

TITLE 28. INSURANCE

**PART 2. TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION**

CHAPTER 127: DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS

**SUBCHAPTER A: DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS
AMEND: §§127.1, 127.5, 127.10, 127.20, and 127.25**

**SUBCHAPTER B: DESIGNATED DOCTOR CERTIFICATION, RECERTIFICATION, AND
QUALIFICATIONS
NEW: §§127.100, 127.110, 127.120, 127.130, and 127.140**

**SUBCHAPTER C: DESIGNATED DOCTOR DUTIES AND RESPONSIBILITIES
NEW: §§127.200, 127.210, and 127.220**

1. INTRODUCTION.

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §§127.1, 127.5, 127.10, 127.20, and 127.25 under Subchapter A, Chapter 127 of this title (relating to Designated Doctor Scheduling and Examinations), and adopts new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 under new Subchapters B and C, Chapter 127 of this title (relating to Designated Doctor Certification, Recertification, and Qualifications and Designated Doctor Duties and Responsibilities, respectively). These sections are adopted with changes to the proposed text as published in the February 24, 2012 issue of the *Texas Register* (37 TexReg 1140) and will be republished. These new and amended sections primarily implement the amendments made to Labor Code §408.0041 and §408.1225 made by House Bill 2605, 82nd Legislature, Regular Session, effective September 1, 2011 (HB 2605). Additionally, these new and amended sections also recodify the provisions of repealed §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings) and repealed §180.21 of this title (relating to Division Designated Doctor List). The repeals of §130.6 of this title and §180.21 of this title are published

elsewhere in this issue of the *Texas Register*. Lastly, these new and amended sections also clarify or improve a number of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling, certification, and examination process.

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

An informal draft of these new and amended sections was published on the Division's website from October 14, 2011 to November 4, 2011, and the Division received 78 informal comments on the draft. Additionally, the Division posted an informal draft of proposed new §127.130(b) on its website from December 17, 2011 to January 11, 2012, and the Division received 29 comments on this draft. Subsequent changes were made to the drafts based on the informal comments received on these drafts, and these new and amended sections were formally proposed in the *Texas Register* on February 24, 2012. A public hearing for this formal proposal was held on March 26, 2012. The public comment period closed on March 26, 2012, and the Division received 34 public comments.

2. REASONED JUSTIFICATION.

HB 2605 added several amendments to §408.0041 and §408.1225 of the Labor Code that will substantially affect the Division's regulation of designated doctors in the workers' compensation system. First, HB 2605 amended Labor Code §408.1225(a-1) - (a-5) and §408.1225(b-2) to specifically require the Division to develop a certification and recertification process for designated

doctors, including adopting eligibility requirements specific to designated doctor duties under Labor Code §408.0041 and adopting standardized training and testing for designated doctors. Second, HB 2605 amended Labor Code §408.1225(f) to require designated doctors to continue providing services related to a claim assigned to the designated doctor, including performing subsequent examinations and acting as a resource for Division disputes, unless the Division authorizes the designated doctor to stop providing services on the claim. Lastly, HB 2605 amended Labor Code §408.0041(b) and (b-1): (1) to require that, except as provided by Labor Code §408.1225(f), a medical examination under Labor Code §408.0041 shall be performed by the next designated doctor on the Division's list of certified designated doctors whose credentials are appropriate for the area of the body affected by the injury and the injured employee's diagnosis; and (2) to provide that if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. The Division has adopted these amended and new sections primarily in response to these amendments as described below.

The Division has also recodified portions of §130.6 of this title and §180.21 of this title, in part, to implement the amendments made by HB 2605 described above. The Division has also elected to recodify these two sections to ensure that substantially all rules applicable to designated doctors and designated doctor examinations can be found in Chapter 127. This recodification enhances the usability and logical structure of the Division's framework for designated doctor regulation, and, furthermore, it harmonizes with the rationale of the Division's similar recodification of former §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures) into §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25 of this title published in the December 17, 2010, issue of the *Texas Register* (35 TexReg 11324). A description of the recodified provisions of §130.6

and §180.21 of this title is provided below, and the repeals of these sections are published elsewhere in this issue of the *Texas Register*.

The Division has also adopted new and amended sections that will clarify or improve a number of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling, certification, and examination process. These new or amended sections are described throughout this proposal and include, but are not limited to, a clarification of Division requirements for all designated doctor examination narrative reports, a new Designated Doctor Examination Data Report to be filed after certain examinations, and limitations on the availability of designated doctor examinations for claims on which the insurance carrier has denied compensability or otherwise denied liability. A complete description of these changes and other new or amended sections is provided below.

Additionally, there have also been nonsubstantive amendments made to these sections to conform to current nomenclature, reformatting, consistency, clarity, editorial reasons, and to correct typographical and/or grammatical errors in respect to the recodified language from proposed repeals of §130.6 and §180.21 of this title.

The Division also adopts these new and amended sections with several changes, all made in response to public comment, from the amendments and new sections formally proposed on February 24, 2012. First, in response to multiple comments, the Division has also deleted "or claimed to be compensable by the injured employee and not disputed by the insurance carrier" from §127.1(b)(4) and from §127.220(c)(2), because this phrase is vague and would likely create administrative confusion for the Division and system participants.

The Division, in response to comment, has also replaced the §127.1(b)(8) requirement that requestors report the dates and names of the examining designated doctors for all previous

designated doctor examinations on an injured employee's claim with a requirement that requestors provide "the date of the most recent examination and the name of the examining designated doctor." The Division believes this change strikes an equitable balance, because information regarding the most recent designated doctor examination assists the Division in determining if the presently requested examination would occur within 60 days of the previous examination. The Division agrees, however, that information regarding examinations before the most recent examination is unnecessary and has, therefore, made this change.

The Division has also, in response to comment, chosen not to delete "below" from §127.1(b)(11) of this title. The deletion of "below" was intended to be a non-substantive change, but, in light of the commenter's request, the Division will leave the preposition in this subsection for clarity.

The Division has also, in response to comment, deleted "or an examination regarding the causation of the claimed injury" from §127.1(b)(11)(C). This clarifying change is necessary because causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

The Division has also, in response to comment, amended §127.1(d) of this title to provide "[t]he division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor." This amendment simply codifies the Division's current practice of sending requestors written denials of their requests for designated doctor examination that explain the reasons for the denial.

The Division has also, in response to multiple comments, deleted proposed §127.1(d)(4) and adopts new §127.1(d)(4) that states that the Division will deny a request for a designated doctor examination "if the insurance carrier has denied the compensability of the claim or otherwise denied

liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved.” Additionally, the Division has deleted §127.1(d)(5), because its requirements became redundant in light of the adopted change to §127.1(d)(4). The Division has also added a new §127.1(e) and recodified former §127.1(e) as §127.1(f) of this title. New §127.1(e) provides that “If a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.” The Division believes that these changes to §127.1(d)(4) and new §127.1(e) create the optimal balance between limiting the costs imposed upon insurance carriers to pay for unnecessary examination and delays in the dispute resolution process imposed by these unnecessary examinations and the need to ensure that the Division has access to sufficient expert medical opinions to properly resolve the issue of medical causation in a compensability dispute.

The Division has also, in response to comment, made a change to §127.1(f) of this title (formerly codified as §127.1(e) of this title). Specifically, the Division has modified the deadline for parties seeking expedited proceedings and the stay of an ordered examination to file their request for expedited proceedings with the division from “within three days” to “within three working days” of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). The Division believes this change is necessary to ensure that parties will not be unduly burdened by being required to submit these requests on weekends or national holidays.

The Division has also, in response to comment, changed §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations). Specifically, the Division has deleted “shall not conduct the examination” and added “If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records.” These changes are necessary to prevent unnecessary cancellations by ensuring designated doctors and injured employees still have the flexibility and discretion to perform the originally scheduled examination if the designated doctor receives the missing medical records promptly while also providing designated doctors the option to cancel that examination and reschedule if the medical records arrive too late for the designated doctor to review them.

The Division has also, in response to comment, changed §127.10(h) of this title to provide that if a designated doctor provides multiple certifications of maximum medical improvement (MMI) and/or impairment ratings (IR) under §127.10(d) “because the designated doctor was also ordered to address the extent of the injured employee’s compensable injury,” the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. This change is necessary to clarify that this language only applies if multiple certifications were provided when required under §127.10(d), specifically when the designated doctor is ordered by the Division to address extent of injury as well as MMI/IR.

The Division has also, in response to multiple comments, made a change to §127.20(a) of this title (relating to Requesting a Letter of Clarification Regarding Designated Doctor Reports). Specifically, the Division has deleted the proposed language that stated “The division will not approve a request that asks a designated doctor to reconsider the doctor’s decision or to issue a

new or amended decision unless the designated doctor failed to address an issue the designated doctor was ordered to address. Additionally, a designated doctor shall not reconsider the doctor's decision or issue a new or amended decision in response to a request for clarification unless the designated doctor failed to address an issue the designated doctor was ordered to address." The Division has replaced this deleted language with the following provision: "Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision." The Division believes that this change is necessary because the Division acknowledges and agrees that in some cases permitting a designated doctor to correct an error in the doctor's report would expedite the dispute resolution process or curtail unnecessary litigation costs. Still, the Division also believes that designated doctors should only make these changes when the request for clarification submitted to them by the Division asks or permits them to do so. The Division, therefore, has elected to adopt this standard, currently implemented by the Division, to ensure that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution while still providing the Division the necessary discretion to monitor the quality and appropriateness of the requests and the authority to limit a designated doctor's responses to the request for clarification submitted to the doctor.

The Division has also, in response to comment, made two changes to §127.25 of this title (relating to Failure to Attend a Designated Doctor Examination). Specifically, the Division has deleted "after the insurance carrier suspends TIBs pursuant to this section" from both §127.25(c) and §127.25(d), because this phrase is unnecessary in these provisions and imposes an undue burden

on designated doctors who will not know if an injured employee's temporary income benefits have been suspended or not.

The Division has also, in response to multiple comments, made a change to §127.100(a)(4) of this title (relating to Designated Doctor Certification). Specifically, the Division has elected to retain its current standard that a doctor applying for certification as a designated doctor must "have maintained an active practice for at least three years during the doctor's career." The Division believes this requirement sufficiently ensures that the doctor will have appropriate clinical knowledge to perform a physical examination while the Division's new training, testing, and certification standards will suffice to ensure that an applicant for certification has the necessary aptitude to address all issues that may be presented to a designated doctor.

The Division has also, in response to comment, made a change to §127.110(a)(3). Specifically, the Division has deleted the requirement that designated doctors who fail to inform the Division that they do not wish to remain certified as designated doctors prior the expiration of their current certification commit an administrative violation. The Division has replaced this requirement with the requirement that "a designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status." These changes are necessary to ensure that designated doctors voluntarily exiting the designated doctor program may do so with minimal administrative burden while still ensuring that designated doctors who seek recertification must do so in a timely fashion.

The Division has also, in response to comment, made a change to §127.110(c) of this title (relating to Designated Doctor Recertification). Specifically, the Division has changed §127.110(c) to

provide that though the Division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the division fails to receive the required information in §127.110(b)(1) - (3) from the designated doctor before that time, "the designated doctor may still provide services on claims to which the designated doctor had been previously assigned." The Division believes this change is appropriate to ensure that even though a designated doctor is delinquent in filing the doctor's application for recertification, the doctor is still available to perform services on claims to which the designated doctor had already been assigned, such as responding to requests for clarification or performing reexaminations. The Division has further changed this section, in response to comment, by deleting the requirement that designated doctor inform the Division that they will not be seeking recertification as a designated doctor at least 45 days prior to the expiration of the designated doctor's certification. The Division has clarified the remaining language to provide "A designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation." These changes are necessary to ensure that designated doctors voluntarily exiting the designated doctor program may do so with minimal administrative burden while still ensuring that designated doctors who seek recertification must do so in a timely fashion. The Division notes that it has also changed §127.220(a)(5) in response to the same comment to clarify that only a designated doctor who wishes to stop practicing as designated doctor before the doctor's current certification as a designated doctor expires must provide the Division with written notice in advance of their voluntary exit from the designated doctor program. This change is necessary to clarify that this requirement does not apply to designated doctor who will simply not be renewing their certification as a designated doctor but intends to practice as a designated doctor for the duration of doctor's current certification.

The Division has also, in response to multiple comments, made a change to §127.110(e). Specifically, the Division has added “requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing” as an express reason for possible denial of a designated doctor’s recertification. The Division believes that this clarifying change is appropriate, because while the Division could have already denied a designated doctor application for recertification for this reason under §127.110(e)(5), adding this reason as an express provision provides better notice to system participants of the emphasis the Division will place on this factor.

The Division has also, in response to multiple comments, made a change to §127.130(b)(7) and §127.130(b)(8)(E) of this title (relating to Qualification Standards for Designated Doctor Examinations). Specifically, the Division has moved the diagnosis “tendon lacerations” and the diagnosis “dislocations” from §127.130(b)(8)(E) to §127.130(b)(7). The Division has made this change because it has determined that board certification is not required to examine these issues, because these diagnoses are frequently treated and evaluated by all physicians in the workers’ compensation system and, therefore, any licensed medical doctor or doctor of osteopathy appropriately trained as a designated doctor should be able to evaluate these diagnoses.

The Division has also, in response to comment, made a change to §127.130(b)(8)(A). Specifically, the Division has included physicians board certified in physical medicine and rehabilitation in the list of qualified providers under this subsection, because the Division has determined that these physicians would also be appropriately trained and qualified to evaluate traumatic brain injuries under this subsection. Doctors board certified in physical medicine and rehabilitation are frequently in charge of treating patients with traumatic brain injuries in the subacute and chronic phase of these injuries and also have extensive neurological training.

The Division has also, in response to comment, made a change to §127.130(b)(8)(C). Specifically, the Division has included physicians who are board certified in surgery in the list of qualified providers under subsection, because the Division has determined that these physicians would also be appropriately trained and qualified to evaluate severe burns under this subsection.

The Division has also, in response multiple comments, made a change to §127.200(a)(14) of this title (relating to Duties of Designated Doctor). Specifically, the Division has removed the requirement that designated doctors must present photo identification to an injured employee upon request because of concerns raised by commenters that this practice would unnecessarily reveal personal information regarding the designated doctor to the injured employee.

The Division has also, in response to comment, made a change to §127.210(a)(3) of this title (relating to Designated Doctor Administrative Violations). Specifically, the Division has clarified that a designated doctor is only prohibited from refusing to accept or perform a Division offered appointment or ordered appointment that relates to claim on which the designated doctor has previously performed an examination, not simply been assigned. This change clarifies that designated doctors are only considered bound to claims if the designated doctor actually performs an examination on the claim. If a designated doctor is simply assigned but the initial examination fails to occur that designated doctor is not bound to the claim for purposes of this subsection.

The Division has also, in response to comment, made a change to §127.220(a)(5) of this title (relating to Designated Doctor Reports). Specifically, the Division has deleted the requirement that designated doctor include “the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable” in their narrative reports. The Division has deleted this

requirement because for most examinations this information will either be reported on the DWC-032, the DWC-068, or both, and, therefore, is not necessary in a designated doctor's narrative report.

The Division has also, in response to comment, deleted the requirement that designated doctors include the time the examination began from §127.220(a)(6) of this title. The Division believes that this information is unnecessary, particularly in light of the timing requirement of §127.220(a)(8).

Lastly, the Division has added a delayed effective date of September 1, 2012 to each adopted rule. The Division believes this delayed effective date is necessary to ensure that system participants receive sufficient time to prepare for the extensive changes adopted by these rules that will become effective before January 1, 2013. The extended effective date is incorporated into the following adopted sections: §§127.1(g), 127.5(f), 127.10(k), 127.20(f), 127.25(g), 127.100(h), 127.110(h), 127.120(b), 127.130(i), 127.140(g), 127.200(c), 127.210(d), and 127.220(d).

3. HOW THESE SECTIONS WILL FUNCTION.

Amended §127.1.

Amended subsection (b)(3) replaces "medical condition and type of health care the injured employee is currently receiving" with "diagnosis or diagnoses and part of the body affected by the injury." This change is necessary to comply with the similar amendment made by HB 2605 to Labor Code §408.0041(b) described above. The Division has also deleted "or claimed to be compensable by the injured employee and not disputed by the insurance carrier" from amended §127.1(b)(4) because this phrase is vague and would likely create administrative confusion for the Division and system participants.

Amended subsection (b)(5) deletes the requirement that a person requesting a designated doctor examination include the injured employee's statutory date of maximum medical improvement (MMI) in every request for a designated doctor examination; instead, requestors will only need to

include this information when requesting an MMI examination under amended subsection (b)(11)(A). New subsection (b)(6) and (7) require requestors to, respectively, identify the workers' compensation health care network certified under Chapter 1305, Insurance Code through which the injured employee is receiving treatment, if applicable, or to identify whether the claim involves medical benefits provided through a political subdivision under Labor Code §504.053(b)(2) and the name of the health plan, if applicable. These new paragraphs are necessary to assist the Division, designated doctors, and all other parties in determining whether a designated doctor has any disqualifying associations relevant to the injured employee's claim.

Amended subsection (b)(8) provides that requestors must also state whether the injured employee has attended any other designated doctor examinations on this claim and, if so, the date of the most recent examination and the name of the examining designated doctor. The Division believes this amendment strikes an equitable balance, because information regarding the most recent designated doctor examination assists the Division in determining if the requested examination would occur within 60 days of the previous examination. But the Division agrees, however, that information regarding examination before the most recent examination is unnecessary and has therefore made this change.

New subsection (b)(10) requires a person requesting a designated doctor examination to submit the request to the Division and a copy of the request to each other party listed in subsection (a) of this section. This new subsection is necessary to provide non-requesting parties increased opportunity and information to dispute the examination or selected designated doctor should the Division approve the request.

Amended subsection (b)(11)(A) requires requestors to submit the injured employee's statutory date of MMI when requesting an MMI examination and deletes the requirement that requestors

submit the dates of MMI, if any, other than statutory MMI date; the date of certification of MMI, if any; the name of the certifying doctor, if any, and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor. Amended subsection (b)(11)(B) requires a person who requests an impairment rating (IR) examination to provide the date of MMI that has been determined to be valid by a final decision of Division or court or by agreement of the parties, if any, and deletes the requirement that requestors submit the date of certification of MMI and prior assigned impairment rating, if any, and the name of the certifying doctor, if any; and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor. These amendments are necessary to ensure that designated doctors receive only necessary information that is not in dispute when accepting and performing a designated doctor examination.

Amended subsection (b)(11)(C) deletes "or an examination regarding the causation of the claimed injury." This clarifying change is necessary because causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

Amended subsection (b)(11)(E) provides that if requestors seek an examination regarding the injured employee's ability to return to work in any capacity and what activities the injured employee can perform, the requestors only need to include the beginning and ending dates for the periods to be addressed if the requestor is requesting the designated doctor to examine the injured employee's work status at a time other than the present. Amended subsection (b)(11)(E) also deletes the requirement that requestors submit a job description for job offers the employer intends to offer the injured employee. These amendments are necessary to minimize costs and administrative processes by only requiring information to be submitted in a request that a designated doctor needs to complete the doctor's examination.

Amended subsection (b)(11)(F) clarifies that if a requestor seeks an examination to determine whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, the requestor must include in the request the beginning and ending dates for the qualifying periods to be addressed. Previously, this provision did not state that only “qualifying” periods were to be addressed by the designated doctor, and this clarification is necessary to ensure designated doctors only making return-to-work determinations under this subsection for “qualifying periods” as that term is defined by §130.101(4) of this title (relating to Definitions).

Amended subsection (d) provides that “[t]he division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor” This amendment simply codifies the Division’s current practice of sending requestors written denials of their requests for designated doctor examination that explain the reasons for the denial.

Amended subsection (d)(4) provides that the Division will deny a request for a designated doctor examination “if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved.” Additionally, amended subsection (e) provides that “If a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.” The Division believes that these changes to §127.1(d)(4) and new §127.1(e) create the optimal balance between limiting costs imposed upon insurance carriers and delays in the dispute resolution process and the need to

ensure that the Division has access to sufficient expert medical opinions to properly resolve the issue of causation in a compensability dispute.

New subsection (f) provides that parties may not dispute a designated doctor examination request or any information on the request until the Division has either approved or denied the request. This amendment clarifies that though pursuant to amended subsection (b)(10) requestors will submit their designated doctor requests to all other parties in addition to the Division, the Division only intends for parties to use these exchanged requests to inform their disputes regarding Division action on the request. The Division will not, therefore, hear disputes regarding the information provided on a request until it has either approved or denied the request, because such a dispute is not ripe for adjudication before the Division.

New subsection (f) also provides that parties may request an expedited contested case hearing for denied requests for a designated doctor examination in addition to approved requests. This amendment clarifies requestors' preexisting right to dispute these denials in an expedited contested case hearing under Chapter 410, Labor Code and Chapter 140 of this title (relating to Dispute Resolution--General Provisions). Additionally, new subsection (f) provides that the Division will only automatically stay a designated doctor examination if a request for the stay and expedited proceedings is timely received and approved.

Lastly, new subsection (f) has modified the deadline for parties seeking expedited proceedings and the stay of an ordered examination to file their request for expedited proceedings with the division from "within three days" to "within three working days" of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). The Division believes this change is necessary to ensure that parties will not be unduly burdened by being required to submit these requests on weekends or national holidays.

Amended §127.5.

Amended subsection (c)(2) deletes the current provision that states that a designated doctor is available to perform an initial examination on a claim if the designated doctor has credentials appropriate to the issue in question, the injured employee's medical condition, and as required by Labor Code §§408.0043, 408.0044, 408.0045, and applicable rules. Amended subsection (c)(2) replaces this language with "is appropriately qualified to perform the examination in accordance with §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations)." This change is necessary to correspond with new §127.130, which addresses the appropriate qualifications for designated doctors performing examinations.

Amended subsection (c)(3) provides that the Division will only select a designated doctor to perform an initial examination of an injured employee if, among other factors, the designated doctor has not failed to timely file for recertification under new §127.110, if applicable. This amendment is necessary to correspond with new §127.110(a) - (c), which provide that the Division shall not offer any new examinations to a designated doctor who fails to file materials required for recertification within the timeframes required by those subsections.

Amended subsection (d) provides that if the Division has previously assigned a designated doctor to the claim at the time a request is made, the Division shall use that doctor again unless the Division has authorized or required the doctor to stop providing services on the claim in accordance with new §127.130. This amendment is necessary to correspond with new §127.130(e) - (g), which provide the circumstances under which the Division may authorize or compel a designated doctor to stop providing services on a claim to which the designated doctor had been previously assigned.

Amended subsection (e) provides that if both the designated doctor and the injured employee agree to reschedule the examination, the rescheduled examination shall be set to occur no later than 21 days after the date of the originally scheduled examination and may not be rescheduled to occur

before the originally scheduled examination. This amendment is necessary to clarify that designated doctor examination dates or times may only be rescheduled through an agreement between the designated doctor and the injured employee and also to ensure that examinations are not rescheduled to occur before the originally ordered examination. Permitting parties to reschedule examinations to occur before the date of the originally scheduled designated doctor examination can, in some cases, interfere with the ability of the insurance carrier and the treating doctor to timely submit medical records and analyses to the designated doctor.

Amended subsection (e) also provides that within one working day of rescheduling, the designated doctor shall contact the injured employee's treating doctor with the time and date of the rescheduled examination in addition to the Division and the insurance carrier. Furthermore, this amendment to subsection (e) deletes the requirement that a designated doctor must inform the injured employee and injured employee's representative of the rescheduled examination. These amendments are necessary both to ensure that treating doctors are informed of rescheduled examinations and, therefore, of the appropriate deadlines for submitting medical records and to remove the redundant requirement that designated doctors inform the injured employee of a rescheduled examination the injured employee agreed to reschedule.

Lastly, amended subsection (e) provides that if an examination cannot be rescheduled to occur on a date no later than 21 days after the scheduled date of the originally scheduled examination or if the injured employee fails to attend the rescheduled examination, the designated doctor shall notify the Division as soon as possible but not later than 21 days after the date of the originally scheduled examination. This amendment simply clarifies that if neither the originally scheduled examination nor a rescheduled examination can timely occur, the designated doctor must inform the Division as soon as possible but no later than 21 days after the date of the originally

scheduled examination. This deadline to notify the Division extends to 21 days because, in some circumstances, the designated doctor may not know that an examination cannot occur until the date of the rescheduled examination.

Amended §127.10.

Amended subsection (a)(3) provides that if the designated doctor does not timely receive medical records from either the insurance carrier or the treating doctor, the designated doctor shall report this violation to the Division within one working day of not timely receiving the records. It further provides that, once notified, the Division shall take action necessary to ensure that the designated doctor receives the records, and the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records if the originally scheduled examination cannot occur. It also provides that "If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records." These amendments are necessary to reduce the likelihood that a designated doctor will perform an examination without all necessary medical records, which was an outcome sometimes permitted under the Division's previous rule.

Amended subsection (b) contains two clarifying amendments. First, subsection (b) provides that designated doctors must review submitted medical records, analyses, and materials submitted by the Division before the designated doctor examination. This amendment is necessary in order to ensure that not only the report but also the examination is informed by those documents. Second, amended subsection (b) also provides that designated doctors shall accept medical records provided by injured employees. This amendment is consistent with both current Division policy and

expectations and is necessary to ensure that a designated doctor receives full and current information the medical condition of the injured employee.

Amended subsection (c) clarifies that designated doctors shall, not may, refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. This amendment is necessary both to conform to the corresponding standard for designated doctor referrals for testing and to ensure that designated doctors do not perform examinations for which they are not qualified but are still able to obtain all necessary information to answer the question(s) at issue. Amended subsection (c) also clarifies any additional testing or examinations requested by the designated doctor shall not be denied retrospectively based on medical necessity, extent of injury, or compensability. This amendment is necessary to clarify that though insurance carriers may not deny designated doctor requested testing or examinations for the listed reasons, the bills submitted for these referrals must still comply with Division billing and fee requirements, and insurance carriers may still retrospectively review these bills for those purposes.

Amended subsection (c) also provides that any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives Division approval for additional time before the expiration of the 15 working days. This amendment is necessary to ensure that designated doctors have sufficient time to provide their reports in situations in which testing or appropriate referral examinations cannot be scheduled promptly. Lastly, amended subsection (c) provides that if the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the Division, the designated doctor shall complete the doctor's

report based on the designated doctor's examination of the injured employee, the medical records, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report. This amendment is necessary to ensure that designated doctors have clear instruction on how to complete their reports when an injured employee refuses or fails to attend the designated doctor's requested testing or referral examination.

Amended subsection (d) provides that any evaluation relating to MMI, an IR, or both, shall be conducted in accordance with §130.1 of this title. This amendment simply recodifies §130.6(a) of this title, which is adopted to be repealed elsewhere in this issue of the *Texas Register*. Amended subsection (d) further provides that if a designated doctor is simultaneously requested to address MMI and/or IR and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and IRs that take into account each possible outcome for the extent of the injury. This amendment updates a previous requirement of repealed §130.6(b)(4) of this title in light of the 2005 amendment to Labor Code §408.0041(a) that provided a designated doctor the ability to examine the extent of an injured employee's compensable injury. To correspond with this amendment, the Division has also amended subsection (d) to state that if the designated doctor provides multiple certifications of MMI and IR, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each IR assigned and a Designated Doctor Examination Data Report pursuant to new §127.220 of this title for the doctor's extent of injury determination. The designated doctor, however, shall only submit one narrative report required by §130.1(d)(1)(B) of this title for all IRs assigned and extent of injury findings. Lastly, amended subsection (d) also clarifies that all designated doctor narrative reports submitted under this subsection shall also comply with the requirements of new §127.220(a), which primarily recodifies all Division required elements for designated doctor narrative reports included in current

§127.10(f) and also expands upon those requirements. The Division has also adopted a parallel requirement for any narrative report submitted by a designated doctor under amended subsection (e), which governs reports filed by a designated doctor who examines an injured employee pursuant to any question relating to return-to-work. The Division has added these parallel requirement to clarify how these amended subsection apply in conjunction with new §127.220(a) of this title.

Amended subsection (f) deletes the current requirements for reports filed by designated doctors on issues other than those listed in §127.10(d) - (e). As discussed above, the Division has recodified and expanded upon these requirements in new §127.220(a). Amended subsection (f) also provides that designated doctors who file narrative reports under this subsection must also file a Designated Doctor Examination Data Report as described by new §127.220(c). This amendment is necessary to conform to the Division's new requirements for this form under that section and is further described below in relation to that new section.

Amended subsection (h) requires that if the designated doctor provides multiple certifications of MMI/IR under subsection (d) because the designated doctor was also ordered to address the extent of the injured employee's compensable injury, the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. This amendment corresponds with the Division's amendments to amended subsection (d) and also updates the requirement of repealed §130.6(f) of this title. Specifically, this amendment takes into account the fact that, pursuant to Labor Code §408.0041(f), an insurance carrier must pay benefits in accordance with the designated doctor's report, which under this circumstance would also include the designated doctor finding on the extent of the injured employee's compensable injury.

Amended subsection (i)(2) provides that a designated doctor must maintain documentation of the agreement of the designated doctor and the injured employee to reschedule the examination and

the notice that the designated doctor provided to the injured employee's treating doctor within one working day of rescheduling the examination. These amendments are necessary to ensure compliance with the Division's other amendments to §127.5(e).

Amended §127.20.

Amended subsection (a) provides that ““Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision.” This amendment is necessary to ensure that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution while still providing the Division the necessary discretion to monitor the quality and appropriateness of the requests and the authority to limit a designated doctor's responses to the request for clarification submitted to the doctor. The Division also notes that this standard is changed from the Division's proposed standard, and the Division has made this change for the reasons discussed in the “Reasoned Justification” section.

Amended §127.25.

Amended subsection (c) provides that if the injured employee who failed to attend a designated doctor examination contacts the designated doctor within 21 days of the scheduled date of the missed examination to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor. Amended subsection (d) provides that if the injured employee fails to contact the designated doctor within 21 days of the scheduled date of the missed examination but wishes to reschedule the examination, the injured employee must request a new examination under §127.1. These two amendments are necessary to ensure that a rescheduled designated doctor examination

of an injured employee who failed to attend an examination does not occur at a time so distant from the originally scheduled examination that injured employee's condition or other dispositive circumstances may have changed.

New §127.100.

New subsection (a) provides the requirements a doctor who is not a designated doctor must meet in order to become certified as a designated doctor. This subsection, in part, recodifies provisions of repealed §180.21(d)(1) - (4) of this title, which addressed the minimum requirements for admission to the Division's designated doctor list on or after September 1, 2007. New subsection (a) also expands upon these recodified sections by including new requirements for a doctor applying to become certified as a designated doctor. Specifically, new subsection (a) provides that a doctor is considered having maintained an "active practice" if the doctor maintains or has maintained routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients. This standard is consistent with the definition of active practice under Texas Medical Board rule 22 Texas Administrative Code §163.11 (relating to the Active Practice of Medicine).

New subsection (a) also requires a doctor applying for certification as a designated doctor to own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the edition of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the Division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the Division. This new subsection is necessary to ensure that a doctor applying to become certified as a designated doctor has the ability to perform the specific designated doctor duties described by Labor Code §408.0041 as required by Labor Code §408.1225(a-2).

New subsection (b) provides elements of a complete application for designated doctor certification and that the application must be submitted on the Division's required form. This subsection primarily recodifies the elements of a complete application for admission to the Division's

designated doctor list under repealed §180.21(g) of this title and is necessary to ensure the Division has sufficient information to review an applicant for designated doctor certification.

New subsection (b) also requires doctors applying for certification to disclose any affiliations the doctor has with a workers' compensation health care network certified under Chapter 1305, Insurance Code or political subdivision under Labor Code §504.053(b)(2). This information is necessary for the Division to monitor possible disqualifying associations related to the doctor and a particular claim if the Division certifies the doctor.

New subsection (b) also requires applicants for certification as a designated doctor to provide the identities of any person(s) with whom the doctor has contracted to assist in performance or administration of the doctor's designated doctor duties. This information is necessary for the Division to monitor and enforce other proposed or current regulations, including monitoring disqualifying associations of a designated doctor.

Lastly, new subsection (b) requires applicants to attest not only to the accuracy of the information submitted but also that the information is and will be updated as required by new §127.200(a)(8). Furthermore, subsection (b) requires applicants to attest that the doctor shall consent to any on-site visits, as provided by new §127.200(a)(15), by the Division at facilities used or intended to be used by the designated doctor to perform designated doctor examinations for the duration of the doctor's certification, regardless of whether the Division is alleging a violation has occurred. This new provision is necessary to ensure that the Division has sufficient means to monitor the quality of facilities used by designated doctors for designated doctor examinations and to otherwise ensure that designated doctors comply with all required duties imposed upon them by the Act or other applicable Division rules. Furthermore, it is necessary to correspond with the related requirement of the Division's new §127.200(a)(15).

New subsection (c) primarily recodifies the provisions of repealed §180.21(j) of this title. Additionally, new subsection (c) also provides that approvals of certification by the Division shall also include the effective and expiration dates of the certification and that a designated doctor's certification shall only be for a term of two years. This amendment is necessary to implement the recertification process for designated doctors required by Labor Code §408.1225(b)(2). The Division fully provides for this process, however, in new §127.110, which is described below.

New subsection (d) recodifies the provisions of repealed §180.21(i) of this title; however, while these standards for denial previously applied to admission to the Division's designated doctor list, they now apply to the denial of a doctor's application for certification as a designated doctor. This subsection is necessary to inform possible applicants of the possible reasons for denial of an application for certification.

New subsection (e) recodifies the majority of repealed §180.21(j) of this title and describes the written appeal process through which a doctor whose application for certification as a designated doctor is denied may dispute that denial. This subsection is necessary to ensure applicants are notified of their remedies if their applications for certification as a designated doctor are denied.

New subsection (f) provides that a designated doctor whose application for certification is approved but wishes to dispute the examination qualification criteria under §127.130 that the Division assigned to the doctor may do so through the procedures described in new subsection (e). Designated doctors must include in their response to the Division the specific criteria they believe should be modified and documentation to justify the requested change. This new provision is necessary to ensure that designated doctor whose applications for certification are approved still have the opportunity to dispute the terms of that approval, if necessary.

New subsection (g) provides that designated doctors who are designated doctors on the effective date of new §127.100 shall be considered certified for the duration of the designated doctor's current certification. New subsection (g) further provides that before the expiration of the designated doctor's current certification, the designated doctor must timely apply for recertification under the applicable requirements of §127.110. This provision is necessary to permit the Division to phase in its proposed new certification requirements over a two year period and to prevent any sudden gaps in designated doctor availability after January 1, 2013. This phase-in period is also necessary to comply with §41(b) of HB 2605, which provides that a designated doctor is not required to obtain designated doctor certification until January 1, 2013. Lastly, the Division clarifies that, for the purposes of this subsection, a designated doctor's "current certification" expires on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title.

New §127.110.

New subsection (a) describes the process through a designated doctor may apply for recertification as a designated doctor if the doctor's certification expires before January 1, 2013. This subsection is necessary to clarify the appropriate recertification procedure for designated doctors who, before January 1, 2013, would have been required to renew their application under repealed §180.21(e) of this title. The Division also clarifies that for the purposes of new subsection (a) a designated doctor's certification is considered to have expired on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title.

New subsection (a)(1) primarily recodifies the application renewal provision of repealed §180.21(e) of this title. Specifically, it provides that designated doctors must renew their application status by submitting to the Division verification that the doctor has completed a minimum of 12

additional hours of Division required training. New subsection (a)(1), however, expands upon this requirement to also require designated doctors to pass all Division required examinations under §127.100 and to submit to the Division an application for certification under new §127.100(b). The Division clarifies that the substance of this required information will not be used to approve or deny a designated doctor seeking recertification under new subsection (a); instead, the Division is only requiring this information to ensure its background information on each designated doctor is fully updated, and the Division has the designated doctor's consent to perform on-site inspections in accordance with new §127.200 of this title in order to ensure compliance with the Act and applicable Division rules. Lastly, new subsection (a)(1) provides that designated doctors who submit the materials required by this subsection will only be recertified as designated doctors under this subsection if the materials are submitted before January 1, 2013.

New subsection (a)(2) provides the process through which the Division will notify a designated doctor of its receipt of the required information in new subsection (a)(1) and of the effective and expiration dates of the designated doctor's new certification. This subsection is necessary to inform applicants for recertification of how they will receive notice of the Division's action on their application.

New subsection (a)(3) provides that "a designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status." This requirement is necessary to ensure that designated doctors maintain current training and testing and are still qualified to perform all designated doctor duties under Labor Code §408.0041 and other applicable statutes and Division rules.

Lastly, new subsection (a)(4) provides that designated doctors who fail to renew their application status before January 1, 2013 must instead apply for recertification under the procedures described under subsection (b) of this section. This requirement is necessary to comply with §41(b) of HB 2605, which provides that a designated doctor is not required to obtain designated doctor certification until January 1, 2013.

New subsection (b) provides the requirements for a designated doctor to be recertified as a designated doctor if the designated doctor's certification expires on or after January 1, 2013. The requirements under this new subsection do not substantially differ from the requirements for a doctor applying for certification under new §127.100(a) and are required for the same reasons as described above in reference to that subsection. The Division further clarifies that for the purposes of this subsection a designated doctor's "certification" expires either on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title or on the expiration date specified by the Division under new subsection (d) of this section.

New subsection (c) provides that the Division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the Division fails to receive the required information in subsection (b)(1) - (3) from the designated doctor before that time though the designated doctor may still provide services on claims to which the designated doctor had been previously assigned. New subsection (c) further provides that "a designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation. A designated doctor who fails to apply for recertification under this section within 30 days after the expiration of the designated doctor's certification may no longer

apply for recertification and must instead apply for certification under §127.100.” These new requirements parallel the analogous requirements in new subsection (a)(3) for designated doctors whose certifications expire before January 1, 2013, and these requirements are necessary for the same reasons described above in reference to that new subsection. Specifically, they are necessary to ensure timely compliance with the Division’s recertification requirements and to ensure that designated doctors maintain current training and testing and are still qualified to perform all designated doctor duties under Labor Code §408.0041 and other applicable statutes and Division rules.

New subsection (d) provides the process through which the Division will notify a designated doctor of approval or denial of the designated doctor’s application for recertification, the effective and expiration dates of the designated doctor’s new certification, and the designated doctor’s examination qualification criteria under new §127.130 that the Division has assigned to the doctor as part of the doctor’s recertification. The Division emphasizes that new subsection (d) differs from the notification process provided in new subsection (a)(2), because under new subsection (d) the Division will either approve or deny a designated doctor’s application for recertification based on several different factors, including the quality of the designated doctor’s decisions and reviews during the previous two years, and a denial of recertification will lead to a designated doctor’s removal from the Division’s designated doctor list. This process differs from the recertification process under new subsection (a)(2), because the recertification process under that subsection entitles a designated doctor to recertification if all required information is timely submitted to the Division. The recertification process under new subsection (d), however, implements Labor Code §408.1225(b), which requires the Division to actively monitor designated doctors and permits the Division to deny renewal of a designated doctor’s certification to ensure the quality of designated doctor decisions

and reviews. Furthermore, this enhanced recertification process is necessary, because of the Division's required phase-in of the certification requirements of Labor Code §408.1225(a-1) - (a-4) and new §127.100 over the next two years. This recertification process will ensure that a designated doctor approved for recertification meets all those required certification standards.

New subsection (e) provides the reasons for which the Division may deny a designated doctor's application for recertification under new subsection (b). These reasons include all the reasons for which the Division would deny a doctor's application for certification as a designated doctor under new §127.100 of this title. New subsection (e)(4) - (5), however, expand upon those denial reasons with several other performance-based factors that the Division will review when deciding whether to deny or approve a designated doctor's application for recertification. This expansion is necessary, because a complete biannual review of a designated doctor's performance, both from an administrative and quality of review perspective, provides the Division with the critical information that can help determine whether a particular designated doctor can still meet the duties of a designated doctor under Labor Code §408.0041 and other applicable provisions of the Act and Division rules. Additionally, this review meets the Division's obligation to have a recertification process that ensures the quality of designated doctor decisions and reviews under Labor Code §408.1225(b)(2).

New subsection (f) describes the process through which a designated doctor may dispute the Division's denial of the doctor's application for recertification. This subsection provides a designated doctor with two options. First, the designated doctor may provide a written response to a denial under new subsection (f)(2). This process parallels the written response process under new §127.100(e) for denials of an application for certification as a designated doctor. Alternatively, however, a designated doctor whose application for recertification was denied may also seek

reconsideration of this denial through an informal hearing before a panel of Commissioner of Workers' Compensation (Commissioner) designated representatives, and new subsection (f)(3) describes the process for this informal hearing, which includes the right for a designated doctor to have an attorney present at the informal hearing. These informal processes are necessary to ensure that designated doctors have a fair opportunity to dispute a denied application for recertification and to ensure the quality and accuracy of the Division's determinations in its proposed recertification process after January 1, 2013, which often may involve detailed or complex facts and analysis.

New subsection (g) provides that a designated doctor whose application for recertification under subsection (b) is approved but wishes to dispute the examination qualification criteria under new §127.130 that the Division assigned to the doctor may do so through the written appeal procedures described in subsection (f)(2) of this section. Designated doctors must include in their response to the Division the specific criteria they wish to be modified and documentation to justify the requested change. This new provision is necessary to ensure that a designated doctor whose application for recertification is approved still has the opportunity to dispute the terms of that approval, if necessary.

New §127.120.

New §127.120 recodifies repealed §180.21(k) of this title and provides that 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 chapter for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute or perform a particular examination. This recodification is necessary to ensure the availability of designated doctor examinations for out-of-state employees who may not be able to locate or travel to a certified designated doctor in Texas or another state.

New §127.130.

New subsection (a) provides that for examinations that will occur before January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor has credentials that are appropriate to the issue in question and the injured employee's medical condition and that meet the requirements of Labor Code §408.0043 and §408.0045, and applicable Division rules, and the designated doctor has no applicable disqualifying associations under new §127.140. This new subsection is necessary to codify the Division's current policy for assigning designated doctors to approved examinations, and this policy will remain in effect until January 1, 2013. This new subsection creates no substantive change in the Division's current practices and ensures that the Division's designated doctor selection process will continue to comply with Labor Code §§408.0041, 408.0043, 408.0045, and 408.1225 and other applicable Division rules until January 1, 2013.

New subsection (b) provides the qualification standard for selecting a designated doctor for an examination that will occur on or after January 1, 2013. The selection criteria under this new qualification standard will create a substantive change in the Division's designated doctor selection process, but this substantive change is necessary to comply with two amendments to Labor Code §408.0041 made by HB 2605 that will apply to all designated doctor examinations on or after January 1, 2013. Specifically, HB 2605, as discussed above, amended §408.0041(b) to provide that a medical examination under Labor Code §408.0041 shall be performed by the next designated doctor on the Division's list of certified designated doctors whose credentials are appropriate for "the area of the body affected by the injury and the injured employee's diagnosis" and deletes the requirement that a designated doctor's credentials must be appropriate for the "issue in question" and the injured employee's "medical condition."

Additionally, however, HB 2605 also amended §408.0041(b-1) to provide that while Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. This conflict provision will substantially limit the application of Labor Code §408.0043 and §408.0045 to a designated doctor selected to perform an examination under Labor Code §408.0041 on or after January 1, 2013. Specifically, though both Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, Labor Code §408.0041 requires designated doctor examinations to be performed by the next available designated doctor who meets the Labor Code §408.0041 criteria.

To implement these amendments, the Division has adopted new subsection (b)(1) - (8). New subsection (b)(1) - (7) provide the substantive core of the Division's new qualification standard. Each of these new paragraphs governs injuries and diagnoses relating to a different area of the body (such as hand and upper extremity or feet, including the toes and heel) and matches that area of the body to particular doctor license types the Division has determined to be qualified and appropriate to examine the injuries and diagnoses of that area of the body. Generally, the Division's based its rationale for these determinations on the fact that for the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

The Division recognizes that the broad categories of new subsection (b)(1) - (7) could potentially in some circumstances permit a designated doctor to evaluate a particular injury or diagnosis that would exceed the scope of the doctor's license or require the doctor to examine an

uncommon, complex diagnosis that may require a higher level of expertise in a particular medical specialty; therefore, the Division has adopted new subsection (b)(8)(A) - (H) and, in part, new subsection (f)(5) and new §127.200(a)(12) of this title (relating to Duties of a Designated Doctor) to prevent these outcomes.

New subsection (b)(8)(A) - (H) address the necessary qualifications of designated doctors to examine certain complex diagnoses less frequently seen in the workers' compensation system. The Division has determined that nearly 90% of designated doctor examinations will be requested to evaluate injuries and diagnoses addressed by new subsection (b)(1) - (7); however, the Division has determined that there also exists a relatively infrequently seen but nonetheless sufficiently impactful subset of diagnoses or injuries in the workers' compensation system that because of their infrequency and complexity require additional qualification criteria. The Division, therefore, has in new subsection (b)(8)(A) - (H) divided these diagnoses or injuries (such as traumatic brain injuries or chemical exposures) into eight subcategories and for each subcategory determined which medical doctors or doctors of osteopathy who are board certified by either the American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists would be appropriate to evaluate that subcategory of diagnoses or injuries. These new subparagraphs thus ensure that these subcategories of diagnoses and injuries are evaluated by optimally qualified individuals with objectively demonstrable expertise while also preventing designated doctors who could not evaluate these conditions within the scope of their license or who may not have the appropriate training and specialty from examining these conditions by separating these conditions from new subsection (b)(1) - (7).

New subsection (c) provides that "[t]o be qualified to perform an initial examination on an injured employee, a designated doctor, other than a chiropractor, must be qualified under Labor

Code §408.0043. A designated doctor who is a chiropractor must be qualified to perform an initial designated doctor examination under Labor Code §408.0045. If, however, the requirements of this subsection would disqualify a designated doctor otherwise qualified under subsection (b), this subsection, pursuant to Labor Code §408.0041(b-1), does not apply.” This new subsection is necessary to both clarify and reiterate the impact of the HB 2605 amendment to Labor Code §408.0041(b-1) discussed above.

New subsection (d) provides that “For any particular designated doctor examination, the division may exempt a designated doctor from the applicable qualification standard if no other designated doctor is qualified and available to perform the examination.” This provision is necessary because the Division must have such an exception as a safeguard for instances in which no doctor qualified under this subsection is available to perform the examination. In these instances, the Division will rely on other designated doctors who, though not optimally qualified, can use both referrals for specialist consultations and their training as designated doctors to incorporate these referrals into their reports to still produce a designated doctor report of high quality. New subsection (d) also provides that the Division may not offer a qualified designated doctor an examination if it is reasonably probable that the designated doctor will not be qualified on the date of the examination. This provision is necessary to ensure the Division has the discretion to select an appropriate designated doctor in uncommon circumstances, such as when a qualified doctor may not be qualified on the date of the examination because a disciplinary action by the doctor’s licensing board will come into effect before that date.

New subsection (e) provides that a designated doctor who performs an initial designated doctor examination of an injured employee and had the appropriate selection criteria to perform that examination under either subsection (a) or (b) of this section, as applicable, shall remain assigned to

that claim and perform all subsequent examinations of that injured employee unless the Division authorizes or requires the designated doctor to discontinue providing services on that claim. This new subsection simply codifies the requirements of the HB 2605 amendment to Labor Code §408.1225(f).

New subsection (f) provides the reasons for which the Division would authorize a designated doctor to leave a claim to which the designated doctor had been previously assigned. These reasons include, but are not limited to, a decision by the doctor to leave the workers' compensation system or a determination by the doctor that examining the injured employee would require the designated doctor to exceed the scope of the doctor's license. The Division notes that this last reason serves as an additional precaution to ensure that a designated doctor does not perform examinations on an injured employee the doctor previously examined if the injured employee's medical condition has developed in such a manner during the life of the claim that it now exceeds the scope of the designated doctor's license.

New subsection (g) provides the reasons for which the Division would compel a designated doctor to leave a claim to which the designated doctor had been previously assigned. The reasons include the following uncommon circumstances: the doctor has failed to become recertified as a designated doctor under either subsection (a) or (b) of §127.110; the doctor no longer has the appropriate qualification criteria under either subsection (a) or (b) of this section, as applicable, to perform examinations on the claim; the doctor has a disqualifying association, as specified in new §127.140, relevant to the claim; the doctor has repeatedly failed to respond to Division appointment, clarification, or document requests regarding the claim; or the doctor's continued service on the claim could endanger the health, safety, or welfare of either the injured employee or doctor. This

new subsection is necessary, because these circumstances either would violate other provisions of the Labor Code or other law or would create administratively unworkable outcomes.

New subsection (h) provides that the Division will prohibit a designated doctor from performing examinations on all new or existing claims if the designated doctor has had the doctor's license revoked or suspended and the suspension has not been probated by an appropriate licensing authority. This amendment is necessary to clarify that no other circumstances will permit a doctor to perform a designated doctor examination if the doctor is wholly unable to practice within the scope of the doctor's license.

New §127.140.

New subsection (a) relates to designated doctor disqualifying associations and primarily recodifies repealed §180.21(a)(2) of this title. Additionally, however, it also adds that a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for the provision of medical benefits to the injured employee may also constitute a disqualifying association.

New subsection (b) provides that, for an examination performed on or after January 1, 2013, a designated doctor shall also have a disqualifying association relevant to a claim if an agent of the designated doctor has an association relevant to the claim that would constitute a disqualifying association under subsection (a) of this section. This amendment is necessary as a logical extension of the Division's current standard of prohibiting any association by a designated doctor with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion and to implement the requirement of Labor Code §408.1225(d) that requires the Division to develop rules that ensure a designated doctor has no conflicts of interest relevant to a claim for which the designated doctor will perform an examination. For without this new subsection, the Division would have no express

prohibition of certain potentially inappropriate system practices, such as when the same third party is both requesting a designated doctor examination on behalf of an insurance carrier while also on the same claim accepting and scheduling designated doctor examinations on behalf of a designated doctor. The Division emphasizes, however, that these potential disqualifying associations must still be examined on a case by case basis in order to determine whether or not the association could reasonably be perceived as having the potential to influence the conduct or decision of a designated doctor. Lastly, the Division has elected to delay implementation of this requirement until January 1, 2013, so that system participants may have time to prepare for its effect on their business practices and so that it may be implemented simultaneously with the Division's other designated doctor selection changes.

New subsection (c) substantially recodifies repealed §180.21(m)(9) of this title but also adds that a designated doctor commits an administrative violation if the designated doctor performs an examination when the designated doctor has a disqualifying association relevant to that claim. This amendment is necessary to ensure diligence on the part of the designated doctor in review of both offered appointments and other documents relating to accepted examination for any possible disqualifying association.

New subsection (d) provides that insurance carriers shall notify the Division of any disqualifying associations between the designated doctor and injured employee because of the network affiliations described under subsection (a)(6) of this section within five days of receiving the Division's order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). This new subsection is necessary to help ensure that injured employees are not subject to nor insurance carriers liable for designated doctor examinations for which the selected designated doctor has a disqualifying association because of an affiliation with a

Chapter 1305, Insurance Code workers' compensation health care network or a contract with a political subdivision or political subdivision health plan under Labor Code §504.053(b)(2).

New subsection (e) provides that if the Division determines that a designated doctor with a disqualifying association performed a designated doctor examination, all reports produced by that designated doctor as a result of that examination shall be stripped of their presumptive weight. This new subsection is necessary to harmonize this new section with current §127.10(g), which provides that the report of the designated doctor is given presumptive weight regarding the issue(s) in question the designated doctor was properly appointed to address.

New subsection (f) provides that a party that seeks to dispute the selection of a designated doctor for a particular examination based on a disqualifying association or to dispute the presumptive weight of a designated doctor's report based on a disqualifying association must do so through the Division's dispute resolution processes in Chapter 410, Labor Code and Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures). This new subsection is necessary to clarify that only the Division may make a final determination regarding the existence of a designated doctor's disqualifying association related to a claim, and parties wishing to raise this issue must do so through the Division's dispute resolution processes.

New §127.200.

New subsection (a) lists certain duties of designated doctors. New subsection (a)(1) provides that a designated doctor must perform designated doctor examinations in a facility currently used and properly equipped for medical examinations or other similar health care services and that ensures safety, privacy, and accessibility for injured employees and injured employee medical records and other records containing confidential claim information. This new subsection is necessary to clarify that designated doctor examination facilities meet basic standards of medical

appropriateness and to be consistent with the general system goal expressed in Labor Code §402.021(a) that injured employees shall have access to high-quality medical care under the Act.

New subsection (a)(2) provides that designated doctors must ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor in the doctor's capacity as a designated doctor for the duration of the retention period specified in §127.10(i) and ensure the destruction of these medical records after both this retention period expires and the designated doctor determines the information is no longer needed. This new subsection is necessary to clarify and ensure that designated doctors must comply with confidentiality provisions of the Act, including, but not limited to, Labor Code §402.083.

New subsection (a)(3) provides that designated doctors must ensure that all agreements with a person or persons that permit those parties to perform designated doctor administrative duties, including but not limited to billing and scheduling duties, on the designated doctor's behalf are in writing and signed by the designated doctor and the person(s) with whom the designated doctor is contracting; define the administrative duties that the person may perform on behalf of the designated doctor; require the person or persons to comply with all confidentiality provisions of the Act and other applicable laws; comply with all medical billing and payment requirements under Chapter 133 of this title (relating to Medical Benefits); do not constitute an improper inducement relating to the delivery of benefits to and injured employee under Labor Code §415.0036 and §180.25 of this title (relating to Improper Inducements, Influence and Threats); and are made available to the Division upon request. This new subsection is necessary to ensure that the agents of a designated doctor are authorized to perform administrative duties on the designated doctor's behalf, that those person(s) comply with the confidentiality provisions of the Act, and to assist the Division in monitoring the disqualifying associations imputed to designated doctors by these third parties.

New subsection (a)(4) provides that designated doctors must notify the Division in writing and in advance if the designated doctor voluntarily decides to defer the designated doctor's availability to receive any offers of examinations for personal or other reasons and specify the duration of and reason for the deferral. This new subsection is necessary for the Division to be able to administratively prepare for these deferrals. The Division also notes that while the Division has elected to leave the frequency and extent of these deferrals to the discretion of the designated doctor, excessive or unnecessary deferrals will be a factor considered if the designated doctor applies for recertification under new §127.110(b).

New subsection (a)(5) provides that a designated doctor must notify the Division in writing and in advance if the designated doctor no longer wishes to practice as a designated doctor before the doctor's current certification as a designated doctor expires; a designated doctor who no longer wishes to practice as a designated doctor before the doctor's current certification expires must expressly surrender the designated doctor's certification in a signed, written statement to the Division. This amendment is necessary to ensure the Division is fully aware and can document that a designated doctor has elected to withdraw from practice a designated doctor before the expiration of the doctor's certification as a designated doctor.

New subsection (a)(6) provides that designated doctors must be physically present in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee that is not referred to another health care provider under §127.10(c). The new subsection is necessary to ensure that designated doctors either perform or directly supervise all elements of a designated doctor examination that are not referred to another health care provider under §127.10(c).

New subsection (a)(7) provides that designated doctors must apply the appropriate edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* and Division-adopted return-to-work guidelines and consider Division-adopted treatment guidelines or other evidence-based medicine when appropriate. This new subsection is necessary to clarify that designated doctors must use these guidelines as required by the Act and other Division rules.

New subsection (a)(8) requires that all designated doctors must provide the Division with updated information within 10 working days of a change in any of the information provided to the Division on the doctor's application for certification or recertification as a designated doctor. This new subsection primarily recodifies repealed §180.21(l) of this title but also reduces the timeframe for submitting these updates from 30 days to 10 working days in order to limit the administrative errors caused by inaccurate designated doctor profile information.

New subsection (a)(9) requires that designated doctors must maintain a professional and courteous demeanor when performing the duties of a designated doctor, including, but not limited to, explaining the purpose of a designated doctor examination to an injured employee at the beginning of the examination and using non-inflammatory, appropriate language in all reports and documents produced by the designated doctor. This new subsection is necessary to ensure that designated doctor examinations meet the express system goal of Labor Code §402.021(a) that all injured employees shall be treated with dignity and respect when injured on the job and to maintain the objectivity of the designated doctor process.

New subsection (a)(10) provides that designated doctors must bill for designated doctor examinations and receive payment in accordance with Chapter 133 of this title and Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). This new

subsection is necessary simply to reiterate and clarify the application of those chapters to designated doctor billing. New subsection (a)(11) is similarly for clarification purposes.

New subsection (a)(12) provides that designated doctors must notify the Division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would require the doctor to exceed the scope of practice authorized by the doctor's license. This new subsection is necessary to conform with the requirements of new §127.130 and to ensure that designated doctors do not perform examinations that are not permitted within the scope of their license.

New subsection (a)(13) provides that designated doctors must not perform required medical examinations, utilization reviews, or peer reviews on a claim to which the designated doctor has been assigned as a designated doctor. This new subsection is necessary to ensure that designated doctors do not intentionally or negligently disqualify themselves from claims to which they have already been assigned.

New subsection (a)(14) provides that designated doctors must identify themselves at the beginning of every designated doctor examination. This requirement is necessary to assist injured employees in verifying that the designated doctor performing examination is the designated doctor that was ordered to perform the examination.

New subsection (a)(15) provides that designated doctors must consent to and cooperate during any on-site visits by the Division pursuant to §180.4 of this title (relating to On-Site Visits); notwithstanding §180.4(e)(2) of this title, the Division's purpose for these visits will be to ensure the designated doctor's compliance with the Act and applicable Division rules, and the notice provided to the designated doctor in accordance with §180.4(e) of this title, either in advance of or at the time of the on-site visit, will specify the duties being investigated by the Division during that visit. This

amendment is necessary to ensure that the Division has sufficient means to monitor the quality of facilities used by designated doctors for designated doctor examinations and to otherwise ensure that designated doctors comply with all required duties imposed upon them by the Act or other applicable Division rules and is adopted in tandem with the requirement that designated doctors provide this consent as a requirement of the certification or recertification as a designated doctor under §127.100 and §127.110 of this title, respectively. The Division notes that though these on-site visits generally shall comply with the requirements of §180.4 of this title, the Division will not necessarily be alleging a specific violation at the time of the on-site visit; instead, the Division may, in some cases, simply be inspecting a designated doctor on a random basis to ensure compliance with the Act and applicable Division rules. The Division will, however, provide the designated doctor notice of the specific duties being investigated during the on-site visit at the time of the visit (for unannounced on-site visits) or in advance of the visit (for announced on-site visits).

New subsection (b) provides that for the purposes of Chapter 127 and Chapter 180 of this title (relating to Monitoring and Enforcement), and all other applicable laws and Division rules, any person with whom a designated doctor contracts or otherwise permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the doctor's "agent" as defined under §180.1 of this title (relating to Definitions). This new subsection is necessary to harmonize this new section with the Division's rules regarding agents in Chapter 180 of this title.

New §127.210.

New subsection (a) primarily recodifies repealed §180.21(m) of this title and provides a non-exhaustive list of designated doctor administrative violations that are not necessarily expressed in any other Division rule. New subsection (a)(3) also clarifies that any refusal to accept or perform a Division offered appointment or ordered appointment that relates to a claim on which the doctor has

previously performed an examination is an administrative violation. This new violation is necessary to implement the HB 2605 amendment to Labor Code §408.1225(f) described above.

New subsection (a)(6) provides that it is an administrative violation for a designated doctor to order or perform unnecessary testing of an injured employee as part of a designated doctor's examination. This new subsection is necessary to clarify that testing should only be performed when necessary to resolve the issue(s) in question and to conform to the analogous standard for health care provider referrals in new subsection (a)(5), which recodifies current §180.21(m)(3).

Additionally, new subsection (a)(12) provides that it is an administrative violation for a designated doctor to behave in an abusive or assaultive manner toward an injured employee. This new subsection is necessary to correspond with the Division's professionalism standard under new §127.200(a)(8) and to ensure injured employee safety and dignity during designated doctor examinations.

Lastly, new subsection (a)(14) provides that designated doctors may not perform examinations that the designated doctor was not ordered to perform. This amendment is necessary to highlight that only the designated doctor assigned to the claim may perform the designated doctor examination of the injured employee.

New subsection (b) provides that designated doctors are liable for all administrative violations committed by their agents on the designated doctor's behalf under this section, other Division rules, or any other applicable law. This amendment is necessary to harmonize this new section with the definition of "agent" in §180.1 of this title and to remind designated doctors of the existing and applicable requirements of that section.

New subsection (c) recodifies repealed §180.21(n) of this title.

New §127.220.

New subsection (a) primarily recodifies repealed §127.10(f)(1) - (8) and also expands upon those subsections in order to both ensure medical and legal sufficiency of designated doctor narrative reports and to provide the Division with information necessary for the monitoring of designated doctor reviews and administrative functions. The majority of these required provisions are either recodified provisions or are necessary in order for the designated doctor to document compliance with other Division rules. The Division also notes that the new proposed requirement that designated doctors must document the time the designated doctor began taking the medical history of the injured employee, physically examining the employee, and engaging in medical decision making and the time the designated doctor completed these tasks is primarily necessary for informational purposes and to assist in the investigation of complaints of injured employee maltreatment or possible fraud. The Division recognizes, however, that the time spent performing these tasks may not necessarily have any bearing on the quality of a designated doctor's review and intends to make no definitive implication of that nature by imposing this requirement.

The Division notes that it has also made two changes, in response to comment, to subsection (a) from the formal proposal. The Division has deleted the requirement that designated doctor include "the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable" in their narrative reports. The Division has deleted this requirement because for most examinations this information will either be reported on the DWC-032, the DWC-068, or both and, therefore, is not necessary in a designated doctor's narrative report. The Division has also deleted the requirement that designated doctor include the time the examination began from §127.220(a)(6)

of this title. The Division believes that this information is unnecessary, particularly in light of the timing requirement of §127.220(a)(8).

New subsection (b) provides that designated doctors who perform examinations under §127.10(d) or (e) shall also complete and file the Division forms required by those subsections with their narrative reports. Designated doctors shall complete and file these forms in manner required by applicable Division rules

New subsection (c) provides that designated doctors who perform examinations under §127.10(f) must, in addition to filing a narrative report that complies with new subsection (a) of this section, also file a Designated Doctor Examination Data Report in the form and manner required by the Division. New subsection (c) then further provides for the required elements of a Designated Doctor Examination Data Report. The purpose of this report is intended to be analogous to the purpose of the Division's DWC-069 form for MMI/IR examinations and is necessary to ensure that the Division has uniform report format for these examination suitable for data harvesting. The elements of this report do not substantially differ from the requirements of designated doctor narrative reports except that they do not require a designated doctor to include any of the narrative elements on the form. The designated doctor's rationale and other narrative elements are only to be included in the designated doctor's narrative report as described by new subsection (a) of this section.

Additionally, however, new subsection (c)(2) also requires that Designated Doctor Examination Data Reports list all injuries determined to be compensable by the Division or accepted as compensable by the insurance carrier. Designated doctors must obtain this information from the Division's DWC-032. Furthermore, designated doctors must also assign a single or multiple diagnosis codes for each listed injury or medical condition. The Division emphasizes, however, that

this translation to a diagnosis code does not constitute a finding of the designated doctor for the purposes benefit payments or presumptive weight under the Act or §127.10(g) or (h). Instead, the Division only requires these codes for informational purposes, because they are necessary for mass data collection. New subsection (c) also provides a similar requirement for the disputed conditions examined by a designated doctor to determine the extent of the compensable injury, and, similarly, the diagnosis code requirement is only for informational purposes and has no other effect.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General: One commenter states that Division's new requirements for designated doctors are too high and too complex. Designated doctors will be overburdened and these rules will not increase quality. An agency cannot legislate quality.

Agency Response: The Division disagrees. These adopted sections are necessary to ensure the quality and availability of designated doctor examinations for reasons stated above and are necessary to comply with the Texas Workers' Compensation Act (Act).

General: One commenter states that the Division's cost note did not take into account the hotel, travel, food, etc. required to attend the training. The commenter states that the real cost is closer to \$1000-\$1500 every two years. Also, the *Official Disability Guidelines* and *Medical Disability Advisor* will cost approximately \$800 a year.

Agency Response: The Division clarifies that travel and lodging expenses are not the result of the rule but are the result of an individual stakeholder's personal decisions. The Division also notes that there are several designated doctor training sessions offered in Texas each year and that doctors are free to choose which training session meets their personal needs in terms of travel and

scheduling. Moreover, even if the costs were the result of the rule, the Division would have no viable means of estimating these costs, because travel costs vary significantly from doctor to doctor depending on a variety of factors, including but not limited to the location of the doctor's primary practice, the training location selected by the doctor, the time of year chosen for the training, and the type of accommodations selected by the doctor. Lastly, the Division has determined that the *Official Disability Guidelines* and *Medical Disability Advisor* can be acquired from \$390-\$780 a year, and designated doctors may contact the Division for further information on acquiring the materials.

General: One commenter states that these rules impose more regulations, costs, and forms on designated doctors but offer no additional compensation to designated doctors. Designated doctor fees should be increased, and they should be paid for no shows.

Agency Response: The Division notes that designated doctor fees and reimbursement procedures are addressed in Chapter 134 of this title and are, therefore, outside the scope of these rules.

General: One commenter states that there are several bad ideas in these rules. They will drive designated doctors out of the system and lead to a shortage of quality examiners.

Agency Response: The Division disagrees. These adopted sections are necessary to ensure the quality and availability of designated doctor examinations for reasons stated above and are necessary to comply with the Texas Workers' Compensation Act (Act). Additionally, the Division will continue to monitor the availability and quality of designated doctor examinations after the adoption of these rules and will make future changes to these rules, if necessary.

§127.1(a): One commenter states that Office of the Injured Employee Counsel's (OIEC) ombudsmen should be added to the list of parties who may request an examination of the injured employee. An injured employee's representative, including a lay representative, is included and ombudsmen need to be listed for the same reasons they do.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.1(b): One commenter states the Division should require that any injuries in dispute be required to be resolved by an extent of injury examination.

Agency Response: The Division disagrees. The Division cannot compel system participants to request a designated doctor examination on the extent of a compensable injury even if that issue is in dispute. Disputing parties are free to request a benefit review conference on the issue, to request a designated doctor examination to address the issue, or to take no action at all despite the dispute if they so choose.

§127.1(b)(1) - (2): One commenter asks that the Division confirm that a prospective date of maximum medical improvement rendered by a previous designated doctor examination is sufficient grounds to approve a new request.

Agency Response: The Division declines to make an absolute confirmation that this circumstance would merit a reexamination, because of a number of possible, though unusual, intervening factors that would make the examination unmerited, such as a possible error in approving the first examination.

§127.1(b)(3): One commenter appreciates the inclusion of "diagnosis and part of the body affected" in this subsection.

Agency Response: The Division appreciates the support.

§127.1(b)(4): One commenter states that the Division should delete the requirement that parties must list all injuries determined to be compensable by the Division. The Division should already have this information and parties may not be aware of injuries deemed to be compensable by the Division in the Division's internal files. Also, requiring requesting parties to include injuries claimed by the injured employees but not disputed does not make sense and could have the unintended effect of allowing injured employees to raise new injuries before the carrier has a chance to investigate these claims. Subsection (b)(4) should be deleted.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that parties should not include injuries determined to be compensable by the Division. The Division does not make internal determinations of compensability; the Division makes determinations of compensability through its dispute resolution processes, and parties are aware of

the outcomes of these disputes. Requestors, therefore, do have full access to this information. The Division agrees, however, that “injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier” is vague and would likely create confusion in the administration of claims. The Division, therefore, has deleted this provision.

§127.1(b)(4): One commenter states that the proposed rule is contradictory. It requires listing of injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier. But there is no point of listing areas claimed to be compensable if they are being disputed by the carrier, and the designated doctor is not being requested to examine extent.

Agency Response: The Division has deleted the requirement that parties list injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier from its adopted rule for other reasons stated above.

§127.1(b)(4): One commenter states that this section in its entirety is too vague, untenable, and repetitive. Without a specific diagnosis, as required in §127.1(b)(3) of this section, the analysis letter under §127.10(a)(2) of this title (relating to General Procedures for Designated Doctor Examinations) is obliterated and creates an avenue for unnecessary disputes and attacks on the designated doctor report. If an injured worker asserts a claim injury or condition, is it compensable?

Agency Response: The Division agrees and disagrees and has made a change. The Division disagrees that the requirement that parties list all injuries determined to be compensable by the Division or accepted as compensable by the insurance carrier is too vague or untenable. The Division notes that this requirement has been in place since February 2011 and has not caused any of the problems suggested by the commenter. The Division agrees, however, that “injuries claimed

to be compensable by the injured employee and not disputed by the insurance carrier” is vague and would likely create confusion in the administration of claims. The Division, therefore, has deleted this proposed provision.

§127.1(b)(8): Multiple commenters state that the Division should already have this information in its own claims management system. Also, this information is irrelevant given that most subsequent designated doctor examinations are on new issues. The Division should be able to screen whether the designated doctor has addressed the same issue based on its own internal files. This requirement is not necessary to determine the appropriateness of a request and is an unnecessary burden on the party requesting the examination. Each designated doctor examination should stand alone as intended.

Agency Response: The Division agrees in part and has made a change. The Division disagrees that this information is wholly irrelevant because information regarding the most recent designated doctor examination assists the Division in determining if the requested examination would occur within 60 days of the previous examination. The Division agrees, however, that information regarding examinations before the most recent examination is unnecessary and has therefore made a change. Specifically, adopted §127.1(b)(8) now only requires requestors to state whether a previous examination has occurred and, if so, to provide information regarding the most recent previous examination.

§127.1(b)(9): One commenter states that OIEC ombudsmen should also receive a copy of the DWC-032. Though injured employees receive a copy of the request often they do not understand the request or appreciate the importance of promptly providing this document to their ombudsmen.

The Division recognizes this when it requires these notices to be sent to the injured employee's representative. Ombudsmen function similarly to lay representative and should be treated the same.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope of this rule.

§127.1(b)(11): One commenter requests that the Division include the modifier "below." Some of us need that clarity of direction to avoid automatically searching backward.

Agency Response: The Division agrees and has kept "below" in the adopted rule.

§127.1(b)(11)(C): One commenter requests that the Division replace the word "injuries" with either "diagnoses" or "conditions" in question.

Agency Response: The Division disagrees. This change is unnecessary because "injuries" includes diagnoses or conditions.

§127.1(b)(11)(C): A commenter requests that the Division remove the language permitting a person to request an examination to determine the "causation of the claimed injury" under this subsection.

Agency Response: The Division agrees to make this change. Causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

§127.1(d): One commenter agrees that the Division needs a specific basis to deny a designated doctor examination request but also requests that the rule provide that the Division state with specificity the grounds for denial with statutory basis, if possible. This request is not to elicit information to which the parties are not or should not be entitled but to ensure that the basis is both objectively justified and understood by the parties. It is unclear why stating the basis for a determination affecting legal rights should not be afforded basic due process.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that its current rule denies “basic due process” and notes that the Division already does provide reasons for its denials of designated doctor requests in those denials. Nonetheless, the Division agrees that this practice is helpful and consistent with the Division’s current procedures and, therefore, has made a change. Specifically, adopted §127.1(d) has been amended to state that the division will provide a written explanation for the denial to the requestor if the Division denies a request for a designated doctor examination.

§127.1(d)(4): Multiple commenters state that this subsection does not implement any portion of Senate Bill 1, House Bill 7, or House Bill 2605, and there is no authority for a designated doctor to resolve compensability disputes. The commenters further state that there is no legislative history to indicate that the designated doctor system was to be used to assist the Division in resolving disputes over the compensability of the claim. The designated doctor system was intended to assist the

Division in resolving medical issues on compensable claims, and this is an issue unique and separate from the scope of a designated doctor authority.

Another commenter states that the Texas Workers' Compensation Act does not grant the Division the authority to appoint a designated doctor to address compensability, because it specifically provides this power to a hearing officer as a finder of fact. If the Legislature intended designated doctors to review compensability, it would have stated so. Because it did not, this exclusion is meaningful.

Agency Response: The Division disagrees with this comment but notes that, for other reasons, it has made a change. First, proposed §127.1(d)(4) (and now adopted §127.1(e)) does not authorize a designated doctor to resolve a compensability dispute or to address compensability. It permits a designated doctor to opine on medical causation (whether a claimed incident caused a claimed injury). Causation is not synonymous with compensability and alone is insufficient to determine the compensability of a claim as a whole. Other required determinations include, but are not limited to, whether the injured employee was an employee of the employer, whether the claimed incident actually occurred as described to the designated doctor, and whether the claimed incident occurred within the course and scope of employment. These determinations may only be made by the Division's Hearing's staff and have not been delegated to designated doctors. Thus, the commenter's concerns regarding a designated doctor's authority to resolve a compensability dispute or address compensability are unfounded, because proposed §127.1(d)(4) does not authorize designated doctors to address compensability.

Additionally, designated doctors cannot resolve a dispute regarding medical causation under proposed §127.1(d)(4) any more than a designated doctor can resolve a dispute regarding any issue under Labor Code §408.0041. Designated doctors never resolve disputes regarding issues

addressed by them in a designated doctor examination. At most, they resolve or answer questions regarding issues under Labor Code §408.0041, but answering questions falls short of actually resolving a dispute and finally determining the liability of an insurance carrier on a particular claim as the Division does through its dispute resolution process. In fact, Labor Code §401.011(15) plainly states that a designated doctor can only “recommend a resolution of a dispute as to the medical condition of an injured employee.” Recommending resolution and resolving are not synonymous actions. Thus, the report of a designated doctor only has presumptive weight, and a party may overcome this presumption through the Division’s dispute resolution process by providing competing evidence and demonstrating that the preponderance of the evidence is contrary to the designated doctor’s report. Permitting a designated doctor, therefore, to address medical causation in an examination no more conflicts with the Act or the duties of the Division and Division hearing officers to resolve disputes than permitting a designated doctor to address maximum medical improvement or extent of injury does.

Additionally, the Division does have the statutory authority to permit designated doctors to address medical causation in a designated doctor examination. Specifically, Labor Code §408.0041(a)(6) authorizes a designated doctor to perform examinations in order to resolve any question on issues similar to those described in Labor Code §408.0041(a)(1) - (5). The medical causation analysis a designated doctor provides under §127.1(d)(4) is, in many cases, substantially identical to the analysis a designated doctor provides when evaluating the extent of a compensable injury. Thus, designated doctors may appropriately address this issue under Labor Code §408.0041(a)(6).

Nonetheless, the Division acknowledges that in some cases the issue of medical causation may not be in dispute, may not be necessary to resolve a dispute regarding compensability of a

claim, or the claimed injury may not require an expert medical opinion on causation; therefore, a designated doctor examination in these cases would create an unnecessary expenditure of system resources and unnecessary delay of the dispute. Additionally, however, determining whether a medical causation dispute exists and whether that dispute would require an expert medical opinion to be resolved at a contested case hearing is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that “if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.”

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carriers and delays in the dispute resolution process and the Division's need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): Multiple commenters state that there is no authority in the Act for a designated doctor to examine a claimant to either resolve or express an opinion regarding or create a presumption regarding the issue of compensability or causation of the initial injury as opposed to extent of injury.

One commenter states that this rule, in tandem with §127.1(a)(6) and §127.1(b), allows the inference that a designated doctor may properly opine on compensability and further confuses the already weakened distinction between causation/extent of injury analysis and compensability analysis.

Another commenter states that the issue of whether an employee suffered a compensable injury is not a "similar issue." All issues listed in Labor Code §408.0041(a) involve compensable claims, which is consistent with a carrier's liability under the Act. Permitting a designated doctor to determine compensability is not a "similar issue" because the carrier has denied all liability in these claims.

Agency Response: The Division disagrees with this comment but notes that for other reasons it has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Additionally, the Division disagrees that designated doctors are not authorized to opine on causation of the initial injury or that medical causation is not a "similar issue" under Labor Code §408.0041(a)(6), because the analysis of medical causation as it presents in a compensability dispute is often substantially identical to the analysis of extent of injury performed by a designated doctor. Extent of injury disputes do not address the compensability of a claim as whole but instead pertain to the dispute of the compensability of a particular aspect of the claim, such as which body areas/systems, injuries, conditions, or symptoms. See *State Office of Risk Management v. Lawton*,

295 S.W.3d 646, 649 (Tex. 2009). Furthermore, these disputes can essentially present in two varieties. First, an extent of injury dispute can involve an insurance carrier disputing that a later developing condition or diagnosis, such as clinical depression, is not causally tied to the injured employee's initial injury and thus should not be included as part of the compensable injury. One could characterize this form of extent of injury dispute as a consequential extent of injury dispute in which the injured employee is not claiming that the condition in dispute was caused by original mechanism of injury or incident but instead naturally resulted from the initial injury or harm. Alternatively, many other extent of injury disputes involve the insurance carrier disputing an injured employee's claim that a particular condition or diagnosis resulted from the initial mechanism of injury. Put another way, the issue in dispute in this form of extent of injury dispute (which one could characterize as a concurrent extent of injury dispute) is whether a disc herniation an injured employee complains of months into a claim also resulted from the accident at work in addition to the broken kneecap and ankle injury, which the insurance carrier had already accepted as compensable. In fact, this fact scenario mirrors the facts presented in the notable extent of injury case *City of Laredo v. Garza*, 293 S.W.3d 625 (Tex. App.-- San Antonio 2009, no pet.), in which the Fourth Court was asked to determine whether the injured employee could establish through lay testimony a strong, logically traceable connection between his on-the-job accident and his injuries or if expert medical testimony was necessary to establish medical causation. Even though the injured employee in this case claimed that the disputed condition was caused by the original mechanism of injury and the dispute itself centered around this fact, the dispute appropriately presented as an extent of injury dispute not a compensability dispute because the insurance carrier was only disputing the compensability of particular aspects of the claim not the compensability of the claim as a whole.

This form of concurrent extent of injury analysis qualifies designated doctors to opine on medical causation in a dispute of compensability of an entire claim, because in fact this form of extent of injury analysis is substantially identical to the medical causation question presented to the designated doctor under proposed §127.1(d)(4). Specifically, both issues require a designated doctor to determine whether the claimed incident caused the claimed injury. Therefore, this form of medical causation is a “similar issue” to determining the extent of a compensable injury under Labor Code §408.0041(a)(6) and appropriate for a designated doctor to evaluate.

Nonetheless, the Division has changed this subsection for other reasons stated above.

§127.1(d)(4): One commenter states that appointing designated doctors to address the compensability of a denied claim conflicts with the purpose of the designated doctor and exceeds their expertise. Designated doctors address disputes with a medical component that arises in a compensable claim. Compensability issues deal with factual and legal concerns related to whether a claimant sustained an injury in the course and scope of employment. The use of designated doctors to determine compensability exceeds their authority to resolve medical disputes.

Agency Response: The Division disagrees for multiple reasons, but for other reasons has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division’s dispute resolution processes with competing, contrary evidence.

Additionally, the Division disagrees that designated doctors do not have the authority to address medical causation because, as described above, it is a "similar issue" under Labor Code §408.0041. Lastly, the Division disagrees with the commenter's contention that designated doctors do not have the expertise to address the medical causation element of a compensability dispute. As described above the analysis a designated doctor must undertake when addressing the extent of a compensable injury is often substantially identical to the analysis the designated doctor must undertake when addressing whether or not a claimed incident caused a claimed injury during a compensability dispute. Thus, designated doctors are trained to address this issue and frequently do so in their capacity as designated doctors.

Nonetheless, the Division notes that for other reasons stated above it has made a change to this subsection.

§127.1(d)(4): A commenter states the Division's changes to this section do not resolve the fundamental problem that designated doctors do not review a complete record regarding the "claimed incident" nor the testimony of other witnesses. The Division does review this record and, therefore, has the responsibility to resolve these disputes.

Another commenter states that the proposed rule shifts the fact-finding responsibility onto the designated doctor. The Division, by assigning designated doctors to determine whether there was an injury resulting from the claimed incident, is creating a presumption that an injury occurred in the course and scope of employment and requiring the carrier to present evidence to overcome the designated doctor's opinion.

Agency Response: The Division agrees in part and disagrees in part. The Division acknowledges that it has primary, exclusive jurisdiction to determine the compensability of a particular claim.

Furthermore, the Division acknowledges that a designated doctor cannot opine as to whether a claimed incident actually occurred, how the incident occurred, or whether that incident occurred within the course and scope of employment. The Division disagrees, however, that these facts are relevant to proposed §127.1(d)(4) because proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

The Division also clarifies that a designated doctor opining on medical causation does not preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenters, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that implied or direct delegation by the agency to the designated doctor is an abrogation of the Division's duties and ultra vires, specifically because the Legislature has otherwise given the designated doctor presumptive weight. Therefore, the ability of a designated doctor to opine on causation should be removed.

Agency Response: The Division disagrees. Permitting designated doctors to opine on medical causation in a claim on which the insurance carrier has denied compensability does not improperly delegate any specific Division duty. As described above, designated doctors may properly opine on this issue as a "similar issue" under Labor Code §408.0041(a)(6) because of its substantial analytic similarity to many extent of injury issues already addressed by designated doctors. The Division acknowledges that a designated doctor's report on this issue will have presumptive weight but only on the issue of medical causation. Additionally, the Division notes that designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters state that Labor Code §408.0041 does not permit designated doctors to determine the compensability of an injury. Instead, Labor Code §410.002 specifically

grants the Division, through dispute resolution, the responsibility to determine liability of an insurance carrier for compensation under the Act. The Division cannot delegate or abdicate this authority.

Agency Response: The Division disagrees with this comment for multiple reasons but notes that for other reasons it has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. More specifically, the commenter's rationale would also imply that permitting designated doctors to address the extent of a compensable injury is also an abdication of authority, because this issue will also ultimately affect an insurance carrier's liability on a claim.

Lastly, the Division notes that though it disagrees with the commenters, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that this rule attempts to separate compensability into medical and legal components. This is an erroneous interpretation of law that creates a situation in which a designated doctor is not making a medical evaluation but instead acting as an adjudicator of compensation liability. The statute does not permit or contemplate this role. Designated doctors were created in House Bill 2600 and this legislation included no discussion or consideration of designated doctors replacing or superseding the authority of a hearing officer.

Agency Response: The Division disagrees. First, the Division clarifies that designated doctors have been in the Texas Workers' Compensation Act since its creation in 1989. House Bill 2600 and then subsequently House Bill 7 each expanded the role of a designated doctor, but neither bill created this role in the Act. Second, the Division clarifies that proposed §127.1(d)(4) does not try to separate compensability into medical and legal components. Compensability is necessarily a legal finding. Causation, however, is a required element of determining compensability. See *Transcontinental Insurance Company v. Crump*, 330 S.W.3d 211, 221-222 (Tex. 2010). Furthermore, Texas courts have also made clear that expert medical testimony is necessary to establish causation as to medical conditions outside the common knowledge and experience of a layperson. See *City of Laredo v. Garza*; and *Guevara v. Ferrer*, 247 S.W.3d 662 (Tex. 2007). Thus, while compensability is a legal issue, in many cases an expert medical opinion will be required to establish compensability if causation is in dispute. Designated doctors can properly provide an expert medical opinion on medical causation as a "similar issue" under Labor Code §408.0041(a)(6), because this form of medical causation analysis is substantially identical to the extent of injury analysis already performed by designated doctors in many cases as described above.

Additionally, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue or supersede a hearing officer's authority to do so any more than they can resolve a dispute on any other issue under Labor Code §408.0041 or supersede a hearing officer's authority to do so because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that designated doctors cannot address whether an injury resulted from a claimed incident until a hearing officer determines whether the incident actually took place as claimed. A designated doctor is not aware of all relevant testimony and evidence that is needed to determine whether or not an injury is compensable. At best, a designated doctor could opine that an injury could have happened but that opinion is still without benefit of legal analysis and consideration of all proper evidence. By statute, hearings officers are the sole judge of the relevance and materiality of the evidence offered and the evidence's weight and credibility.

Agency Response: The Division disagrees in part and agrees in part. The Division agrees that hearings officers are the sole judge of the relevance and materiality of the evidence offered and the evidence's weight and credibility. The Division disagrees, however, that a designated doctor may not opine on medical causation until a hearings officer determines that the incident actually took place, because designated doctors are not being asked to resolve a compensability dispute. Compensability of a claim as whole is a question of law that the Division agrees a designated doctor cannot address. Designated doctors, however, are being asked a far narrower question regarding medical causation, and the designated doctor's report addressing this issue would have no bearing or weight on the finding as to whether the incident took place as claimed. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter asks that when determining whether a designated doctor examination should be scheduled because it would "help a finder of fact resolve an element of that dispute" we are unsure who is the finder of fact and how the designated doctor's opinion would help resolve compensability? The commenter further asks would not the designated doctor now, in effect, be assigned as the de facto trier of fact?

Agency Response: The Division disagrees. First, the Division clarifies that the language quoted by the commenter was only in the informal draft of proposed §127.1(d)(4) and was removed from the Division's formally proposed amendment to that rule and is not adopted in either amended §127.1(d)(4) or §127.1(e). That portion of the comment, therefore, is outside the scope of this proposal.

Second, the Division notes that, as explained above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Third, the Division also clarifies that a designated doctor opining on medical causation does not make a designated doctor a de facto trier of fact or preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through

the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter argues permitting a designated doctor to resolve compensability violates due process. Designated doctors base their opinions upon unsworn representations and incomplete records that parties cannot challenge prior to the issuance of the report.

Agency Response: The Division disagrees. First, the Division notes that, as explained above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation.

Second, no due process violation can occur as a result of the designated doctor examination under §127.1(d)(4) because, as stated above, designated doctors can only recommend the resolution of a dispute not resolve the dispute; designated doctors, therefore, cannot resolve a

dispute on medical causation any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Additionally, a designated doctor opining on medical causation fact or preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): A commenter states permitting designated doctors to resolve compensability allows the presumptive weight of a designated doctor's report to apply to this dispute, which effectively shifts the burden of proof to the insurance carrier. This is not authorized by statute or Texas jurisprudence and violates due process.

Agency Response: The Division disagrees. First, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Additionally, as stated above, because designated doctors can only address medical causation under proposed §127.1(d)(4), they only have presumptive weight on this issue.

Additionally, the Division also clarifies that a designated doctor's report does not shift the burden of proof in dispute resolution; the designated doctor's report simply has presumptive weight on issues the designated doctor was properly appointed to address unless the preponderance of the evidence is to the contrary. Furthermore, even if a designated doctor's report did shift the burden of proof in a dispute over medical causation and, therefore, violate due process under the commenter's rationale, then a designated doctor's report would also shift the burden of proof on all other issues under Labor Code §408.0041(a), meaning all designated doctor examinations under that section, or at least all examinations that resulted in reports favorable to burdened parties, would violate due process. The Division disagrees with this interpretation.

Lastly, the Division notes that though it disagrees with the relevance of the commenters' concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that assigning a designated doctor to a dispute claim violates a insurance carrier's due process rights. Insurance carriers have a property interest in their liability for a claim. To assign a designated doctor in a completely denied claim would result in a carrier paying the expenses associated with a designated doctor examination in a claim where compensability has been disputed and benefits are not owed. This conflicts with Labor Code §409.021 and other provisions of the Act, because an insurance carrier is only liable for benefits if it does not timely dispute compensability. This rule lacks fundamental fairness, resulting in a denial of a carrier's substantive due process. It is also not equitable to require an insurance carrier to pay the costs of a designated doctor exam on a disputed claim.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that proposed §127.1(d)(4) of this title violates an insurance carrier's due process rights, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Thus, no benefits would be due under Labor Code §409.021 or Labor Code §408.0041, because a designated doctor does not resolve compensability or make any other finding that would, alone, entitle an injured employee to benefits under proposed §127.1(d)(4).

The Division agrees, however, that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or if the claimed injury does not require an expert

medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearing officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that “if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.”

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): Multiple commenters states that the Act requires that the carrier must pay benefits in accordance with the designated doctor report. One commenter additionally states that the Division has previously stated that designated doctor examinations cannot be nonbinding. The proposed

rule, therefore, requires carriers to pay benefits on a denied claim until the dispute resolution process is complete. The commenters state it is clear the statute would create this obligation and require payment on dubious claims before a carrier is able to have evidence heard and able to question witnesses. Furthermore, because designated doctor opinions have presumptive weight, this would effectively shift the burden of proof to carriers that the injured employee did not suffer a compensable injury. One commenter also state that this rule also requires carrier to incur expenses as a result of reimbursing the designated doctor on a denied claim.

Agency Response: The Division disagrees in part and agrees in part. First, the Division agrees that designated doctor examinations may not be nonbinding. Pursuant to Labor Code §408.0041(e) - (f), a designated doctor's report has presumptive weight unless the preponderance of the evidence is to the contrary, and insurance carriers must pay benefits in accordance with a designated doctor's report during the pendency of any dispute. The Division disagrees that these requirements reverse the burden of proof or require payment on dubious claims, however. As stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Thus, no benefits would be due under Labor Code §409.021 or Labor Code §408.0041 or any other provision of the Act, because a determining that a claimed incident did cause a claimed injury does not alone entitle an injured employee to benefits.

Second, the Division also clarifies that the Division also clarifies that a designated doctor's report does not shift the burden of proof in dispute resolution; the designated doctor's report simply has presumptive weight on issues the designated doctor was properly appointed to address unless the preponderance of the evidence is to the contrary.

The Division agrees, however, that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or if the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that “if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.”

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that it is fallacious to divide compensability into medical and legal components. Neither the definition of "compensable injury" nor "injury" make this division. Furthermore, this distinction allows designated doctors to examine only one side, the "medical" side, of a single and independent issue, which is not authorized by the Act. Under this logic, all issues under Labor Code §408.0041 should be able to be parsed into elements for examination but each of those issues are whole issues that cannot be separated into medical and legal issues. For example, one could parse maximum medical improvement (MMI) into a legal (statutory MMI) and a medical (clinical MMI) component. Additionally, under the Act, the only language regarding the medical aspect of a claim relates to medical benefits from a compensable injury; therefore, there must be a compensable injury before medical aspects of a claim are available for a doctor to examine. Any interpretation allowing designated doctors to examine the medical aspect of a disputed claim conflict with the Act and are invalid. Hearing officers do not and cannot rule on only one element of an issue when issuing decisions, and a designated doctor cannot limit his opinion to only part of the issue either. Appeals Panel decision No. 043168 states that the designated doctor must address the entirety of the compensable injury.

Agency Response: The Division disagrees. As explained above, Texas law is clear that causation is a required element of establishing compensability, and Texas law is equally clear that, in many cases, causation can only be established through an expert medical opinion. To state, therefore, that there are no medical aspects of a claim until compensability is established would prevent parties from offering required evidence. The Division disagrees with this outcome and, furthermore, clarifies that designated doctors may address medical causation because, as explained above, it is a "similar issue" under Labor Code §408.0041 and because Texas courts have held that expert medical opinions are required in many cases to establish causation.

Additionally, the Division disagrees with the commenter's statement that if designated doctors may opine medical causation in a compensability dispute, parties must also be able to impermissibly parse the other "whole issues" under Labor Code §408.0041 into separate issues. The Division disagrees, because it does not believe these issues are all "whole issues." Impairment rating necessarily includes a finding of the extent of a compensable injury, but designated doctors are not required to address both issues simultaneously. Determining whether disability is the direct result of a work-related injury implies the existence of disability and a defined extent of the compensable injury yet a designated doctor is not required to determine these issues in addition to direct result. Thus, the Division disagrees with this portion of the comment because it essentially argues that all DD opinions are flawed and impermissible because they rely on facts or findings that can be disputed.

Even if one assumes the issues under Labor Code §408.0041(a)(1) - (5) are "whole issues," however, it is still not clear why this fact would prohibit a designated doctor from addressing medical causation under Labor Code §408.0041(a)(6) as a similar issue when it is a substantially identical issue to many issues already addressed by a designated doctor when examining the extent of a compensable injury. The commenter's logic appears to imply for an issue to be "similar" to the issues in Labor Code §408.0041(a)(1) - (5), it must be identical to those issues or at least similar to them in one particular way (be a "whole issue"). Labor Code §408.0041 imposes no such requirements, however, and the general likeness between extent of injury analysis and the medical causation analysis performed under proposed §127.1(d)(4) and adopted §127.1(e) is sufficient to establish similarity between the two issues.

Furthermore, the Division is unclear as to the relevance of Appeals Panel Decision No. 043168. This appeals panel decision held that a designated doctor must rate the entirety of the

compensable injury when assigning an impairment rating to an injured employee's compensable injury. The Division is unclear as to why requiring a designated doctor to comply with the legal definition of "impairment rating" would result in the conclusion that a designated doctor cannot limit the doctor's opinion to only part of an issue, specifically medical causation in the context of compensability. The comment appears to reason that a designated doctor must not only address all the issues Division ordered the designated doctor to address, but the designated doctor must also address all issues associated with the issue the doctor was ordered to address even if the Division did not order the designated doctor to address those issues. The Division disagrees with this reasoning.

Lastly, the Division notes that though it disagrees the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters state that this rule will unnecessarily increase system costs. One commenter emphasizes that this rule conflicts with the system goal of reducing costs by requiring carriers to pay for these examinations. Another commenter states that allowing parties to increase costs and prolong the dispute resolution process should not be allowed simply because a party styles their request under a catch all provision.

Agency Response: The Division agrees in part and has made a change. Specifically, the Division agrees that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its

denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearing officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that “if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.”

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that a designated doctor examination should never be assigned to a denied claim prior to adjudication of the denial. In any claim, a treating doctor is on the scene preceding the investigation of a claim or filing of a compensability dispute and has initiated treatment for a condition asserted as work-related by a claimant. This treatment has technically established a medical premise that an injury or work-related condition has occurred. Why would this

medical opinion carry any less weight than the opinion of a designated doctor and what specialized training would a designated doctor possess in order to determine this issue with any more medical certainty? It is not clear, therefore, what need there would be for a designated doctor examination.

Agency Response: The Division disagrees. First, while a treating doctor's diagnosis may suffice to establish that an injury exists, a diagnosis without further analysis will not always suffice to establish that the work-related incident was a producing cause of that diagnosis, which is a necessary element for an injured employee to prove the compensability of the employee's claim. Specifically, as discussed above, in many cases causation requires an expert medical opinion, and expert medical opinions must be based upon a reliable foundation. *See Transcontinental Insurance Company v. Crump*, 330 S.W.3d 211, 221-222 (Tex. 2010). Thus, in most cases, unless the treating doctor has additionally provided analysis based upon a reliable foundation to demonstrate that the work-related injury was a producing cause of the injured employee's diagnosis, then the treating doctor's participation in the claim will not meet the required standards for an injured employee to prove this element of the employee's claim.

A designated doctor's report, however, will fully address this issue, and because medical causation analysis is substantially identical to many of the issues a designated doctor will analyze when addressing the extent of the compensable injury, the designated doctor will be uniquely trained and experienced to address this issue.

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that assigning designated doctors on disputed claims also unfairly obligates public funds, which are already scarce for Texas school districts, without due process, and a finding of non-compensability does not release that obligation. This obligation is compounded by possible designated doctor referrals or testing, which cannot be reviewed.

Agency Response: The Division agrees in part and has made a change. Specifically, the Division agrees that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearing officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that the Division may order an injured employee to attend a required medical examination on compensability if the Division determines that it needs further medical evidence on a claim in which the insurance carrier has disputed compensability. The commenter reasons that this remedy would be more appropriate than a designated doctor examination, because it would not compel an insurance carrier to pay benefits pursuant to the report.

Agency Response: The Division disagrees for several reasons. Most importantly, the Division does not have the statutory authority to order an injured employee to attend a required medical examination under Labor Code §408.0041 on the Division's own motion; therefore, the commenter's suggested remedy is not possible. Furthermore, the Division disagrees that benefits would be due based on a report of a designated doctor asked to determine whether a claimed incident caused a claimed injury under proposed §127.1(d)(4). Specifically, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Thus, no benefits would be due under

Labor Code §409.021 or Labor Code §408.0041 or any other provision of the Act, because a designated doctor does not resolve compensability under proposed §127.1(d)(4).

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters support this rule because of an injured employee's difficulty in obtaining a medical causation opinion, which is even more pronounced on network claims. One commenter states that, in addition, the Division's Appeals Panel continues to expand the number of cases where medical evidence of causation is necessary. Moreover, this cost is properly borne by insurance carriers, because insurance carriers are entitled to subsequent injury fund reimbursement. Another commenter states that this rule is consistent with the stated intent of the Act in Labor Code §402.021. Specifically, this proposed amendment ensures Injured employees have access to medical evidence. Also, this comports with the general principle that the Act shall be liberally construed in favor of the injured employee and the *quid pro quo* principle of *Texas Workers' Compensation Commission v. Garcia*, 893 S.W.2d 504 (Tex. 1995).

Agency Response: The Division agrees in part and disagrees in part and has made a change. Specifically, the Division agrees that designated doctor can and, in some cases, should address medical causation. The Division believes that the authority for these examinations is within the Act and necessary for many of the policy reasons proposed by the commenters. The Division disagrees, however, that insurance carriers should be required to pay for these examination in all cases in which compensability has been denied, particularly those in which medical causation is not at issue. The Division also acknowledges that in some cases it would be appropriate to require an insurance

carrier to pay the costs of a designated doctor exam on a disputed claim. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearing officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that “if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.”

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(5): Multiple commenters support this rule. One commenter states expresses agreement with the denial of a designated doctor request for these reasons. Medical evidence is not generally required to overcome a denial based on these sections of the Labor Code.

Agency Response: The Division appreciates the support but notes that it has deleted this proposed provision for reasons described above.

§127.1(e): One commenter states that the Division should impose a 10 day deadline upon itself to respond to requests for expedited contested case hearings. As stated in §127.1, parties requesting expedited contested case hearings must do so within 3 days of receiving the order. Section 142.6 states that the Division shall set an expedited contested case hearing no later than 30 days after receipt of the request. But the necessity of an expedited hearing respecting a designated doctor setting is to prevent inappropriate examinations prior to threshold issues being addressed. Failure to timely respond to a request for hearing and stay the examination may result in irreparable harm. The commenter states that it makes this request under Labor Code §408.0041(f-3).

Agency Response: The Division disagrees. While the Division intends to respond to all requests for expedited contested case hearings as quickly as possible, the Division sees no reason to impose an arbitrary deadline on its administrative discretion. Moreover, the Division notes that if the requestor has timely requested a stay of the designated doctor examination, the irreparable harm described by the commenter would not occur because the examination would have been stayed. Lastly, the Division notes that Labor Code §408.0041(f-3) is not relevant to this subsection or the dispute of approved designated doctor examinations. Labor Code §408.0041(f-3) applies to post-designated doctor examination required medical examinations or treating doctor examinations. Therefore, a designated doctor examination must have already occurred for Labor Code §408.004(f-3) to apply.

§127.1(e): One commenter states that under current §127.1(e), failure to meet the three calendar day deadline has been determined to not be a waiver of the right to dispute the setting of the designated doctor examination. The currently proposed §127.1(e) adds the word "timely." The commenter is concerned that "timely" provides the DWC with the justification to refuse to set an

expedited hearing and stay the designated doctor evaluation for failure to timely file. The Division has previously acknowledged in prior rule preamble that a three calendar day timeframe is untenable and unreasonable, and a proposed a three to five working day deadline or five calendar day deadline. The commenter requests these timelines be used for requesting a stay of a designated doctor examination.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division's previous statement regarding waiver of the ability to dispute the approval of a designated doctor examination request is not applicable to the staying of an approved designated doctor examination. Specifically, in its December 17, 2010 adoption order for §127.1, the Division stated:

Comment: One commenter states that it should be clarified that failure to request expedited proceedings or any other hearing under §127.1(e) in order to dispute an ordered designated doctor examination does not waive a party's right to dispute the appointment of a designated doctor at a later time.

Response: The Division agrees and disagrees. The Division agrees that parties do not waive their right to contest the appointment of a designated doctor or approval of an examination if they fail to do so under §127.1(e). The Division disagrees that any clarification is necessary, however, as nothing in the rule would imply this outcome. Moreover, the rule states no deadline for non-expedited disputes, thus it is not clear how a party could lose the ability to seek dispute resolution under this rule provided the subject of dispute had not already been adjudicated through the Division's dispute resolution process. (35 *TexReg* 11330)

The commenter's requested clarification and the Division's response concerned the authority of parties to still dispute an approved designated doctor examination under other provisions of the Division's rule and the Act if the party fails to request expedited proceedings under §127.1(e). The Division did not, however, state that untimely requests for a stay would be approved. The Division, therefore, has added "timely" to adopted subsection (e) to further clarify that requests for a stay must be timely received. If the Division were required to stay examinations at any time, it would lead to

undue hardship on designated doctors and injured employees who had already made preparations for the examination. But the Division does agree that in some instances a three calendar day deadline for the request of a stay would be unduly burdensome on requesting parties, such as in instances that would require parties to submit the party's request on a weekend or national holiday. The Division, therefore, has modified this deadline to extend to three working days in adopted §127.1(e).

§127.1(e): One commenter supports prohibiting parties from disputing a DWC-032 until the Division has approved or denied the request.

Agency Response: The Division appreciates the support.

§127.5(a): Multiple commenters request the Division impose a 10 day or other similar deadline upon itself to approve or deny a designated doctor examination request.

Agency Response: The Division disagrees. Though the Division will strive in all cases to process these requests as timely as possible, imposing an arbitrary and extra-statutory deadline upon approving these requests would unnecessarily restrict the Division's administrative flexibility.

§127.5(a): Multiple commenters state that injured employees should be required to call and write the designated doctor that they will attend the designated doctor examination or otherwise confirm their intention to attend the examination to the designated doctor when they receive the Division's order. The commenters reason that the majority of DWC-032s have inaccurate injured employee contact information. This change, therefore, would help coordinate and confirm the examinations and reduce missed examinations by injured employees. Additionally, if this information is inaccurate the

designated doctor cannot contact the injured employee if the designated doctor needs to reschedule. Also, if the Division expects designated doctors to review the medical records before the examination, this change makes missed examinations even more costly. Designated doctors often travel several hours to the examination site, and rescheduled examinations can require significant travel obligations for all parties.

Agency Response: The Division disagrees, because such a requirement is unnecessary. Once a Division order has been issued, all parties subject to that order must comply. If a designated doctor is unable to contact an injured employee, the designated doctor should contact the Division for assistance. The Division further clarifies that injured employees are not required to contact a designated doctor before an examination, and a designated doctor's failure to contact an injured employee does not alleviate that designated doctor of the duty to attend the ordered examination.

§127.5(a): One commenter requests that OIEC ombudsmen receive the order for designated doctor examinations under this section.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.5(b): One commenter states that injured employees and designated doctors should be able to change locations without Division approval if both parties agree and that agreement is documented. These types of location changes are often to the mutual convenience of the parties. Alternatively, a designated doctor should be able to offer alternative locations for the examinations within 50 miles of the original county.

Agency Response: The Division disagrees. Permitting location changes without the knowledge of the Division would permit examinations to be held at potentially non-approved examination locations, thus preventing the Division from monitoring the suitability of the new location. Moreover, the Division selects designated doctors, in part, based on their stated available practice locations. Allowing these locations to change without Division approval thwarts this process.

§127.5(c)(3): One commenter states that this subsection should change "offered" to "performed." If the designated doctor is not certified on the date of the examination, the examination is not valid.

Agency Response: The Division disagrees. The Division can only verify if a designated doctor is certified the day the examination is offered, because certain extraordinary circumstances could lead to a designated doctor no longer being certified or otherwise available on the day the examination takes place, such as the issuance of an emergency cease and desist order by the Division. The Division emphasizes, however, that these instances are rare and in almost all cases a designated doctor certified on the day the examination is offered will be certified on the day the examination takes place. Furthermore, a doctor must be certified as a designated doctor to perform a designated doctor examination, and a doctor who violates this requirement commits an administrative violation.

§127.5(c)(4): One commenter states that if a designated doctor has ever treated an injured employee in a non-designated doctor capacity, this should be a disqualifying association. This follows the rationale that if the treating doctor is in the same network as the injured employee it has a disqualifying association.

Agency Response: The Division disagrees. The Division clarifies that §127.5(c)(4) does not exempt any doctor/patient relationships from its disqualifying association requirements. Specifically, as the Division previously stated in its December 17, 2010 adoption order for §127.5:

Comment: One commenter states that §127.5(c)(4) improperly operates as a special exception to the disqualifying associations described in 28 TAC §180.21. The commenter explains that this exception is improper because a designated doctor who had a doctor/patient relationship with an injured employee regarding another medical condition thirteen months before the designated doctor examination certainly creates a sufficient appearance of influence to preclude the designated doctor from being the designated doctor on the claim under 28 TAC §180.21.

Response: The Division disagrees. Section 127.5(c)(4) does not qualify any designated doctor to perform an examination, exempt any designated doctor from the disqualifying association provisions of 28 TAC §180.21, or otherwise operate as a special exception; instead, §127.5(c)(4) simply disqualifies two particular classes of designated doctors: those who have treated the injured employee on an unrelated medical condition within the past 12 months and those who have treated the injured employee on the medical condition at issue at any time. Thus, §127.5(c)(4) does not disqualify or qualify the designated doctor described in the commenter's example, because that designated doctor does not fit in either class addressed by §127.5(c)(4). Pursuant to §127.5(c)(1), however, the disqualifying association provisions of 28 TAC §180.21 would apply to the designated doctor described in the commenter's example just as it would apply to any other designated doctor. If the commenter, therefore, believes the application of 28 TAC §180.21 to such a designated doctor should disqualify that doctor from the claim at issue, the commenter may pursue that argument through the Division's dispute resolution process. (35 *TexReg* 11331).

The Division, therefore, declines to make the commenter's suggested change because whether or not the commenter's described scenario constitutes a disqualifying association may still be determined under the requirements of §127.140 of this title (relating to Disqualifying Associations).

§127.5(d): One commenter agrees with the use of the mandatory "shall" in this subsection.

Agency Response: The Division appreciates the support.

§127.5(e): A commenter suggests that if the designated doctor and injured employee agree and all medical records have been received, examinations should be able to be rescheduled before the originally scheduled examination. Another commenter suggests rescheduled examinations before the originally scheduled appointment should be permitted if the injured employee requests it, all other parties agree, and the Division approves.

Agency Response: The Division disagrees. Incorporating the commenter's suggested change into this subsection would require the Division to confirm the agreement of the insurance carrier, treating doctor, designated doctor, and injured employee and to verify receipt of medical records, and this practice would be too administratively burdensome for the Division. Additionally, there appears to be little advantage to these recommendations, because if the medical records have not been received, it is not appropriate to reschedule the examination before the original examination; and, if the records have been received, it is unlikely that there will still be sufficient time for the designated doctor to both fully review the records and to schedule the examination at an earlier date.

§127.5(e): One commenter states that designated doctors can only fulfill the obligation of informing parties of rescheduling if they receive all appropriate information.

Agency Response: The Division agrees, though the Division notes that inaccurate information does not relieve the designated doctor of the doctor's duty to contact the insurance carrier and treating doctor. If the designated doctor believes the information received is inaccurate, the designated doctor should contact the Division for assistance.

§127.5(e): One commenter requests clarification as to whether a new designated doctor appointed under §127.5(e) for failure to reschedule within 21 days will be retained and kept on as the designated doctor for all future examinations.

Agency Response: The Division clarifies that this determination will be made on a case-by-case basis and depend largely on the reasons for which the examination could not originally occur. In some cases, the selection of a new designated doctor may be necessary for the examination to occur, and, because the previously selected designated doctor never examined the injured employee, there should be no disadvantage to this new selection. The Division further clarifies, however, that if the originally selected designated doctor had previously examined the injured employee, the Division would not select a new designated doctor unless the original designated doctor had been authorized or compelled by the Division to stop providing services on the claim under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations).

§127.10(a)(2): One commenter states that OIEC ombudsmen should also receive the analysis as representatives do under this subsection.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether

OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.10(a)(2): One commenter states that the Division should specify that analyses under subsection must be neutral.

Agency Response: The Division disagrees. The requirements for these analyses are statutorily prescribed and the Division declines to expand upon that prescription.

§127.10(a)(3): A commenter asks the Division to clarify whether the examination must still take place if the medical records are not timely received.

Agency Response: The Division clarifies the examination shall still take place and be performed by the selected designated doctor at the originally scheduled or at a rescheduled date, because adopted §127.10(a)(3) provides that “the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records.”

§127.10(a)(3): One commenter states that this subsection is unclear as to when a physician should receive medical records from the division in order to comply with the regulation.

Agency Response: The Division clarifies that adopted §127.10(a)(3) requires a designated doctor to receive the medical records within three working days of the scheduled examination in all cases. It

is only in cases where this requirement is not met that the Division shall intervene to ensure that the medical records are received by the designated doctor.

§127.10(a)(3): One commenter notes that though the Division should be notified within 3 working days of the examination, the examination should not be cancelled until within one working day of the examination. Cancelling 3 working days out before the Division and parties can attempt to resolve the records issue may cause undue hardship on traveling parties.

Agency Response: The Division agrees in part and has made a change. The Division agrees that requiring cancellation in all cases in which a designated doctor notifies the Division that medical records have not been timely received may be an overly broad requirement. The Division, however, notes that, in many cases, prompt cancellation may be necessary to prevent unnecessary travel by the injured employee or designated doctor. In light of these determinations, the Division has changed adopted §127.10(a)(3). Specifically, the Division has deleted "shall not conduct the examination" and added "If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records."

§127.10(a)(3): One commenter states that the "shall" in this subsection should be a "may" given the number of participants in the process, the complexity of the process, and the fact there is so much room for error. Carriers are frequently at the mercy of vendors who habitually state that no records have been received, and there will, at times, be circumstances beyond the carrier's control.

Agency Response: The Division disagrees. "Shall" is correct because the Division will, in all cases, take some form of action in order to ensure that the designated doctor receives the necessary medical records. The Division clarifies that the action in any given case will vary upon the factors described by the commenter and other concerns, which may make an order to produce appropriate in some cases and a simple, clarifying phone call appropriate in others. The Division further clarifies that any action taken to ensure the designated doctor receives the medical records is separate from any enforcement action the Division may take if either the treating doctor or insurance carrier did, in fact, fail to timely submit the medical records.

§127.10(a)(3): One commenter states that records should be required to arrive five working days prior in light of the requirement to review the records before the examination.

Agency Response: The Division disagrees. Three working days is sufficient time for a designated doctor to review the records, especially because the designated doctor may still review and refer to those records after the examination of the injured employee.

§127.10(a)(3): One commenter states that designated doctors should report the violation within three working days of not receiving the records not one working day, so the complaint is made on the day of the violation.

Agency Response: The Division disagrees. The violation occurs on the day the designated doctor fails to timely receive the medical records. If the designated doctor waits three working days from the date the doctor fails to receive the records, the designated doctor would be reporting the violation three working days after the violation and would not provide the Division with sufficient time to rectify the situation and possibly allow the scheduled examination to proceed.

§127.10(a)(3): One commenter states that treating doctors and insurance carriers should be required to send records by verifiable means. There is currently no rule in place to enforce or monitor record submission, and the commenter states that the Division never takes action on these complaints.

Agency Response: The Division disagrees. Section 127.10(a)(3) plainly requires insurance carriers and treating doctors to submit these medical records to the designated doctor within 3 working days of the designated doctor examination; therefore, there is an enforceable standard for this duty and a verifiable means requirement is not necessary for this standard to be enforced.

§127.10(b): One commenter states that records provided by injured employees should be subject to the same timeframe as other system participants' medical records.

Agency Response: The Division disagrees. Unlike insurance carriers and treating doctors, the injured employee will be attending the examination, and, therefore, imposing an additional cost upon the injured employee to mail or fax their records to the designated doctor creates an unnecessary burden. Furthermore, unlike insurance carriers or treating doctors, injured employees are not required to submit medical records to the designated doctor.

§127.10(c): One commenter states that the Division should return to the 17 working days total time period for designated doctor reports that include testing or referrals. This extended period would ensure all necessary time for diagnostic testing.

Agency Response: The Division disagrees. First, the Division clarifies that its rules never contained a uniform 17 working days after the date of the examination deadline for designated

doctors to submit their reports after a referral for testing or examination by another health care provider. Instead, the former Division rule §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures) provided up to 17 working days for reports submitted after the date of an MMI/IR examination and up to 7 calendar days plus up to 10 working days to submit the report after the date of all other examinations. Under current §127.10(c) of this title, designated doctors have 15 working days after the date of all examinations to submit their reports. Thus, designated doctors have never uniformly been entitled to the deadline recommended by the commenter. Moreover, the Division finds the deadline requested by the commenter unnecessary in light of the Division's newly included exception to adopted §127.10(c) that permits a designated doctor to request that the Division grant the doctor additional time to submit the doctor's report, if necessary.

§127.10(c): Multiple commenters state that this proposed language lacks safeguards to ensure that the referrals are medically necessary and reasonable, and that the Division has the statutory duty to ensure that the workers' compensation system is cost effective. Designated doctors often order diagnostic testing that has been recently performed for the sake of generating revenue. This rule provision needs to be amended to clarify that a designated doctor may not order diagnostic testing when the testing is not medically necessary, not appropriate as related to the diagnosis, has previously been performed, exceeds the standard of care or is not required to complete the examination. Designated doctor testing should be the subject of a medical quality review panel audit and considered as a performance measure for designated doctor performance based oversight. Furthermore, the Division should take action on any complaints submitted by carriers to the MGRP and sanction violating doctors and order refunds to the carrier under Labor Code §413.016.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division fully agrees it has the responsibility of the Division to monitor this particular practice carefully, because of its unique exception from insurance carrier review. In light of this responsibility, the Division has added “requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing” to adopted §127.110(e)(4) of this title (relating to Designated Doctor Recertification) as a factor the Division will consider when determining whether to deny a designated doctor’s application for recertification. Additionally, the Division notes that unnecessary referrals may constitute an administrative violation under adopted §127.210(a) of this title. Furthermore, the Division encourages system participants to submit complaints regarding any possible unnecessary testing, and the Division will investigate those complaints and take all appropriate actions, including, if merited, the ordering of refunds.

The Divisions disagrees, however, that any amendments to §127.10(c) are necessary because this subsection already contains sufficient standards for the Division to monitor and regulate the necessity and merits of designated doctor referrals for examinations and additional testing.

§127.10(c): One commenter states that if the Division is going to require referrals for testing, it needs to assist designated doctors in finding these referral doctors. Many physicians will always decline workers’ compensation referrals.

Agency Response: The Division disagrees. While Division will make efforts to assist designated doctors in finding the appropriate referral providers, the Division reminds designated doctors that the ultimate duty to obtain all necessary testing and referrals falls upon the designated doctor. Furthermore, the Division reminds designated doctors that this standard simply returns to the

previous standard for referral examinations under repealed §126.7 of this title, which was in effect from 2006 until February 2011.

§127.10(c): One commenter agrees with designated doctor testing and referrals not being subject to retrospective review.

Agency Response: The Division appreciates the support.

§127.10(c): One commenter states this rule blurs the lines between treating doctor and designated doctor, which will decrease the objectivity of the designated doctor opinion. Treating doctors should be required to perform or request the necessary testing if it was suggested by the doctor.

Agency Response: The Division disagrees. Designated doctors must answer all questions submitted to them to a reasonable degree of medical certainty and if additional testing is necessary to achieve this certainty then the designated doctor must request it.

§127.10(d): One commenter agrees with this rule but disagrees with the repeal of §130.6. The commenter states that this change leaves injured employees no avenue to have injured areas claimed to be compensable examined by a designated doctor if those areas are disputed by a carrier. This matter should be addressed by designated doctors regardless of whether the injured employee or insurance carrier requested extent. House Bill 2605 did not require the repeal of §130.6 and by repealing this rule you have required injured employees to have direct knowledge of the designated doctors administrative system and to understand their diagnoses. This rule prevents designated doctors from examining disputed areas and denies due process to injured employees.

Agency Response: The Division appreciates the commenter's support on this subsection. The Division disagrees, however, with the commenter's concerns regarding the repeal of §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings) published elsewhere in this issue of the *Texas Register*. Though the Division also expresses its rationale for this disagreement in response to the commenter's comments on the repeal of §130.6 of this title, the Division reiterates here that the repeal of §130.6 was necessary for several reasons. Most relevantly, the majority of the rule's provisions were unnecessary because they were redundant with other rules related to designated doctor examinations found in Chapter 127 of this title. Additionally, the requirement that designated doctors issue multiple impairment ratings if the designated doctors determines that the extent of the injured employee's compensable injury is in dispute is no longer necessary because designated doctors can now be requested to opine on the extent of a compensable injury. When the multiple impairment rating requirement of §130.6 of this title was adopted in 2001, designated doctors could not opine on that issue. Therefore, because parties can now request that designated doctors provide an opinion on extent of injury in addition to MMI/IR, it is no longer appropriate to permit designated doctors to consider the extent of the injured employee's injury if the parties have not requested the designated doctor to do so.

The Division does clarify, however, that if a designated doctor is requested to address MMI/IR and not extent, the designated doctor should base the doctor's rating upon the medical records and other documentation provided to the doctor.

§127.10(e) - (f): One commenter requests that designated doctors be required to send copies of reports under these subsections to OIEC ombudsmen as well.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.10(f): One commenter states that designated doctors cannot fill out the DWC-068 if the information is not given. The Division should not accept a designated doctor examination request unless all information needed to complete the form required by this subsection is provided. Designated doctors should not be put into situation in which that information is not available.

Agency Response: The Division agrees and disagrees. The Division denies designated doctor examination requests based on the reasons provided in §127.1 of this title (relating to Requesting Designated Doctor Examinations) and declines to modify those reasons to address each individual field required by the DWC-068. That said, the Division agrees that a designated doctor may have difficulty providing information not supplied on the DWC-032, and the designated doctor should contact the Division if this should occur. Moreover, the Division clarifies that if the designated doctor was not provided information on a DWC-032 that should have been provided on that form, the Division will consider this factor heavily when evaluating the designated doctor's compliance with §127.220 of this title.

§127.10(g): Multiple commenters state that this rule does not clarify what weight should be given to a designated doctor's opinion on a question the designated doctor was not appointed to address.

The Division's appeals panel has been inconsistent on this issue. There is no statutory authority to give these opinions presumptive weight or to ignore them. Instead, it appears the proper remedy is to give those opinions appropriate weight based on credibility and the record as a whole.

Agency Response: The Division agrees and disagrees. The Division agrees that if a designated doctor opines on issues the designated doctor was not ordered to address, the designated doctor's report will not receive presumptive weight regarding those issues; instead, the report would be weighed as any other medical report on those issues that the designated doctor was not ordered to address. The Division disagrees, however, that §127.10(g) of this title is unclear on this issue.

Under §127.10(g), a designated doctor's report is only given presumptive weight on issues in question the designated doctor was properly appointed to address. If a designated doctor was not ordered to address an issue, the issue is not in question and the designated doctor was not appointed to address it; therefore, the doctor's report has no presumptive weight on those issues.

§127.10(h): One commenter states that this subsection should state that a carrier must only pay benefits for multiple maximum medical improvement examinations if the designated doctor was asked to address extent.

Agency Response: The Division agrees with this clarification, because it matches the intent of the Division's proposed amendment to this subsection and has made a change to the adopted subsection.

§127.20: One commenter requests that the Division require parties to resubmit a DWC-032 with requests for clarification, so that the designated doctor will have updated information on the injured employee's condition, particularly in circumstances in which the request is received long after the original examination.

Agency Response: The Division disagrees. If a designated doctor does not feel that the doctor has sufficient or sufficiently current information on an injured employee to respond to the request for clarification, the designated doctor should request that the Division order a reexamination. If, in fact, the request for clarification has come after dispositive and substantial changes have occurred on an injured employee's claim, a reexamination would likely be appropriate in most cases.

§127.20(a): Multiple commenters state that the Division should remove its proposed amendments to this rule. Some commenters state that this rule protects bad doctors at the expense of the rights of system participants. Most requests for clarification ask designated doctors to reconsider their decision or issue a new decision based on submitted evidence or legal considerations. This rule effectively eliminates this possibility and will require parties to go to benefit review conferences or contested case hearings, which goes against the system goals of workers' compensation. Other commenters state that to approve requests for clarification for only one reason (the doctor failed to address an ordered issue) is extremely limiting and makes the process largely futile. Requests for clarification are the most efficient way of correcting an error. Otherwise, these errors can only be corrected through litigation. For instance, requests for clarification can address instances in which multiple dates of maximum medical improvement and impairment ratings were required; when the impairment rating was calculated in error; or the report is incomplete and the ordered issue was not fully addressed. Also, designated doctors often do not meet the Division's Appeals Panel's standards

for medical probability when addressing causation or extent questions. Letters of clarification provided by designated doctors can remedy these defects.

Agency Response: The Division agrees in part and disagrees in part and has made a change. Specifically, the Division disagrees that prohibiting designated doctors from amending their reports would make the letter of clarification process futile. This prohibition would not have prevented doctors from resolving ambiguity in their reports or from further explaining their reasoning.

Nonetheless, the Division acknowledges and agrees, however, that in some cases permitting a designated doctor to correct an error in the doctor's report would expedite the dispute resolution process and curtail unnecessary litigation costs. Still, the Division also believes that designated doctors should only make these changes when the request for clarification submitted to them by the Division asks or permits them to do so. The Division, therefore, has made a change to this subsection. Specifically, the Division has removed its proposed limitations on requests for clarification and replaced them with this standard that clarifies the Division's current procedure when reviewing requests for clarification: "Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision." This standard, currently implemented by the Division, ensures that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution. Additionally, this standard also provides the Division the necessary discretion to monitor the quality and appropriateness of the requests and clarifies its authority to limit a designated doctor's responses to the request for clarification submitted to the doctor.

§127.20(a): One commenter agrees that the introduction of new or additional medical records through the request for clarification process should be disallowed.

Agency Response: The Division generally agrees that most requests which ask the designated doctors to review new or additional medical would most properly be denied and resubmitted as new examination requests; however, the Division declines to bar this practice entirely, as in some cases it may be appropriate.

The Division also notes that it has made a change to this subsection for other reasons as described above.

§127.20(a): One commenter states that this rule proposal is internally inconsistent in permitting parties to "request clarification on issues already addressed by the designated doctor's report" yet affirmatively limiting reconsideration or new decisions only to instances when the designated doctor failed to address an issue the designated doctor was ordered to address.

Agency Response: The Division disagrees with this alleged inconsistency. The commenter's alleged inconsistency only exists if clarification can only be achieved if the designated doctor reconsiders the doctor's decision or issues a new decision. Because the Division does not agree with this interpretation, the Division fails to see the alleged inconsistency in its proposed rule.

The Division also notes, however, that it has made a change to this subsection for other reasons as described above.

§127.20(a): One commenter states that this rule change is illogical, arbitrary, and capricious, and wholly ignores the purpose of clarification process utilized by injured workers and insurers to resolve observed vagueness, ambiguity, or problems in a received opinion as early in the process as

possible. The commenter strongly recommends the Division remove this arbitrary limitation on designated doctors to correct errors.

Agency Response: The Division disagrees in part and agrees in part and has made a change. The Division disagrees that its proposal was “illogical, arbitrary, and capricious.” The Division provided a rational basis for its proposed amendment. Specifically, the Division stated:

“This amendment is necessary to prevent overlapping determinations by a designated doctor that can both muddle the presumptive weight given to a designated doctor’s initial report and confuse an insurance carrier’s entitlement to reimbursement from the subsequent injury fund for benefits paid by the insurance carrier pursuant to an overturned designated doctor report. Furthermore, the Division also notes that this new standard for appropriate requests for clarification of a designated doctor parallels the standard for requests for clarification of an independent review organization’s decision under §133.308(t)(B)(iv) of this title (relating to MDR by Independent Review Organizations).

The Division fails to see how this constitutes arbitrary and capricious reasoning, particularly because this standard has been successfully implemented in the medical necessity dispute context.

These factors notwithstanding, the Division acknowledges and agrees, however, that in some cases permitting a designated doctor to correct an error in the doctor’s report would expedite the dispute resolution process and curtail unnecessary litigation costs and has, therefore, made a change to this subsection as described above.

§127.20(b)(3): One commenter states that leading questions are not always inflammatory and are often an essential means of reaching the truth. A party who believes that a designated doctor has misapplied the AMA guides must ask leading questions to inquire as to whether the designated doctor did comply with those guides.

Agency Response: The Division disagrees. Leading questions are not necessary to elicit truth nor determine compliance with the AMA Guides. For example, if a party needs to ask a designated

doctor whether the designated doctor complied with a particular provision of the AMA Guides, the party may simply ask the designated doctor if the doctor did so. The party does not need to suggest the preferred answer through the question or otherwise attempt to influence the designated doctor's response with the party's questions. The designated doctor is neither hostile nor adverse to any party and, therefore, direct questions are more than appropriate for the purposes of a request for clarification.

§127.25: Multiple commenters support this rule.

Agency Response: The Division appreciates the support.

§127.25: One commenter asks why an injured employee must request a new examination if the injured worker failed to contact he designated doctor within 21 days of the missed examination.

Agency Response: The Division clarifies that an injured employee must request a new designated doctor examination at that time in order to ensure that a rescheduled designated doctor examination of an injured employee who failed to attend an examination does not occur at a time so distant from the originally scheduled examination that the injured employee's medical condition or other dispositive circumstances may have changed. The submission of a new DWC-032 will prevent these outcomes.

§127.25(c): One commenter states that the rule should be amended to remove "if, after the insurance carrier suspends temporary income benefits" because designated doctors will not know if temporary income benefits have been suspended or ever received.

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

§127.100: One commenter states that the Division should implement a pre-approval process as well as a timeline for the certification process to temper the out-of-pocket expenses of designated doctors who apply but are not approved for certification. The commenter states that these expenses could be up to \$2200.

Agency Response: The Division disagrees. Completing all required Division training and testing is a threshold requirement for a doctor to even be considered a candidate to become a designated doctor. The time and other Division resources that would be expended by the Division reviewing physicians who may not even be able to pass all required testing would result in a waste of state resources.

§127.100(a): One commenter states that Division should replace its new active practice requirements with standards based on specific performance and adherence to the applicable aspects of regulation. Designated doctors all have active licenses and attend continuing medical education, and even the Division's own medical advisor could not meet the Division's proposed active practice standard.

Agency Response: The Division disagrees but has made a change for other reasons. The Division cannot base its original certification determination on the specific performance of a doctor, because, in almost all cases, a doctor applying for certification, as opposed to recertification, has never been a designated doctor before and, therefore, there is no performance to evaluate. Nonetheless, the Division has, for other reasons described below, modified this requirement to provide that a designated doctor must have had three years of active practice in their career and not within the past ten years.

§127.100(a) and §127.110(c): A commenter asks if the Division could simply e-mail copies of its treatment and return-to-work guidelines to designated doctors instead of requiring designated doctors to purchase the documents.

Agency Response: The Division declines to e-mail copies of its treatment guidelines and return-to-work guidelines to designated doctors. These guidelines are copyrighted material and the unlicensed distribution to designated doctors described by commenter would be inappropriate.

§127.100(a)(2): One commenter asks what are the required tests under this subsection and when will they be offered? The commenter also asks how often will designated doctors have to take these tests?

Agency Response: The Division will clarify the specific requirements of its new designated doctor certification and recertification tests later this year when it completes development of these tests. The Division does clarify, however, that pursuant to §127.110 of this title (relating to Designated Doctor Recertification), testing will be required bi-annually before a designated doctor can become recertified as a designated doctor.

§127.100(a)(4): Multiple commenters suggest that the Division remove its proposed active practice requirements. One commenter states that the proposed active practice requirements will put an undue burden on the workers' compensation system. Another commenter states that no changes in HB 2605 require this new requirement. Additionally, the Division's new designated doctor qualification criteria under proposed §127.130 does not involve the doctors current clinical practices but on the testing and training qualifications and the diagnosis and body part affected and doctor

license type. Therefore, it is not clear why the active practice requirement is necessary. It should be replaced with a requirement to have an active medical license and current continuing medical education.

Agency Response: The Division agrees in part and disagrees in part. The Division agrees that its proposed active practice requirement may be unnecessarily burdensome and could prevent some qualified doctors from becoming certified designated doctors. The Division, therefore, has elected to retain its current standard for active practice that requires designated doctors to have engaged in active practice for at least three years in their career not within the past ten years and has included this standard in adopted §127.100(a)(4). The Division believes this requirement sufficiently ensures that the doctor will have appropriate clinical knowledge to perform a physical examination while the Division's new, more rigorous training, testing, and certification standards will suffice to ensure that an applicant for certification has the necessary aptitude to address all issues that may be presented to a designated doctor.

The Division disagrees, however, with the commenter's suggested standard for certification, because it would not meet the necessary standards described above even in conjunction with the Division's other increased standards for certification as a designated doctor.

§127.100(a)(4): One commenter states that though this section certainly attempts to address the problem of doctors with limited recent clinical experience, this provision does not go far enough. It would still allow doctors out of practice for seven years to become designated doctors. The rule should require that within the past five years the doctor must have earned as much treating patients as providing expert opinions.

Agency Response: The Division disagrees with the commenter's suggested standard for designated doctor certification because it would be nearly impossible for the Division to verify unless the Division fully audited an applicant's income from practice over a five year period, which is not administratively feasible. Moreover, the Division has also determined, for reasons stated above, that its current standard for active practice will continue to suffice for the purposes of designated doctor certification and has, therefore, elected to retain this standard.

§127.100(a)(5): One commenter asks how the Division will verify compliance with this requirement.

Agency Response: The Division will verify this compliance through required attestations by the designated doctor in a conjunction with its normal investigation and monitoring of designated doctor compliance.

§127.100(c): One commenter states that if a designated doctor takes the certification test early, that designated doctor's certification should be extended to compensate for the early training in light of the few trainings offered by Division.

Agency Response: The Division disagrees. Designated doctor certifications in all cases, unless revoked or suspended, last for two years and this duration can neither be shortened nor extended by the date the designated doctor completes the Division's required testing.

§127.100(d)(3): One commenter states that the term "relevant restriction" is vague and should be detailed because it is a reason for denial. This requirement as proposed may be subject to too much interpretation.

Agency Response: The Division disagrees. The Act provides the Division with the discretion to determine the appropriate standards for certification as a designated doctor, and, therefore, the Division declines to limit this discretion with unnecessary specification. The Division has successfully implemented this standard for certification since 2006 and believes it will continue to suffice for this purpose. The Division does clarify, however, that, pursuant to §127.100 of this title (relating to Designated Doctor Certification) the Division will inform a doctor of the reason for its denial of the doctor's application for certification and the doctor will have the opportunity to respond to that reason in writing.

§127.100(d)(4): One commenter states that "other activities" is unclear and vague and should be detailed because it is a reason for denial.

Agency Response: The Division disagrees. The Act provides the Division with the discretion to determine the appropriate standards for certification as a designated doctor, and, therefore, the Division declines to limit this discretion with unnecessary specification. The Division has successfully implemented this standard for certification since 2006 and believes it will continue to suffice for this purpose. The Division does clarify, however, that, pursuant to §127.100 of this title (relating to Designated Doctor Certification) the Division will inform a doctor of the reason for its denial of the doctor's application for certification and the doctor will have the opportunity to respond to that reason in writing.

§127.110(a) and (c): One commenter states that designated doctors should not have to take recertification examinations if they maintain their continuing medical education. It is unnecessary and financially burdensome.

Agency Response: The Division disagrees. Continuing medical education will not address the workers' compensation specific issues regularly presented to a designated doctor and, therefore, will be insufficient for the purposes of designated doctor recertification. The Division tailors its training and testing to ensure that designated doctors are prepared for and sufficiently competent to address questions posed to them. The Division further clarifies that any financial burden imposed on a designated doctor are voluntary as no doctor is required to be a designated doctor.

§127.110(a)(2): One commenter states that designated doctor recertifications should be effective on the date approved and not on the date the training was completed. If it is on the training date, the certification time period should compensate for early training.

Agency Response: The Division disagrees. Certifications will generally be effective on the day after the last effective day of the designated doctor's previous certification to prevent a lapse in certification. The Division notes, however, that late filing of applications for recertification could cause a lapse in certification. In all cases, barring a suspension or revocation of certification, the designated doctor's certification will only be effective for two years.

§127.110(b)(2): One commenter asks how the Division will verify compliance with this requirement?

Agency Response: The Division will verify this compliance through required attestations by the designated doctor in a conjunction with its normal investigation and monitoring of designated doctor compliance, including the investigation of complaints and auditing of designated doctors.

§127.110(b)(3): One commenter states that the application to become a designated doctor asks about a designated doctor's active practice requirements. Does this imply that they have to meet this requirement for recertification? Do designated doctors have to complete MMI/IR testing?

Agency Response: The Division clarifies that its active practice requirements only apply to doctors applying for their initial certification as a designated doctor and not to designated doctors applying for recertification. Additionally, the Division clarifies that designated doctors will be required to complete all Division required testing in order to be approved for recertification and that, for designated doctors, testing required to assign impairment ratings is simply one element of the required testing to maintain designated doctor certification.

§127.110(c): One commenter recommends that the rule be amended to permit expiring designated doctors to still be able to perform reexaminations and respond to letters of clarification during the 45 day pre-expiration period. Assigning a new designated doctor in these situations would be a great system cost.

Agency Response: The Division agrees and has made a change. The 45 day pre-expiration period is only intended to prevent designated doctors from receiving offers of new examinations and not to prevent the designated doctor from providing all services on claims to which the designated doctor was previously assigned and the Division has made a change to clarify this point.

§127.110(c): One commenter states that this rule will be impossible to impose because the Division only offers its training four times a year. Also, the grace period of thirty days after expiration is not sufficient time for a doctor to apply for recertification based on current designated doctor training availability.

Agency Response: The Division disagrees. First, the Division clarifies that the Division currently does and will continue to offer more frequent training than claimed by the commenter. Even if the commenter's statement were correct, however, quarterly training would still be sufficient for a designated doctor to meet the certification requirements. Moreover, the thirty day grace period is more than sufficient considering that a designated doctor had eighteen months to meet all applicable requirements. The thirty day grace period is intended simply to help designated doctors adjust to the implementation of these new recertification requirements.

§127.110(c): One commenter states that the affirmative opt-out of this rule and §127.110(a)(3) of this section should be removed. This penalty seems excessive. A doctor who fails to inform that the doctor no longer wishes to be a designated doctor the Division should simply expire.

Agency Response: The Division agrees and has made a change. Specifically, the Division has deleted the requirements that doctors who no longer wish to be certified as designated doctors must notify the Division of this fact or commit an administrative violation from both §127.110(a)(3) and §127.110(c). The Division has further clarified under these subsections that only designated doctors who seek to remain certified as designated doctors and fail to timely renew their application status under §127.110(a)(3) or timely apply for recertification under §127.110(c) commit an administrative violation. The Division believes these changes remove the possibly excessive penalty discussed by the commenter while also ensuring that designated doctors who no longer wish to be designated doctor after their current certification expires are not included in the timely filing requirements.

The Division notes that it has also changed §127.200(a)(5) in response to this comment to clarify that only designated doctor who wishes to stop practicing as a designated doctor before the doctor's current certification as a designated doctor expires must provide the Division with written

notice in advance of the doctor's voluntary exit from the designated doctor program. This change is necessary to clarify that this requirement does not apply to a designated doctor who will simply not be renewing the doctor's certification as a designated doctor but intends to practice as a designated doctor for the duration of the doctor's current certification.

§127.110(d): One commenter states that this section should be changed from two years to two years from the date of approved.

Agency Response: The Division disagrees. The Division will, in all possible cases, choose the date that both ensures no lapse of certification while also preventing an overlap of certifications. In cases of delinquent application for recertification, however, there may be a lapse in certification and the Division will determine an appropriate effective date for the certification on a case-by-case basis. The Division also notes that a designated doctor's initial certification under §127.100 of this title will become effective on the date the doctor's application for certification is approved by the Division.

§127.110(e)(4)(E): One commenter states that this requirement appears very subjective and it is unclear who will decide whether the criterion is met.

Agency Response: The Division clarifies that the Division's Medical Advisor, Medical Quality Review Panel, and other medical staff will review for compliance with this standard. The Division disagrees with the alleged "very subjective" nature of this requirement, because this form of medical case review is a common practice for the Division and compliance with it can be determined with a reasonable degree of medical certainty through expert reviews and dialogue with the subject of the review.

§127.120: One commenter generally supports the rule but seeks that the rule provide that the doctor shall be paid the same reimbursement amount as a doctor located in Texas. The commenter states that the fee for Texas doctors is more than adequate.

Agency Response: The Division disagrees. For out-of-state injured employees, the Division must have the authority to take whatever steps necessary to ensure that a designated doctor examination can be performed. Furthermore, the Division reminds system participants that, pursuant to §413.011(d-4), an insurance carrier may contract with a health care provider for fees in excess of the Division's fee guidelines if necessary to secure health care for an injured employee. Lastly, the Division notes that reimbursement rates for designated doctors are governed by §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services) and is currently outside the scope of these rules.

§127.120: One commenter asks if the Division will provide all parties with written notice of any waived requirements prior to the exam in order to avoid complaints from the parties.

Agency Response: The Division clarifies that it will make all possible efforts to inform parties and Division staff involved in any subsequent dispute resolution processes of any exceptions made to its designated doctor certification requirements.

§127.130: One commenter states that the Division maintains the sole responsibility to determine the qualification of a designated doctor for a particular claim based on previously provided information and matrix completion. The responsibility should be on Division to confirm the designated doctor's matrix matches the particular claims.

Agency Response: The Division agrees. The Division agrees that it will assign all doctors to claims based on the information it has regarding the claim and the information it has on the doctor. The Division reminds designated doctors, however, of their duty under §127.200(a)(12) of this title (relating to Duties of a Designated Doctor) to notify the Division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would required the doctor to exceed the scope of practice authorized by the doctor's license.

§127.130: One commenter states that the commenter generally supports this section but also thinks designated doctors should be required to refer to specialists if the designated doctor is not qualified completely for the claim.

Agency Response: The Division agrees but notes that §127.10(c) of this title already requires a designated doctor to refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question.

§127.130(b): One commenter states that this subsection will be extremely problematic to all system participants and will ultimately increase costs and promote unnecessary delays in resolving disputes. The specialist requirements of §127.130(b)(5) - (8) will make it harder for the Division to find qualified physicians who will accept the appointment. Moreover, the exception in subsection (d), which actually undermines this rule, will only delay disputes and increase costs.

Agency Response: The Division disagrees. The Division believes this subsection will decrease system costs and expand access to care. The Division anticipates that very few designated doctor examinations will fail to have a qualified designated doctor because of the "specialist requirements"

of this subsection. Moreover, the Division emphasizes that Labor Code §408.0041 requires the Division to account for specific diagnoses, among other factors, when determining the credentials appropriate for a particular designated doctor examination.

Additionally, the Division disagrees that §127.130(d) of this title undermines this subsection, because the Division must have such an exception as a safeguard for instances in which no doctor qualified under this subsection is available to perform the examination. In these instances, the Division will rely on other designated doctors who through the use of referrals for specialist consultations and their training as designated doctors to incorporate these referrals into their reports can still produce a designated doctor report of high quality.

§127.130(b): One commenter states that the human body cannot, in all cases, be separated into different parts. Frequently, one part will affect another and the pathology spreads. Only a doctor with proper training and experience can appreciate the "wholeness" of the human body.

Compensable body parts are not a decision to be made by an insurance carrier.

Agency Response: The Division clarifies that any dispute by an insurance carrier regarding the compensability of a claim or the extent of a compensable injury must ultimately be resolved by the Division if the injured employee disagrees with the insurance carrier's determination. Regarding the commenter's statement on the wholeness of the human body, Labor Code §408.0041 requires the Division to select designated doctors for examinations based, in part, on the injured employee's diagnosis and body party affected by the injury.

§127.130(b): One commenter is concerned about the subsequent review of a patient who has undergone or been referred for surgical intervention. The commenter states that the rules should

reflect that when a surgical intervention has been proposed or performed, a surgeon with the same or similar licensure and certification should perform the designated doctor examination.

Agency Response: The Division disagrees. While the Division acknowledges that surgical intervention may create unique clinical circumstances in a particular claim, the Division notes that the statutory factors the Division must consider when assigning a designated doctor to a claim are the injured employee's diagnosis and the body part(s) affected by the injury. The Division also notes, however, that designated doctors are required to refer injured employees for evaluations by other health care providers if the designated doctor is not qualified to perform the evaluation and the evaluation is necessary to answer the issue in question.

§127.130(b): One commenter states that a designated doctor's background, education, training, or board certification have no bearing on the quality of a designated doctor's report. The quality of a report is contingent on the effort of the designated doctor and on the designated doctor's education regarding the AMA Guides, 4th Edition and how to address the issues on the DWC-032. There needs to be a test to reflect these skills. The commenter states that nothing in the training of a medical doctor or doctor of osteopathy prepares the doctor to perform designated doctor examinations except for the actual patient examinations. Designated doctor practice should be treated like a specialty with substantial maintenance requirements.

Agency Response: The Division disagrees. While the Division agrees that a designated doctor's personal effort and specific education regarding the applicable version of the AMA Guides and other workers' compensation issues are critical to a designated doctor's ability to produce quality reports, the Division strongly disagrees that a designated doctor's background, education, training, or board certification have no bearing on this quality as well. Furthermore, the Division notes that a system

that attempted to assign designated doctors through standards based on personal effort and knowledge and application of the AMA Guides would lead to subjective doctor selections on an unacceptable number of examination requests and, therefore, inconsistent assignments of designated doctor examinations. One strength of the Division's adopted selection criteria for examinations that occur on or after January 1, 2013 is the objective standards it uses in its selection process and, therefore, the transparency in the selection of a designated doctor it provides to system participants.

§127.130(b): One commenter states that physicians certified in emergency medicine are not qualified to perform any designated doctor evaluations. Emergency medicine physicians only have training in acute conditions.

Agency Response: The Division disagrees. First and foremost, the Division disagrees that physicians board certified in emergency medicine are not qualified to perform any examinations, because the Division has determined that for the vast majority of diagnoses seen in the Texas workers' compensation system, specifically those covered by §127.130(b)(1) - (7) of this title, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

Furthermore, the Division also believes that designated doctors who are board certified in emergency medicine are among those physicians specially qualified to perform examinations on certain complex diagnoses that are uncommon in the workers' compensation system. Specifically, the Division believes that board certification in emergency medicine will especially qualify a

designated doctor to examine multiple bone fractures, certain chemical exposures, and heart and cardiovascular conditions because these conditions most frequently present in the emergency room context and are, therefore, frequently seen by these physicians, especially multiple bone fractures. And though the Division acknowledges that the long-term outpatient treatment of these conditions would likely not be performed by a doctor board certified in emergency medicine, their frequent experience with those conditions is rare and applicable and, moreover, their experience with these conditions as acute conditions will be particularly helpful when examining injured employees for extent of injury or medical causation issues.

§127.130(b): One commenter states that physicians who are board certified in Occupational/Preventive Medicine are not qualified to perform designated doctor examinations.

Agency Response: The Division disagrees. First and foremost, the Division disagrees that physicians board certified in occupational/preventive medicine (occupational medicine doctors) are not qualified to perform any examinations, because the Division has determined that for the vast majority of diagnoses seen in the Texas workers' compensation system, specifically those covered by §127.130(b)(1) - (7) of this title, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

Additionally, the Division believes that occupational medicine doctors are among those physicians specially qualified to perform designated doctor examinations on several complex diagnoses infrequently seen in the workers' compensation system. These diagnoses include spinal cord injuries, severe burns, and multiple bone fractures under §127.130(b)(8)(B), (C) and (E)

because occupational medicine doctors are familiar with and trained to evaluate these injuries in the chronic phase for return-to-work and extent of injury issues and are generally trained to assess post-trauma patients for fitness for duty and functional ability. The Division has also determined that occupational medicine doctors are qualified to evaluate CRPS under §127.130(b)(8)(D) because occupational medicine doctors are trained in their residency to evaluate and diagnose this condition that is most frequently related to work-related injuries. The Division has also determined that occupational medicine doctors are qualified to evaluate complicated infectious diseases under §127.130(b)(8)(F) because occupational medicine doctors frequently provide post-exposure prophylaxis for blood borne pathogen exposures, are involved in the care of patients who contract infectious diseases from their work, and are trained in travel medicine for that purpose. The Division has also determined that occupational medicine doctors are qualified to evaluate chemical exposures under §127.130(b)(8)(G) because occupational medicine doctors are trained in toxicology and routinely assess patients for possible chemical exposures at work and also provide medical surveillance to prevent these exposures. Finally, the Division has determined that occupational medicine doctors are qualified to evaluate cardiovascular conditions under §127.130(b)(8)(H) because occupational medicine doctors must routinely perform cardiovascular assessments for fitness for duty examinations, medical surveillance, driver examinations for other agencies, and, in many instances, as Aviation Medical Examiners for pilots.

§127.130(b): One commenter states that this subsection will substantially decrease the qualifications for a designated doctor and will result in the substantial decrease in the quality of designated doctor evaluations, increase costs to injured employees and insurance carriers, and adversely affect injured employee care. Essentially, the proposed rules seem to indicate that any physician who takes a two

day course for evaluating maximum medical improvement and has a copy of the appropriate AMA guides has sufficient training to act as a designated doctor. The commenter concludes musculoskeletal injuries, other than the most minor injuries, should be treated by either an orthopedic surgeon or a specialist in physical medicine and rehabilitation.

Agency Response: The Division disagrees. The Division believes the commenter's characterization of the Division's current training is inaccurate. The Division's training has changed in recent years and expanded its coverage of all issues a designated doctor must address and not simply MMI. Furthermore, the Division, in light of the HB 2605 amendments to §408.1225, is currently in the process of developing new tests and training required for designated doctor certification that will further ensure that designated doctors certified or recertified by the Division will be more than adequately trained to evaluate the vast majority of injuries presented to that doctor provided those injuries can be evaluated by that doctor within the scope of the doctor's license. Thus, the Division believes that this subsection, in addition to the other rules adopted with this subsection, will increase the quality of designated doctor examinations and reports. Lastly, the Division notes that qualification standard recommended by the commenter would likely lead to drastic access to care issues because it would reduce the number of qualified designated doctors by approximately 75% and, therefore, appears largely administrative infeasible.

§127.130(b): One commenter states that this subsection subverts the legislative intent of Labor Code §408.0041 and §408.0043. If the legislature meant "professional licensure" it would have not stated "professional certification." While the conflict provision included in this subsection may match the letter of law, it overrides this legislative intent of these sections.

Agency Response: The Division disagrees. The Division must comply with the Act and declines to ignore the plain language of its provisions, including the conflict provision in Labor Code §408.0041(b-1) mentioned by the commenter. Additionally, the Division notes that the legislative intent behind amendments made by HB 2605 to §408.0041, including amendments governing the criteria to be used by the Division in selecting a designated doctor, can be found in the Sunset Advisory Commission's final decisions regarding the Texas Department of Insurance, Division of Workers' Compensation. A copy of the Sunset Advisory Commission's report can be found here: http://www.sunset.state.tx.us/82ndreports/wcd/wcd_fr.pdf.

§127.130(b)(1): One commenter states that the qualified designated doctors under this subsection should be limited to orthopedic and hand surgeons and physicians certified in physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph and §127.130(b)(2) - (7).

§127.130(b)(1) - (7): One commenter states that these categories are broad and could let a doctor practice outside the scope of their license. The commenter states that though the Division's new

scope of license requirements should prevent most of these outcomes, §127.130(b)(4) is still concerning, specifically regarding the definition of "foot." The Division should expressly exclude the "ankle" from this subsection pursuant to *Texas Orthopaedic Ass'n v. Texas State Bd. of Podiatric Medical Examiners*, 254 S.W.3d 714 (Tex. App.—Austin 2008, pet. denied). Also, "relating to" is too broad and implies inclusion of the ankle because the ankle is related to the foot.

Agency Response: The Division disagrees. Though the Division acknowledges that it may be possible that in some exceptional circumstances its qualification criteria under §127.130(b) could permit a designated doctor to exceed the scope of their license, the Division believes the duty that this section and §127.200 of this title (relating to Designated Doctor Duties) imposes on designated doctors to notify the Division if the doctor's participation on a claim would cause the designated doctor to exceed the scope of the doctor's license suffices to remedy these exceptional circumstances and, moreover, presents the most administratively feasible means of addressing this issue. Regarding the commenter's concerns regarding §127.130(b)(4), the Division declines to make the recommended exclusion or amendment. These scope of license determinations are best made by practitioners subject to the applicable laws and licensing boards, and the Division expects its designated doctors to be vigilant and forthcoming in informing the Division if they feel a claim would require the designated doctor to exceed their scope of practice.

§127.130(b)(2): One commenter states that the qualified designated doctors under this subsection should be limited to orthopedic surgeons and doctors board certified in physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can

evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1), and §127.130(b)(3) - (7).

§127.130(b)(3): One commenter states that the qualified designated doctors under this subsection should be limited to doctors board certified in orthopedic surgery, neurosurgery, physical medicine and rehabilitation, and chiropractic for injuries to the spine. The commenter also states that for torso injuries, general surgeons would be preferred.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1) and (2), and §127.130(b)(4) - (7).

§127.130(b)(4): One commenter states that the qualified designated doctors under this subsection should be limited to doctors board certified in orthopedic surgery and physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1) - (3), and §127.130(b)(5) – (7).

§127.130(b)(5): One commenter states that the designated doctors qualified under this subsection should be limited to licensed dentists or doctors board certified in plastic surgery.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

§127.130(b)(6): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in ophthalmology or licensed in optometry.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately

qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

§127.130(b)(7): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in family medicine, ear, nose, and throat, or plastic surgery, except for mental and behavioral conditions. Those conditions should be evaluated by a psychiatrist or psychologist.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph and §127.130(b)(1) - (6). The Division also notes that psychologists cannot become designated doctors, because they are not "doctors" as that term is defined in the Act.

§127.130(b)(8): One commenter states that board certified providers will not produce better reports. While they may provide better treatment, designated doctors perform evaluations not treatment and the State-approved training makes distinctions based on certification. The assignment of designated doctor examinations should be equal among all designated doctors based on their scope of practice. This would comply with the intent of Labor Code §§408.0041, 408.0043, and 408.0045.

Agency Response: The Division disagrees. The Division believes that for the certain complex and uncommon diagnoses, physicians with more extensive clinical expertise and appropriate designated doctor training will be optimally qualified to produce the most high quality reports in the most expedient fashion. The Division agrees that designated doctors do not provide treatment but this fact does not make clinical experience irrelevant, particularly for the complex diagnoses selected by the Division that many practitioners may have no or little experience in treating or evaluating. Lastly, the Division notes that Labor Code §408.0041 requires the Division to take specific diagnoses into account when determining the credentials appropriate for a doctor selected to perform designated doctor examination.

§127.130(b)(8): One commenter states that “board certification” implies an assumption that board certified doctors know what they're doing, particularly in regard to pain management doctors and the diagnosis of RSD.

Agency Response: The Division agrees that “board certification” implies that board certified doctors “know what they’re doing” and the Division agrees with this implication. Furthermore, the Division also believes that physicians board certified in anesthesiology with a subspecialty in pain management are among those physicians specially qualified to evaluate complex regional pain syndrome or RSD.

§127.130(b)(8): One commenter states that board certification is not necessary to address dislocations or tendon lacerations. These issues are thoroughly addressed by the Official Disability Guidelines and American Medical Association’s Guidelines to the Evaluation of Permanent Impairment. A designated doctor’s reports are the best gauge of their competence.

Agency Response: The Division agrees that board certification is not required to examine these issues, because these diagnoses are frequently treated and evaluated by all physicians in the workers' compensation system and, therefore, any licensed medical doctor or doctor of osteopathy appropriately trained as a designated doctor should be able to evaluate these diagnoses. The Division, therefore, has moved these diagnoses to §127.130(b)(7) of this title.

§127.130(b)(8): Multiple commenters state that it is not clear why chiropractors are excluded from this subsection when the use of the "SP" modifier has always been in place for exactly this reason i.e., in order to reach out to a specialist for a consultation. Is use of the "SP" modifier being removed?

Agency Response: The Division clarifies that neither this subsection nor any other rule adopted in this order remove the authority for a designated doctor to request the consultation of a specialist if necessary and appropriate under §127.10(c) of this title. The Division, however, also clarifies that the Division does not believe that the diagnoses in this subsection would generally fall within the scope of a chiropractor's license and, therefore, excludes them from this subsection.

§127.130(b)(8): One commenter states that a better solution to the criteria in this subsection is simply to allow designated doctors to use referrals under §127.10(c) of this title.

Agency Response: The Division disagrees that permitting designated doctors to use referrals under §127.10(c) of this title would produce better qualification outcomes than the criteria the Division has currently adopted, because the Division believes that the clinical background and training of the physicians selected in this subsection provides them with greater experience and familiarity in evaluating the uncommon and complex diagnoses under this subsection. Moreover, the Division notes that though most designated doctors could also produce reports of sufficient quality

on these diagnoses with the proper use of referral consultations, the physicians selected under this subsection are optimally qualified because they would not require referrals, leading to more expedient outcomes and high-quality reports. Additionally, Labor Code §408.0041 requires the Division to consider the diagnoses of a injured employee when establishing the appropriate qualification criteria for designated doctor selection and simply requiring the use of referrals would not meet this requirement.

§127.130(b)(8): One commenter states that it is not clear that the Division is properly applying Labor Code §408.0043. The Division's listed certifications do not appear to match the requirements of this section. Specifically, it is not clear whether occupational medicine certification is appropriate to treat traumatic brain and spinal cord injuries, complicated infectious diseases, or cardiovascular conditions. The commenter doubts that this certification would be appropriate and recommends the Division review this section to make it more closely conform with Labor Code §408.0043.

Agency Response: The Division disagrees that it is not properly applying Labor Code §408.0043 in this subsection. As the Division explained in its proposal of these amendments and earlier in this adoption order, the new conflict provision in Labor Code §408.0041(b-1) is dispositive in determining the proper application of Labor Code §408.0043 to designated doctor selection. Specifically, HB 2605 amended §408.0041(b-1) to provide that while Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing an examination, if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. Thus, though both Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, Labor Code §408.0041 also requires designated doctor examinations to be performed by the next available designated doctor who meets the Labor Code §408.0041(b) criteria.

§127.130(b)(8): One commenter states that doctors should be able to be board certified by "any equivalent board" not simply the ABMS or AOABOS. The Division had this provision in its informal draft but has excluded it from this proposal.

Agency Response: The Division disagrees. The ABMS and the AOABOS are the standard certifying boards approved by the Texas Medical Board for the specialties included in this subsection, and the Division has, therefore, elected to limit its definition of board certification to certifications granted by the member boards of the ABMS and the AOABOS. See 22 Texas Administrative Code §164.4. The Division acknowledges that the Texas Medical Board also approves board certifications by other certifying boards on a case-by-case basis, but the Division has no procedures or standards to perform these evaluations and, therefore, this exception is administratively infeasible for the Division to implement. Furthermore, the Division notes, as discussed above in the preamble description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

§127.130(b)(8): One commenter states that finding board certified doctors is more difficult, particularly in rural areas where the doctors are also likely to have a disqualifying association.

Agency Response: The Division disagrees. As discussed above in the Division's description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the

Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

The Division does acknowledge, however, that this data cannot fully anticipate the effects of disqualifying associations and changes in designated doctor travel patterns; therefore, the Division assures system participants that the Division will closely monitor access to care outcomes throughout 2013 and beyond to ensure that the Division's new qualification standards have anticipated successful impact.

§127.130(b)(8): One commenter states that appointments under this subsection will increase burdens on the Division. These types of cases are rare, and, therefore, designated doctors will be less likely to accept these single appointments because of the additional costs of travel. Also, designated doctors who are board certified will decrease their traveling locations to avoid these cases, because the state average "no-show" rate is estimated to be around 20% to 25% and that rate will likely be higher in uniquely burdensome cases such as these.

Agency Response: The Division disagrees that this subsection will increase burdens on the Division. As discussed above in the Division's description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements. Thus, the Division anticipates a relatively manageable implementation of this new standard beginning on January 1, 2013. The Division also notes that a consistent pattern of turning

down examinations by a designated doctor, even if the doctor never exceeds the 4 declined appointment offers in a given 90 day period, will likely be a factor the Division will consider when examining the designated doctor's application for recertification. Additionally, the Division notes that based on its internal data less than 9% of examinations involve a "no-show" by an injured employee.

Lastly, the Division does acknowledge, however, that this data cannot fully anticipate the effects of disqualifying associations and changes in designated doctor travel patterns; therefore, the Division assures system participants that the Division will closely monitor access to care outcomes throughout 2013 and beyond to ensure that the Division's new qualification standards have anticipated successful impact.

§127.130(b)(8): One commenter states that the Division does not have enough designated doctors board certified in neurosurgery or neurology to meet the demands of this subsection. Fortunately, the Division has included its exception under §127.130(d) of this title.

Agency Response: The Division disagrees it has insufficient numbers of qualified doctors to perform examinations under this subsection for reasons stated above but appreciates the support regarding its safeguard availability provision in §127.130(d) of this title.

§127.130(b)(8)(A): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in neurosurgery, neurology, and physical medicine and rehabilitation. The commenter's excludes physicians board certified in psychiatry from this subsection.

Agency Response: The Division agrees and disagrees. The Division disagrees that physicians board certified in psychiatry are not qualified to examine traumatic brain injuries, because physicians

board certified in psychiatry have training and background through their residency in neurological testing and evaluations and, furthermore, are qualified to test and evaluate the cognitive function of an injured employee who has suffered a traumatic brain injury.

The Division agrees, however, that physicians board certified in neurology or neurosurgery are appropriately qualified and, therefore, did and continues to include them in this subsection. Lastly, the Division also agrees with the commenter that designated doctors board certified physical medicine and rehabilitation are qualified and sufficiently trained to perform evaluations under this subsection and has added them to this subsection. Doctors board certified in physical medicine and rehabilitation are frequently in charge of treating patients with traumatic brain injuries in the subacute and chronic phase of these injuries and also have extensive neurological training.

§127.130(b)(8)(B): Multiple commenters state that the phrase "profound peripheral neuropathy" is broad and vague. The commenters ask what range of neurological involvement will this phrase cover? It seems that any and all motor or sensory complaints could meet this description and peripheral neuropathy is within the scope of license of a chiropractor. The commenters ask for more specific ICD-9 codes that could be used.

Agency Response: The Division agrees that this term is unacceptably vague and has removed it from this subsection. The Division has determined that the severe neuropathies intended to be captured by the deleted term will still be captured under the chemical exposure diagnoses found in §127.130(b)(8)(G) of this title and, therefore, the deletion of the term will also not permit non-qualified designated doctors to evaluate these diagnoses.

§127.130(b)(8)(B): Multiple commenters state that "spinal cord injuries" is vague. The commenters ask, for instance, would it cover a multiple level disc bulge causing stenosis or does it include disc injuries causing nerve root impingement. More specific language would be helpful.

Agency Response: The Division disagrees that "spinal cord injuries" is vague. A spinal cord injury is a diagnosis based upon objective clinical signs, acute and chronic characteristics, and historical and physical findings of spinal cord damage. Furthermore, neither diagnosis mentioned by the commenter would necessarily qualify as a spinal cord injury. A multiple level disc bulge causing spinal stenosis is a radiological diagnosis that does not imply spinal cord damage but may affect spinal cord function. Additionally, disc injuries causing nerve root impingement do not qualify as spinal cord injuries because they affect nerve fibers outside the spinal cord.

§127.130(b)(8)(C): One commenter states that general surgeons should be able to examine severe burns. The head of the "burn department" at Texas Tech is a general surgeon. The commenter states that the only certification that the Division has included under this subsection that is relevant to burns is plastic surgery.

Agency Response: The Division agrees that physicians certified in general surgery would be appropriately qualified to examine injured employees with diagnoses with under this subsection and has made a change.

§127.130(b)(8)(D) - (H): One commenter states that the Division has removed doctors board certified in family medicine from these subsections, but the commenter believes they are appropriate in these subsections. The commenter states that the exclusion of doctors board certified in family medicine from this subsection may create access to care issues in rural areas.

Agency Response: The Division disagrees. First, the Division clarifies that the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

Additionally, however, the Division also does not believe that physicians board certified in family medicine (family medicine doctor) will meet the optimally qualified standards of these subsections. Specifically, the Division does not agree family medicine doctors would be optimally qualified to evaluate complex regional pain syndrome (CRPS), because their training in the complexities of anatomy, pathophysiology, and treatment of peripheral nerve, spinal nerve root, and spinal cord ailments is limited. Additionally, CRPS is very uncommon and controversial diagnosis and family practice doctors may not be familiar with current developments regarding this diagnosis because they typically refer the patient to specialists who diagnose and manage the care short and long term. Furthermore, the Division also disagrees family medicine doctors should be included in §127.130(b)(8)(E), because family medicine doctors would not typically see multiple bone fractures in their office practice.

Additionally, the Division declines to include family medicine doctors under §127.130(b)(8)(F) of this title because family medicine doctors typically do not admit patients to hospitals to care for infectious processes requiring intravenous antibiotics, so do not have the requisite residency training to evaluate patients hospitalized for prolonged antibiotic treatment. Lastly, the Division declines to include family medicine doctors under §127.130(b)(8)(G), because though family medicine physicians are trained to diagnose and treat cutaneous and ingested forms of exposure, inhalation

exposure is more complex in its causation and evaluation and family doctors typically would not treat these conditions.

§127.130(b)(8)(E): Multiple commenters state that this subsection does not explain whether "multiple bone fractures" must be displaced or nondisplaced. Doctors of chiropractic can see injured employees with healed nondisplaced fractures.

Agency Response: The Division clarifies that this subsection applies to either displaced or nondisplaced fractures and while chiropractors may be able to evaluate some of these injuries within scope of their license, the Division has determined that the optimally qualified doctors to examine this diagnosis are the doctors with the board certifications listed in this subsection.

§127.130(b)(8)(E): One commenter states that the designated doctors qualified under this subsection should not include physicians board certified in occupational/preventive medicine, plastic surgery, or emergency medicine.

Agency Response: The Division disagrees. Occupational/preventive medicine physicians and emergency medicine physicians are appropriately included under this subsection for reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection. Similarly, physicians board certified in emergency medicine are also appropriately qualified for the reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection. Physicians board certified in plastic surgery are appropriately qualified in this subsection because plastic surgery training requires training with a wide range of acute and chronic conditions involving multiple bone fractures, particularly open

fractures, and plastic surgeons also have training and experience regarding extremity functional assessment and in dealing with patients with multiple injuries.

§127.130(b)(8)(F): One commenter states that designated doctor qualified under this subsection should include physicians board certified in the specialty of infectious diseases.

Agency Response: The Division disagrees that any change to the rule is necessary. The Division notes that this subsection already includes physicians board certified in internal medicine and infectious diseases is a subspecialty of internal medicine.

§127.130(b)(8)(F) - (H): One commenter states that the designated doctors qualified under these subsections should be limited to doctors board certified in internal medicine or family medicine.

Agency Response: The Division disagrees. Family medicine doctors are not properly included in these subsections for the reasons stated above, except for in §127.130(b)(8)(H) which already includes family medicine doctors. Occupational/preventive medicine physicians and emergency medicine physicians are appropriately included under this subsection for reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection.

§127.130(b)(8)(H): One commenter states that the designated doctor qualified under this subsection should include physicians board certified in cardiovascular disease and interventional cardiology.

Agency Response: The Division disagrees that a change is necessary. The Division notes that this subsection already includes physicians board certified in internal medicine and cardiovascular disease and interventional cardiology are subspecialties of internal medicine.

§127.130(f): One commenter generally supports the rule but asks that this section be amended to state that designated doctors may still respond to requests for clarification even if they seek not to pursue recertification.

Agency Response: The Division agrees and disagrees. The Division agrees that in many cases it would be appropriate for a designated doctor to continue to provide certain services on claims, such as responding to requests for clarification; in others, however, such as if the designated doctor entirely leaves the workers' compensation system, this requirement would not be appropriate. The Division, therefore, clarifies that it will make these determinations on a case-by-case basis depending on the designated doctor's reasons for being authorized to leave a claim or being compelled to do so.

§127.130(h): One commenter also recommends that the Division also include felony convictions or guilty pleas. Felons should be disqualified from performing designated doctor examinations.

Agency Response: The Division disagrees. A doctor who has had the doctor's license revoked or suspended can legally not perform an examination of an injured employee; therefore, the Division includes this reason as the sole basis for the extraordinary remedy under §127.130(h). On the other hand under the commenter's facts, if the doctor still has an active license, it is at least possible the doctor could still be appropriately qualified to perform an examination (the Division also notes that if the doctor's license was suspended or revoked because of a felony conviction, §127.130(h) as proposed would already suffice). The Division notes, however, that any criminal conviction is an appropriate basis for a sanction, including possible revocation of the designated doctor's

certification, and, furthermore, the Division may pursue an emergency cease and desist order if the Division believes the health, safety, or welfare of a person is possibly subject to imminent harm.

§127.140: One commenter states that designated doctors are neither influenced nor affected by third parties; designated doctors treat each assignment on a case-by-case basis. Furthermore, the Division chooses the doctor for the claim, so the third party's role should not present a concern.

Agency Response: The Division disagrees but clarifies except for network or political subdivision health plan affiliations under §127.140(a)(6), no other circumstance under §127.140 automatically creates a disqualifying association in all cases. The Division will make these determinations on a case-by-case basis to establish whether the association at issue may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor.

§127.140: One commenter states that the Division emphasizes in its preamble that disqualifying associations are determined on a case-by-case basis but does not include this language in the rule. It should include it in the rule.

Agency Response: The Division disagrees that any change to the rule is necessary. Section 127.140(a) plainly states that the listed circumstances “may,” not “shall,” constitute a disqualifying association, and, therefore, that determination must be made on a case-by-case basis by the Division. The Division also notes that the “receipt of income, compensation or payment of any kind not related to health care provided by the doctor” has been a disqualifying association for designated doctors for several years and has not caused any of the problems identified by the commenters.

§127.140(a)(1): Multiple commenters state that these sections as written are so broad that they would potentially disqualify all current designated doctors and all Texas doctors from serving as a designated doctor. It is also important to note that treating doctors provide health care. Designated doctors do not provide health care. As drafted, this subsection makes the receipt of income, compensation or payment of any kind not related to health care provided by the doctor a disqualifying association regardless of whether or not the association may be reasonably perceived as having the potential to influence the conduct or decision of a designated doctor.

Agency Response: The Division disagrees. Section 127.140(a) plainly states that the listed circumstances “may,” not “shall,” constitute a disqualifying association, and, therefore, that determination must be made on a case-by-case basis by the Division. The Division also notes that the “receipt of income, compensation or payment of any kind not related to health care provided by the doctor” has been a disqualifying association for designated doctors for several years and has not caused any of the problems identified by the commenters.

§127.140(a)(8): One commenter states that injured employee's representative should be included in this disqualifying association as well.

Agency Response: The Division disagrees, because it has not listed the representative of any party in this subsection, such as the employer's representative or the insurance carrier's representative. The Division also clarifies, however, that any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor may constitute a disqualifying association and this standard is sufficiently broad to include associations with the agent or representative of any system participant, if appropriate.

§127.140(c): One commenter states that the Division should also notify the injured employee and all other parties if the Division is notified about a disqualifying association.

Agency Response: The Division acknowledges it will make all possible efforts to notify all relevant parties of the disqualifying association promptly.

§127.140(c) and §127.220: One commenter states that designated doctors are not credentialing services for the Division. Designated doctors will not know all a treating doctors or referral doctors or network affiliations or the affiliations of an injured employee. Presumably, all designated doctor regulations apply equally to referral doctors and the burden should be on them. Also, designated doctors can certainly not know this information all over the state. This is the duty of the Division not designated doctors.

Agency Response: The Division disagrees. The duty of investigating whether or not a designated doctor may have a disqualifying association relevant to a claim requires vigilance on the part of all parties, because no single party will have in all cases sufficient information to determine the existence of all possible disqualifying associations. However, the Division also notes that the designated doctor has had the duty to notify the Division of disqualifying associations for several years, including the network affiliations of an injured employee. The Division further clarifies that though a designated doctor who performs an examination with a disqualifying association commits a violation, whether or how the Division pursues enforcement action against that doctor will be heavily influenced by the extent to which the designated doctor could have been aware of the disqualifying association. The Division also clarifies that the disqualifying association provision of this section do not apply to referral doctors, because those doctors are neither the designated doctor on the claim nor agents of the designated doctor on the claim. The Division reminds designated doctors,

however, the financial disclosure requirements of §180.24 of this title (relating to Financial Disclosure) do apply to all referrals made by designated doctors under §127.10(c) of this title.

§127.140(e): Multiple commenters state that though a designated doctor's report is stripped of presumptive weight, it may nonetheless serve as a basis for ordering benefits or denying benefits in spite of the disqualifying association. This is insufficient. The designated doctor report should not be admitted into evidence at all or held as void if a disqualifying association is found, and it should not be used for any purposes.

Agency Response: The Division disagrees. Labor Code §410.165 requires that a hearing officer accept into evidence all written reports signed by a health care provider; the Division, therefore, cannot legally exclude a designated doctor report from evidence. The Division clarifies, however, that hearing officers will certainly take the existence of a disqualifying association into account when judging the credibility of the designated doctor's report.

§127.200(a)(6): Multiple commenters disagree with this subsection. One commenter states that it is an insurmountable logistical problem to be in the same room as the employee for all testing, such as a functional capacity examination. It also affords the designated doctor no privacy and quiet to conduct consultations or to complete reports. Also, if employee can't complete testing that day, the designated doctor would have to return to be in the same room. Another commenter states that designated doctors should not have to be in the same room if a medical assistant or technician providing the same service has attended the same certification training as the designated doctor. If the medical assistant or technician is certified, the general practice of physician supervision should

apply here which would require that the designated doctor be in the same office or suite and available.

Agency Response: The Division disagrees. The Division's designated doctors are uniquely trained to perform examinations assigned to them by the Division, and permitting designated doctors to delegate large portions of the examination that the doctor is already qualified to perform or permitting designated doctors to participate in an examination only through on-site supervision thwarts the purpose of assigning the designated doctor to the claim originally. The Division clarifies, however, that designated doctor does not need to be in the same room as the injured employee when the designated doctor completes the report nor does a designated doctor need to be physically present for any appropriately requested testing or referral examinations under §127.10(c) of this title.

§127.200(a)(7): One commenter states that designated doctors should be made aware that the Division's return-to-work guidelines presuppose optimal treatment and cannot be mechanically applied.

Agency Response: The Division clarifies that all designated doctors are trained in proper application of the Division's treatment and return-to-work guidelines.

§127.200(a)(9): One commenter states that the subjective nature of this requirement could provide too much leeway for injured employee who is dissatisfied with a report to use this requirement against the designated doctor.

Agency Response: The Division disagrees. This subsection outlines the Division's reasonable expectations for designated doctors to be professional and courteous when performing designated doctor examinations on the Division's behalf. In keeping with the existing rules regarding complaints

and the Division's current complaint handling procedures, the Division will investigate complaints filed with the Division to determine its merits on a case-by-case basis and then take appropriate action as needed.

§127.200(a)(14): Multiple commenters state that this requirement raises privacy concerns.

Designated doctors may not wish to show their driver's license or other forms of identification because it would reveal their personal information. This could be a problem if the injured employee becomes disgruntled.

Agency Response: The Division agrees and has made a change. Specifically, §127.200(a)(14) now requires designated doctors to identify themselves to injured employees but does not require the presentation of photographic identification upon the request of an injured employee.

§127.210(a)(3): A commenter states that this subsection appears to subject a designated doctor to sanctions if he or she declines a designated doctor examination even if the medical records or injured employee fail to arrive or attend the examination.

Agency Response: The Division agrees this subsection is ambiguous and has made a change. This subsection only applies if the designated doctor has previously examined the injured employee. If a designated doctor has never examined the injured employee, and the injured employee fails to attend the examination or the medical records fail to arrive, the Division may redesignate if appropriate. If, however, the designated doctor has previously examined the injured employee designated doctors must accept and perform all subsequent examinations unless the Division authorizes or compels the designated doctor to leave the claim. Furthermore, if the injured employee fails to attend the examination or the medical records fail to timely arrive, the Division and

other parties shall take necessary steps to ensure that the examination occurs at a later date as appropriate under §127.10(c) or §127.25 of this title as appropriate.

§127.210(a)(3): One commenter states that the Division should permit designated doctors one refusal of an offered designated doctor examination in a 90 day period even if the designated doctor has already been assigned to the claim. During the summer when doctors are on vacation or are covering vacation time for other doctors, it can be difficult to get time off to see one injured employees, especially in outlying areas.

Agency Response: The Division disagrees. Labor Code §408.1225(f) requires that a designated doctor continue providing all services on a claim to which the designated doctor has been previously assigned unless the Division has authorized or compelled the designated doctor to discontinue providing services on the claim. The Division notes, however, that a designated doctor may reschedule an assigned examination under §127.5(e) of this title with the agreement of the injured employee, and this provision should provide designated doctors sufficient flexibility in most cases to meet the demand of their personal schedules.

§127.220(a): One commenter states that the Division fails to state what happens if a designated doctor fails to include a required element.

Agency Response: The Division clarifies that failure to meet these requirements constitutes an administrative violation. The narrative report maintains its presumptive weight, though failure to meet these requirements may also affect credibility a Division hearing officer or the Division Appeals Panel assigns to the narrative report or constitute evidence to overcome the presumptive weight. But

a narrative report's failure to comply with this section will not invalidate or otherwise require exclusion of the narrative report from dispute resolution proceedings.

§127.220(a)(5): One commenter states that designated doctor narrative reports do not need to include information regarding whether the injured employee is being treated through a workers' compensation health care network under Chapter 1305, Insurance Code or a network under Chapter 504, Labor Code. It is not relevant to a designated doctor narrative report, and most designated doctors will not know this information. Furthermore, the Division is now requiring this information to be in all designated doctor requests.

Agency Response: The Division agrees and has removed this requirement from this subsection, but the Division notes that for data collection purposes designated doctors must still provide this information pursuant to §127.220(c) of this title on the new DWC-068 form when a designated doctor conducts an examination under §127.10(f) of this title.

§127.220(a)(6): One commenter states that the Division should remove the requirement that a designated doctor include the time the examination began. There are several factors to consider when determining this time including when it is scheduled and time spent filling out necessary paperwork by injured employees. This rule is not clear regarding these concerns and should be removed.

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

§127.220(a)(6): One commenter supports this provision.

Agency Response: The Division appreciates the support.

§127.220(a)(7): One commenter states that a designated doctor may not know the dates of the additional testing at the time the designated doctor's report is submitted.

Agency Response: The Division disagrees. If the designated doctor has received the reports of the referral doctors, those reports should contain the dates of the testing or examination. If the reports do not contain these dates, the reports should have sufficient information for the designated doctor to contact the referral provider and find out the appropriate dates.

§127.220(a)(8): Multiple commenters state that this requirement should be removed. The commenters state that it is unduly burdensome and inefficient for designated doctors to track the time the physician spends taking medical history, examining, and engaging in medical decision making. Moreover, this rule demonstrates a lack of understanding of realistic designated doctor/patient relationships and punishes good designated doctors. One commenter states that if Division knows which designated doctors are the problem, the Division should simply take action against those doctors, not punish other good designated doctors. Another commenter asks if the Division makes no definitive implication of the nature of the quality of the examination through this requirement, then why have it at all? One commenter also notes that the DWC is not raising reimbursement to compensate for the time spent performing these tasks. Another commenter states that the purpose of this requirement is unclear because each examination presents a unique situation. One commenter also states that the Division has no standard time that is desired, and it is not required for billing; therefore, considering the differences between cases, it is impossible for the Division to determine the appropriate time or to enforce this requirement.

Agency Response: The Division disagrees. This requirement is necessary for informational purposes and to assist in the investigation of complaints of injured employee mistreatment or possible fraud. Furthermore, though the Division recognizes that the time spent performing these tasks may not necessarily have any direct bearing on the quality of a designated doctor's review and intends to make no definitive implication of that nature by imposing this requirement, this recognition does not mean that this information could never be factor in a determination by the Division. Additionally, the Division notes that this requirement is not unduly burdensome as it ultimately amounts only to the transcription of two numbers (the time these activities began and the time they were completed) in a designated doctor's report and is ultimately analogous to the billing procedures designated doctors use in other health care contexts. Finally, the Division notes that designated doctor reimbursement is outside the scope of this rule project.

§127.220(a)(8): One commenter states that the Division's clarification regarding the effect this timing requirement implies on a designated doctor's quality of examination should be included in the rule.

Agency Response: The Division disagrees. It is unnecessary to include this language in the rule because nothing in the rule precludes this application of the rule nor does any provision require a different interpretation.

§127.220(a)(8): One commenter supports this timing requirement but states that segmenting these practices is not possible. It should only be the time spent from start to finish on all of these tasks.

Agency Response: The Division clarifies that this subsection only requires designated doctors to record the time spent perform all of these tasks in aggregate, not individually.

§127.220(b): One commenter states that if much of the information on the DWC-068 is on the DWC-032, then the Division does not need the DWC-068. The commenter states that this only creates more unnecessary work without more additional compensation for designated doctors.

Agency Response: The Division disagrees. The DWC-068 is necessary to ensure that the Division has information regarding the outcome of extent of injury examinations and other examinations performed under §127.10(f) of this title so that the Division can effectively monitor the quality of these examinations the same way it does for examinations on impairment rating, maximum medical improvement, and an injured employee's ability to return-to-work. The information the Division is collecting on extent of injury examinations and other examinations under §127.10(f) of this title through the DWC-068 form is similar to the information the Division already collects on designated doctor examinations regarding impairment rating, maximum medical improvement, and return-to-work issues through the DWC-069 and DWC-073 forms.

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

For: None.

For, with changes: American Insurance Association; Insurance Council of Texas; Texas Medical Association.

Against: Texas Independent Evaluators, LLC.

Neither for nor against, with changes: Examworks; Genesis Medical Management Solutions; IWP; Office of the Injured Employee Counsel; Property Casualty Insurers Association of America; RMJ Evaluations; State Office of Risk Management; and Texas Association of School Boards Risk Management Fund.

CHAPTER 127: DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS
SUBCHAPTER A: DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS
§§127.1, 127.5, 127.10, AND 127.20

6. STATUTORY AUTHORITY.

The amendments are adopted under the Labor Code §408.0041 and §408.1225 and under the general authority of Labor Code §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. Section 408.1225 provides, in relevant part, that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for Division disputes, unless the Division authorizes the designated doctor to discontinue providing services.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT

§127.1. *Requesting Designated Doctor Examinations.*

(a) At the request of the insurance carrier, an injured employee, the injured employee's representative, or on its own motion, the division may order a medical examination by a designated doctor to resolve questions about the following:

- (1) the impairment caused by the injured employee's compensable injury;
- (2) the attainment of maximum medical improvement (MMI);
- (3) the extent of the injured employee's compensable injury;
- (4) whether the injured employee's disability is a direct result of the work-related injury;
- (5) the ability of the injured employee to return to work; or

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

(b) To request a designated doctor examination a requestor must:

(1) provide a specific reason for the examination;

(2) explain any change of condition if the requestor indicates that the injured employee's medical condition has changed since a previous designated doctor examination on the same claim;

(3) report the injured employee's current diagnosis or diagnoses and part of the body affected by the injury;

(4) provide a list of all injuries determined to be compensable by the division or accepted as compensable by the insurance carrier;

(5) provide general information regarding the identity of the requestor, injured employee, employer, treating doctor, insurance carrier;

(6) identify the workers' compensation health care network certified under Chapter 1305, Insurance Code through which the injured employee is receiving treatment, if applicable;

(7) identify whether the claim involves medical benefits provided through a political subdivision under Labor Code §504.053(b)(2) and the name of the health plan, if applicable;

(8) state whether the injured employee has attended any other designated doctor examinations on this claim and, if so, provide the date of the most recent examination and the name of the examining designated doctor;

(9) submit the request on the form prescribed by the division under this section. A copy of the prescribed form can be obtained from:

(A) the division's website at www.tdi.texas.gov/wc/indexwc.html; or

(B) the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744 or any local division field office location;

(10) submit the request to the division and a copy of the request to each party listed in subsection (a) of this section who did not request the designated doctor examination;

(11) provide all information listed in subparagraphs (A) - (G) of this paragraph below applicable to the type of examination the requestor seeks:

(A) if the requestor seeks an examination on the attainment of MMI, include the statutory date of maximum medical improvement, if any;

(B) if the requestor seeks an examination on the impairment rating of the injured employee, include the date of MMI that has been determined to be valid by a final decision of division or court or by agreement of the parties, if any;

(C) if the requestor seeks an examination on the extent of the compensable injury, include a description of the accident or incident that caused the claimed injury and a list of all injuries in question;

(D) if the requestor seeks an examination on whether the injured employee's disability is a direct result of the work-related injury, include the beginning and ending dates for the claimed periods of disability; state if the injured employee is either not working or is earning less than pre-injury wages as defined by Labor Code §401.011(16);

(E) if the requestor seeks an examination regarding the injured employee's ability to return to work in any capacity and what activities the injured employee can perform, include the beginning and ending dates for the periods to be addressed if the requestor

is requesting for the designated doctor to examine the injured employee's work status during a period other than the current period;

(F) if the requestor seeks an examination to determine whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, include the beginning and ending dates for the qualifying periods to be addressed and whether or not this period involves the ninth quarter or a subsequent quarter of supplemental income benefits;

(G) if the requestor seeks an examination on topics under subsection (a)(6) of this section, specify the issue in sufficient detail for the doctor to answer the question(s);
and

(12) provide a signature to attest that every reasonable effort has been made to ensure the accuracy and completeness of the information provided in the request.

(c) If a party submits a request for a designated doctor examination under subsection (b) of this section that would require the division to schedule an examination within 60 days of a previous examination of the injured employee that party must provide good cause for scheduling that designated doctor examination in order for the division to approve the party's request. For the purposes of this subsection, the commissioner or the commissioner's designee shall determine good cause on a case by case basis and will require at a minimum:

(1) if that requestor also requested the previous examination, a showing by the requestor that the submitted questions could not have reasonably been included in the prior examination and a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits; or

(2) if that requestor did not request the previous examination, a showing by the requestor a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits.

(d) The division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor:

(1) if the request does not comply with any of the requirements of subsection (b) or (c) of this section;

(2) if the request would require the division to schedule an examination in violation of Labor Code §§408.0041, 408.123, or 408.151;

(3) if the commissioner or the commissioner's designee determines the request to be frivolous because it lacks either any legal or any factual basis that would merit approval; or

(4) if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved.

(e) If a division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.

(f) A party may dispute the division's approval or denial of a designated doctor request through the dispute resolution processes outlined in Chapters 140 – 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures). Parties may not dispute a designated doctor

examination request or any information on the request until the division has either approved or denied the request. Additionally, a party is entitled to seek an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings) to dispute an approved or denied request for a designated doctor examination. The division, upon timely receipt and approval of the request for expedited proceedings, shall stay the disputed examination pending the decision and order of the expedited contested case hearing. Parties seeking expedited proceedings and the stay of an ordered examination must file their request for expedited proceedings with the division within three working days of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

(g) This section will become effective on September 1, 2012.

§127.5. *Scheduling Designated Doctor Appointments.*

(a) The division, within 10 days after approval of a valid request, shall issue an order that assigns a designated doctor and shall notify the designated doctor, the treating doctor, the injured employee, the injured employee's representative, if any, and the insurance carrier that the designated doctor will be directed to examine the injured employee. The order shall:

- (1) indicate the designated doctor's name, license number, examination address and telephone number, and the date and time of the examination or the date range for the examination to be conducted;
- (2) explain the purpose of the designated doctor examination;
- (3) require the injured employee to submit to an examination by the designated doctor;
- (4) require the designated doctor to perform the examination at the indicated examination address; and

(5) require the treating doctor, if any, and insurance carrier to forward all medical records in compliance with §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations).

(b) The examination address indicated on the order in subsection (a)(4) of this section may not be changed by any party or by an agreement of any parties without good cause and the approval of the division.

(c) Except as provided in subsection (d) of this section, the division shall select the next available doctor on the designated doctor list for a medical examination requested under §127.1 of this title (relating to Requesting Designated Doctor Examinations). A designated doctor is available to perform an examination at any address the doctor has filed with the division if the doctor:

(1) does not have any disqualifying associations as described in §127.140 of this title (relating to Disqualifying Associations);

(2) is appropriately qualified to perform the examination in accordance with §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations);

(3) is a certified designated doctor on the day the examination is offered and has not failed to timely file for recertification under §127.110 of this title (relating to Designated Doctor Recertification), if applicable ; and

(4) has not treated or examined the injured employee in a non-designated doctor capacity within the past 12 months and has not examined or treated the injured employee in a non-designated doctor capacity with regard to a medical condition being evaluated in the designated doctor examination.

(d) If the division has previously assigned a designated doctor to the claim at the time a request is made, the division shall use that doctor again unless the division has authorized or required the

doctor to stop providing services on the claim in accordance with §127.130 of this title.

Examinations under this subsection must be conducted at the same examination address as the designated doctor's previous examination of the injured employee or at another examination address approved by the division.

(e) The designated doctor's office and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least one working day prior to the appointment. The one working day requirement will be waived in an emergency situation. If both the designated doctor and the injured employee agree to reschedule the examination, the rescheduled examination shall be set to occur no later than 21 days after the scheduled date of the originally scheduled examination and may not be rescheduled to occur before the originally scheduled examination. Within one working day of rescheduling, the designated doctor shall contact the division, the injured employee or the injured employee's representative, if any, the injured employee's treating doctor, and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled no later than 21 days after the scheduled date of the originally scheduled examination or if the injured employee fails to attend the rescheduled examination, the designated doctor shall notify the division as soon as possible but not later than 21 days after the scheduled date of the originally scheduled examination. After receiving this notice, the division may select a new designated doctor.

(f) This section will become effective on September 1, 2012.

§127.10. General Procedures for Designated Doctor Examinations.

(a) The designated doctor is authorized to receive the injured employee's confidential medical records and analyses of the injured employee's medical condition, functional abilities, and return-to-

work opportunities to assist in the resolution of a dispute under this subchapter without a signed release from the injured employee. The following requirements apply to the receipt of medical records and analyses by the designated doctor:

(1) The treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. For subsequent examinations with the same designated doctor, only those medical records not previously sent must be provided. The cost of copying shall be reimbursed in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation).

(2) The treating doctor and insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities. The analysis may include supporting information such as videotaped activities of the injured employee, as well as marked copies of medical records. If the insurance carrier sends an analysis to the designated doctor, the insurance carrier shall send a copy to the treating doctor, the injured employee, and the injured employee's representative, if any. If the treating doctor sends an analysis to the designated doctor, the treating doctor shall send a copy to the insurance carrier, the injured employee, and the injured employee's representative, if any. The analysis sent by any party may only cover the injured employee's medical condition, functional abilities, and return-to-work opportunities as provided in Labor Code §408.0041.

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are received by the designated doctor no later than three working days prior to the date of the designated doctor examination. If the designated doctor has not received

the medical records or any part thereof at least three working days prior to the examination, the designated doctor shall report this violation to the division within one working day of not timely receiving the records. Once notified, the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records.

(b) Before examining an injured employee, the designated doctor shall review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor in accordance with subsection (a) of this section, and any materials submitted to the doctor by the division. The designated doctor shall also review the injured employee's medical condition and history as provided by the injured employee, any medical records provided by the injured employee, and shall perform a complete physical examination of the injured employee. The designated doctor shall give the medical records reviewed the weight the designated doctor determines to be appropriate.

(c) The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with

the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the expiration of the 15 working days. If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report.

(d) Any evaluation relating to either maximum medical improvement (MMI), an impairment rating, or both, shall be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). If a designated doctor is simultaneously requested to address maximum medical improvement (MMI) and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury. A designated doctor who determines the injured employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, or who determines the injured employee has not reached MMI, shall complete and file a report as required by §130.1 of this title and §130.3 of this title (relating to Certification of Maximum Medical

Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor).

If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) (of this title) for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor extent of injury determination. The designated doctor, however, shall only submit one narrative report required by §130.1(d)(1)(B) of this title for all impairment ratings assigned and extent of injury findings. All designated doctor narrative reports submitted under this subsection shall also comply with the requirements of §127.220(a) of this title.

(e) A designated doctor who examines an injured employee pursuant to any question relating to return to work is required to file a Work Status Report that meets the required elements of these reports described in §129.5 of this title (relating to Work Status Reports) and a narrative report that complies with the requirements of §127.220(a) of this title within seven working days of the date of the examination of the injured employee. This report shall be filed with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the reports with the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(f) A designated doctor who resolves questions on issues other than those listed in subsections (d) and (e) of this section, shall file a Designated Doctor Examination Data Report that complies with §127.220(c) of this title and a narrative report that complies with §127.220(a) of this title within seven working days of the date of the examination of the injured employee. These reports shall be filed

with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall provide these reports to the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the reports by other verifiable means.

(g) The report of the designated doctor is given presumptive weight regarding the issue(s) in question the designated doctor was properly appointed to address, unless the preponderance of the evidence is to the contrary.

(h) The insurance carrier shall pay all benefits, including medical benefits, in accordance with the designated doctor's report for the issue(s) in dispute. If the designated doctor provides multiple certifications of MMI/impairment ratings under subsection (d) of this section because the designated doctor was also ordered to address the extent of the injured employee's compensable injury, the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. For medical benefits, the insurance carrier shall have 21 days from receipt of the designated doctor's report to reprocess all medical bills previously denied for reasons inconsistent with the findings of the designated doctor's report. By the end of this period, insurance carriers shall tender payment on these medical bills in accordance with the Act and Chapters 133 and 134 of this title. For all other benefits, the insurance carrier shall tender payment no later than five days after receipt of the report.

(i) The designated doctor shall maintain accurate records for, at a minimum, five years from the anniversary date of the date of the designated doctor's last examination of the injured employee. This requirement does not reduce or replace any other record retention requirements imposed upon a designated doctor by an appropriate licensing board. These records shall include the injured

employee's medical records, any analysis submitted by the insurance carrier or treating doctor (including supporting information), reports generated by the designated doctor as a result of the examination, and narratives provided by the insurance carrier and treating doctor, to reflect:

- (1) the date and time of any designated doctor appointments scheduled with an injured employee;
- (2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled and, if applicable, documentation of the agreement of the designated doctor and the injured employee to reschedule the examination and the notice that the doctor provided to the division, the injured employee's treating doctor, and the insurance carrier within 24 hours of rescheduling an appointment;
- (3) the date of the examination;
- (4) the date medical records were received from the treating doctor or any other person;
- (5) the date reports described in subsections (d), (e) and (f) of this section were submitted to all required parties and documentation that these reports were submitted to the division, treating doctor, and insurance carrier by facsimile or electronic transmission and to other required parties by verifiable means;
- (6) the name(s) of any referral health care providers used by the designated doctor, if any; the date of appointments by referral health care providers; and the reason for referral by the designated doctor; and
- (7) the date, if any, the doctor contacted the division for assistance in obtaining medical records from the insurance carrier or treating doctor.

(j) Parties may dispute any entitlement to benefits affected by a designated doctor's report through the dispute resolution processes outlined in Chapters 140 – 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures).

(k) This section will become effective on September 1, 2012.

§127.20. *Requesting a Letter of Clarification Regarding Designated Doctor Reports.*

(a) Parties may file a request with the division for clarification of the designated doctor's report. A copy of the request must be provided to the opposing party. The division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. Parties may only request clarification on issues already addressed by the designated doctor's report or on issues that the designated doctor was ordered to address but did not address. Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision.

(b) Requests for clarification must:

- (1) include the name of the designated doctor, the reason for the designated doctor's examination, the date of the examination, and the name and signature of the requestor;
- (2) explain why clarification of the designated doctor's report is necessary and appropriate to resolve a future or pending dispute;
- (3) include questions for the designated doctor to answer that are neither inflammatory nor leading; and

(4) provide any medical records that were not previously provided to the designated doctor and explain why these records are necessary for the designated doctor to respond to the request for clarification.

(c) The division, at its discretion, may also request clarification from the designated doctor on issues the division deems appropriate.

(d) To respond to the request for clarification, the designated doctor must be on the division's designated doctor list at the time the request is received by the division. The designated doctor shall respond, in writing, to the request for clarification within five working days of receipt and send copies of the response to the parties listed in §127.10(f) of this title (relating to General Procedures for Designated Doctor Examinations). If, in order to respond to the request for clarification, the designated doctor has to reexamine the injured employee, the doctor shall:

(1) respond, in writing, to the request for clarification advising of the need for an additional examination within five working days of receipt of the request and provide copies of the response to the parties specified in §127.10(f) of this title;

(2) if the division orders the reexamination, conduct the reexamination within 21 days from the date the order is issued by the division at the same examination address as the original examination; and

(3) respond, in writing, to the request for clarification based on the additional examination within seven working days of the examination and provide copies of the response to the parties specified in §127.10(f) of this title.

(e) Any refusal or failure by a designated doctor to conduct a reexamination that is necessary to respond to a request for clarification is an administrative violation.

(f) This section will become effective September 1, 2012.

§127.25. *Failure to Attend a Designated Doctor Examination.*

- (a) An insurance carrier may suspend temporary income benefits (TIBs) if an injured employee, without good cause, fails to attend a designated doctor examination.
- (b) In the absence of a finding by the division to the contrary, an insurance carrier may presume that the injured employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the injured employee has both:
- (1) failed to submit to the examination; and
 - (2) failed to contact the designated doctor's office to reschedule the examination.
- (c) If the injured employee contacts the designated doctor within 21 days of the scheduled date of the missed examination to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor.
- (d) If the injured employee fails to contact the designated doctor within 21 days of the scheduled date of the missed examination but wishes to reschedule the examination, the injured employee must request a new examination under §127.1 of this title (relating to Requesting a Designated Doctor Examination).
- (e) The insurance carrier shall reinstate TIBs effective as of the date the injured employee submitted to the rescheduled examination under subsection (c) of this section or the examination scheduled pursuant to the injured employee's request under subsection (d) of this section unless the report of the designated doctor indicates that the injured employee has reached MMI or is otherwise not eligible for income benefits. The re-initiation of TIBs shall occur no later than the seventh day following:

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

(2) the date that the insurance carrier was notified that the division found that the injured employee had good cause for not attending the examination.

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

(g) This section will become effective September 1, 2012.

**SUBCHAPTER B: DESIGNATED DOCTOR CERTIFICATION, RECERTIFICATION, AND
QUALIFICATIONS**

NEW: §§127.100, 127.110, 127.120, 127.130, and 127.140

6. STATUTORY AUTHORITY.

The new sections are adopted under the Labor Code §§408.0041, 408.0043, 408.0045, and 408.1225 and under the general authority of Labor Code §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. In relevant part, Section 408.0043 requires designated doctors, other than dentists and chiropractors, who review a specific workers' compensation case to meet certain professional specialty requirements. Section 408.0045 provides, in relevant part, that a designated doctor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic. Section 408.1225 provides that the Commissioner by rule shall develop a process for the certification of a designated doctor and that the Division may deny renewal of a designated doctor's certification. Section 408.1225 also provides that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for division disputes, unless the division authorizes the designated doctor to discontinue providing services.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§127.100. *Designated Doctor Certification.*

(a) In order to serve as a designated doctor, a doctor who is not a designated doctor must be certified as a designated doctor. To be certified as a designated doctor, a doctor who is not a designated doctor must:

- (1) submit a complete designated doctor certification application as described by subsection (b) of this section;
- (2) submit a certificate or certificates certifying that the doctor has successfully completed all division required trainings and passed all division required testing on the specific duties of a designated doctor under the Act and division rules, including demonstrated proficient knowledge of the currently adopted edition of the American Medical Association Guides to Evaluation of Permanent Impairment and the division's adopted treatment and return-to-work guidelines;
- (3) be licensed in Texas;
- (4) have maintained an active practice for at least three years during the doctor's career. For the purposes of this subsection, a doctor has an active practice if the doctor maintains or has maintained routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients; and
- (5) own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the current edition of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division.

(b) For the purposes of subsection (a) of this section, a complete designated doctor certification application must be completed on the division's required form for certification applications and must include:

- (1) contact information for the doctor;
- (2) information on the doctor's education;
- (3) a description of the doctor's license(s), certifications, and professional specialty, if any;
- (4) a description of the doctor's work history and hospital or other health care provider affiliations;
- (5) a description of any affiliations the doctor has with a workers' compensation health care network certified under Chapter 1305, Insurance Code or political subdivision under Labor Code §504.053(b)(2);
- (6) information regarding the doctor's current practice locations;
- (7) disclosure questions regarding the doctor's professional background, education, training, and fitness to perform the duties of a designated doctor, including disclosure and summary of any disciplinary actions taken against the doctor by any state licensing board or other appropriate state or federal agency;
- (8) the identities of any person(s) with whom the doctor has contracted to assist in performance or administration of the doctor's designated doctor duties;
- (9) an attestation that:
 - (A) all information provided in the application is accurate and complete to the best of the doctor's knowledge;
 - (B) the doctor will inform the division of any changes to this information as required by §127.200(a)(8) of this title (relating to Duties of a Designated Doctor); and

(C) the doctor shall consent to any on-site visits, as provided by §127.200(a)(15) of this title, by the division at facilities used or intended to be used by the designated doctor to perform designated doctor examinations for the duration of the doctor's certification.

(c) The division shall notify a doctor of the commissioner's approval or denial of the doctor's application to be certified as a designated doctor in writing. Denials will include the reason(s) for the denial. Approvals only certify a doctor for a term of two years and will include the effective date and expiration date of the certification. Approvals will also include the examination qualification criteria under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations) that the division has assigned to the designated doctor as part of the doctor's certification.

(d) Doctors shall be denied certification as a designated doctor:

(1) if the doctor did not submit the information required by subsection (a) of this section, including having completed all division required training and passed all division required examinations;

(2) if the doctor did not submit a complete application for certification as required by subsection (b) of this section;

(3) for having a relevant restriction on their practice imposed by a state licensing board, certification authority, or other appropriate state or federal agency, including the division; or

(4) for other activities that warrant denial of a doctor's application for certification as a designated doctor, such as grounds that would allow the division to sanction a health care provider under the Act or division rules.

(e) Within 15 working days after receiving a denial, a doctor may file a written response with the division, which addresses the reasons given to the doctor for denial.

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

(2) If a written 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 still a denial, the division's final notice shall provide the reason(s) why the doctor's response did not change the commissioner's decision to deny the doctor's application for certification as a designated doctor. The denial will be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(f) Designated doctors whose application for certification is approved but wish to dispute the examination qualification criteria under §127.130 of this title that the division assigned to the doctor may do so through the procedures described in subsection (e) of this section. Designated doctors must include in their response to the division the specific criteria they believe should be modified and documentation to justify the requested change.

(g) Designated doctors who are designated doctors on the effective date of this section shall be considered certified for the duration of the designated doctor's current certification. Before the expiration of the designated doctor's current certification, the designated doctor timely must apply for recertification under the applicable requirements of §127.110 of this title (relating to Designated Doctor Recertification).

(h) This section will become effective on September 1, 2012.

§127.110. *Designated Doctor Recertification.*

(a) If a designated doctor's certification expires before January 1, 2013:

(1) A doctor previously admitted to the division's designated doctor list who seeks to remain on the list must renew the doctor's application status by submitting to division verification that the doctor has completed a minimum of 12 additional hours of division required training and passed all division required testing described under §127.100(a) of this title (relating to Designated Doctor Certification) since the effective date of the designated doctor's last certification or recertification. Designated doctors must also submit a complete application that meets the requirements of §127.100(b) of this title. Designated doctors who submit the materials required by this subsection will be recertified as designated doctors if the materials are submitted before January 1, 2013.

(2) The division shall notify a designated doctor of its receipt of this submitted information in writing, and this notice will renew the designated doctor's certification for a period of two years. The notice will also include the effective and expiration dates of that certification.

(3) A designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status.

(4) Designated doctors who fail to renew their application status before January 1, 2013 must instead apply for recertification under the procedures described under subsection (b) of this section.

(b) If a designated doctor's certification expires on or after January 1, 2013, the designated doctor must apply for recertification. Designated doctor seeking recertification after this date must:

(1) submit to the division certificate(s) evidencing that the doctor has, within the past 18 months, successfully completed all division required trainings and passed all division required testing on the specific duties of a designated doctor under the Act and division rules, including demonstrated proficient knowledge of the current division adopted edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and the division's adopted treatment and return-to-work guidelines;

(2) own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the current edition of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division; and

(3) submit to the division a complete application for recertification that meets the requirements of §127.100(b) of this title.

(c) The division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the division fails to receive the required information in subsection (b)(1) - (3) of this section from the designated doctor before that time though the designated doctor may still provide services on claims to which the designated doctor had been previously assigned during this period. A designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) of this section at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation. A designated doctor who fails to apply for recertification under this section within 30 days after the expiration of the designated doctor's certification may no longer apply for recertification and must instead apply for certification of §127.100 of this title.

(d) The division will notify a doctor in writing of the commissioner's approval or denial of the doctor's application to be recertified as a designated doctor under subsection (b) of this section. Denials will include the reason(s) for the denial. Approvals recertify a doctor for a term of two years and will include the effective date and expiration date of the certification. Approvals will also include the designated doctor's examination qualification criteria under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations) that the division has assigned to the doctor as part of the doctor's recertification.

(e) The division may deny an application for recertification under subsection (b) of this section for the following reasons:

- (1) the doctor did not submit the information required by subsection (b) of this section, including verification of having timely completed all division-required training and passed all division-required examinations;
- (2) if the doctor failed to properly update the doctor's initial application for certification under §127.100(b) of this title;
- (3) for having a relevant restriction on their practice imposed on the doctor by a state licensing board, certification authority, or other appropriate state or federal agency, including the division;
- (4) for requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing; or
- (5) for other activities that warrant denial of a doctor's application for recertification as a designated doctor, including but not limited to:
 - (A) the quality of the designated doctor's past reports;

- (B) the designated doctor's history of complaints;
- (C) excess requests for deferral from the designated doctor list by the doctor;
- (D) a pattern of overturned reports by the division and/or a court;
- (E) a demonstrated lack of ability to apply or properly consider the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division;
- (F) a demonstrated lack of ability to consistently perform designated doctor examinations in a timely manner;
- (G) a demonstrated failure to identify disqualifying associations;
- (H) a demonstrated lack of ability to ensure the confidentiality of injured employee medical records and claim information provided to or generated by the designated doctor; or
- (I) any other grounds that would allow the division to sanction a health care provider under the Act or division rules.

(f) Within 15 working days after receiving a denial, a doctor may file a written response with the division that addresses the reasons given to the doctor for denial or may submit a written request for an informal hearing before the division to address the reasons given for the denial.

(1) If neither a response nor a written request for informal hearing is received by the 15th working day after the date the doctor received the notice, the denial will be final effective the following day. No further notice will be sent.

(2) If a written response which disagrees with the denial is timely received, the division will review the response and will notify the doctor of the commissioner's final decision in writing. If

the final decision is still a denial, the division's final notice shall provide the reason(s) why the doctor's response did not change the commissioner's decision to deny the doctor's application for recertification as a designated doctor. The denial will be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(3) If a written request for informal hearing is timely received, the division will set the informal hearing to occur no later than 31 days after the request is received. At the informal hearing, the designated doctor may present evidence that addresses the reasons the doctor was denied recertification to the commissioner's designated representatives. The designated doctor may have an attorney present. At the conclusion of the informal hearing, the designated representatives will provide the designated doctor with their final recommendation regarding the doctor's recertification. If the final recommendation is still a denial, the designated representatives will provide the reason(s) why they decided not to recertify the doctor as a designated doctor. After the informal hearing, the designated representatives will forward their recommendation to the commissioner who will review the final recommendation and all evidence presented at the informal hearing and make a final decision. The division shall notify the designated doctor of the commissioner's final decision in writing. The decision will be effective the day following the date the doctor receives notice of the decision unless otherwise specified in the notice.

(g) Designated doctors whose application for recertification under subsection (b) of this section is approved but wish to dispute the examination qualification criteria under §127.130 of this title that the division assigned to the doctor may do so through the procedures described in subsection (f) of this section. Designated doctors must include in their response to the division or present at the informal

hearing the specific criteria they wish to be modified and documentation to justify the requested change.

(h) This section will become effective on September 1, 2012.

§127.120. *Exception to Certification as a Designated Doctor for Out-of-State Doctors.*

(a) 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 chapter for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute or perform a particular examination.

(b) This section will become effective on September 1, 2012.

§127.130. *Qualification Standards for Designated Doctor Examinations.*

(a) For examinations performed before January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor has credentials that are appropriate to the issue in question, the injured employee's medical condition, that meet the requirements of Labor Code §408.0043, §408.0045, and applicable division rules, and the designated doctor has no applicable disqualifying associations under §127.140 of this title (relating to Disqualifying Associations).

(b) For examinations performed on or after January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor meets the appropriate qualification criteria for the area of the body affected by the injury and the injured employee's diagnosis and has no disqualifying associations under §127.140 of this title. A designated doctor's qualification criteria are determined as follows:

(1) To examine injuries and diagnoses relating to the hand and upper extremities, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(2) To examine injuries and diagnoses relating to the lower extremities excluding feet, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(3) To examine injuries and diagnoses relating to the spine and torso, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(4) To examine injuries and diagnoses relating to the feet, including the toes and heel, a designated doctor must be a licensed medical doctor, doctor of osteopathy, doctor of chiropractic, or doctor of podiatric medicine.

(5) To examine injuries and diagnoses relating to the teeth and jaws, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of dental surgery.

(6) To examine injuries and diagnoses relating to the eyes, including the eye and adnexal structures of the eye, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of optometry.

(7) To examine injuries and diagnoses relating to other body areas or systems, including but not limited to internal systems; ear, nose, and throat; head and face; skin; mental and behavioral disorders; tendon lacerations; and dislocations, a designated doctor must be a licensed medical doctor or doctor of osteopathy.

(8) Notwithstanding paragraphs (1) - (7) of this subsection, a designated doctor must be a licensed medical doctor or doctor of osteopathy who has the required board certification to examine any of the following diagnoses. For purposes of this section, a designated doctor is "board certified" in a required specialty or subspecialty, as applicable, if the designated doctor holds a

general certificate in the required specialty or a subspecialty certificate in the required subspecialty from the American Board of Medical Specialties (ABMS) or if the designated doctor holds a primary certificate in the required specialty and a certificate of special qualifications or certificate of added qualifications in the required subspecialty from the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

(A) To examine traumatic brain injuries, a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, or psychiatry by the ABMS or board certified in neurological surgery, neurology, physical medicine or rehabilitation, or psychiatry by the AOABOS.

(B) To examine spinal cord injuries, including spinal fractures with documented neurological deficit, a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopaedic surgery, or occupational medicine by the ABMS or board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopedic surgery, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(C) To examine severe burns, including chemical burns, defined as 3rd or 4th degree burns over 9 percent or greater of the body, a designated doctor must be board certified in dermatology, physical medicine and rehabilitation, plastic surgery, orthopaedic surgery, surgery, or occupational medicine by the ABMS or board certified in dermatology, physical medicine and rehabilitation, plastic and reconstructive surgery, orthopedic surgery, surgery (general), preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(D) To examine complex regional pain syndrome (reflex sympathetic dystrophy), a designated doctor must be board certified in neurological surgery, neurology, orthopaedic surgery, anesthesiology with a subspecialty in pain medicine, occupational medicine, or physical medicine and rehabilitation by the ABMS or board certified in neurological surgery, neurology, orthopedic surgery, preventive medicine/occupational-environmental medicine, preventive medicine/occupational, anesthesiology with certificate of added qualifications in pain management, or physical medicine and rehabilitation by the AOABOS.

(E) To examine multiple bone fractures, excluding spinal fractures, a designated doctor must be board certified in emergency medicine, orthopaedic surgery, plastic surgery, physical medicine and rehabilitation, or occupational medicine by the ABMS or board certified in emergency medicine, orthopedic surgery, plastic surgery, physical medicine and rehabilitation, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(F) To examine complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens, a designated doctor must be board certified in internal medicine or occupational medicine by the ABMS or board certified in internal medicine, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(G) To examine chemical exposure, excluding chemical exposure limited to skin exposure, a designated doctor must be board certified in internal medicine, emergency medicine, or occupational medicine by the ABMS or board certified in internal medicine, emergency medicine, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(H) To examine heart or cardiovascular conditions, a designated doctor must be board certified in internal medicine, emergency medicine, occupational medicine, thoracic and cardiac surgery, or family medicine by the ABMS or board certified in internal medicine, emergency medicine, preventive medicine/occupational-environmental medicine, preventive medicine/occupational, thoracic and cardiovascular surgery or family practice and osteopathic manipulative treatment by the AOABOS.

(c) To be qualified to perform an initial examination on an injured employee, a designated doctor, other than a chiropractor, must be qualified under Labor Code §408.0043. A designated doctor who is a chiropractor must be qualified to perform an initial designated doctor examination under Labor Code §408.0045. If, however, the requirements of this subsection would disqualify a designated doctor otherwise qualified under subsection (b) of this section, pursuant to Labor Code §408.0041(b-1), does not apply.

(d) For any particular designated doctor examination, the division may exempt a designated doctor from the applicable qualification standard if no other designated doctor is qualified and available to perform the examination. Additionally, the division may not offer a qualified designated doctor an examination if it is reasonably probable that the designated doctor will not be qualified on the date of the examination.

(e) A designated doctor who performs an initial designated doctor examination of an injured employee and had the appropriate selection criteria to perform that examination under either subsection (a) or (b) of this section, as applicable, shall remain assigned to that claim and perform all subsequent examinations of that injured employee unless the division authorizes or requires the designated doctor to discontinue providing services on that claim.

(f) The division may authorize a designated doctor to stop providing services on a claim if the doctor:

- (1) decides to stop practicing in the workers' compensation system;
- (2) decides to stop practicing as a designated doctor in the workers' compensation system;
- (3) relocates the doctor's residence or practice;
- (4) has asked the division to indefinitely defer the doctor's availability on the designated doctor list;
- (5) determines that examining the injured employee would require the designated doctor to exceed the scope of practice authorized by the doctor's license; or
- (6) can otherwise demonstrate to the division that the doctor's continued service on the claim would be impracticable or could impair the quality of examinations performed on the claim.

(g) The division will prohibit a designated doctor from providing services on a claim if:

- (1) the doctor has failed to become recertified as a designated doctor under §127.110(a) or (b) of this title (relating to Designated Doctor Recertification);
- (2) the doctor no longer has the appropriate qualification criteria under either subsection (a) or (b) of this section, as applicable, to perform examinations on the claim;
- (3) the doctor has a disqualifying association, as specified in §127.140 of this title, relevant to the claim;
- (4) the doctor has repeatedly failed to respond to division appointment, clarification, or document requests, or other division inquiries regarding the claim;
- (5) the doctor's continued service on the claim could endanger the health, safety, or welfare of either the injured employee or doctor; or
- (6) the division has revoked or suspended the designated doctor's certification.

(h) The division will prohibit a designated doctor from performing examinations on all new or existing claims if the designated doctor has had the doctor's license revoked or suspended and the suspension has not been probated by an appropriate licensing authority.

(i) This section will become effective on September 1, 2012.

§127.140. *Disqualifying Associations.*

(a) A disqualifying association is any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor. Disqualifying associations may include:

- (1) receipt of income, compensation, or payment of any kind not related to health care provided by the doctor;
- (2) shared investment or ownership interest;
- (3) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;
- (4) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, billing services agents, documentation management or storage services or warranties, or any other services related to the management or operation of the doctor's practice;
- (5) personal or family relationships;
- (6) a contract with the same workers' compensation health care network certified under Chapter 1305, Insurance Code or a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for the provision of medical benefits to the injured employee; or

(7) 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) For examination performed after January 1, 2013, a designated doctor shall also have a disqualifying association relevant to an examination or claim if an agent of the designated doctor has an association relevant to the claim that would constitute a disqualifying association under subsection (a) of this section.

(c) A designated doctor shall not perform an examination if that doctor has a disqualifying association relevant to that claim. If a designated doctor learns of a disqualifying association relevant to a claim after accepting the examination, the designated doctor must notify the division of that disqualifying association within two working days of learning of the disqualifying association. A designated doctor who performs an examination even though the doctor has a disqualifying association relevant to that claim commits an administrative violation.

(d) Insurance carriers shall notify the division of any disqualifying associations between the designated doctor and injured employee because of the network affiliations described under subsection (a)(6) of this section within five days of receiving the division's order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

(e) If the division determines that a designated doctor with a disqualifying association performed a designated doctor examination, all reports produced by that designated doctor as a result of that examination shall be stripped of their presumptive weight.

(f) A party that seeks to dispute the selection of a designated doctor for a particular examination based on a disqualifying association or to dispute the presumptive weight of a designated doctor's

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report based on a disqualifying association must do so through the division's dispute resolution processes in Chapter 410, Labor Code and Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures).

(g) This section will become effective on September 1, 2012.

SUBCHAPTER C: DESIGNATED DOCTOR DUTIES AND RESPONSIBILITIES
NEW: §§127.200, 127.210, and 127.220

6. STATUTORY AUTHORITY.

The new sections are adopted under the Labor Code §§402.083, 408.0041, 408.1225, and 415.021 and under the general authority of Labor Code §§402.00128, 402.021 and 402.061.

Section 402.083 provides that Information in or derived from a claim file regarding an employee is confidential and may not be disclosed by the division except as provided by Title 5, Subtitle A of the Labor Code or other law. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. Section 408.1225 provides that the Commissioner by rule shall develop a process for the certification of a designated doctor and that the Division may deny renewal of a designated doctor's certification. Section 408.1225 also provides that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for division disputes, unless the division authorizes the designated doctor to discontinue providing services. Section 415.021 provides that a person commits an administrative violation if the person violates, fails to comply with, or refuses to comply with this subtitle or a rule, order, or decision of the Commissioner.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.021 provides the basic goals of the workers' compensation system of this state, including that each employee shall be treated with dignity and respect when injured on the job and that each injured employee shall have access to prompt, high-quality medical care within the framework established by this subtitle. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

7. TEXT.

§127.200. *Duties of a Designated Doctor.*

(a) All designated doctors shall:

(1) perform designated doctor examinations in a facility currently used and properly equipped for medical examinations or other similar health care services and that ensures safety, privacy, and accessibility for injured employees and injured employee medical records and other records containing confidential claim information;

(2) ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor in the doctor's capacity as a designated doctor for the duration of the retention period specified in §127.10(i) of this title (relating to General Procedures for Designated Doctor Examinations) and ensure the destruction of these medical records after both this retention period expires and the designated doctor determines the information is no longer needed;

(3) ensure that all agreements with person(s) that permit those parties to perform designated doctor administrative duties, including but not limited to billing and scheduling duties, on the designated doctor's behalf:

(A) are in writing and signed by the designated doctor and the person(s) with whom the designated doctor is contracting;

(B) define the administrative duties that the person may perform on behalf of the designated doctor;

(C) require the person or persons to comply with all confidentiality provisions of the Act and other applicable laws;

- (D) comply with all medical billing and payment requirements under Chapter 133 of this title (relating to General Medical Benefits);
 - (E) do not constitute an improper inducement relating to the delivery of benefits to and injured employee under Labor Code §415.0036 and §180.25 of this title (relating to Improper Inducements, Influence and Threats); and
 - (F) made available to the division upon request;
- (4) notify the division in writing and in advance if the designated doctor voluntarily decides to defer the designated doctor's availability to receive any offers of examinations for personal or other reasons and the notice must specify the duration of and reason for the deferral;
- (5) notify the division in writing and in advance if the designated doctor no longer wishes to practice as a designated doctor before the doctor's current certification as a designated doctor expires; a designated doctor who no longer wishes to practice as a designated doctor before the doctor's current certification expires must expressly surrender the designated doctor's certification in a signed, written statement to the division;
- (6) be physically present in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee that is not referred to another health care provider under §127.10(c) of this title;
- (7) apply the appropriate edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and division-adopted return-to-work guidelines and consider division-adopted treatment guidelines or other evidence-based medicine when appropriate;

- (8) provide the division with updated information within 10 working days of a change in any of the information provided to the division on the doctor's application for certification or recertification as a designated doctor;
- (9) maintain a professional and courteous demeanor when performing the duties of a designated doctor, including, but not limited to, explaining the purpose of a designated doctor examination to an injured employee at the beginning of the examination and using non-inflammatory, appropriate language in all reports and documents produced by the designated doctor;
- (10) bill for designated doctor examinations and receive payment for those examinations in accordance with Chapter 133 of this title and 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments);
- (11) respond timely to all division appointment, clarification, document requests, or other division inquiries;
- (12) notify the division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would required the doctor to exceed the scope of practice authorized by the doctor's license;
- (13) not perform required medical examinations, utilization reviews, or peer reviews on a claim to which the designated doctor has been assigned as a designated doctor;
- (14) identify themselves at the beginning of every designated doctor examination;
- (15) consent to and cooperate during any on-site visits by the division pursuant to §180.4 of this title (relating to On-Site Visits); notwithstanding §180.4(e)(2) of this title, the division's purpose for these visits will be to ensure the designated doctor's compliance with the Act and applicable division rules, and the notice provided to the designated doctor in accordance with

§180.4 of this title, either in advance of or at the time of the on-site visit, will specify the duties being investigated by the division during that visit;

(16) cooperate with all division compliance audits, quality reviews; and

(17) otherwise comply with all applicable laws and rules.

(b) For the purposes of this chapter, Chapter 180 of this title (relating to Monitoring and Enforcement), and all other applicable laws and division rules, any person with whom a designated doctor contracts or otherwise permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the doctor's "agent" as defined under §180.1 of this title (relating to Definitions).

(c) This section will become effective on September 1, 2012.

§127.210. Designated Doctor Administrative Violations.

(a) In addition to the grounds for issuing sanctions against a doctor under §180.26 of this title (relating to Criteria for Imposing, Recommending, and Determining Sanctions; Other Remedies), other division rules, or the Texas Workers' Compensation Act, the commissioner may revoke or suspend a designated doctor's certification as a designated doctor or otherwise sanction a designated doctor for noncompliance with requirements of this chapter or for any of the following:

(1) four refusals within a 90-day period to accept or perform a division offered appointment or ordered appointment for which the doctor is qualified and that relates to a claim to which the doctor has not been previously assigned;

(2) four consecutive refusals to perform within the required time frames a division ordered appointment for which the doctor is qualified and that relates to a claim to which the doctor has not been previously assigned;

- (3) any refusal to accept or perform a division offered appointment or ordered appointment that relates to a claim on which the doctor has previously performed an examination;
- (4) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;
- (5) submitting unnecessary referrals to other health care providers for the answering of any question submitted to the designated doctor by the division;
- (6) ordering or performing unnecessary testing of an injured employee as part of a designated doctor's examination;
- (7) submission of inaccurate or inappropriate reports due to insufficient medical history or physical examination and analysis of medical records;
- (8) submission of designated doctor reports that fail to include all elements required by §127.220 of this title (relating to Designated Doctor Reports), §127.10 of this title (relating to General Procedures for Designated Doctor Examinations), and other division rules;
- (9) failure to timely respond to a request for clarification from the division regarding an examination or any other information request by the division;
- (10) failure to successfully complete training and testing requirements as specified in §127.110 of this title (relating to Designated Doctor Recertification);
- (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;
- (12) behaving in an abusive or assaultive manner toward an injured employee, the division, or other system participant;
- (13) failing to maintain the confidentiality of patient medical and claim file information;

(14) performing a designated doctor examination which the designated doctor was not ordered by the division to perform; or

(15) other violations of applicable statutes or rules while serving as a designated doctor.

(b) Designated doctors are liable for all administrative violations committed by their agents on the designated doctor's behalf under this section, other division rules, or any other applicable law.

(c) The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Restoration) except that suspension, revocation, or other sanction relating to a designated doctor's certification will be in effect during the pendency of any appeal.

(d) This section will become effective on September 1, 2012.

§127.220. Designated Doctor Reports.

(a) Designated doctor narrative reports must be filed in the form and manner required by the division and at a minimum:

(1) identify the question(s) the division ordered to be addressed by the designated doctor examination;

(2) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions;

(3) sufficiently explain how the designated doctor determined the answer to each question within a reasonable degree of medical probability;

(4) demonstrate, as appropriate, application or consideration of the *American Medical Association Guides to the Evaluation of Permanent Impairment*, division-adopted return-to-work and treatment guidelines, and other evidence-based medicine, if available;

(5) include general information regarding the identity of the designated doctor, injured employee, employer, treating doctor, insurance carrier;

- (6) state the date of the examination and the address where the examination took place;
- (7) summarize any additional testing conducted or referrals made as part of the evaluation, including the identity of any health care providers to which the designated doctor referred the injured employee under §127.10(c) of this title (relating to General Procedures for Designated Doctor Examinations), the types of tests conducted or referrals made and the dates the testing or referral examinations occurred, and explain why the testing or referral was necessary to resolve a question at issue in the examination;
- (8) include a narrative description of the medical history, physical examination, and medical decision making performed by the designated doctor, including the time the designated doctor began taking the medical history of the injured employee, physically examining the employee, and engaging in medical decision making and the time the designated doctor completed these tasks;
- (9) list the specific medical records or other documents the designated doctor reviewed as part of the evaluation, including the dates of those documents and which, if any, medical records were provided by the injured employee;
- (10) be signed by the designated doctor who performed the examination;
- (11) include a statement that there is no known disqualifying association as described in §127.140 of this title (relating to Disqualifying Associations) between the designated doctor and the injured employee, the injured employee's treating doctor, the insurance carrier, the insurance carrier's certified workers' compensation health care network, or a network established under Chapter 504, Labor Code;
- (12) certify the date that the report was sent to all recipients required by and in the manner required by §127.10 of this title; and

(13) indicate on the report that the designated doctor reviewed and approved the final version of the report.

(b) Designated doctors who perform examinations under §127.10(d) or (e) of this title shall also complete and file the division forms required by those subsections with their narrative reports. Designated doctors shall complete and file these forms in the manner required by applicable division rules.

(c) Designated doctors who perform examinations under §127.10(f) of this title must, in addition to filing a narrative report that complies with subsection (a) of this section, also file a Designated Doctor Examination Data Report in the form and manner required by the Division. A Designated Doctor Examination Data Report must:

(1) include general information regarding the identity of the designated doctor, injured employee, insurance carrier, as well as the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable;

(2) list all injuries included on the examination request as:

(A) determined to be compensable by the division;

(B) accepted as compensable by the insurance carrier; or

(C) for informational purposes only, the diagnosis code for each injury;

(3) identify the question(s) the division ordered to be addressed by the designated doctor examination;

(4) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions. For extent of injury examinations,

the designated doctor should also provide, for informational purposes only, a diagnosis code for each disputed injury;

(5) state the date of the examination, the time the examination began, and the address where the examination took place;

(6) list any additional testing conducted or referrals made as part of the evaluation, including the identity of any health care providers to which the designated doctor referred the injured employee under §127.10(c) of this title, the types of tests conducted or referrals made and the dates the testing or referral examinations occurred;

(7) be signed by the designated doctor who performed the examination.

(d) This section will become effective on September 1, 2012.

8. CERTIFICATION.

This agency hereby certifies that this order has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on the 9th day of July 2012.

X

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

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that §§127.1, 127.5, 127.10, 127.20, 127.25, 127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 specified herein, concerning Designated Doctor Procedures and Requirements, are adopted.

Rod Bordelon
Commissioner of Workers'
Compensation

ATTEST:

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