Performance Based Oversight
2021 Assessment
Health Care Providers

The Texas Department of Insurance, Division of Workers' Compensation (DWC) is required to monitor workers' compensation system participants' compliance with the Texas Labor Code and DWC rules. Compliance objectives are achieved through Performance Based Oversight (PBO), data monitoring, complaint handling, audits, and enforcement actions.

As part of the overall compliance plan, Texas Labor Code §402.075 requires DWC to assess the performance of system participants in meeting the key regulatory goals established by the commissioner of workers' compensation.

Based on the performance assessment, health care providers are placed into regulatory tiers: poor performers, average performers, and high performers. DWC focuses its regulatory oversight on the poor performers.

The 2021 PBO assessment will evaluate health care providers on the following categories:

- DWC Form-073, *Work Status Report;* and
- DWC Form-069, *Report of Medical Evaluation*.

Weighted Measures

The health care providers selected will be assessed on the following measures:

DWC Form-073, *Work Status Report* Category

1. Documentation supporting how the injured employee's medical condition prevents them from returning to (any) work as reported on the DWC Form-073, *Work Status Report* measure[1] - 70% weight.
2. Completeness of the DWC Form-073, *Work Status Report* measures[2] - 30% weight.

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

1. Timeliness of filing the DWC Form-069, *Report of Medical Evaluation* measure[3] - 100% weight.

Time Frames and Data Sources Used for 2021 Assessment

The data used to assess performance of health care providers for the 2021 PBO assessment is based on the following parameters:

DWC Form-073, *Work Status Report* Category:

DWC Form-073 services identified through the medical bill and payment data submitted by insurance carriers to DWC, between June 1, 2020, and February 28, 2021, with a date of service

1 See Attachment A for an explanation of how this measure will be evaluated.
2 See Attachment B for a copy of 28 Texas Administrative Code §129.5.
3 See Attachment C for a copy of 28 Texas Administrative Code §§127.10 and 130.1.

30 or more days after the date of injury. The review will include DWC Form-073s with dates of injury on or after June 1, 2020, where the injured employee's initiation of temporary income benefits occurred between June 1, 2020, and September 30, 2020.

Selected health care providers will be responsible for submitting the specific DWC Form-073s as requested through a data call.

Timeliness of filing the DWC Form-069, *Report of Medical Evaluation* Category:

The designated doctor DWC Form-069s will be identified from the DWC database where the form is received on or before May 31, 2021. The review will include DWC Form-069s where examinations occurred between January 1, 2021, and April 30, 2021.

Selection Criteria

The following describes how the health care providers are selected for the 2021 PBO assessment:

DWC Form-073, *Work Status Report* Category

The health care providers selected for assessment on these measures are based on their volume of DWC Form-073, *Work Status Reports* identified in the data time frame. The minimum volume of forms will be determined based on the overall volume of the assessment data and DWC resources, but will not be less than 20 forms.

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

The health care providers selected for assessment on this measure is based on their volume of DWC Form-069, *Report of Medical Evaluations* identified in the assessment data timeframe. The minimum volume of forms will be determined based on the overall volume of the assessment data and DWC resources, but will not be less than 20 forms.

Tier Structure and Placement Methodology

Three regulatory tiers are used to make a distinction between poor, average, and high performers in the workers' compensation system. The health care providers assessed are considered to have an impact on the workers' compensation system due to their volume of filings. DWC is not asserting that a high volume has a negative impact on the system. Health care providers who are not assessed due to low volume are not absolved from regulatory duties or regulatory oversight.

DWC will conduct several steps to place each health care provider into an overall regulatory 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 (the value is rounded up). This calculation of two percentages will then be multiplied by 100 to obtain a weighted value (the value is rounded up). For measures where the weight is 100%, the weighted value becomes the overall score for the measure. For multiple measures, the weight value of each measure will be added together to calculate the overall score (no rounding). The overall score identifies the performance standard for the assessed entity. The overall performance standard is defined below.

The performance standards are:

High Tier: 95.00 or greater

Average Tier: 80.00 through 94.99

Poor Tier: 79.99 or less

Example of Scoring and Tier Placement:

Health Care Provider XYZ	**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
Measure 1 – Documentation of how the injury prevents an injured employee from returning to work	95.00%	70%	66.50		
Measure 2 – Completeness of DWC Form-073	81.4%	30%	24.42		
				90.92	**Average**

Assessment Process

DWC will identify DWC Form-073s to be reviewed from its medical bill and payment database. In April 2021, health care providers associated with the DWC Form-073s measure will be provided with the list of DWC Form-073s and asked to respond by submitting imaged copies of the identified forms for agency staff to conduct an initial review.

DWC will distribute the preliminary findings of all the measures to the respective health care providers during the summer of 2021. Health care providers will be given an opportunity to review these preliminary findings. 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 to refute any findings. DWC will review management responses, evidence, and legal arguments. A summary document indicating whether the initial finding has changed and, if so, the reason for the change will be provided to the health care provider.

The final results of the 2021 PBO health care provider assessment will be published on the TDI website after the results have been shared with each of the respective health care providers. DWC expects to publish these results in December 2021.

Tentative Timeline

The following is a tentative timeline of milestones for the 2021 PBO health care provider assessment process:

May 2020: Announce the 2021 PBO assessment.

April 2021: Request DWC Form-073s from health care providers.

April – June 2021: Review DWC Form-073s received from health care providers.

July 2021: Distribute initial findings for all measures.

August – October 2021: DWC reviews management responses to initial findings.

November 2021: DWC distributes results.

December 2021: Publish results and tier placements.

Incentives

Incentives given to system participants:

1. Limited audit exemption: Health care providers in the high and average performer categories may benefit from limited audits. 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, DWC can also audit average and high performers as necessary.
2. Modified penalties: DWC will consider high performer designation as a factor when determining appropriate enforcement action. As a result, DWC may assess penalties that are lower for high performers than ordinarily assessed.
3. Publically recognize high tier perfomers: Tier results will be published on the TDI website.
4. High performer logo: A high performer logo may be used as a marketing tool by system participants placed in the high performing tier.
5. Reduced penalties: Reduced penalties for self-disclosure of noncompliance.

Attachment A

Documentation Supporting How the Injured Employe's Medical Condition Prevents Them from Returning to (Any) Work as Reported on the DWC Form-073, *Work Status Report*

1. The DWC Form-073s, for each health care provider, will be identified through DWC's medical bill and payment data, when 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 Part II, item 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-073s. This number is the numerator.
3. Obtain a percentage score by dividing the numerator by the denominator.
4. If any DWC Form-073s where Part II, item 13, box "c" is indicated, DWC will request medical records from the health care providers that offer off work rationale.
5. If the medical rationale for an off work status is accepted after a Medical Quality Review Panel (MQRP) review, then add these DWC Form-073s to the numerator.
    1. **MQRP Review:**
        i. The MQRP review will first involve an evaluation of documentation that illustrates whether 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; and
            - 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. ACOEM[4], etc.) and contemporaneous written explanation provided by the health care provider. Determination of an off work status may consider:
            - Restriction based on personal protective measures required to prevent recurrence, additional injury, or foster recovery.
            - Attendance is required at a place of care (hospital, physician's office, or physical therapy).
            - Recovery (or quarantine) requires confinement to bed or home.

        iii. 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.

4 http://www.acoem.org/uploadedFiles/Public_Affairs/Policies_And_Position_Statements/Guidelines/Position_Statements/The_Personal_Physician_s_Role_in_Helping_Patients.21.pdf

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 §180.22(c) and (e) of this title (relating to Health Care Provider Roles and Responsibilities);

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

(3) "change in work status" means a change in the injured 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 medical condition:

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

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

(C) prevents the injured employee from returning to work.

(b) A treating doctor may delegate authority to complete, sign, and file a work status report to a licensed physician assistant authorized under Texas Labor Code §408.025. The delegating treating doctor is responsible for the acts of the physician assistant under this subsection.

(c) The doctor or delegated physician assistant shall file a Work Status Report in the form and manner prescribed by the division.

(d) The doctor or delegated physician assistant shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the division, signed, and contains at minimum:

(1) identification of the injured 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 injured employee);

(3) identification of any applicable activity restrictions;

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

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

(e) The doctor or delegated physician assistant shall file the Work Status Report:

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

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

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

(f) The Work Status Report filed as required by subsection (e) of this section shall be provided to the injured employee at the time of the examination by hand delivery or electronic transmission if the injured employee agrees to receive the report by electronic transmission, and shall be sent, not later than the end of the second working day after the date of examination, to the insurance carrier and the employer.

(g) In addition to the requirements under subsection (e) of this section, the treating doctor or delegated physician assistant shall file the Work Status Report with the insurance carrier, employer, and injured 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 injured 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 injured employee can return to work with or without restrictions.

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

(i) The doctor or delegated physician assistant shall file the Work Status Report as follows:

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

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

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

(j) Notwithstanding any other provision of this title, a doctor or delegated physician assistant may bill for, and an insurance 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 insurance carrier, its agent, or the employer through its insurance carrier asks for an extra copy. The amount of reimbursement shall be $15. A doctor or delegated physician assistant 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 or delegated physician assistants are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors or delegated physician assistants 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 or delegated physician assistant is billing for a report required under subsections (e)(1), (e)(2), and (g) of this section;

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

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

(k) As provided in §126.6(g) of this title (relating to Order for Required Medical Examinations), a doctor who conducts a required medical examination in which the doctor determines that the injured 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(g).

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; amended to be effective October 31, 2018, 43 TexReg 7171

Attachment C

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 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 reasonable 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 December 6, 2018.

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; amended to be effective November 4, 2018, 43 TexReg 7149

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