lifted by the commission; and

(5) doctors granted a temporary exception from the requirement to be on the ADL pursuant to subsection (e) of this section or on a case-by-case basis.

(j) Doctors who are on the ADL or who have applied to be on the ADL shall provide the commission with updated information within 30 days of a change in any of the information provided to the commission on the doctor's ADL application.

(k) Level 1 Certificates of Registration are valid for two years from date of issuance, and Level 2 Certificates of Registration are valid for four years from date of issuance unless the Certificate provides otherwise, the date is revised by agreed settlement pursuant to §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or Texas Government Code §2001.056 (relating to Informal Disposition of Contested Case), Commission order or decision, or the doctor has been removed from the ADL. Upon expiration of a doctor's Certificate of Registration, the doctor must reapply for the ADL.

The provisions of this §180.20 adopted to be effective March 14, 2002, 27 TexReg 181; amended to be effective June 5, 2003, 28 TexReg 4294; amended to be effective September 12, 2004, 29 TexReg 8613.

§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;

(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;

(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

(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

(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;

(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 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).

(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;

(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 subsection (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 heath 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

(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.

The provisions of this §180.21 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective June 5, 2003, 28 TexReg 4294; amended to be effective September 12, 2004, 29 TexReg 8613; amended to be effective August 16, 2006, 31 TexReg 6370.

§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;

(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;

(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);

(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:

(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 ~~a~~ 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.

(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, 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.

The provisions of this §180.22 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective August 16, 2006, 31 TexReg 6370.

§180.23. Commission Required Training for Doctors/Certificate of Registration Levels.

(a) This section identifies the training requirements for doctors to be approved to provide various services within the Texas workers' compensation system.

(b) The commission, in order to ensure that injured employees (employees) have access to health care and insurance carriers (carriers) have access to evaluations of an employee's health care and income benefit eligibility, may grant a doctor exceptions to certain training and registration requirements and may allow a doctor to perform functions not normally permitted by the doctor's Level of Certificate of Registration. Such exceptions may be granted on a per request, per case basis. When an exception is granted on a per request, per case basis, the commission shall provide a copy of the approval to the carrier.

(c) Doctors on the approved doctor list (ADL) shall have a Level 1 or Level 2 Certificate of Registration.

(1) A Level 1 Certificate of Registration allows a doctor to:

(A) infrequently provide health care to employees (providing care, other than emergency or immediate post-injury medical care, to 18 Texas workers' compensation claimants or fewer per calendar year);

(B) perform utilization review or peer review functions;

(C) participate in a regional network established under Texas Labor Code §408.0221; and/or

(D) provide medical services to an unlimited number of Texas workers' compensation claimants if the doctor's medical practice is Anesthesiology - Surgical Only (excludes pain management), Radiology, or Pathology and does not, by nature, include ongoing medical management of injured employees, and the doctor requests a Non-Medical Management designation. "However, this designation does not allow the doctor to perform any of the functions listed in subsection (c)(1)(B) of this section."

(2) A Level 2 Certificate of Registration allows a doctor to serve in any role authorized in the Texas workers' compensation system with the exception of serving as a designated doctor unless the doctor is also on the designated doctor list which is governed by §180.21 of this title (relating to the Commission Designated Doctor List).

(d) A doctor seeking admission to the ADL shall receive training from the commission and/or a commission-approved trainer.

(e) A person or organization seeking to become a commission-approved trainer shall apply for approval in the form and manner prescribed by the commission.

(f) For each doctor trained, the commission-approved trainer shall file or provide the doctor's training information in the form and manner prescribed by the commission.

(g) Notwithstanding any other subsection of this section:

(1) a doctor not licensed in this state shall not perform utilization reviews and/or peer reviews for an insurance carrier or its agent unless the doctor performs the reviews under the direction of a doctor who:

(A) is licensed in this state,

(B) is on the ADL with a Level 2 Certificate of Registration, and

(C) has agreed to direct the doctor's reviews; and

(2) the commission may restrict or reduce a doctor's privileges or authorizations as provided in the Statute or Rules.

(h) ADL approval at a minimum requires a doctor to successfully complete commission-prescribed training prior to admission and renewal at a minimum requires a doctor to successfully complete follow-up training as required.

(1) Required training shall focus on the requirements of the Texas workers' compensation system with an emphasis on return to work, efficient utilization of care, entitlement to benefits, maximum medical improvement (MMI), and the determination of the existence of permanent impairment.

(2) Training may be completed through either self-study/distance learning (including online) or by attending training in person, as available.

(3) Application for a Level 1 Certificate of Registration requires completing the Limited Participation Doctor Training Module or other training as prescribed by the Commission in the application form. Application for a Level 2 Certificate of Registration requires completing the Doctor Training Module.

(4) Renewal of a Level 1 Certificate of Registration requires follow-up training every two years and renewal of a Level 2 Certificate of Registration requires follow-up training every four years unless the Certificate provides otherwise, the date is revised by agreed settlement pursuant to §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or Texas Government Code §2001.056 (relating to Informal Disposition of Contested Case), Commission order or decision, or the doctor has been removed from the ADL. Follow-up training will serve as a refresher course but emphasize relevant changes in the Statute and Rules.

(i) This subsection governs authorization relating to certification of MMI, determination of permanent impairment, and assignment of impairment ratings in the event that a doctor finds permanent impairment exists when the examination of the employee occurs on or after September 1, 2003.

(1) Any doctor on the ADL, or who has been granted a temporary exception to be on the ADL pursuant to §180.20(e) or on a case-by-case basis, is authorized to determine whether an employee has permanent impairment resulting from a compensable injury. If the doctor finds that the employee does not have permanent impairment, the doctor is also authorized to certify the employee as reaching MMI.

(2) Full authorization to assign an impairment rating and certify MMI in an instance where the employee is found to have permanent impairment requires a doctor to receive commission certification by successfully completing the commission-prescribed Impairment Rating Training Module and passing the test. To remain certified, a doctor is required to successfully complete follow-up training and testing every four years.

(3) A doctor who has not completed the commission-prescribed training under subsection (i)(2) of this section but who has had similar training in the *AMA Guides* from a commission-approved vendor within the prior two years may submit the syllabus and training materials from that course to the commission for review. If the commission determines that the training is substantially the same as the commission-prescribed training and the doctor passes the commission-prescribed test, the doctor is fully authorized under this subsection. The ability to substitute training only applies to the initial training requirement, not the follow-up training.

(4) Notwithstanding any other provision of this subsection, a doctor who has not successfully completed training and testing required by this subsection for authorization to assign impairment ratings and certify MMI when there is permanent impairment may receive permission by exception to do so from the commission on a specific case basis.

(5) Full authorization under this section is one of the minimum requirements to be on the Designated Doctor List (DDL). Section 180.21 of this title governs DDL membership requirements and procedures.

The provisions of this §180.23 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective June 5, 2003, 28 TexReg 4294.

§180.24. Financial Disclosure.

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

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

(2) Financial interest means:

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

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

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

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

(1) If a health care practitioner refers an injured employee (employee) to another health care provider in which the health care practitioner has a financial interest, the health care practitioner shall file a disclosure with the commission within 30 days of the date the first referral is made unless the disclosure was previously made. This disclosure shall be filed for each health care provider to whom an employee is referred and shall include the information in subsection (b)(3) of this section.

(2) In addition, as a condition for a certificate of registration for the approved doctor list (ADL), the doctor shall file with the commission at the time of application for a certificate of registration for the ADL in accordance with §180.20 of this title (relating to Commission Approved Doctor List) a disclosure of financial interests of the doctor in the form and manner prescribed by the commission. Thereafter, a doctor registered on the ADL shall report to the commission within 30 days, on the doctor's own initiative, any changes in the information the doctor previously provided when applying for registration.

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

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

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

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

(c) Failure to disclose. On or after September 1, 2003, in addition to any penalties provided by the Statute and Rules, failure to disclose a financial interest when the health care practitioner had actual knowledge of the financial interest or acted in reckless disregard or deliberate ignorance as to the existence of the financial interest is subject to a penalty of forfeiture of the right to reimbursement for any services rendered on the claim during the period of noncompliance, regardless of whether the circumstances of the services themselves were subject to disclosure, and regardless of whether the services were medically necessary.

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

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

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

The provisions of this §180.24 adopted to be effective March 14, 2002, 27 TexReg 1817.

§180.25. Improper Inducements, Influence and Threats.

(a) Offering, paying, soliciting, or receiving an improper inducement relating to medical benefit delivery is prohibited as are improper attempts to influence medical benefit delivery, including through the making of improper threats. This section applies to all participants in the workers' compensation system and their agents.

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

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

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

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

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

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

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

(3) Except as provided by Texas Labor Code §408.0222, providing any financial incentive or promising or threatening to provide employee evaluation reports or other medical opinions that could enhance or reduce the employee's income benefits or affect the employee's work release status as an inducement to have the employee treat with or be evaluated by the provider or comply with the provider's proposed treatment.

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

(5) Intentionally, knowingly, or willfully making, presenting, filing, or threatening to make, present, or file any frivolous claim or assertion against a system participant, medical peer reviewer, or any other person performing duties arising under the Statute or Rules, with the commission or any licensing, certifying, regulatory, or investigatory body.

(6) Intentionally, knowingly, or willfully making or causing to be made a threat against life, safety, or property directed to a system participant related to their performance of duties arising under the Statute or Rules.

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

(d) Nothing in this section prohibits an employer or carrier from offering employees an incentive to obtain health care from doctors within an insurance carrier network established under Texas Labor Code §408.0223. However, such incentives shall not:

(1) limit the right of the employee to request the authority to select an alternate treating doctor under Texas Labor Code §408.023 (including to change to a doctor out of the network); or

(2) require the employee to give up entitlement to or refund the incentive the employer or carrier offered or provided to the employee during the period that the employee's treating doctor was within the network.

The provisions of this §180.25 adopted to be effective March 14, 2002, 27 TexReg 1817.

§180.26. Doctor and Insurance Carrier Sanctions.

(a) This section is in addition to and does not affect other sanctions provided by statute or by rules adopted under §415.023(b) or other Rules and it establishes:

(1) the grounds (conduct, actions, inactions, and events) that will require the Executive Director to delete a doctor from the Approved Doctor List (ADL);

(2) the grounds that allow the commission to delete a doctor from the ADL or otherwise issue a sanction against a carrier or doctor;

(3) the evidence the commission may consider as establishing the grounds to delete a doctor or issue a sanction (including the evidence that conclusively establishes the grounds) ; and

(4) the types of sanctions the commission may recommend or impose.

(b) The Executive Director shall delete from the ADL a doctor:

(1) who fails to meet the registration and certification requirements (which also includes required testing/training) of §180.20 of this title (relating to Commission Approved Doctor List);

(2) who is deceased;

(3) who requests to be removed from the ADL; or

(4) whose license to practice in this state is revoked, suspended, or not renewed by the appropriate licensing or certification authority. This includes, but is not limited to, suspensions or revocations that are stayed, deferred, or probated and voluntarily relinquishment of the license to practice.

(c) Except as provided by subsection (e) of this section, the Medical Advisor (as defined by Texas Labor Code §413.0511) shall recommend deletion of a doctor from the ADL if any of the following occurs:

(1) significant violation(s) of the Statute, Rules, or a commission decision or order or agreement including, but not limited to:

(A) committing a willful or intentional violation(s) of the Statute, Rules, or a commission decision or order or agreement;

(B) having an uncorrected pattern of practice of violating the Statute, Rules, or commission decisions or orders or agreements;

(2) significant violation of other statutes or regulations not administered by the commission but relevant to the provision of and payments for health care including, but not limited to:

(A) committing an offense that results in the doctor being sanctioned by the Medicare or Medicaid program;

(B) being convicted of a violation of state or federal statutes relating to:

(i) dangerous drugs, controlled substances, or any other drug-related offense;

(ii) fraud;

(iii) moral turpitude; or

(iv) conduct that either resulted in physical harm to or otherwise endangered a person;

(C) committing an act that results in suspension, revocation of license, or issuance of a practice restriction(s) or other limitation(s) by the appropriate licensing or certification authority (even if stayed, deferred, or probated);

(D) being convicted of a criminal offense that indicates an unwillingness or inability to provide quality treatment or to abide by the Statute, Rules or a commission decision or order;

(3) professional failure to practice medicine or provide health care, including chiropractic care, in an acceptable manner consistent with the public health, safety, and welfare, including but not limited to:

(A) engaging in any negligent practice resulting in death, significant injury, or substantial probability of death or significant injury to the provider's patient(s);

(B) providing substandard clinical care as evidenced by:

(i) excessive or deficient care;

(ii) an excessive complication rate such as having to repeat surgeries or treat post-operative infections in excess of relevant benchmarks;

(iii) practicing beyond the doctor's scope of licensure or certification; or

(iv) having three or more final adverse malpractice judgments against the doctor during the doctor's career;

(C) having an uncorrected pattern of practice of failing to timely and appropriately release employees to return to work as compared to relevant benchmarks or based upon the work release guidelines adopted by the commission;

(D) being excluded or removed from participation in other health plans for cause;

(E) losing hospital privileges for cause;

(F) abusing drugs, alcohol, or other substances;

(G) having a medical or other condition that impacts the doctor's judgment or ability to safely practice medicine;

(H) willfully over-prescribing potentially dangerous medications such as narcotics or doing so as a pattern of practice;

(4) having a significant (uncorrected or willful) pattern of practice relating to the delivery or evaluation of health care that the commission finds is not fair and reasonable or that the commission determines does not meet professionally recognized standards of health care including, but not limited to:

(A) having unjustifiable differences between the doctor's diagnoses or treatments and acceptable standards of care;

(B) having unjustifiable differences between the doctor's billing practices and the commission's Rules or Fee Guidelines such as by submitting medical bills that demonstrate a pattern of practice of inappropriate coding or which is abusive or violates Rules and Guidelines, including but not limited to, such practices as upcoding and unbundling as defined in §133.1 (relating to Definitions for chapter 133) and that, if relied upon by the carrier, has the potential of unlawfully increasing the doctor's reimbursement;

(C) administering improper, unreasonable, or medically unnecessary health care and/or seeking approval for same;

(D) failing to fulfill responsibilities set out in §180.22 of this title (relating to Health Care Provider Roles and Responsibilities);

(E) submitting medical bills that demonstrate a pattern of practice of coding or billing for noncompensable injuries, conditions, or body areas;

(F) improperly or unjustifiably denying requests for preauthorization or concurrent review or issuing peer review or utilization review opinions improperly or unjustifiably denying payment for reasonable and necessary health care (as evidenced by denial rates significantly higher than relevant benchmarks);

(G) certifying Maximum Medical Improvement (MMI) and/or assigning impairment ratings in violation of the Statute and Rules, including, but not limited to, not complying with the applicable *AMA Guides* when assigning an impairment rating;

(H) making improper or unjustifiable recommendations regarding the reasonableness and medical necessity of care provided or proposed to be provided to an employee;

(I) making unnecessary referrals;

(5) dishonest conduct including but not limited to:

(A) submitting a false statement or misrepresentation, or omitting pertinent facts when claiming payment under the Texas Workers' Compensation Act or when supplying information used to determine the right to payment under the Texas Workers' Compensation Act;

(B) submitting a false statement, incorrect information, or misrepresentation, or omitting pertinent facts that, if relied upon by the carrier, has the potential of unlawfully increasing the doctor's reimbursement;

(C) submitting a false statement, incorrect information, or misrepresentation, or omitting pertinent facts that, if relied upon by the insurance carrier, has the potential to result in approval of requests for health care that is not reasonable and necessary or the denial of health care that is reasonable and necessary;

(D) submitting a false statement or misrepresentation or omitting pertinent facts to the commission that could affect the commission's decision to:

(i) include the doctor on the ADL (per §180.20 of this title);

(ii) certify the doctor for a specific certification level (per §180.23 of this title (relating to commission Approved Training for Doctors /Certification Levels)); or

(iii) otherwise allow the doctor to provide health care in the Texas workers' compensation system;

(E) practicing without credentials or practicing with falsified credentials;

(6) refusing to refund monies improperly paid to the doctor in compliance with an order; or

(7) other activities that warrant deletion.

(d) The Medical Advisor may recommend a sanction against a doctor or a carrier or the deletion or suspension of a doctor from the ADL if any of the following occurs:

(1) violation of the Statute, Rules, or a commission decision or order or agreement;

(2) violation of other statutes or regulations not administered by the commission but relevant to the provision of and payments for health care;

(3) conduct relating to the delivery, evaluation, or remuneration of health care that the commission finds is not fair and reasonable or that the commission determines does not meet professionally recognized standards of health care;

(4) refusing to pay monies owed under the Statute or Rules to a health care provider for reasonable and necessary health care related to the compensable injury; or

(5) other activities that warrant sanction.

(e) A carrier or doctor (sanctionee) may enter into a progressive disciplinary agreement with the commission if the commission believes such an agreement will achieve the goals of improving medical quality and cost containment in the Texas workers' compensation system. An agreement reached under this section may be entered into before or after formal notification under §180.27 of this title (relating to Sanctions Process/Appeals/Restoration/Reinstatement) and:

(1) may include any sanction(s) authorized by the Statute and Rules or agreed to by the commission and the sanctionee;

(2) shall include a description of the action(s)/behavior(s) which was the grounds for the sanction(s) and not include language in which the sanctionee denies the grounds,

(3) shall describe: what sanction(s) was agreed upon, the duration of the agreement, the specific goal(s) of the agreement, the way that progress towards the goal(s) shall be measured, and the consequences of failing to meet the goals or breaking the agreement; and

(4) shall provide that the sanctionee shall pay the commission for costs associated with:

(A) the review that resulted in the sanction; and

(B) monitoring compliance with the agreement and the progress towards the goal(s) of the agreement.

(f) The evidence the commission may consider to establish the grounds for the recommendation or imposition of a sanction of a carrier or doctor or the suspension or the deletion of a doctor from the ADL or designated doctor list (DDL) include, but are not limited to:

(1) the findings of fact and legal conclusions made by a federal, state, or local court, an administrative law judge, an Independent Review Organization (whether considering a Texas workers' compensation matter or a matter from another health care system), or appropriate licensing, certification, or regulatory authority on a matter in which the doctor or carrier was, or had the opportunity to be, a party;

(2) a plea of guilty or nolo contendere (no contest) by the carrier or doctor that has been accepted by a federal, state, or local court, an administrative law judge, an Independent Review Organization (whether considering a Texas workers' compensation matter or matter from another health care system), or appropriate licensing, certification, or regulatory authority;

(3) the findings of experts working for or with the commission to evaluate a doctor or carrier (this includes, but is not limited to, members of the Medical Quality Review Panel or an Independent Review Organization);

(4) the stipulations of an agreement entered into by the carrier or doctor whom the commission is sanctioning (even if the agreement is not with the commission); or

(5) information or documentation from:

(A) the commission's records;

(B) the records of an appropriate licensing or certification authority;

(C) the records of another regulatory or law enforcement authority; or

(D) the records of a system participant or the general public.

(g) The existence of a finding, conclusion, plea, or stipulation under subsections (f)(1), (2), or (4) of this section that establishes the existence of grounds for sanction, deletion, or suspension under this section is conclusive evidence until and unless the finding, conclusion, plea, or stipulation is subsequently overturned.

(h) The sanctions that the commission may recommend or impose against a doctor or carrier under this section include, but are not limited to:

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

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

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

(4) deletion or suspension from the ADL and/or DDL;

(5) restrictions on appointment (such as reducing the roles the doctor is allowed to play in a claim or reducing the number of workers' compensation claimants the doctor will be allowed to treat except in an emergency);

(6) conditions or restrictions on a carrier regarding actions by carriers under the Statute and Rules in accordance with a memorandum of understanding adopted between the commission and the Texas Department of Insurance regarding Article 21.58A, Insurance Code; and

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

(i) A doctor who has been deleted or suspended from the ADL shall not directly or indirectly provide services under the Statute or Rules (other than emergency or immediate post-injury medical care) or receive direct or indirect remuneration under the Statute or Rules while suspended or deleted and shall, within seven days of deletion or suspension, notify all employees the doctor is treating that they must receive health care from a different doctor.

The provisions of this §180.26 adopted to be effective March 14, 2002, 27 TexReg 1817.

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

(a) If the commission intends to take action under §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or action against a designated doctor under §180.21 of this title (relating to Commission Designated Doctor List), other than in the case where a progressive disciplinary agreement under §180.26(e) of this title was entered into, the commission shall notify the person ("person" also includes a carrier) to be sanctioned by verifiable means of the commission's intent.

(1) Not later than 20 days after receiving the notice, a doctor may request a hearing at the State Office of Administrative Hearings by filing such a request with the Chief Clerk of Proceedings at the commission.

(2) If no request for hearing is filed within the time allowed, the recommendation for sanction will be reviewed by the commissioners at a public meeting and a decision made. If a hearing was held, the commissioners shall review the decision of the administrative law judge (ALJ) after the hearing is held.

(b) If the commission modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the ALJ, the commission's final order shall state the legal basis and the specific reasons for the change.

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

(d) Failure to comply with the sanction may result in further sanctioning by the commission.

(e) A person who was sanctioned can apply to have the sanction lifted (whether through restoration of privileges or recertification) by applying in the form and manner prescribed by the commission.

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

(A) If, in the Medical Advisor's opinion, the person has all the appropriate unrestricted licenses/certifications, has overcome the conditions that resulted in sanction, and should be reinstated, the Medical Advisor shall recommend that the commissioners reinstate the doctor or restore the privileges removed or restricted by the sanction.

(B) If, in the Medical Advisor's opinion, the person has not met the requirements for reinstatement or restoration of privileges, the commission shall notify the person by verifiable means of the intent to recommend to the commissioners that the sanctions not be lifted. Within 15 days after receiving the notice, a doctor may file a response that addresses the reasons given that the recommendation was to be made. The Medical Advisor shall review the response and make a final recommendation to the commissioners. A copy of the requestor's response to the commission shall be provided to the commissioners for consideration.

(2) The commissioners shall consider the matter in a public meeting and shall notify the requestor by verifiable means with a copy to the appropriate licensing or certification authority. If the commissioners choose to not lift the sanction, the commissioners may include in their final decision the conditions that the sanctioned person must meet before the commission will reconsider lifting the sanctions including, but not limited to, the amount of time that the person must wait prior to rerequesting lifting the sanction.

(f) Notwithstanding any other provision of this section, deletion from the Approved Doctor List by the Executive Director pursuant to §180.26(b) of this title shall be governed by this subsection.

(1) Prior to deletion, the Executive Director or designee shall notify a doctor of the intention to delete the doctor and the grounds for that action.

(2) Within five working days (as defined by §102.3(b) of this title (relating to Computation of Time)) after receiving the notice of intent, a doctor may file a response to the reasons given as grounds for the deletion with the Executive Director or designee.

(A) If a response is not received by the fifth working day after the date the doctor received the notice of intent, the doctor shall be deleted effective the following day. No subsequent notice shall be sent.

(B) If the response is agreement, the doctor shall be deleted effective on the earlier of the date the doctor agrees to the deletion or the day following the fifth working day after the date the doctor received the notice of intent. No subsequent notice shall be sent.

(C) If a response which disagrees with the grounds for deletion is timely received and after reviewing the response, the Executive Director or designee determines:

(i) that the grounds do not exist for deletion under §180.26(b) of this title, the doctor shall be notified that he was not deleted; or

(ii) that the grounds for deletion do exist under §180.26(b) of this title, the doctor shall be deleted effective the day following the date the doctor receives notice of the deletion unless otherwise specified in the notice.

(3) 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).

The provisions of this §180.27 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective September 12, 2004, 29 TexReg 8613.

§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;

(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:

(1) non-compliance with the provisions of §180.22 of this title (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.

The provisions of this §180.28 adopted to be effective August 16, 2006, 31 TexReg 6370.