

Performance Based Oversight 2015 Assessment Health Care Providers

As a regulatory agency, the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) is required to monitor workers' compensation system participants' compliance with the Texas Workers' Compensation Act and TDI-DWC Rules and to take appropriate action to ensure compliance. Compliance objectives are achieved through Performance Based Oversight (PBO), data monitoring, complaint handling, audits, and when appropriate, enforcement actions.

As part of the overall compliance plan, the Texas Labor Code §402.075 mandates the TDI-DWC to, at least biennially, assess the performance of health care providers in meeting the key regulatory goals (KRG) established by the Commissioner of Workers' Compensation.

Based on the performance assessment, health care providers will be placed into regulatory tiers: poor performers, average performers, and consistently high performers, in accordance with the Texas Labor Code §402.075. The TDI-DWC must then focus its regulatory oversight on the poor performers.

For the 2015 PBO assessment, the TDI-DWC will assess the health care providers on four measures.

- Completeness of the DWC Form-073, *Work Status Report*.
- Documentation supporting why the injured employee is prevented from returning to work as reported on the DWC Form-073, *Work Status Report*.
- Timeliness of filing the DWC Form-069, *Report of Medical Evaluation*.
- Medical record documentation supporting the ordering of a Lumbar Spine Magnetic Resonance Image prior to 21 days from the date of injury.

HEALTH CARE PROVIDER SELECTION

The health care providers selected for the 2015 PBO assessment are selected based on the several criteria.

For the completeness of DWC Form-073, *Work Status Report*, and documentation supporting why the injured employee is prevented from returning to work measures:

- Health care providers who requested reimbursement for 20 or more DWC Form-073s and the billing data is received by February 28, 2014;
- DWC Form-073s with a date of service 30 or more days after the date of injury (June 1, 2013 or greater); and
- The injured employee's initiation of temporary income benefits occurred between July 1, 2013 and September 30, 2013.

For the timeliness of filing the DWC Form-069, *Report of Medical Evaluation*, measure:

- Health care providers who filed 20 or more DWC Form-069s with the TDI-DWC;
- Examination date occurred between August 1, 2013 and November 30, 2013; and
- Health care provider is on the Approved Designated Doctor List.

For the medical record documentation supporting the ordering of a Lumbar Spine Magnetic Resonance Image (MRI) prior to 21 days from the date of injury measure:

- Health care providers who ordered 10 or more MRIs on injured employees with a low back injury¹; and
- Date of injury was between March 1, 2013 and November 30, 2013.

DATA SOURCES FOR ASSESSMENT

The following describes where the data for the assessment will be obtained.

DWC Form-073, *Work Status Report*, measures

The DWC Form-073s will be identified through the medical bill and payment data submitted by insurance carriers to the TDI-DWC between June 1, 2014 and February 28, 2015. The review will include DWC Form-073s with dates of injuries on or after June 1, 2014 where the injured employee's initiation of temporary income benefits occurred between July 1, 2014 and September 30, 2014. The selected health care providers will be responsible for submitting the specific DWC Form-073s as requested through a data call.

DWC Form-069, *Report of Medical Evaluation*, measure

The DWC Form-069s will be identified from the TDI-DWC database where the form was received on or before May 31, 2015. The review will include DWC Form-069s where examinations occurred between January 1, 2015 and April 30, 2015.

Medical record documentation supporting the ordering of a Lumbar Spine MRI prior to 21 days from the date of injury measure

The MRIs will be identified through the medical bill and payment data submitted by insurance carriers to the TDI-DWC on or before May 31, 2015. MRIs ordered with dates of injuries between June 1, 2014 and February 28, 2015 will be reviewed.

CALCULATIONS and WEIGHTS OF MEASURES

The selected health care providers will be assessed on the following measures for the 2015 PBO assessment:

Completeness of the DWC Form-073, *Work Status Report* measures² - 100% weight

Numerator: Total number of forms reviewed - Total number of forms with errors found
Denominator: Total number of forms reviewed

Documentation of why an injured employee is prevented from returning to work³ - 100% weight

Numerator: Total number of forms reviewed - Total number of forms with insufficient documentation to justify an off work status
Denominator: Total number of forms reviewed

Timeliness of filing the DWC Form-069, *Report of Medical Evaluation* measure⁴ – 100% weight

Numerator: Total number of forms reviewed - Total number of late forms
Denominator: Total number of forms reviewed

1 See Attachment A on a list of ICD 9 codes used to identify low back injuries.

2 See Attachment B for a copy of 28 Texas Administrative Code §129.5

3 See Attachment C for an explanation of how this measure will be evaluated.

4 See Attachment D for a copy of 28 Texas Administrative Code §127.10 and 130.1

Medical record documentation supporting the ordering of a Lumbar Spine MRI prior to 21 days from the date of injury⁵ – 100% weight

Numerator: Total number of MRIs reviewed - Total number of MRIs done outside of treatment guidelines with insufficient documentation to justify the MRI prior to 21 days from the date of injury
 Denominator: Total number of MRIs reviewed

TIER STRUCTURE AND PLACEMENT METHODOLOGY

There are three regulatory tiers that distinguish among poor, average, and high performers in the workers’ compensation system. Those assessed are deemed to have an impact on the workers’ compensation system due to their volume of filings or MRIs. The TDI-DWC is not asserting that a high volume has a negative impact on the system. Those health care providers who are not assessed due to low volume are not absolved from regulatory duties or regulatory oversight when necessary.

In placing the selected health care providers into regulatory tiers, the TDI-DWC will conduct several steps to place each health care provider into an overall tier for each category. The first step is to calculate the performance score (percentage) for each measure. Next, the performance score for each measure will be multiplied by the assigned weight value. This calculation will then be multiplied by 100 to obtain a weighted value. The weighted value becomes the overall score for the measure. The overall score will identify the performance standard for the assessed entity. The overall performance standard is defined below.

The final scores will be placed into three regulatory tiers based on pre-determined performance standards that distinguish among poor, average, and high performers in the workers’ compensation system.

The performance standards are:

- High Tier: 95 or greater**
- Average Tier: 80.00 through 94.99**
- Poor Tier: 79.99 or less**

Example: DWC Form-073 category tier placement for Health Care Provider X

Measure	Step 1 Calculate Individual Measure	Step 2 Weight of Individual Measure	Step 3 Multiply Score by 100 to obtain weighted value	Step 4 Overall Score	Step 5 Overall Tier Placement
Completeness of DWC Form-073	82%	100%	82	82	AVERAGE

ASSESSMENT PROCESS

The TDI-DWC will identify DWC Form-073s to be reviewed from its medical bill and payment database. In April 2015, health care providers associated with the DWC Form-073s measure will be provided with the list of DWC Form-073s and asked to respond to TDI-DWC by submitting imaged copies of the identified forms for agency staff to conduct an initial review.

The TDI-DWC anticipates distributing the initial findings of all the measures to the respective health care providers by July 2015. Health care providers will be given an opportunity to review these

⁵ See Attachment E for an explanation of how this measure would be evaluated.

initial findings and, if any findings are refuted, the health care provider will be able to submit a management response (response template to be posted on the TDI website) and applicable evidence. The TDI-DWC will review all management responses and prepare a summary of changes document. Any review of medical records will be done by a member of the Medical Quality Review Panel. This document will indicate whether the initial finding is changed and, if so, the reason for the change. This summary of changes document will provide the feedback to the assessed health care provider on the TDI-DWC requirements.

The final results of the 2015 PBO health care provider assessments will be published on the TDI-DWC website after the results have been shared with each of the respective health care providers. The TDI anticipates the publication of the results in December 2015.

TENTATIVE TIMELINE

The following is a tentative timeline of milestones for the 2015 PBO health care provider assessment process:

June 2014: Public announcement of 2015 PBO Assessment

June 2014: Notification letters sent to health care providers selected for the 2015 PBO assessment

April 2015: Request DWC Form-073s from health care providers

April – May 2015: Review DWC Form-073s received from health care providers

July 2015: Distribute initial findings and request management responses (includes submission of applicable medical records)

August – October 2015: TDI-DWC reviews management responses to initial findings and sends summary of changes

November 2015: TDI-DWC distributes final results

December 2015: Publication of final results and tier placements

INCENTIVES

The TDI-DWC will afford incentives to system participants.

1. Limited audit exemption – Health care providers in the high and average performer categories may benefit from limited audits. Instead, the TDI-DWC will focus its annual audit plan on those health care providers assessed as poor performers. However, if a compliance problem is identified, such as an increase in complaints, the TDI-DWC can also audit average and high performers as deemed necessary.
2. Modified penalties – The TDI-DWC will consider high performer designation as a factor when determining appropriate enforcement action. As a result, the TDI-DWC may assess penalties that are lower for high performers than ordinarily assessed.
3. Publication of all tier results – Tier results will be published on the TDI website.
4. High Performer logo – The High Performer logo will be available for use as a marketing tool by those system participants whose scores put them in the high performing tier.
5. Reduced penalties – Reduced penalties for self-disclosure of non-compliance.

ENFORCEMENT

The TDI-DWC's emphasis is on early detection of noncompliance and informal discussions to resolve any noncompliant issues. The TDI-DWC will initiate enforcement actions, including Warning Letters and the assessment of penalties, when appropriate and necessary, to ensure compliance and deter future noncompliance.

To determine an appropriate enforcement action, the TDI-DWC will consider the following:

- Section 415.021(c) of the Texas Labor Code:
 - æ Seriousness of the violations;
 - æ History and extent of previous administrative violations;
 - æ Demonstration of good faith;
 - æ Amount of penalty to deter future violations; and
 - æ Other matters that justice may require; and
- 28 Texas Administrative Code §180.26

ATTACHMENT A

CD9

Code	Description
720.2	Sacroiliitis, not elsewhere classified
721.3	Lumbosacral spondylosis without myelopathy
722.1	Displacement of lumbar intervertebral disc without myelopathy
722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.32	Schmorl's nodes, lumbar region
722.52	Degeneration of lumbar or lumbosacral intervertebral disc
722.83	Postlaminectomy syndrome of lumbar region
722.93	Other and unspecified disc disorder of lumbar region
724	Other and unspecified disorders of back
724.0	Spinal stenosis, other than cervical
724.02	Spinal stenosis of lumbar region, without neurogenic claudication
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Backache, unspecified
724.6	Disorders of sacrum
724.7	Disorders of coccyx
724.70	Unspecified disorder of coccyx
724.71	Hypermobility of coccyx
724.79	Other disorders of coccyx
724.8	Other symptoms only referable to back
724.9	Other unspecified back disorders
739.3	Nonallopathic lesions of lumbar region, not elsewhere classified
739.4	Nonallopathic lesions of sacral region, not elsewhere classified
805.4	Closed fracture of lumbar vertebra without mention of spinal cord injury
805.6	Closed fracture of sacrum and coccyx without mention of spinal cord injury
839.2	Closed dislocation, thoracic and lumbar vertebra
839.20	Closed dislocation, lumbar vertebra
839.41	Closed dislocation, coccyx
839.42	Closed dislocation, sacrum
846	Sprains and strains of sacroiliac region
846.0	Lumbosacral (joint) (ligament) sprain
846.1	Sacroiliac (ligament) sprain
846.2	Sprain and strain of sacrospinatus (ligament)
846.3	Sprain and strain of sacrotuberous (ligament)
846.8	Other specified sites of sacroiliac region sprain
846.9	Unspecified site of sacroiliac region sprain
847.2	Lumbar sprain
847.3	Sprain of sacrum
847.4	Sprain of coccyx
847.9	Sprain of unspecified site of back
922.3	Contusion of back
922.31	Contusion of back
922.32	Contusion of buttock

ATTACHMENT B

Texas Administrative Code

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 129	INCOME BENEFITS--TEMPORARY INCOME BENEFITS
RULE §129.5	Work Status Reports

(a) As used in this section:

(1) the term "doctor" means either the treating doctor or a referral doctor, as defined by §133.4 of this title (relating to Consulting and Referral Doctors);

(2) "substantial change in activity restrictions" means a change in activity restrictions caused by a change in the employee's medical condition which either prevents the employee from working under the previous restrictions or which allows the employee to work in an expanded and more strenuous capacity than the prior restrictions permitted (approaching the employee's normal job);

(3) "change in work status" means a change in the employee's work status from one of the three choices listed in subsection (a)(4) of this section to another of the choices in that subsection; and

(4) the term "work status" refers to whether the injured employee's (employee) medical condition:

(A) allows the employee to return to work without restrictions (which is not equivalent to maximum medical improvement);

(B) allows the employee to a return to work with restrictions; or

(C) prevents the employee from returning to work.

(b) The doctor shall file a Work Status Report in the form and manner prescribed by the Commission.

(c) The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum:

(1) identification of the employee's work status;

(2) effective dates and estimated expiration dates of current work status and restrictions (an expected expiration date is not binding and may be adjusted in future Work Status Reports, as appropriate, based on the condition and progress of the employee);

(3) identification of any applicable activity restrictions;

(4) an explanation of how the employee's workers' compensation injury prevents the employee from returning to work (if the doctor believes that the employee is prevented from returning to work); and

(5) general information that identifies key information about the claim (as prescribed on the report).

(d) The doctor shall file the Work Status Report:

(1) after the initial examination of the employee, regardless of the employee's work status;

(2) when the employee experiences a change in work status or a substantial change in activity restrictions; and

(3) on the schedule requested by the insurance carrier (carrier), its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee.

(e) The Work Status Report filed as required by subsection (d) of this section shall be provided to the employee at the time of the examination and shall be sent, not later than the end of the second working day after the date of examination, to the carrier and the employer.

(f) In addition to the requirements under subsection (d), the treating doctor shall file the Work Status Report with the carrier, employer, and employee within seven days of the day of receipt of:

(1) functional job descriptions from the employer listing available modified duty positions that the employer is able to offer the employee as provided by §129.6(a) of this title (relating to Bona Fide Offers of Employment); or

(2) a required medical examination doctor's Work Status Report that indicates that the employee can return to work with or without restrictions.

(g) Filing the Work Status Report as required by subsection (f) of this section does not require a new examination of the employee.

(h) The doctor shall file the Work Status Report as follows:

(1) A report filed with the carrier or its agent shall be filed by facsimile or electronic transmission;

(2) A report filed with the employer shall be filed by facsimile or electronic transmission if the doctor has been provided the employer's facsimile number or e-mail address; otherwise, the report shall be filed by personal delivery or mail; and

(3) A report filed with the employee shall be hand delivered to the employee, unless the report is being filed pursuant to subsection (f) of this section and the doctor is not scheduled to see the employee by the due date to send the report. In this case, the doctor shall file the report with the employee by facsimile or electronic transmission if the doctor has been provided the employee's facsimile number or e-mail address; otherwise, the report shall be filed by mail.

(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows:

(1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;

(2) CPT code "99080" with modifiers "73" and "RR" (for "requested report") shall be used when the doctor is billing for an additional report requested by or through the carrier under subsection (d)(3) of this section; and

(3) CPT code "99080" with modifiers "73" and "EC" (for "extra copy") shall be used when the doctor is billing for an extra copy of a previously filed report requested by or through the carrier.

(j) As provided in §126.6(f) of this title (relating to Order for Required Medical Examinations), a doctor who conducts a required medical examination (on anyone's behalf) in which the doctor determines that the employee can return to work immediately with or without restrictions, shall file the Work Status Report required by this section, but shall do so in accordance with the requirements of §126.6(f).

Source Note: The provisions of this §129.5 adopted to be effective December 26, 1999, 24 TexReg 11420; amended to be effective July 16, 2000, 25 TexReg 6520

ATTACHMENT C

DOCUMENTATION OF WHY AN INJURED EMPLOYEE IS PREVENTED FROM RETURNING TO WORK MEASURE

1. The DWC Form-073s, for each health care provider, will be identified through the TDI-DWC's medical bill and payment data where there was a billing. The DWC Form-073s will be collected from the health care providers. The total number of DWC Form-073s is the denominator.
2. From Section II, 13 of the DWC Form-073s count the number of forms where Box C was selected. Subtract this number from the total number of DWC Form-073. This number is the numerator.
3. Obtain a percentage score by dividing the numerator by the denominator.
4. If any DWC Form-073's, Section II, 13 Box C is indicated, the TDI-DWC will request medical records from the health care providers that offer an off work rationale.
5. If the medical rationale for an off work status is accepted after an *MQRP Review* then add that DWC Form-073(s) to the numerator.

1. **MQRP Review:**

- i. The MQRP review will first involve an evaluation of documentation that illustrates the off work dates are in conjunction with the Medical Disability Advisor (MDA), disability duration tables. Documentation for this review may include the following:
 - DWC Form-074, *Description of Injured Employee's Employment*
 - Medical Records indicating injured employee's job classification
 - Medical records indicating MDA calculation
- ii. Absent any medical documentation showing an assessment of the injured employee per the MDA disability durations, a case-by-case clinical review will occur based on other evidence-based medical literature (i.e. ACOEM⁶, etc) and contemporaneous written explanation provided by the health care provider. Determination of an off work status may consider:
 - Attendance is required at a place of care (hospital, physician's office, physical therapy).
 - Recovery (or quarantine) requires confinement to bed or home.
 - Being in the workplace or traveling to work is medically contraindicated (poses a specific hazard to the public, coworkers, or to the injured employee personally, i.e., risks damage to tissues or delays healing).

6. Recalculate Results

- i. The following is a list of some examples that, without a written explanation or documentation in the medical records, will not be accepted as a reason for preventing an injured employee from returning to work:
 - Work (restricted or not) was not available by the employer;
 - Pending further tests, rehabilitation, physical therapy, surgery, etc;
 - Pain;
 - Rest, no mobility, no activity, immobility;
 - Injuries – severe, multiple; or
 - Per another/different physician's assessment/recommendation.

⁶ **ACOEM Paper on Preventing Needless Disability** - Copyright © 2006 American College of Occupational and Environmental Medicine. Published in September 2006 *JOEM*

ATTACHMENT D

Texas Administrative Code

TITLE 28

INSURANCE

PART 2

TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 127

DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS

SUBCHAPTER A

DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS

RULE §127.10

General Procedures for Designated Doctor Examinations

(a) The designated doctor is authorized to receive the injured employee's confidential medical records and analyses of the injured employee's medical condition, functional abilities, and return-to-work opportunities to assist in the resolution of a dispute under this subchapter without a signed release from the injured employee. The following requirements apply to the receipt of medical records and analyses by the designated doctor:

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

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

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are received by the designated doctor no later than three working days prior to the date of the designated doctor examination. If the designated doctor has not received the medical records or any part thereof at least three working days prior to the examination, the designated doctor shall report this violation to the division within one working day of not timely receiving the records. Once notified, the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if the designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records.

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

and history as provided by the injured employee, any medical records provided by the injured employee, and shall perform a complete physical examination of the injured employee. The designated doctor shall give the medical records reviewed the weight the designated doctor determines to be appropriate.

(c) The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the expiration of the 15 working days. If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report.

(d) Any evaluation relating to either maximum medical improvement (MMI), an impairment rating, or both, shall be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury. A designated doctor who determines the injured employee has reached MMI or who assigns an impairment rating, or who determines the injured employee has not reached MMI, shall complete and file a report as required by §130.1 of this title and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor). If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor's extent of injury determination. The designated doctor, however, shall only submit one narrative report required by §130.1(d)(1)(B) of this title for all impairment ratings assigned and extent of injury findings. All designated doctor narrative reports submitted under this subsection shall also comply with the requirements of §127.220(a) of this title.

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

(f) A designated doctor who resolves questions on issues other than those listed in subsections (d) and (e) of this section, shall file a Designated Doctor Examination Data Report that complies with §127.220(c) of this title and a narrative report that complies with §127.220(a) of this title within seven working days of the date of the examination of the injured employee. These reports shall be filed with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall provide these reports to the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the reports by other verifiable means.

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

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

(i) The designated doctor shall maintain accurate records for, at a minimum, five years from the anniversary date of the date of the designated doctor's last examination of the injured employee. This requirement does not reduce or replace any other record retention requirements imposed upon a designated doctor by an appropriate licensing board. These records shall include the injured employee's medical records, any analysis submitted by the insurance carrier or treating doctor (including supporting information), reports generated by the designated doctor as a result of the examination, and narratives provided by the insurance carrier and treating doctor, to reflect:

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

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

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

Source Note: The provisions of this §127.10 adopted to be effective February 1, 2011, 35 TexReg 11324; amended to be effective September 1, 2012, 37 TexReg 5422

Texas Administrative Code

TITLE 28	INSURANCE
PART 2	TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION
CHAPTER 130	IMPAIRMENT AND SUPPLEMENTAL INCOME BENEFITS
SUBCHAPTER A	IMPAIRMENT INCOME BENEFITS
RULE §130.1	Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment

(a) Authorized Doctor.

(1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment.

(A) Doctors serving in the following roles may be authorized as provided in subsection (a)(1)(B) of this section.

(i) the treating doctor (or a doctor to whom the treating doctor has referred the injured employee for evaluation of MMI and/or permanent whole body impairment in the place of the treating doctor, in which case the treating doctor is not authorized);

(ii) a designated doctor; or

(iii) a required medical examination (RME) doctor selected by the insurance carrier and approved by the division to evaluate MMI and/or permanent whole body impairment after a designated doctor has performed such an evaluation.

(B) Prior to September 1, 2003 a doctor serving in one of the roles described in subsection (a)(1)(A) of this subsection is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI. On or after September 1, 2003, a doctor serving in one of the roles described in subsection (a)(1)(A) of this section is authorized as follows:

(i) a doctor whom the division has certified to assign impairment ratings or otherwise given specific permission by exception to, is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI; and

(ii) a doctor whom the division has not certified to assign impairment ratings or otherwise given specific permission by exception to is only authorized to determine whether an injured employee has permanent impairment and, in the event that the injured employee has no impairment, certify MMI.

(2) Doctors who are not authorized shall not make findings of permanent impairment, certify MMI, or assign impairment ratings and shall not be reimbursed for the examination, certification, or report if one does so. A certification of MMI, finding of permanent impairment, and/or impairment rating assigned by an unauthorized doctor are invalid. If a treating doctor finds that the injured employee has permanent impairment but is not authorized to assign an impairment rating, the doctor is also not authorized to certify MMI and shall refer the injured employee to a doctor who is so authorized.

(3) A doctor who is authorized under this subsection to certify MMI, determine whether permanent impairment exists, and assign an impairment rating and who does, shall be referred to as the "certifying doctor."

(b) Certification of Maximum Medical Improvement.

(1) Maximum medical improvement (MMI) is:

(A) the earliest date after which, based on reasonable medical probability, further material recovery from or lasting improvement to an injury can no longer reasonably be anticipated;

(B) the expiration of 104 weeks from the date on which income benefits begin to accrue; or

(C) the date determined as provided by Texas Labor Code §408.104.

(2) MMI must be certified before an impairment rating is assigned and the impairment rating must be assigned for the injured employee's condition on the date of MMI. An impairment rating is invalid if it is based on the injured employee's condition on a date that is not the MMI date. An impairment rating and the corresponding MMI date must be included in the Report of Medical Evaluation to be valid.

(3) Certification of MMI is a finding made by an authorized doctor that an injured employee has reached MMI as defined in subsection (b)(1) of this section.

(4) To certify MMI the certifying doctor shall:

(A) review medical records;

(B) perform a complete medical examination of the injured employee for the explicit purpose of determining MMI (certifying examination);

(C) assign a specific date at which MMI was reached.

(i) The date of MMI may not be prospective or conditional.

(ii) The date of MMI may be retrospective to the date of the certifying exam.

(D) Complete and submit required reports and documentation.

(c) Assignment of Impairment Rating.

(1) An impairment rating is the percentage of permanent impairment of the whole body resulting from the current compensable injury. A zero percent impairment may be a valid rating.

(2) A doctor who certifies that an injured employee has reached MMI shall assign an impairment rating for the current compensable injury using the rating criteria contained in the appropriate edition of the AMA Guides to the Evaluation of Permanent Impairment, published by the American Medical Association (AMA Guides).

(A) The appropriate edition of the AMA Guides to use for all certifying examinations conducted before October 15, 2001 is the third edition, second printing, dated February, 1989.

(B) The appropriate edition of the AMA Guides to use for certifying examinations conducted on or after October 15, 2001 is:

(i) the fourth edition of the AMA Guides (1st, 2nd, 3rd, or 4th printing, including corrections and changes as issued by the AMA prior to May 16, 2000). If a subsequent printing(s) of the fourth edition of the AMA Guides occurs, and it contains no substantive changes from the previous printing, the division by vote at a public meeting may authorize the use of the subsequent printing(s); or

(ii) the third edition, second printing, dated February, 1989 if, at the time of the certifying examination, there is a certification of MMI by a doctor pursuant to subsection (b) of this section made prior to October 15, 2001 which has not been previously withdrawn through agreement of the parties or previously overturned by a final decision.

(C) This subsection shall be implemented to ensure that in the event of an impairment rating dispute, only ratings using the appropriate edition of the AMA Guides shall be considered.

Impairment ratings assigned using the wrong edition of the AMA Guides shall not be considered valid.

(3) Assignment of an impairment rating for the current compensable injury shall be based on the injured employee's condition on the MMI date considering the medical record and the certifying examination. An impairment rating is invalid if it is based on the injured employee's condition on a date that is not the MMI date. An impairment rating and the corresponding MMI date must be included in the Report of Medical Evaluation to be valid. The doctor assigning the impairment rating shall:

(A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury;

(B) document specific laboratory or clinical findings of an impairment;

(C) analyze specific clinical and laboratory findings of an impairment;

(D) compare the results of the analysis with the impairment criteria and provide the following:

(i) A description and explanation of specific clinical findings related to each impairment, including zero percent (0%) impairment ratings; and

(ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained.

(E) assign one whole body impairment rating for the current compensable injury;

(F) be responsible for referring the injured employee to another doctor or health care provider for testing, or evaluation, if additional medical information is required. The certifying doctor is responsible for incorporating all additional information obtained into the report required by this rule:

(i) Additional information must be documented and incorporated into the impairment rating and acknowledged in the required report.

(ii) If the additional information is not consistent with the clinical findings of the certifying doctor, then the documentation must clearly explain why the information is not being used as part of the impairment rating.

(4) After September 1, 2003, if range of motion, sensory, and strength testing required by the AMA Guides is not performed by the certifying doctor, the testing shall be performed by a health care practitioner, who within the two years prior to the date the injured employee is evaluated, has had the impairment rating training module required by §180.23 (relating to Division Required Training for Doctors) for a doctor to be certified to assign impairment ratings. It is the responsibility of the certifying doctor to ensure the requirements of this subsection are complied with.

(5) If an impairment rating is assigned in violation of subsection (c)(4), the rating is invalid and the evaluation and report are not reimbursable. A provider that is paid for an evaluation and/or report that is invalid under this subsection shall refund the payment to the insurance carrier.

(d) Reporting.

(1) Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report.

(A) The Report of Medical Evaluation must be signed by the certifying doctor. The certifying doctor may use a rubber stamp signature or an electronic facsimile signature of the certifying doctor's personal signature.

(B) The Report of Medical Evaluation includes an attached narrative report. The narrative report must include the following:

- (i) date of the certifying examination;
- (ii) date of MMI;
- (iii) findings of the certifying examination, including both normal and abnormal findings related to the compensable injury and an explanation of the analysis performed to find whether MMI was reached;
- (iv) narrative history of the medical condition that outlines the course of the injury and correlates the injury to the medical treatment;
- (v) current clinical status;
- (vi) diagnosis and clinical findings of permanent impairment as stated in subsection (c)(3);
- (vii) the edition of the AMA Guides that was used in assigning the impairment rating (if the injured employee has permanent impairment); and
- (viii) a copy of the authorization if, after September 1, 2003, the doctor received authorization to assign an impairment rating and certify MMI by exception granted from the division.

(2) A Report of Medical Evaluation under this rule shall be filed with the division, injured employee, injured employee's representative, and the insurance carrier no later than the seventh working day after the later of:

- (A) date of the certifying examination; or
- (B) the receipt of all of the medical information required by this section.

(3) The report required to be filed under this section shall be filed as follows:

(A) The Report of Medical Evaluation shall be filed with the insurance carrier by facsimile or electronic transmission; and

(B) The Report of Medical Evaluation shall be filed with the division, the injured employee and the injured employee's representative by facsimile or electronic transmission if the doctor has been provided the recipient's facsimile number or email address; otherwise, the report shall be filed by other verifiable means.

(e) Documentation. The certifying doctor shall maintain the original copy of the Report of Medical Evaluation and narrative as well as documentation of:

- (1) the date of the examination;
- (2) the date any medical records necessary to make the certification of MMI were received, and from whom the medical records were received; and
- (3) the date, addressees, and means of delivery that reports required under this section were transmitted or mailed by the certifying doctor.

Source Note: The provisions of this §130.1 adopted to be effective June 7, 2000, 25 TexReg 5352; amended to be effective January 2, 2002, 26 TexReg 10910; amended to be effective March 14, 2004, 29 TexReg 2328; amended to be effective August 25, 2013, 38 TexReg 5263

ATTACHMENT E

MEDICAL RECORD DOCUMENTATION OF ORDERING A LUMBAR SPINE MAGNETIC RESONANCE IMAGE PRIOR TO 21 DAYS FROM THE DATE OF INJURY MEASURE

1. Select a group of health care providers, who have billed for 10 or more MRIs on injured employees with a low back injury with a date of injury between June 1, 2014 and September 30, 2014. The total number of MRIs for each health care provider will be the denominator.
2. From the MRIs, identified in #1 subtract the number of patients who received a lumbar spine MRI prior to 21 days from the date of injury. The remainder is the numerator.
3. Obtain a percentage score by dividing the numerator by the denominator.
4. For those health care providers with MRIs ordered prior to 21 days from the date of injury, medical records will be requested to show the clinical rationale for the MRI. The health care provider will highlight the area of the records that justify the clinical rationale.
5. Using the list(s) in the Official Disability Guidelines (ODG) and clinical judgment, determine if the clinical rationale supports performance of the MRI scan. A Clinical Review will be conducted by a member of the MQRP.
6. If the clinical rationale for the MRI ordered prior to 21 days from date of injury is accepted after Clinical Review, then add that MRI to the numerator.
7. Recalculate final scores.