CHAPTER 127 – Designated Doctor Procedures and Requirements
SUBCHAPTER A – Designated Doctor Scheduling and Examinations
28 TAC New §§127.1, 127.5, 127.15, 127.20, and 127.25

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division) adopts new §§127.1, 127.5, 127.10, 127.15, 127.20 and 127.25, concerning designated doctor scheduling and examinations under new Subchapter A with changes to the proposed text as published in the July 16, 2010, issue of the *Texas Register* (35 TexReg 6229). These new sections primarily recodify the provisions of repealed §126.7 concerning Designated Doctor Examinations: Requests and General Procedures. The adoption of the repeal of §126.7 is published elsewhere in this issue of the *Texas Register*.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble 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, and the reasons why the Division agrees or disagrees with the comments and recommendations.

A public hearing was held on August 17, 2010. The public comment period closed August 17, 2010.

2. REASONED JUSTIFICATION. House Bill 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 (HB 7) amended §408.0041 of the Labor Code to provide that the Commissioner has the discretion to approve or deny requests for designated doctor examinations. Specifically, HB 7 changed subsection (a) of Labor Code §408.0041 to provide that the Commissioner "may" order a designated doctor examination at the request of an insurance carrier or an injured employee. Previously, Labor Code §408.0041 stated that the Commissioner "shall" order a designated doctor examination upon receiving such a request. Additionally, HB 7 also amended subsection (b) of Labor Code §408.0041 to provide that Division shall assign a designated doctor 10 days after a request for an examination is "approved." Previously, Labor Code §408.0041 required the Division to assign a designated doctor within 10 days after a request was "received." Lastly, HB 7 added subsection (l) to Labor Code §408.0041, which states that if a person submits a frivolous request for a designated doctor examination, as determined by the Commissioner, that person commits an administrative violation. Taken together, these amendments to Labor Code §408.0041 demonstrate a clear mandate for the Division to take a greater role in monitoring and evaluating requests for designated doctor examinations, and these new sections are necessary to implement that mandate.

These new sections also provide that the Division may require designated doctors to remain appointed to a claim so long as that doctor is still qualified to examine the injured employee. This change will improve the quality and availability of designated doctor examinations and is anticipated to increase the efficiency of the Division's dispute resolution process. The change is also supported by the Sunset Advisory Commission. In

its April 2010 Staff Report, the Sunset Advisory Commission found that appointing multiple designated doctors to a single claim can muddle the dispute resolution process for that claim, and that multiple appointments to a single claim were common (at least 906 disputes that were set for a benefit review conference at the Division in fiscal year 2009 involved claims to which multiple designated doctors had been appointed). These new adopted sections address these concerns.

Additionally, these new adopted sections also describe how parties may dispute the approval or denial of a designated doctor appointment before the disputed examination takes place and clarify several of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling and examination process.

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

In response to a comment, the Division has removed the proposed §127.1(b)(6)(C) requirement that a requestor who seeks an examination on the extent of the compensable injury or an examination regarding the causation of the claimed injury must provide a list of all injuries accepted as compensable by the insurance carrier or determined to be compensable by the Division. Instead, the Division has amended §127.1(b)(3) as proposed to provide that requestors of any type of designated doctor examination must

provide this information. This information is generally helpful in any type of designated doctor examination.

The Division has also made a style change to proposed §127.1(c)(1) and (2) in response to the stakeholder comment. Specifically, in proposed §127.1(c)(1) the Division has moved "if that requestor also requested the previous examination" to beginning of the subsection and replaced "that" with "the." In proposed §127.1(c)(2) the Division also moved "if that requestor did not request the previous examination" to beginning of that subsection and replaced "that" with "the." These changes are without substantive effect and are for clarity only.

The Division has also made another clarifying change to proposed §127.1(c)(1) and (2) in response to a comment. Specifically, the Division has clarified its use of the terms "questions" and "issues" in those sections. In adopted §127.1(c)(1), the Division has replaced "requested issues" with "submitted question(s)" and added "a designated doctor examination" after "and" to clarify that a minimum demonstration of good cause under that subsection requires that the requestor demonstrate that a designated doctor examination is reasonably necessary to resolve the submitted question(s). The Division also made a similar change to adopted §127.1(c)(2).

In response to several comments, the Division has also removed the provision of proposed §127.10(c) that permitted insurance carriers to retrospectively review designated doctor referrals for additional testing. By removing this provision, the Division returns to its previous position on this issue, expressed in the August 11, 2006, issue of the *Texas Register* (31 TexReg 6368), that stakeholder concerns regarding the necessity or

reasonableness of designated doctor referrals for testing are best addressed through the Division's complaint and monitoring procedures, and the Division has now stated this position in adopted §127.10(c). This outcome ensures that designated doctors can confidently have access to all necessary testing procedures while still permitting the Division to monitor designated doctor referrals. This outcome also comports with the Labor Code §408.0041(h)(1) requirement that insurance carriers pay for designated doctor examinations, because referrals for additional testing are often absolutely necessary for and thus essentially part of the designated doctor's examination of an injured employee. Lastly, the Division has also, in light of one stakeholder comment, included a reminder to all designated doctors that their testing referrals and other referrals are subject to the financial disclosure requirements of §180.24 of this title (relating to Financial Disclosure).

The Division has also made another change to proposed §127.10(c) in response to a comment. Specifically, the Division has deleted the requirements that additional testing be completed within 10 days of the designated doctor's physical examination of the injured employee and that additional testing extends the deadline for filing a report by 10 days from the date of the physical examination. The Division has replaced these requirements with the single requirement that all designated doctor testing and reports must be completed within 15 working days of the designated doctor's physical examination of the injured employee.

In response to several comments, the Division has also made a clarifying change to proposed §127.10(h). Specifically, the Division has removed the phrases "otherwise due under the Texas Workers' Compensation Act and division rules" and "the applicable" from

the subsection and inserted "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 (relating to General Medical Provisions" and Benefits--Guidelines for Medical Services, Charges, And Payments, respectively). This clarification is necessary to explain that though the findings of a designated doctor report can compel an insurance carrier to pay past or future medical benefits if the insurance carrier's reason for denial are wholly in conflict with the designated doctor's report, insurance carriers still may deny payment of those medical benefits for any other permissible reason under the Act or Division rules that does not conflict with the findings of the designated doctor's report.

The Division also made a change to proposed §127.20(d) in response to a comment. Specifically, the Division changed the deadline for designated doctors to respond to requests for clarification, both when a reexamination is necessary and when one is not, from five days to five working days. This change ensures that designated doctors will always have one work week to respond to the request, and the change to working days also makes these deadlines consistent with other designated doctor reporting deadlines in this proposal.

In response to a separate comment, the Division made another change to proposed §127.20(d)(2). Specifically, the Division inserted "if the division orders the reexamination" at the beginning of the subsection and replaced "the request" with the "the date the order is issued." This change corresponds with the Division's original intent for this provision

that after a designated doctor advises the Division of a need for a reexamination to respond to a request for clarification, the reexamination must be held within 21 days of the date the Division issues an order scheduling the examination.

Lastly, the Division added an effective date provision at the end of each section. The effective date of each section is February 1, 2011.

3. HOW THE SECTIONS WILL FUNCTION.

New §127.1. New subsection (a) primarily recodifies language from repealed §126.7(a) - (c) of this title (relating to Designated Doctor Examinations: Requests and General Procedures), though it also deletes the provision that prohibited designated doctors who are working for networks under Chapter 1305 of the Insurance Code from examining injured employees who are receiving health care through the same network. This prohibition is redundant with the requirements for a designated doctor to be qualified to be appointed to a claim and is addressed by new §127.5(c) and (d). New subsection (b) describes the information requesters must include when requesting a designated doctor examination. While it primarily incorporates the provisions of current Division Form DWC032, subsection (b) also requires requesters to provide a specific reason for the examination, to state any injuries that have already been accepted by the insurance carrier as compensable or determined by the Division to be compensable, and, if the requester indicates that the injured employee's medical condition has changed since a previous designated doctor examination, to explain that change of condition. New subsection (c) requires that a requester demonstrate good cause if that requester submits a request for a

designated doctor examination that would require the Division to schedule an examination within 60 days of a previous examination of an injured employee. Subsection (c) also describes the minimum demonstration of good cause. New subsection (d) provides the reasons for which the Division shall deny a request for a designated doctor examination. New subsection (e) describes the dispute resolution process system participants may use to dispute the Division's approval or denial of a designated doctor request and states that if an expedited proceeding is approved, such a dispute shall stay an approved examination request.

New §127.5. New subsection (a) primarily recodifies language from repealed §126.7(e). New subsection (a) also clarifies that designated doctors must perform examinations at the ordered address and removes the requirement that designated doctor examinations may not occur earlier than 14 days after the order for the examination is issued. New subsection (b) clarifies the Division's current policy that designated doctors and injured employees may not reschedule the location of an examination without good cause and Division approval. New subsection (c) primarily recodifies language from repealed §126.7(h) of this title. It also describes how the Division shall appoint a designated doctor to a claim when no other qualified doctor has been appointed to the claim, including the new rule requirement that designated doctors must be on the designated doctor list on the day the appointment is offered. New subsection (d) provides that if the Division has previously appointed a designated doctor to a claim, the Division may appoint that doctor again provided the doctor still meets the four listed qualifications of subsection (c) of this section. New subsection (d) also provides that designated doctors

must perform subsequent examinations on a claim at the same examination address as the designated doctor's previous examination of the claimant or at another examination address approved by the Division. New subsection (e) recodifies language from repealed §126.7(f) of this title.

New §127.10. New subsection (a) primarily recodifies language from repealed §126.7(i) of this title. It also clarifies that analysis sent to a designated doctor by a treating doctor or insurance carrier may only be provided in accordance with Labor Code §408.0041(c) and that the cost of copying medical records provided to designated doctors shall be reimbursed in accordance with §134.120 of this title (relating to Reimbursement of Medical Documentation). Additionally, new subsection (a) also requires that insurance carriers and treating doctors must ensure that designated doctors receive an injured employee's medical records three working days, rather than the previous requirement of one working day, before a designated doctor's examination of an injured employee. New subsection (b) recodifies the language of repealed §126.7(j) of this title. New subsection (c) primarily recodifies the language of repealed §126.7(k) of this title. New subsection (c) also clarifies when a designated doctor may make a referral to another health care provider and that additional testing or referral to another health care provider extends designated doctors' time to complete the testing and file their reports by 15 additional working days from the date of their physical examination of the injured employee. New subsection (d) recodifies the language of repealed §126.7(n) of this title. New subsection (e) primarily recodifies the language of repealed subsection §126.7(o) of this title. It also clarifies the specific provisions of §129.5 of this title (relating to Work Status Reports)

applicable to Work Status Reports filed by designated doctors. Additionally, new subsection (e) extends the time to file a Work Status Report under this subsection to seven working days, as opposed to calendar days, and requires Work Status Reports to be filed with the Division as well. New subsection (f) primarily recodifies language from repealed §126.7(p) of this title. It also extends the time designated doctors have to file their narrative reports under that subsection to seven working days, as opposed to the previous requirement of calendar days, requires the narrative reports to be filed with the Division, and lists the required elements of the narrative reports. New subsection (g) primarily recodifies the language of repealed §126.7(d) of this title but also clarifies that presumptive weight only applies to issues the designated doctor was properly appointed to address. New subsection (h) primarily recodifies the language of repealed §126.7(r) of this title but also clarifies that, as required by Labor Code §408.0041, insurance carriers must pay all accrued benefits, including medical benefits, pursuant to a designated doctor's report. New subsection (i) primarily recodifies the language of repealed §126.7(q) of this title. It also clarifies that designated doctors shall maintain injured employee records, analyses, and narratives provided by insurance carriers and treating doctors for five years from the anniversary date of the date of the designated doctor's last examination of the injured employee. This requirement is intended to harmonize the Division's record retention requirements with the minimum requirements for record retention among licensing boards applicable to designated doctors. Importantly, this subsection also clarifies that this record retention requirement does not reduce or replace any other record retention requirement imposed on designated doctors by their respective licensing boards.

Additionally, new subsection (i) requires designated doctors to maintain reports they generate as well as documentation that they fulfilled certain administrative requirements when applicable. New subsection (j) clarifies that parties may dispute any entitlement to benefits affected by a designated doctor report through the dispute resolution processes outlined in Chapters 140 – 144 and 147 of this title.

New §127.15. New subsection (a) primarily recodifies language from repealed §126.7(l) of this title. It also clarifies that a designated doctor may initiate communication with any health care provider who has previously treated or examined the injured employee for the work-related injury or with a peer review doctor identified by the insurance carrier who reviewed the injured employee's claim or any information regarding the injured employee's claim. New subsection (b) recodifies language from repealed §126.7(m) of this title.

New §127.20. New subsection (a) primarily recodifies language from repealed §126.7(u) of this title. It also clarifies that 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. New subsection (b) lists required elements for all requests for clarification. New subsection (c) recodifies language from repealed §126.7(u) of this title. New subsection (d) primarily recodifies language from repealed §126.7(u) of this title and also clarifies various administrative requirements for designated doctors responding to requests for clarification and for the scheduling of reexamination pursuant to a request for clarification. New subsection (e) clarifies that any failure to respond to a request for clarification is an administrative violation.

New §127.25. New subsections (a) - (d) recodify language from repealed §126.7(g) of this title that pertains to injured employees' failure to attend designated doctor examinations.

4. SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General

Comment: A commenter states that in cases in which an insurance carrier has denied compensability, benefit review officers should be allowed to schedule non-binding maximum medical improvement and impairment rating designated doctor examinations if the parties mutually consent to such an examination.

Response: The Division disagrees. The Labor Code does not permit designated doctor examinations to be nonbinding.

Comment: One commenter states that designated doctors should be able to perform any examination if they are willing and certified, regardless of their credentials as a physician. The commenter also states that the Division's current designated doctor selection matrix is unnecessary and discriminatory.

Response: The Division disagrees in part. Labor Code §§408.0041(b), 408.0043, 408.0044, and 408.0045 all require the Division to take a designated doctor's credentials into consideration when appointing a designated doctor to a claim. The remainder of this comment regarding the Division's current designated doctor selection matrix is outside the

scope of these rules, which do not address how the Division determines a designated doctor's credentials.

Comment: One commenter states that the Division should adopt more rigorous testing standards for designated doctors and should make greater efforts to verify the active practice requirements it imposes on designated doctors.

Response: This comment is outside the scope of these rules, which only address designated doctor procedures and examinations.

Comment: Two commenters states that designated doctors should only be able to take appointments in their practice area and see patients in their primary office location.

Response: The Division disagrees. Such requirements would greatly diminish the availability of qualified designated doctors throughout the state, particularly in rural areas and other areas with limited access to qualified physicians.

Comment: The Division should make its designated doctor selection criteria matrix available in a rule.

Response: This comment exceeds the scope of this rulemaking proposal, which only addresses designated doctor procedures and examinations.

Comment: One commenter states that the ability to stay a designated doctor examination is insufficient to prevent gaming in the designated doctor system. The Division should add

a provision to its rules that permits the Division to void any order for a designated doctor examination and any reports produced from that examination if the requester submitted inaccurate information on the request for designated doctor examination. Without this provision, the only remedy for inaccurate requests is administrative violation proceedings, and this is insufficient to prevent parties from benefitting from gaming the system.

Response: The Division disagrees. The Division believes that the combination of dispute resolution and administrative violation proceedings are sufficient to address the commenter's concerns. Moreover, the Division also notes that Labor Code §410.165(b) would prohibit the Division from entirely voiding a designated doctor, or any health care provider's, report. The Division can, in cases of improperly ordered designated doctor examinations, strip the designated doctor's report of presumptive weight, but completely voiding the report is not a permissible option under the Labor Code.

Comment: One commenter requests that the Division expand "injured employee's representative" to "person acting on behalf of the injured employee" in order to include ombudsman in the category.

Response: The Division disagrees. The commenter's suggested language is too broad and would include persons far beyond ombudsmen. Moreover, the Labor Code only provides the Division with monitoring jurisdiction of representatives, not persons acting on behalf of claimants, thus the Division declines to extend its regulatory requirements outside of the scope of persons who qualify as representatives.

Comment: One commenter states that the Division should clarify that when an injured employee disagrees with a first certification of MMI/IR, the carrier is required to pay for an alternate MMI/IR certification by the injured employee's treating or referral doctor.

Response: This comment is outside the scope of these rules, which address only designated doctor procedures and examinations.

Comment: One commenter states that the Division should allow some reimbursement when an injured employee fails to show because a doctor will have done significant preparation. This will encourage more high quality doctors to enter the system.

Response: This comment is outside the scope of these rules, which address only designated doctor procedures and examinations.

Comment: One commenter states the Division should do away with required medical examinations except post-designated doctor examination required medical examinations.

Response: This comment is outside the scope of these rules, which address only designated doctor procedures and examinations. Furthermore, insurance carriers are entitled to these required medical examinations under Labor Code §408.004.

Comment: One commenter stated that designated doctor examinations are currently assigned by counties. They should be assigned by mileage from the injured employee's home. Doctors will not have to work in unfamiliar locations if examinations are assigned in this manner.

Response: The Division declines to make a change as it believes its current procedures for appointing designated doctors are sufficient to ensure the availability of designated doctors throughout the state. The Division also notes that designated doctors are not required to work in unfamiliar locations and must only do so only if they opt to make themselves available in those locations.

Comment: Two commenters state that the proposed rules will hinder dispute resolution and limit stakeholder access to designated doctor examinations and clarifications of designated doctor reports. The comments suggest that instead of the proposed rules, the Division should focus on removing noncompliant designated doctors from the workers' compensation system.

Response: The Division disagrees. The Division disagrees that these rules will hinder dispute resolution, as they offer increased clarity and access to the dispute resolution process for designated doctor issues. Additionally, because the rules are primarily either recodifications of repealed §126.7 or codifications of existing procedures, they will not limit access to designated doctor examinations or clarifications of designated doctor reports. Instead, they should bring increased efficiency to the process. Lastly, though the Division generally agrees that it should and does monitor and take enforcement actions against noncompliant designated doctors, the Division does not view this goal as incompatible with its rules. Moreover, designated doctor monitoring would not address many of the Division stated goals in this rulemaking, such as the regulation of designated doctor examination requests.

Comment: One commenter states that the Division's designated doctor selection process and matrix is discriminatory toward chiropractors.

Response: This comment is outside the scope of these rules, which only address designated doctors procedures and examinations.

§127.1(a)

Comment: Commenter requests that the Division include "whether there is an injury resulting from the claimed incident" as a question that a designated doctor can address, because permitting these examinations is already Division procedure.

Response: The Division disagrees. While the Division acknowledges that it does approve requests for this type of examination, the Division disagrees that the requested change is necessary. These examinations constitute "other similar issues" under the Labor Code and §127.1(a), and, therefore, they can already be requested and approved.

§127.1(b)

Comment: One commenter states that because §127.1(b)(5) already requires requests for designated doctor examinations to be submitted on a form, the Division does not need to list every requirement of the form in the rule.

Response: The Division disagrees. While in practice submission of the form and the submission of the required information generally coincide, the requirements are conceptually distinct. Thus, compliance with one does not ensure compliance with the other, and the Division seeks to ensure that both requirements are met.

§127.1(b)(6)(B)

Comment: One commenter states that the Division should require a list of all injuries determined to be compensable or accepted as compensable by the insurance carrier when a party requests an maximum medical improvement or impairment rating examination.

Response: The Division agrees and has made a change. Adopted §127.1(b)(4) requires parties to submit a list of all injuries determined to be compensable or accepted as compensable by the insurance carrier when a party requests any type of designated doctor examination.

§127.1(b)(6)(D)

Comment: One commenter states that the Division should replace "If the requestor seeks an examination on whether the injured employee's disability is a direct result of work-related injury" with "If the requestor seeks an examination on whether the injured employee's disability is a direct result of the injured employee's inability to earn pre-injury wages."

Response: The Division disagrees. The Division adopted language in §127.1(b)(6)(D) is derived directly from Labor Code §408.0041(a)(4), and the Division declines to deviate from this statutory language.

§127.1(b)(6)(F)

Comment: One commenter states that the Division should include clarifying language that designated doctors must explain "whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity as a result of the compensable injury." The commenter states this language will clarify that designated doctors must explain how the compensable injury causes a total inability to return to any type of work in any capacity.

Response: The Division disagrees with the suggested change. The Division believes that the provisions of §127.10(e) and §129.5(c)(4) of this title already sufficiently address the commenter's concerns.

§127.1(b)(7)

Comment: One commenter states that the Division should only require that a, not every, reasonable effort be made to ensure the accuracy and completeness of the information provided in the request.

Response: The Division disagrees. The commenter's suggested change significantly weakens the standard to which requesters must attest, and the Division, in light of the importance of accuracy in designated doctor requests, declines to lower this standard.

Comment: One commenter states that requiring an adjuster's signature will slow the designated doctor examination request process for insurance carriers, because they use outside firms or vendors to assist with the designated doctor examination request process.

Response: The Division disagrees. Section 127.1(b)(7) does not require an adjuster's signature. The Division requires the signature of the requestor, because this signature is necessary to ensure the accuracy and completeness of all designated doctor examination requests.

§127.1(c)

Comment: One commenter states that the Division should have a hearing to determine good cause to hold a designated doctor examination more frequently than every 60 days. For it is essential that both parties be able to present evidence and be present when good cause is determined.

Response: The Division disagrees. Requiring a good cause hearing for every request that would lead to a second designated doctor examination in a 60 day period would create an unnecessary administrative burden in cases in which neither party nor the Division disagrees with the merits of the claimed good cause. The Division does clarify, however, that a party may contest any approved examination under adopted §127.1(e).

§127.1(c)(1) and (2)

Comment: One commenter states that the Division's use of the words "questions" and "issues" makes the rule ambiguous. Commenter states it appears that the Division is stating that examinations on different issues may not occur within 60 days of each other even though the statute does not necessarily require this outcome.

Response: The Division agrees that the wording of the provision is somewhat ambiguous and makes a clarifying change. Specifically, the Division has replaced "requested issues" with "submitted question(s)" and added "a designated doctor examination" after "and" to clarify that a minimum demonstration of good cause under that subsection requires that the requestor demonstrate that a designated doctor examination is reasonably necessary to resolve the submitted question(s). The Division also made a similar change to adopted §127.1(c)(2). Lastly, the Division clarifies that the statute does generally prohibit multiple examinations on different issues within 60 days of each other.

Comment: One commenter recommends two style changes to §127.1(c)(1) and (2). Specifically, the commenter recommends that, in §127.1(c)(1), the Division move "if that requestor also requested the previous examination" to beginning of the subsection and replace "that" with "the." The commenter also recommends that in §127.1(c)(2) the Division move "if that requestor did not request the previous examination" to beginning of that subsection and replace "that" with "the."

Response: The Division agrees and has made these changes.

§127.1(d)

Comment: Commenter states that it appears §127.1(d) permits the Division to deny a request for a designated doctor examination simply because the Division cannot schedule the examination within the Labor Code §408.0041 timeline. If this is the case, the Division

should provide an alternative mechanism through which the party can obtain resolution of the question.

Response: The Division disagrees. Section 127.5(e) states that if an appointment ultimately cannot be scheduled within the stated timelines of that rule, a new designated doctor will be assigned to the claim. Thus, the commenter's requested remedy is unnecessary.

Comment: One commenter states that while the commenter agrees with the need for the Division to have a specific basis for denying designated doctor examination requests, the rule should also provide that the Division must state with specificity the grounds for denial, citing statutory basis, so that the party can determine its further actions.

Response: The Division disagrees that any change to the rule is necessary. The Division does generally agree that parties should be provided with sufficient information in any denial of a designated doctor examination to reasonably ensure that the party can understand the reason for the denial. The Division disagrees, however, with the suggestion that it should require itself by rule to assist parties in planning future actions on a claim.

Comment: One commenter states that the Division should only deny requests that do not comply with applicable, not any, requirements of §127.1(b) and (c).

Response: The Division disagrees that a change is necessary. The Division agrees that not every part of §127.1(b) and (c) applies to every request. The Division disagrees,

however, that any change is necessary because §127.1(b) and (c) indicates which provision are required for a particular request and which provisions are not.

§127.1(d)(2)

Comment: Commenter states that the Division should not state that it will deny maximum medical improvement and/or impairment rating examination requests because the examination is in violation of Labor Code §408.123. The Division cannot know when a party received the report certifying an injured employee to be at maximum medical improvement that begins the 90 day finality period. Also, the Division should not be raising a defense for opposing parties.

Response: The Division disagrees. Denying designated doctor examinations because they are attempting to dispute maximum medical improvement outside of the 90 day finality period is not raising a defense for a party; rather, it is simply enforcing Labor Code §408.123. Moreover, while Division acknowledges that in some cases it is possible that its denial may be incorrect, parties are still permitted to dispute these denials through the Division's dispute resolution process.

§127.1(d)(3)

Comment: The Division should delete §127.1(d)(3), because it is redundant with §127.1(d)(1) and (2). Alternatively, the Division should remove reference to legal basis in (d)(3).

Response: The Division disagrees. The standard for frivolity stated in §127.1(d)(3) is not redundant with either §127.1(d)(1) or §127.1(d)(2). For example, simply because the Division denies a request because the request would require the Division to schedule an examination in violation of Labor Code §408.123 does not imply that the request lacked any legal basis. Moreover, §127.1(d)(1) and (2) do not address requests that lack a factual basis that would merit approval.

Comment: One commenter states that the Division should clarify what is meant by frivolous regarding designated doctor requests.

Response: The Division disagrees that this clarification is necessary. Whether a particular request is frivolous is primarily determined on a case-by-case basis; therefore, any clarification beyond the general terms already stated in §127.1(d)(3) would unnecessarily limit the Division's discretion.

§127.1(e)

Comment: One commenter stated §127.1(e) provides no meaningful remedy to insurance carriers denied designated doctor appointments because of the length of the dispute resolution process. The commenter also states that the stay in §127.1(e) promotes gaming in the system and should either be struck or the rule should clarify that continuances will not be granted in expedited hearings.

Response: The Division disagrees. The Labor Code authorizes the Division to deny some designated doctor requests, and the dispute resolution process is the only remedy

the Division can provide for stakeholders who had their requests denied. Furthermore, though the Division generally agrees that participants could pursue frivolous disputes under §127.1(e) to delay designated doctor examinations, the Division believes that this potential is insufficient reason to strike an otherwise important and necessary procedure. All Division procedures are potentially subject to bad faith abuse by stakeholders, and the Division monitors stakeholder behavior to minimize this abuse.

Comment: One commenter states that the Division should develop a timeline for expedited disputes under this section, because §140.3 of this title (relating to Expedited Proceedings) does not contain one.

Response: The Division disagrees. Attempting to apply a uniform timeline to all expedited disputes would unnecessarily limit both the disputes themselves and the discretion of Division hearings officers in adjudicating the disputes.

Comment: One commenter states that the Division should include a 10 day timeframe in which the Division must respond to a request for expedited contested case hearing in §127.1(e).

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 that is not required by statute.

Comment: One commenter states that insurance carriers will only be able to reasonably seek an expedited hearing to contest an examination if they have access to the Division's TXCOMP database.

Response: The Division disagrees that insurance carriers need access to the Division's TXCOMP database to seek expedited hearings. The Division believes that sufficient information is provided on the order for an examination for insurance carriers or parties generally to become aware of the need for a dispute. Furthermore, failure to file for expedited proceedings does not deprive parties of the ability to dispute the examination at a later date.

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.

Comment: One commenter states that the Division should clarify that a frivolous request for expedited or other proceedings under §127.1(e) is an administrative violation. The commenter also requests that at any hearing that results from the staying of a designated doctor appointment, the issue of whether the request for the stay was frivolous should be addressed.

Response: The Division agrees and disagrees. While the Division agrees that a frivolous request for hearing under this section is an administrative violation, the Division believes that clarification of this outcome is unnecessary. A frivolous request is already an administrative violation under Labor Code §415.009. Furthermore, the Division disagrees with the commenter's request that whether the request for expedited proceeding was frivolous should be addressed at the hearing. Determinations of whether requests for expedited proceedings are frivolous are matter for the Division's enforcement section, and if a party believes that such a request was frivolous that party should file a complaint with the Division.

Comment: Two commenters state that the three day response requirement for expedited hearings is unrealistic. The Division should extend the deadline to five days or three working days.

Response: The Division disagrees. While the Division does recognize that in some cases the deadline may be difficult or impossible to meet, extending the deadline any further would lead to delayed examinations in too many cases. Furthermore, the Division notes that even if a party fails to request expedited proceedings, that party may still

dispute the approval of the designated doctor request through the Division's general dispute resolution procedures.

Comment: One commenter states the Division should include in §127.1(e) a provision to allow for dispute of designated doctor examinations where an insurance carrier raises an absolute defense under Labor Code §409.002 or §409.004 or a lack of coverage issue.

Response: The Division agrees and disagrees. The Division agrees that, under §127.1(e), parties may dispute the approval or denial of a designated doctor examination for any permissible reason under the Act or Division rules. The Division disagrees, however, that additional provisions that itemize all possible bases for dispute under that section are necessary, because nothing in §127.1(e) precludes a party from raising a permissible defense under the Labor Code.

§127.5(a)

Comment: One commenter states that the Division should state that the examination should not be scheduled sooner than 14 days after the designated doctor is notified.

Response: The Division disagrees. While the Division does generally agree that examinations can, in some cases, be scheduled too soon after a request for examination is approved, the Division declines to prohibit the possibility of an examination scheduled within 14 days of the Division's order preemptively. Moreover, the Division notes that designated doctors always are aware of the possible dates of the examination before they accept the examination.

Comment: Several commenters suggest that the Division should give a timeline for how long it will take to approve or deny a designated doctor request.

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(b)

Comment: Several commenters suggest that the Division should permit injured employees and designated doctors to agree to change the location of an examination without requiring Division approval to do so.

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.

Comment: One commenter states that permitting designated doctors and claimants to change the location of examinations for good cause creates new opportunities for gaming the system and, thus, the provision should be struck.

Response: The Division disagrees. Certain circumstances, such as the sudden unavailability of a leased location, require changes of location and designated doctors or claimants, with Division approval, should be permitted to make these changes. Therefore, to preclude the option entirely offers no alternative for parties who legitimately need a location change.

§127.5(c)(4)

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.

§127.5(d)

Comment: One commenter states that the Division should not change the language in §127.5(d) from mandatory to permissive.

Response: The Division disagrees. While it is true that the language of §127.5(d) is permissive, the substance of the rule has been changed to increase the Division's discretion regarding the use of designated doctors on subsequent appointments. Specifically, while the language of former §126.7(h) was mandatory, it also conditioned the use of doctors on subsequent appointments upon the availability of those designated doctors. This condition led to the problematic outcome that designated doctors who no longer traveled to particular counties could not be required to perform subsequent examinations on claims that arose in those counties. To prevent this outcome, adopted §127.5(d) no longer conditions the use of a designated doctor on the availability of those doctors. Instead, so long as the designated doctor is still qualified to perform the examination, the Division may require the doctor to perform the examination regardless of

whether the doctor is accepting new appointments in that county or at that examination address. Because the language is permissive, however, the Division retains the discretion to, under certain exceptional circumstances, use a different designated doctor for subsequent examinations.

Comment: One commenter asks what would happen if a designated doctor were to lose his lease at a particular location and were no longer traveling to that location but then received a request to reexamine a claimant at that location.

Response: The Division, if it chose to have that doctor perform the subsequent examination and the designated doctor was still qualified to perform the examination, would expect the designated doctor to either return to the previous address or, if that were not possible, to return to another approved examination address proximate to the previous location. The Division notes, however, that if a designated doctor elects to no longer accept appointments in a particular location, that designated doctor would no longer receive, and thus no longer be obligated to accept, initial appointments in that location.

Comment: One commenter states that designated doctors and injured employees should be permitted to change the location of subsequent examinations without Division approval if they mutually consent.

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. Additionally, in the case of subsequent examinations, the designated doctor has already performed an examination on the injured employee at the scheduled location because the designated doctor stated they were available to perform examinations at that location; therefore, the designated doctor should explain why this location is no longer feasible before the Division permits a change.

§127.5(e)

Comment: One commenter states that if an examination cannot be held within the 21 days of the originally scheduled examination, the Division should permit the examination to be held outside that time period or require the injured employee to attend.

Response: The Division disagrees. While the Division acknowledges that administrative feasibility requires that some flexibility for rescheduling examinations be permitted, removing all deadlines for an examination to be held could lead to extensive and unnecessary delays in designated doctor scheduling. Furthermore, requiring an injured employee to attend is unnecessary as injured employees, like designated doctors, are already required to attend the examinations unless they have properly rescheduled it for another time or date.

Comment: Two commenters suggest that the Division should require good cause before parties can reschedule the time or date of a designated doctor examination, because Labor Code §408.0041(i) requires injured employees to have good cause for failure or

refusal to appear at an examination. Furthermore, this rescheduling provides parties an opportunity to game the system by creating false scheduling conflicts.

Response: The Division disagrees for multiple reasons. First, the Labor Code §408.0041(i) is inapplicable to this provision as an injured employee who seeks to reschedule an appointment before the appointment occurs has, by definition, not failed or refused to appear at an examination. Furthermore, in many instances, it is the designated doctor who seeks to reschedule the time or date of the examination, and Labor Code §408.0041(i) would not apply to such a scenario. Additionally, regarding the commenters' concerns that designated doctors or other parties game the system through this procedure, the Division believes that this alleged abuse is minimized by the ultimate 42 day deadline for an examination to occur. Lastly, the Division disagrees generally with depriving parties of a useful and necessary administrative procedure based upon possible occurrences of bad faith abuse, though the Division does encourage stakeholders to submit complaints if they are, in fact, aware of such abuse.

§127.10(a)

Comment: One commenter states that the Division should require that medical records be sent in date order in order to decrease the amount of time designated doctors must spend sorting through the medical records.

Response: The Division disagrees. While this requirement may save designated doctors time in sorting through records, it will only increase the time it takes for insurance carriers and treating doctors to prepare the records. Moreover, the Division does not believe that it

could possibly enforce such a rule, because the Division could never determine the exact order the records were in when they were received by the designated doctor. The Division notes, however, that these adopted rules require medical records to be received by designated doctors at least three working days before the examination whereas the repealed §126.7(i)(4) only required the records to arrive one working day before the examination. The Division believes this change may help address the commenter's concerns.

§127.10(a)(2)

Comment: One commenter states that because insurance carriers frequently use the analysis of §127.10(a)(2) to lobby their positions, the Division should make this analysis subject to the same scrutiny as a request for clarification.

Response: The Division disagrees. Labor Code §408.0041 plainly permits treating doctors and insurance carriers to submit analysis on these three topics and it does not restrict their ability to submit analysis on these topics. Thus, the Division disagrees with this suggested change; however, the Division agrees that the analysis should not exceed the scope of the statutory topics, and these adopted rules reflect that position.

Comment: One commenter states the Division should remove "only" from §127.10(a)(2), because it improperly restricts the scope of the analysis an insurance carrier or treating doctor may submit.

Response: The Division disagrees. Labor Code §408.0041 entitles insurance carriers to submit analysis on an injured employee's medical condition, functional abilities, and return-to-work opportunities, and §127.10(a) does nothing to infringe upon this entitlement. Stating that the word "only" improperly restricts the scope of the analysis an insurance carrier or treating doctor may submit suggests that the Labor Code entitles parties to submit analysis beyond the three stated topics. Nothing in the Labor Code, however, supports this suggestion. Thus, the Division, by using the word "only," is simply declining to expand the permissible scope of analysis under §127.10(a)(2) beyond the three express statutory topics.

§127.10(a)(3)

Comment: One commenter disagrees with the new timeframe of this subsection stating that it is impossible for an insurance carrier to ensure that a designated doctor receives medical records within a certain period or by a certain date. Also, the wording of the rule also forbids insurance carriers from relying on deemed receipt. Finally, commenter states that the Division has provided no reason to propose this new timeline as opposed to the previous timeline of §126.7.

Response: The Division disagrees. While the Division acknowledges that insurance carriers and treating doctors may not be able to achieve absolute certainty in the timely delivery of medical records to designated doctors, the Division clarifies that, for the purposes of compliance, the deemed receipt provisions of 28 TAC 102.4 (relating to General Rules for Non-Commission Communication) apply to this rule and should resolve

the commenter's concerns. Additionally, the Division changed the deadline for designated doctors to receive medical records from one working day before the examination to three working days before the examination in order to provide designated doctors with more time to prepare for examinations and in response to several stakeholder comments on its informal draft of these rules requesting such a change.

Comment: One commenter states that treating doctors should be allowed a good cause exception to extend the deadline to submit medical records.

Response: The Division disagrees. Timely receipt of medical records by designated doctors is necessary for the doctor to effectively examine injured employees. Moreover, the Division notes that any good cause exception would have to be extended to insurance carriers as well. The Division also notes, however, that it would take into consideration any reasons a treating doctor provided for untimely submission of records if the Division were pursuing an enforcement action against that doctor.

§127.10(c)

Comment: One commenter states that the Division should omit the requirement that testing be completed within 10 days of the original examination of the injured employee, and only require that it be done 17 working days from the examination, since this is when the report is due.

Response: The Division agrees in part and disagrees in part. While the Division generally agrees that the time for designated doctor testing is insufficient and needs

extending, it disagrees with the commenter's suggested deadline. Instead, for administrative consistency, these adopted rules will require all testing and reports to be completed within 15 working days of the designated doctor's original physical examination of the injured employee.

Comment: One commenter states that doctors should not be required to indicate that they are unqualified before being allowed to refer an injured employee to another health care provider.

Response: The Division disagrees. If a designated doctor is qualified to provide the health care at issue, the designated doctor should not be referring the injured employee to another health care provider.

Comment: One commenter strongly agrees the Division's proposed change that would make designated doctor referrals for testing subject to retrospective review for medical necessity and reasonableness. The commenter supports the change because the commenter believes many designated doctors are ordering testing completely inconsistent with the requirements of the *Official Disability Guidelines - Treatment in Workers' Comp* (ODG).

Response: The Division appreciates the support but disagrees with premise of this comment. Neither designated doctor examinations nor designated doctor referrals for testing constitute treatment of an injured employee; therefore, the ODG, which the Division

has adopted as treatment guidelines, is not the applicable standard of review for these forms of health care.

Comment: One commenter strongly disagrees with the Division proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers. The commenter states that testing performed to determine an impairment rating is not treatment, because it does nothing to cure and relieve the effects of an injury. Thus, the commenter believes that subjecting this testing to retrospective review would have a chilling effect on testing referrals because of fear regarding non-payment. The commenter states then that if doctors have a pattern of making unnecessary referrals for testing, this matter is best addressed by the Division's monitoring and oversight authority over the designated doctor list.

Response: The Division agrees in part and disagrees in part and has made a change. The Division agrees that designated doctor examinations do not constitute treatment under the Act, though the Division disagrees that this reason alone is sufficient to strike the provision from its rules. The Division agrees, however, that reviews of the necessity of designated doctor testing referrals are best addressed by the Division's monitoring and oversight authority, and the Division has, therefore, removed the proposed language in §127.10(c) that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules. The adopted rule language also clarifies that designated doctor testing referrals are not subject to retrospective review by insurance carriers.

Comment: One commenter disagrees with the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers. The commenter disagrees with this change, because the commenter believes this will cause testing not to be performed out of fear or dispute or payment. The commenter also raises concerns that this change will spoil the neutrality of designated doctors, because this change will make designated doctors see that they are providing health care and, thus, become an indirect advocate of the injured employee. The commenter also believes this will add system costs as it will delay as clinical maximum medical improvement will be delayed.

Response: The Division agrees in part and disagrees in part and has made a change. The Division generally agrees with the commenter's concerns regarding this issue and has removed the proposed language in §127.10(c) that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules and has clarified that designated doctor testing referrals are not subject to retrospective review by insurance carriers. The Division disagrees, however, that subjecting designated doctor testing referrals to retrospective review by insurance carriers would, in itself, cause designated doctor examination to qualify as health care under the Act, because designated doctors are providing health care to injured employees as that term is defined under the Act.

Comment: Two commenters disagree with the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by

insurance carriers. The commenters disagree because they believe that retrospective review will disrupt, invalidate, and interfere with designated doctors' ability to answer the questions posed to them by the Division.

Response: The Division agrees in part and disagrees in part and has made a change. While the Division agrees that in some cases retrospective review of designated doctor testing referrals by insurance carriers could interfere with the valid completion of a designated doctor report, the Division does not agree that the possibility of this outcome in some cases would generally invalidate designated doctors' abilities to perform their duties under the Act. The Division, however, has, for this and other reasons, has removed the proposed language in §127.10(c) that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules and, instead, clarified that designated doctor testing referrals are not subject to retrospective review.

Comment: One commenter states that the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers is unnecessary because designated doctors are already required by the insurance system to affirm by affidavit under the penalty of perjury that the tests they order are "reasonable, necessary, and customary." Moreover, the commenter states that the Division already precludes designated doctors from having any financial interest or reward in referring for testing.

Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that any attestations made by designated doctors in the insurance

system regarding the necessity of their testing referrals are alone sufficient to ensure that designated doctors always make testing referrals that are necessary to determine the issues in question in their examinations. The Division does agree, however, that its financial disclosure requirements under 28 TAC §180.24 should discourage unnecessary referrals for testing in some instances and does remind designated doctors to be aware of these provisions when making such referrals for testing. Therefore, for this and other reasons explained in other responses, the Division has removed the proposed language that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules and, instead, clarified that designated doctor testing referrals are not subject to retrospective review by insurance carriers.

Comment: One commenter disagrees with the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers because it would allow insurance carriers to have undue influence on the decisions and examinations of designated doctors. The commenter states that insurance carriers will deny requested testing to save money and, therefore, also overburden the system with unnecessary disputes. The commenter also states that the proposed change will put designated doctors at risk of committing administrative violations, because they will not be able to find health care providers to perform the required testing in time to meet the rule's deadline. Lastly, the commenter recommends that the Division should either strike the provision entirely or establish specific criteria and guidelines by which insurance carriers must review designated doctors.

Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees with the commenter's concern regarding insurance carrier influence created by the opportunity to retrospectively review designated doctor referrals for testing. The Division does agree with the commenter's concerns regarding increased disputes and the possibility of unduly created administrative violations because of testing availability. For these and other reasons then, the Division has removed the provision that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules and, instead, clarified that designated doctor testing is not subject to retrospective review by insurance carriers.

Comment: One commenter disagrees with the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers because designated doctor examination testing referrals are often forensic, not medical, in nature. Thus, reviewing this testing under medical care statutes is not feasible.

Response: The Division agrees and has made a change. While designated doctor examinations do qualify as health care under the Act, designated doctor examinations are not treatment and plainly are not intended to promote recovery or have curative effect. Thus, normal standards for medical necessity, such as those articulated in the definition of "medical benefit" or those articulated in the ODG, do not apply. Thus, the Division agrees with the commenter's concern about the standard of review applicable to designated doctor referrals for additional testing and has, for this and other reasons, removed the

provision that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules.

§127.10(e)

Comment: One commenter states that the Division should add "disability" to §127.10(e) because disability opinions also require Work Status Reports.

Response: The Division disagrees. Disability is a legal determination that cannot be made by designated doctors.

Comment: Two commenters suggest that the Division should ensure that designated doctors use the Medical Disability Advisor, the Division's adopted return-to-work guideline, when performing return-to-work examinations.

Response: These comments exceed the scope of these rules. New §127.10(e) only addresses the procedural, not substantive, elements of a return-to-work examination by a designated doctor.

§127.10(f)

Comment: One commenter requests that the Division clarify that all designated doctor examinations under this section must be based on evidence-based medicine.

Response: This comment is outside the scope of the current rulemaking proposal. Section 127.10 only addresses the procedural elements of conducting examinations not the substantive requirements of conducting those examinations.

§127.10(f)(5)

Comment: One commenter states that "description of what medical records or other information the designated doctor reviewed as part of the evaluation" is too vague, because it is unclear whether the Division is requiring designated doctors to itemize every document they review or simply to summarize the documents generally.

Response: The Division disagrees. The rule language does not permit or imply that a general summary of records is sufficient to meet its requirement. The designated doctor must instead provide a sufficient description of each medical record or other source of information used that a party later examining the records could match each record to each description.

§127.10(f)(7)

Comment: One commenter supports the inclusion of §127.10(f)(7).

Response: The Division appreciates the support.

§127.10(h)

Comment: One commenter states that the Division should clarify that insurance carriers retain all defenses to payment of medical bills under this rule.

Response: The Division agrees in part and has made a change. The Division's proposed language sought to address this issue, but the Division agrees that the language was not clear enough. The Division also notes, however, that this provision does not entitle insurance carriers to any new defenses or expand previous defenses, and insurance carriers that have lost a defense for other reasons under the Act or Division rules, such as

failure to timely raise them under Labor Code §408.027, may not rely upon this provision to cure those defects.

Comment: One commenter states that insurance carriers should only have to pay a previously denied medical bill in accordance with a designated doctor report if the insurance carrier receives a request for reconsideration or the health care provider otherwise timely disputes the denial of the bill. Health care providers have the opportunity to pursue denied bills as subclaimants, and if they choose not to, or if they choose not to submit a request for reconsideration as provided in other rules, the insurance carrier's determination is final; therefore, the denied bill should not be treated differently from any other denied bill. Requiring the insurance carrier to go through a claim file and reprocess all previously denied bills is not contemplated by the statute, overly burdensome, and subjects the Subsequent Injury Fund to exhaustion of resources.

Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that the Labor Code generally precludes reprocessing previously denied medical bills. The Division does agree, however, that the reprocessed bills should be treated similarly to other medical bills, and insurance carriers may still deny payment based on any defenses still available to them under the Act and Division rules that are not inconsistent with the designated doctor's report.

Comment: One commenter requests that the Division remove the requirement that insurance carriers "reprocess applicable medical bill(s)" and replace it with "upon receipt of

the designated doctor's report, the insurance carrier shall not deny payment of medical bills for reasons of compensability or extent of injury that conflict with the opinion of the designated doctor during the pendency of any dispute." The commenter recommends this change because "applicable" is too vague. The commenter also states that the current provision conflicts with Labor Code §408.0041(f), which only requires insurance carriers to pay benefits based on a designated doctor report during "the pendency of any dispute." Thus, insurance carriers should not be required to reprocess bills that were denied before any party disputed the report of the designated doctor. Payment should only be a "go-forward" basis. Finally, the commenter notes that requiring insurance carriers to reprocess and pay previously denied medical bills exposes the subsequent injury fund to much more possible liability.

Response: The Division agrees in part and disagrees in part and has made a change. The Division agrees that "applicable" alone is too vague and has clarified that insurance carriers must reprocess medical bills to which the findings of the designated doctor report apply. The Division disagrees with the commenter's suggested language and interpretation of Labor Code §408.0041(f). The statutory language cited by the commenter only addresses when payment of the relevant benefits is due not when liability for that payment arose. Moreover, §408.0041(f) does not limit benefits that an insurance carrier must pay to those that accrue after the report of the designated doctor. The Division also disagrees that requiring insurance carriers to reprocess previously denied medical bills exposes the subsequent injury fund to increased liability, because the Division believes that this exposure already exists in Labor Code §408.0041.

§127.20(a)

Comment: The Division should state that if it believes that part of a request for clarification is acceptable but part of the request is not, the Division will still send forward the acceptable portion of the request.

Response: The Division agrees in part and disagrees in part. While the Division agrees that if specific portions of a request for clarification are acceptable while other specific portions are not, the acceptable portion should in most cases be forward to the designated doctor, the Division also believes that nothing in its new rules precludes this outcome. Thus, the Division declines to make a change.

Comment: One commenter states that the Division should include a deadline for parties to request clarification of a designated doctor report.

Response: The Division disagrees. Requests for clarification are often helpful, if not necessary, long after an examination is performed, and thus the Division declines to preemptively preclude their use in all cases.

Comment: One commenter states that the Division should remove requirements that the Division must approve requests for clarification and send forward all requests.

Response: The Division disagrees. Labor Code §408.0041 and §408.125 both state that after an examination contact with the designated doctor may only be made through the Division, and there would be no reason for this requirement if the Division was only

expected to forward all requests for clarification to designated doctors without monitoring the character of those requests.

§127.20(b)

Comment: The Division needs guidelines that clarify what is and what is not acceptable in a request for clarification.

Response: The Division agrees generally that guidelines for requests for clarification are necessary, but the Division believes that the standards articulated in §127.20(b) are sufficient to meet this need.

§127.20(b)(2)

Comment: One commenter states that the word "future" conflicts with the basis upon which a designated doctor may be requested under Labor Code §408.0041. Designated doctors should not be asked to opine on any future dispute.

Response: The Division agrees in part and disagrees in part. The Division agrees that designated doctors should not opine on non-existent disputes. The Division disagrees, however, that a conflict is created by its use of the word "future" in §127.20(b)(2). When a party submits their request for clarification to the Division, that party is being asked to explain to the Division, not the designated doctor, how the submitted questions will help resolve a pending or future dispute. The designated doctor will never receive that information, because it is only for the purpose of determining whether the request will be approved or denied.

§127.20(b)(3)

Comment: One commenter objects to the prohibition on leading questions in §127.20(b)(3), because generally in legal proceedings when questioning an expert witness not chosen by a party, the party is allowed to use leading questions to cross-examine the witness. Thus, leading questions should be permitted to elicit the truth.

Response: The Division disagrees. The commenter's comparison is inapt as designated doctors are not expert witnesses nor are they adversely positioned in respect to a requester. Moreover, a request for clarification is not part of a legal proceeding. Thus, the Division does not wish for requests for clarification to be misconstrued as a means by which designated doctors can be subject to cross-examination.

§127.20(d)

Comment: Three commenters suggest that the Division should not require that designated doctors be on the designated doctor list in order to respond to a request for clarification, or the Division should entitle parties to new designated doctor examination if a designated doctor is unable to respond for a request for clarification. Otherwise, parties may unfairly be required to comply with an incorrect designated doctor's report simply because the reporting designated doctor was no longer on the designated doctor list.

Response: The Division disagrees. The statute plainly only gives presumptive weight to the report of a designated doctor, and any doctor who is not on the designated doctor list is, by definition, not a designated doctor. Permitting these doctors to respond to letters of clarification could, therefore, not cure the commenters' complaints. Moreover, the Division

declines to entitle parties to new designated doctor examinations if a doctor is no longer available to respond to a request for clarification. The Division's dispute resolution process and, in the case of insurance carriers, potential for subsequent injury fund reimbursement are sufficient remedies for any harm caused by complying with an incorrect designated doctor report.

Comment: The Division should allow designated doctors five working days, not calendar days, to respond to a request for clarification.

Response: The Division agrees and has made the change.

§127.20(d)(1)

Comment: One commenter states that the Division should schedule reexaminations pursuant to requests for clarification. This would clarify the formal nature of the examination, reduce delays, and make sure that deadlines are met.

Response: The Division agrees and has made a clarifying change. This change corresponds with the original intent of repealed §126.7(u), and, therefore, the Division makes a clarifying change to indicate that, after a designated doctor advises the Division of a need to perform a reexamination to respond to a request for clarification, the Division may order the reexamination. The doctor will then have 21 days from the order to perform the examination if ordered.

§127.25

Comment: One commenter requests that the Division should clarify that if an insurance carrier properly suspended benefits under this section, and then is ordered to restore and repay benefits, interest is not due because the suspension was proper.

Response: The Division agrees and disagrees. While the Division agrees that interest would not be due under the circumstances described by the commenter, the Division also believes that clarification is unnecessary as this outcome is already plain under 28 TAC §126.12.

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

For, with changes: Insurance Council of Texas, Office of Injured Employee Counsel, Texas Medical Association.

Neither for nor against, with changes: State Office of Risk Management, Maven Exams, Genesis Independent Medical Examinations, Flahive, Ogden, and Latson, Texas Association of School Boards, Texas Mutual Insurance Company

Against, with changes: Property Casualty Insurers Association of America.

6. STATUTORY AUTHORITY. The new sections are adopted under the Labor Code §§408.0041, 408.0043, 408.0044, 408.0045 and under the general authority of §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. In relevant part, §408.0043 requires designated doctors, other than dentists and chiropractors, who review a specific workers'

compensation case to meet certain professional specialty requirements. In relevant part, §408.0044 provides that a designated doctor who is a dentist and reviews a dental service in conjunction with a specific workers' compensation case must be licensed to practice dentistry. 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 license to engage in the practice of chiropractic.

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 medical condition and the type of health care the injured employee is currently receiving;

(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, as well as the statutory date of maximum medical improvement, if any;

(6) 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.state.tx.us/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;

(7) provide all information listed below applicable to the type of examination the requestor seeks:

(A) if the requestor seeks an examination on the attainment of MMI, include the date of MMI if any; the date of certification of MMI 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;

(B) if the requestor seeks an examination on the impairment rating of the injured employee, include the date of MMI, if any, 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;

(C) if the requestor seeks an examination on the extent of the compensable injury or an examination regarding the causation of the claimed 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); and list all injuries determined to be compensable by the division or accepted as compensable by the insurance carrier;

(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 and a job description for job offers the employer intends to offer the injured employee;

(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 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

(8) 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:

(1) if the request does not comply with any of the requirements of subsections (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; or

(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.

(e) 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). 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 request for a designated doctor examination. The division, upon 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 days of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

(f) This section becomes effective on February 1, 2011.

§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 §180.21 of this title (relating to Division Designated Doctor List);

(2) 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;

(3) is on the designated doctor list on the day the examination is offered; 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 may use that doctor again if the doctor meets the requirements of subsection (c)(1) - (4) of this section. Examinations under this subsection

must be conducted at the same examination address as the designated doctor's previous examination of the claimant 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 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation. The rescheduled examination shall be set to occur within 21 days of the originally scheduled examination. Within 24 hours of rescheduling, the designated doctor shall contact the division's field office, the injured employee or the injured employee's representative, if any, and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled within 21 days of the originally scheduled examination, the designated doctor shall notify the division immediately, and the division may select a new designated doctor.

(f) This section becomes effective on February 1, 2011.

§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 §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 and

reschedule the examination. The doctor shall conduct the rescheduled examination regardless of whether or not the injured employee's complete medical records have been timely received.

(b) 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, as well as the injured employee's medical condition and history as provided by the injured employee, and shall perform a complete physical examination. The designated doctor shall give the medical records reviewed the weight the doctor determines to be appropriate.

(c) The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor may 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 or retrospective review requirements 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.

(d) 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 the report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor, respectively).

(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 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 report 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 provide the report 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 report by other verifiable means. Reports under this subsection must be filed in the form and manner prescribed by the division and must contain at a minimum:

(1) identification of the question(s) addressed by the designated doctor evaluation;

(2) general information regarding the identity of the designated doctor, injured employee, employer, treating doctor, insurance carrier, as well as the identity of the certified workers' compensation health care network, if applicable;

(3) general information regarding the designated doctor's evaluation, including the date and address where the examination took place;

(4) a summary of any additional testing conducted as part of the evaluation, including the identity of any referral health care providers utilized to perform additional testing, the types of tests conducted and the dates the testing occurred;

(5) a narrative description of the physical examination itself as well as a description of what medical records or other information the designated doctor reviewed as part of the evaluation; and

(6) a summary of the designated doctor's response(s) to each of the questions addressed during the designated doctor's evaluation, including an explanation of the findings and conclusions used to support the designated doctor's response;

(7) a statement that there is no known disqualifying association as described in §180.21 of this title (relating to Division Designated Doctor List) between the designated doctor and the injured employee, the injured employee's treating doctor, the insurance carrier or the insurance carrier's certified workers' compensation health care network, if applicable; and

(8) a certification by the designated doctor of the date that the report was sent to all of the recipients as required by this subsection and that the report was sent in the manner required by this subsection.

(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. 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 notice that the doctor provided to the division 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 becomes effective on February 1, 2011.

§127.15. *Undue Influence on a Designated Doctor*.

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

(1) except as provided by §127.10(a) of this title (relating to General Procedures for Designated Doctor Examinations), only the injured employee or appropriate division staff may communicate with the designated doctor prior to the examination of the injured employee by the designated doctor regarding the injured employee's medical condition or history;

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

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

(b) The insurance carrier, treating doctor, injured employee, or injured employee's representative, if any, may contact the designated doctor's office to ask about administrative matters, including but not limited to whether the designated doctor received the records, whether the exam took place, or whether the report has been filed, or other similar matters.

(c) This section becomes effective on February 1, 2011.

§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.

(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 becomes effective on February 1, 2011.

§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, after the insurance carrier suspends TIBs pursuant to this subsection, the injured employee contacts the designated doctor to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor. The insurance carrier shall reinstate TIBs effective as of the date the injured employee submitted to the

examination 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.

(d) An injured employee is not entitled to TIBs for a period during which the insurance carrier suspended benefits pursuant to this subsection 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.

(e) This section becomes effective on February 1, 2011.

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

Issued at Austin, Texas, on December 3, 2010.

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

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25 specified herein, relating to designated doctor scheduling and examinations are adopted.

_____
ROD BORDELON
COMMISSIONER OF WORKERS' COMPENSATION

ATTEST:

_____
Dirk Johnson
General Counsel

COMMISSIONER ORDER NO _____