

# 28 Texas Administrative Code

## Chapter 180 - Monitoring and Enforcement

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[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac\\_view=4&ti=28&pt=2&ch=180](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=28&pt=2&ch=180).

### Subchapter A- General Rules for Enforcement

#### §180.1. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings.

- (1) Act--The Texas Workers' Compensation Act, Labor Code, Title 5, Subtitle A.
- (2) Administrative violation--A violation, failure to comply with, or refusal to comply with the Act, or a rule, order, or decision of the commissioner. This term is synonymous with the terms "violation" or "violate."
- (3) Agent--A person with whom a system participant utilizes or contracts for the purpose of providing claims service or fulfilling duties under Labor Code, Title 5 and rules. The system participant who utilizes or contracts with the agent may also be responsible for the administrative violations of that agent.
- (4) Appropriate credentials--The certification(s), education, training, and experience to provide the health care that an injured employee is receiving or is requesting to receive.
- (5) Commissioner--The commissioner of workers' compensation.
- (6) Complaint--A written submission to the division alleging a violation of the Act or rules by a system participant.
- (7) Compliance Audit (also Performance Review)--An official examination of compliance with one or more duties under the Act and rules. A compliance audit does not include monitoring or review activities involving the Medical Advisor or the Medical Quality Review Panel.
- (8) Conviction or convicted--
  - (A) A system participant is considered to have been convicted when:
    - (i) a judgment of conviction has been entered against the system participant in a federal, state, or local court;
    - (ii) the system participant has been found guilty in a federal, state, or local court;
    - (iii) the system participant has entered a plea of guilty or nolo contendere (no contest) that has been accepted by a federal, state, or local court;
    - (iv) the system participant has entered a first offender or other program and judgment of conviction has been withheld; or
    - (v) the system participant has received probation or community supervision, including deferred adjudication.
  - (B) A conviction is still a conviction until and unless overturned on appeal even if:

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

(ii) an appeal is pending; or

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

(9) Department--Texas Department of Insurance.

(10) Division--Texas Department of Insurance, Division of Workers' Compensation.

(11) Emergency--As defined in §133.2 of this title (relating to Definitions). This definition does not apply to "emergency" as used in the term "ex parte emergency cease and desist orders."

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

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

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

(15) Notice of Violation (NOV)--A notice issued to a system participant by the division when the division has found that the system participant has committed an administrative violation and the division seeks to impose a sanction in accordance with Labor Code, Title 5 or division rules.

(16) Peer Review--An administrative review by a health care provider performed at the insurance carrier's request without a physical examination of the injured employee.

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

(18) Rules--The division's rules adopted under Labor Code, Title 5.

(19) Sanction--A penalty or other punitive action or remedy imposed by the commissioner on an insurance carrier, representative, injured employee, employer, or health care provider, or any other person regulated by the division under the Act, for an administrative violation.

(20) SOAH--The State Office of Administrative Hearings.

(21) System Participant--A person or their agent subject to the Act or a rule, order, or decision of the commissioner.

*The provisions of this §180.1 adopted to be effective July 29, 1991, 16 TexReg 3940; amended to be effective March 14, 2002, 27 TexReg 1817; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691.*

### **§180.2. Filing a Complaint.**

(a) Any person may submit a complaint to the division for alleged administrative violations.

(b) A person may submit a complaint to the division:

- (1) through the division's website;
- (2) through electronic correspondence;
- (3) through written correspondence;
- (4) through facsimile correspondence; or
- (5) in person and the complaint will be reduced to writing.

(c) A complaint submitted on the form provided by the division or in any other written format shall contain the following information as applicable:

- (1) complainant's name and contact information;
- (2) name and contact information of the subject or parties of the complaint, if known;
- (3) name and contact information of witnesses, if known;
- (4) claim file information including, but, not limited to, the name, address, and date of injury of the injured employee, if known;
- (5) the statement of the facts constituting the alleged violation including the dates or time period the alleged violation occurred;
- (6) the nature of the alleged violation, including, the specific sections of the Act and division rules alleged to have been violated, if known;
- (7) supporting documentation relevant to the allegation that may include, but, is not limited to, medical bills, Explanation of Benefits Statements, copy of payment invoices or checks, and medical reports as applicable;
- (8) supporting documentation for alleged fraud may include photographs, video, audio, and surveillance recordings, and reports; and
- (9) other sources of pertinent information, if known.

(d) Contact information may include, but, is not limited to, name, address, telephone number, facsimile number, email address, business name, business address, business telephone number, and websites.

(e) A complaint shall contain sufficient information for the division to investigate the complaint.

(f) Upon receipt of a complaint, the division will review, monitor and may investigate the allegation against a person or entity who may have violated the Act or division rules.

(g) The division will assign priorities to complaints being investigated based on a risk-based complaint investigation system that considers:

- (1) the severity of the alleged violation;
- (2) continued noncompliance of the alleged violation;
- (3) whether a commissioner order has been violated; or

(4) other risk-based criteria the division determines necessary.

(h) A person commits an administrative violation if the person submits a complaint to the division that is:

(1) frivolous, as defined in §180.1 of this title (relating to Definitions);

(2) groundless or made in bad faith; or

(3) done specifically for competitive or economic advantage.

*The provisions of this §180.2 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873.*

### **§180.3. Compliance Audits.**

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

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

(c) The division shall provide reasonable notice in advance of a compliance audit. That notice shall:

(1) be in writing;

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

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

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

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

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

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

(2) respond to reasonable needs of auditors on-site or to inquiries by auditors; and

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

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

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

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

(h) Final compliance audit reports may be published on the division's Internet website and shall be redacted to not include any confidential claim file information.

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

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

(k) The auditee shall submit payment by check, made payable to the order of the Texas Department of Insurance, for the expenses within 25 days after receipt of the bill.

*The provisions of this §180.3 adopted to be effective July 29, 1991, 16 TexReg 3940; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691.*

#### **§180.4. On-Site Visits. - NEW 2/14/2012**

(a) As often as it considers necessary, the division may review the operations of a system participant to determine compliance with the Act or division rules.

(b) When reviewing the operations of a system participant to determine compliance with the Act or division rules, the division may conduct on-site visits to the system participant's premises. On-site visits may be announced or unannounced.

(c) The on-site visit will occur during the system participant's normal business hours.

(d) An on-site visit must not disturb a health care provider's actual provision of health care to a patient.

(e) The division shall provide written notice of each announced and unannounced on-site visit. This notice shall:

(1) be sent at least 10 days before the on-site visit unless the on-site visit is unannounced in which case the notice will be provided at the time of the on-site visit;

(2) specify the alleged violation(s) that is the subject of the on-site visit;

(3) specify the types of records that must be made available during the on-site visit;

(4) list the name and telephone number of the division staff representative; and

(5) specify the date, time, location, and conditions of the on-site visit.

(f) The person who is the subject of the on-site visit shall designate a general contact person at the premises. During the on-site visit the contact person shall:

(1) provide access to requested personnel and information;

(2) respond to the needs of division staff and to inquiries by division staff; and

(3) be familiar with the system participant's procedures and recordkeeping systems that are related to the records and information requested during the on-site visit.

(g) The person subject to an on-site visit shall make available to the division in the format and manner specified by the division all records specified in the written notice provided under subsection (e) of this section. A written notice may specify for inspection any records related to the person's participation in the workers' compensation system, including:

- (1) claim files;
- (2) medical records and reports;
- (3) payment records;
- (4) billing records;
- (5) electronic records;
- (6) communications;
- (7) adjustor notes;
- (8) accident reports;
- (9) notifications of lost time;
- (10) notifications of injuries;
- (11) payroll data and wage statements;
- (12) investigative reports;
- (13) filed division forms; and
- (14) contracts.

*The provisions of this §180.4 adopted to be effective February 14, 2012, 37 TexReg 691.*

**§180.5. Access to Workers' Compensation Related Records and Information.**

(a) Upon written request from the division any system participant shall provide copies of or access to all records and information held by that system participant related to issues being reviewed or investigated in the format and manner specified by the division.

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

*The provisions of this §180.5 adopted to be effective July 29, 1991, 16 TexReg 3941; amended to be effective February 14, 2012, 37 TexReg 691.*

**§180.8. Notices of Violation; Notices of Hearing; Default Judgments.**

(a) A notice of violation (NOV) is a notice issued to a system participant when the division finds that the system participant has committed an administrative violation and the division seeks to impose a sanction under the Act or division rules. A NOV is not required to be issued before or after the issuance of an ex parte emergency cease and

desist order.

(b) A NOV shall be in writing and include:

- (1) the provision(s) of the Act, rule, order, or decision of the commissioner that the system participant violated;
- (2) a summary of the facts that establish that the violation(s) occurred;
- (3) a description of the proposed sanction that the division intends to impose;
- (4) the right to consent to the charge and the proposed sanction(s);
- (5) the right to request a hearing; and
- (6) other information about the rights, obligations, and procedures for requesting a hearing.

(c) The charged party shall file a written answer to the NOV not later than the twentieth day after the day the notice is received. The answer shall either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing by being filed with the division's chief clerk of proceedings. If the charged party fails to respond to the NOV within 20 days of receipt of the notice, the division shall schedule a hearing at the State Office of Administrative Hearings (SOAH) and provide notice of hearing to the charged party that meets the requirements of §148.5 of this title (relating to Notice of Hearing).

(d) A charged party that receives a notice of hearing under subsection (c) of this section shall, within 20 days of the date on which the notice of hearing is provided to the party, file a written answer or other responsive pleading. Such response shall be filed in accordance with 1 TAC §155.101 (relating to Filing Documents) and §155.103 (relating to Service of Documents on Parties).

(e) For purposes of this section, events described in paragraphs (1) or (2) of this subsection constitute a default on the part of a charged party who receives a notice of hearing under subsection (c) of this section:

- (1) failure of the charged party to file a written response as provided by subsection (d) of this section; or
- (2) failure of the charged party to appear in person or by legal representative on the day and at the time set for hearing in a contested case at SOAH, regardless of whether a written response has been filed.

(f) In the event that a charged party defaults as described by subsection (e) of this section, the division may seek informal disposition by default by the commissioner as permitted by Government Code §2001.056.

(g) For purposes of this subchapter, "disposition by default" shall mean the issuance of an order against the charged party in which the allegations against the party in the notice of hearing are deemed admitted as true, upon the offer of proof to the commissioner that proper notice was provided to the defaulting party. For purposes of this section, proper notice means notice sufficient to meet the provisions of the Government Code §2001.051 and §2001.052 and §148.5 of this title.

(h) After informal disposition of a contested case by default, a charged party may file a written motion to set aside the default order and reopen the record. A motion by the charged party to set aside the default order and reopen the record shall be granted by the commissioner if the charged party establishes that the failure to file a written response or to attend the hearing was neither intentional nor the result of conscious indifference, and that such failure was due to a mistake or accident. A motion to set aside the default order and reopen the record shall be filed by the charged party with the division's chief clerk of proceedings prior to the time that the order of the commissioner becomes final pursuant to the applicable provisions of Government Code, Chapter 2001, Subchapter F.

(i) A motion to set aside the default order and reopen the record is not a motion for rehearing and is not to be considered a substitute for a motion for rehearing. A motion for rehearing is required in order to exhaust administrative remedies. The filing of a motion to set aside the default order and reopen the record has no effect on either the statutory time periods for the filing of a motion for rehearing or on the time period for ruling on a motion for rehearing, as provided in applicable provisions of the Government Code, Chapter 2001, Subchapter F.

*The provisions of this §180.8 adopted to be effective July 29, 1991, 16 TexReg 3941; amended to be effective December 4, 1995, 20 TexReg 9717; amended to be effective September 14, 2003, 28 TexReg 7711; amended to be effective January 9, 2011, 35 TexReg 11873; amended to be effective February 14, 2012, 37 TexReg 691.*

**§180.9. Proposals for Decision. – NEW 2/14/2012**

(a) If a hearing was conducted in conjunction with Labor Code §§407.046, 408.023, 415.0215, or 415.034, or in another case under the Act that is not subject to Labor Code §402.073(b), the commissioner shall review the proposed decision of the administrative law judge. If the commissioner modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the administrative law judge, the commissioner's final order shall state the legal basis and the specific reasons for the change.

(b) The division shall notify the person by issuing an order that describes the effects of the sanction. This order shall be delivered by verifiable means with a copy to the appropriate licensing or certification authority.

(c) Failure to comply with the sanction may result in additional administrative violations.

*The provisions of this §180.9 adopted to be effective February 14, 2012, 37 TexReg 691.*

**§180.10. Ex Parte Emergency Cease and Desist Orders. - NEW 2/14/2012**

(a) The commissioner ex parte may issue an emergency cease and desist order upon application by division staff if:

(1) the commissioner believes a person regulated by the division under Labor Code, Title 5 is engaging in conduct violating a law, rule or order; and

(2) the commissioner believes that the alleged conduct under paragraph (1) of this subsection will result in harm to the health, safety, or welfare of another person.

(b) The order must contain the following information:

(1) the name and last known address of the person against whom the order is entered;

(2) the alleged conduct that the commissioner believes the person regulated by the division under Labor Code, Title 5 is engaging in that is a violation of a law, rule, or order and that the commissioner believes will result in harm to the health, safety, or welfare of another person;

(3) a statement that the person is to immediately cease and desist from the acts, methods, or practices stated in the order;

(4) the rights of the person against whom the order is entered with regard to requesting a hearing to contest the order. (This statement must include a reference to the specific statute, rule, or order found to have been violated, a statement of the legal authority and jurisdiction under which the order is issued, specific reference to the time limit for requesting a hearing to contest the order, and reference to the statute or statutes in which the time limit is contained. This statement must include the fact that the burden of requesting the hearing is on the person against whom the order was entered);

(5) a statement that the order is final on the 31st day after the date the affected person receives the order unless the affected person requests a hearing; and

(6) a statement regarding the actions that may be taken or sanctions that may be imposed against the person against whom the order was entered in the event of violation of the order.

(c) A request for a hearing to contest the order must be requested not later than the 30th day after the date the affected person receives the order and must:

(1) be in writing;

(2) be directed to the commissioner and filed with the division's chief clerk of proceedings; and

(3) state the grounds for the request to set aside or modify the order.

(d) On receiving a request for a hearing the division shall serve notice of the time and place of the hearing at the State Office of Administrative Hearings (SOAH). The hearing shall be held not later than the 10th day after the date the commissioner receives the request for a hearing unless the parties mutually agree to a later hearing date. At the hearing, the person requesting the hearing is entitled to show cause why the order should not be affirmed and the burden of proof is on the division to show why the order should be affirmed.

(e) Agreements to hold the hearing at a later date must be in writing. The person who is adversely affected by the issuance of the ex parte emergency cease and desist order and who desires a hearing regarding such order must file any such agreement with the division's chief clerk of proceedings before the expiration of the 10th day after the date the request for hearing is received.

(f) Following receipt of the proposal for decision from SOAH regarding the hearing the commissioner shall review the proposed decision of the administrative law judge and wholly or partly affirm, modify, or set aside the order. If the commissioner modifies, amends, or changes a recommended finding of fact or conclusion of law, or order of the administrative law judge, the commissioner's final order shall state the legal basis and the specific reasons for the change.

(g) Pending a hearing, the order continues in effect unless the order is stayed by the commissioner.

(h) If the person against whom the order was entered submits a motion for stay of the ex parte emergency cease and desist order, the motion may be granted by the commissioner before the date of the show cause hearing. If the parties agree to a later show cause hearing date pursuant to subsection (d) of this section, the motion for stay may be granted by the commissioner before the date of the show cause hearing upon written motion by any party to the hearing. If the motion for stay is granted, notice shall be sent to the requesting party that the order has been stayed in whole or in part and what part of the order continues to be in effect. If the motion is not granted before the date of the show cause hearing the motion is denied and notice is not required of the denial.

*The provisions of this §180.9 adopted to be effective February 14, 2012, 37 TexReg 691.*

#### **§180.19. Incentives.**

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

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

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

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

(4) promote safe and healthy workplaces;

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

(6) limit disputes to those appropriate and necessary.

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

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

(1) high performers;

(2) average performers; or

(3) poor performers.

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

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

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

(1) public recognition, and

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

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

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

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

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

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

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

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

## Subchapter B - Medical Benefit Regulation

### §180.21. *Division Designated Doctor List.*

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

(1) Active practice--A doctor has an active practice if the doctor maintains routine office hours of at least 20 hours per week for the treatment of patients.

(2) Disqualifying association--Any association that may reasonably be perceived as having potential to influence the conduct or decision of a doctor, which may include:

(A) receipt of income, compensation, or payment of any kind not related to health care provided by the doctor;

(B) shared investment or ownership interest;

(C) contracts or agreements that provide incentives, such as referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;

(D) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of the doctor's practice;

(E) personal or family relationships;

(F) a contract with the same workers' compensation health care network that is responsible for the provision of medical benefits to the injured employee; or

(G) any other financial arrangement that would require disclosure under the Labor Code or applicable Division rules, the Insurance Code or applicable Department rules, or any other association with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion.

(b) In order to serve as a designated doctor, a doctor must be on the Designated Doctor List (DDL).

(c) To be on the DDL prior to January 1, 2007, the doctor shall at a minimum:

(1) be currently active on the Division's Approved Doctor List (ADL) with a Level 2 Certificate of Registration with no condition(s) or restriction(s) or have a temporary exception to the requirement to be on the ADL as set forth in Labor Code §408.023 and §180.20 of this title (relating to Commission Approved Doctor List);

(2) have had an active practice for one year during their career;

(3) be fully authorized to assign impairment ratings and certify maximum medical improvement (MMI) under §180.23(i) of this title (relating to Commission Required Training for Doctors/Certificate of Registration Levels);

(4) have filed a request in the form and manner prescribed by the Division and have been approved by the Commissioner to be included on the DDL; and

(5) either maintain an active practice or successfully complete Division-approved supplemental training on medical issues relevant to workers' compensation and/or serving as a designated doctor. Supplemental

training shall be completed between 18 and 30 months following the doctor's passing the test required to obtain and retain full MMI/impairment authorization.

(d) To be on the DDL on or after January 1, 2007, the doctor shall at a minimum:

(1) meet the registration requirements, or the exceptions thereto, of subsection (c)(1) of this section or, upon expiration or waiver of the ADL in accordance with Labor Code §408.023(k), comply with all successor requirements, including but not limited to financial disclosure under Labor Code §413.041;

(2) have filed an application to be on the DDL, which must be renewed biennially;

(3) have successfully completed Division-approved training and examination on the assignment of impairment ratings using the currently adopted edition of the American Medical Association Guides, medical causation, extent of injury, functional restoration, return to work, and other disability management topics; and

(4) have had an active practice for at least three years during the doctor's career.

(e) A doctor shall renew an application status biennially and shall have completed and submitted to the Division information verifying 12 additional credit hours of training in accordance with subsection (d)(3) of this section with each renewal application.

(f) An incomplete application for registration to be admitted to the DDL pursuant to this section and other applicable rules shall be rejected and shall not be processed.

(g) A complete application shall include:

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

(2) the training certificate certifying that the doctor applicant has successfully completed the Division-approved training in accordance with subsection (d)(3) of this section;

(3) Impairment Rating Skills Examination score;

(4) verification of licensure;

(5) information on the doctor's training and experience in various types of health care and injury areas;

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

(7) other information required by the Division to confirm the doctor's training and ability to determine:

(A) the extent of the injured employee's compensable injury;

(B) whether the injured employee's disability is the direct result of a work-related injury;

(C) the ability of the injured employee to return to work; or

(D) issues similar to those described in Labor Code §408.0041(a)(1) - (6).

(h) The Commissioner may utilize members of the Medical Quality Review Panel (MQRP) for evaluating DDL applications and making recommendations to the Medical Advisor to approve or deny admission to the DDL. The Commissioner may also utilize members of the MQRP regarding deletion, suspension, or other sanction of a

designated doctor as provided in this section.

(i) Doctors shall be denied admission to the DDL:

(1) if the doctor does not meet the requirements of subsection (c)(1) of this section prior to January 1, 2007 or subsection (d)(1) of this section on or after January 1, 2007;

(2) if the doctor has not completed required training in accordance with §180.23(i) of this title and passed the Division approved examination;

(3) for failing to submit a complete application in accordance with this section;

(4) for having a relevant restriction on their practice (including, but not limited to, prior deletion from the ADL or DDL, or a prior ADL restriction); or

(5) for other activities that warrant denial of the application to be on the DDL, such as grounds that would require the Medical Advisor to recommend deletion of a doctor from the ADL or other sanction of a doctor as specified in §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or other applicable statutes or rules.

(j) The Division shall notify a doctor of the Commissioner's approval or denial of the doctor's application to be on the DDL.

(1) Denials shall include the reason(s) for the denial.

(2) Within 15 working days after receiving the notice, the doctor may file a response, which addresses the reasons given for the denial.

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

(B) If a response which disagrees with the denial is timely received, the Division shall review the response and shall notify the doctor of the Commissioner's final decision. If the final decision is a denial, the Division's final notice shall provide the reason(s) why the doctor's response did not convince the Commissioner to admit the doctor to the DDL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(3) Notwithstanding other provisions of this subsection, for denials pursuant to subsection (i)(1), (2), (3) and (5) of this section, the doctor may within five working days of receipt of notice, file a response which addresses the reason(s) given for the denial.

(A) If a response is not received by the fifth working day after the date the doctor received the notice, the action shall be final effective the following day. No further notice shall be sent.

(B) If a response which disagrees with the action is timely received, the Division shall review the response and shall notify the doctor of the Commissioner's final decision. A final decision denying the doctor admission to the DDL shall provide the reason(s) why the doctor's response did not convince the Commissioner to grant the doctor admission to the DDL. The denial shall be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(4) All notices under this subsection shall be delivered by a verifiable means. Date of receipt for notices shall be determined in accordance with §102.5(d) of this title (relating to General Rules for Written Communication to and from the Commission).

(5) The fact that the Commissioner did not take action to deny or restrict admission to the DDL does not waive the Commissioner's right to review or further review a doctor and take action at a later date.

(k) When necessary because the injured employee is temporarily located or is residing out-of-state, the Division may waive any of the requirements as specified in this rule for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute.

(l) Doctors on the DDL shall provide the Division with updated information within 30 days of a change in any of the information provided to the Division on the doctor's DDL application.

(m) In addition to the grounds for deletion or suspension from the ADL or for issuing other sanctions against a doctor under §180.26 of this title, the Commissioner shall delete or suspend a doctor from the DDL, or otherwise sanction a designated doctor for noncompliance with requirements of this section or any of the following:

- (1) four refusals within a 90-day period, or four consecutive refusals to perform within the required time frames, a Division requested appointment for which the doctor is qualified;
- (2) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;
- (3) having a pattern of practice of unnecessary referrals to other health care providers for the assignment of an impairment rating or determination of MMI;
- (4) submission of inaccurate or inappropriate reports as a pattern of practice due to insufficient examination and analysis of medical records;
- (5) failure to timely respond as a pattern of practice to a request for clarification from the Division regarding an examination;
- (6) assignments of MMI and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision;
- (7) any of the factors listed in subsection (i) of this section that would allow for denial of admission to the DDL;
- (8) failure to successfully complete training and testing requirements as specified in subsection (c) or (d) of this section;
- (9) failure to notify the Division of any disqualifying association, including conflicts caused by the doctor's and the injured employee's association with the same workers' compensation health care network, within 48 hours of receiving notice of being selected as a designated doctor as a pattern of practice or conducting an examination when there is a disqualifying association;
- (10) failure to maintain an active practice or failure to maintain the alternate training requirements outlined in subsection (c)(5) of this section;
- (11) self-referring, including referral to another health care provider with whom the designated doctor has a disqualifying association, for treatment or becoming the employee's treating doctor for the medical condition evaluated by the designated doctor; or
- (12) other violation of applicable statutes or rules while serving as a designated doctor.

(n) The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Sanctions Process/Appeals) except that suspension, deletion, or other sanction relating to the DDL shall be in effect during the pendency of any appeal.

(o) The Division shall make available through its website the names of:

- (1) doctors on the DDL;
- (2) doctors deleted or suspended from the list or otherwise sanctioned by the Commissioner (including a description of the sanction); and
- (3) doctors reinstated to the list or whose sanctions were lifted by the Commissioner.

(p) When a doctor is added to the DDL or readmitted following a suspension or deletion, the doctor shall be placed at the bottom of the list for rotation purposes under Labor Code §408.0041.

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

**§180.22. Health Care Provider Roles and Responsibilities.**

(a) Health care providers as defined in subsections (c) - (e) of this section shall provide all health care reasonably required by the nature of the injury as and when needed to:

- (1) cure or relieve the effects naturally resulting from the compensable injury;
- (2) promote recovery; or
- (3) enhance the ability of the injured employee to return to or retain employment.

(b) In addition to the general requirements of this section, health care providers shall timely and appropriately comply with all applicable requirements under the Act and department and division rules, including, but not limited to:

- (1) reporting required information;
- (2) disclosing financial interests;
- (3) impartially evaluating an injured employee's condition;
- (4) correctly billing for health care provided;
- (5) examine an injured employee to determine a date of maximum medical improvement and design impairment ratings as and when appropriate; and
- (6) complying with all applicable provisions of the Americans with Disabilities Act.

(c) The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall:

- (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section;
- (2) maintain efficient utilization of health care;
- (3) communicate with the injured employee, injured employee's representative, if any, employer, and

insurance carrier about the injured employee's ability to work or any work restrictions on the injured employee;

(4) make available, upon request, in the form and manner prescribed by the division:

(A) work release data;

(B) cost and utilization data; and/or

(C) patient satisfaction data, including comorbidity, patient outcomes, return-to-work outcomes, functional health outcomes, and recovery expectations; and

(5) examine an injured employee to determine a date of maximum medical improvement and assign impairment ratings when appropriate.

(d) The consulting doctor is a doctor who examines an injured employee or the injured employee's medical record in response to a request from the treating doctor, the designated doctor, or the division. The consulting doctor shall:

(1) perform unbiased evaluations of the injured employee as directed by the requestor including, but not limited to, evaluations of:

(A) the accuracy of the diagnosis and appropriateness of the treatment of the injured employee;

(B) the injured employee's work status, ability to work, and work restrictions;

(C) the injured employee's medical condition; and

(D) other similar issues;

(2) submit a narrative report to the treating doctor, the injured employee, the injured employee's representative (if any), the insurance carrier, and the division (if the requestor was the division);

(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the consulting doctor is making an approved referral knows the identity and contact information of the treating doctor;

(4) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and

(5) become a referral doctor if the doctor begins to prescribe or provide health care to an injured employee.

(e) The referral doctor is a doctor who examines and treats an injured employee in response to a request from the treating doctor. The referral doctor shall:

(1) supplement the treating doctor's care;

(2) timely report the injured employee's status to the treating doctor and the insurance carrier as required by applicable division rules; and

(3) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the referral doctor is making an approved referral knows the identity and contact information of the treating doctor.

(f) The Required Medical Examination (RME) doctor is a doctor who examines the injured employee's medical condition in response to a request from the insurance carrier or the division pursuant to Labor Code §§408.004, 408.0041, or 408.151. The RME doctor shall:

(1) perform unbiased evaluations of the injured employee as directed by the RME notice issued by the division;

(2) not make referrals without the approval of the treating doctor and when such approval is obtained, ensure that the health care provider to whom the RME doctor is making an approved referral knows the identity and contact information of the treating doctor;

(3) initiate or provide treatment only if the treating doctor approves or recommends the treatment; and

(4) not evaluate, except following an examination by a designated doctor:

(A) the impairment caused by the injured employee's compensable injury;

(B) the attainment of maximum medical improvement;

(C) the extent of the injured employee's compensable injury;

(D) whether the injured employee's disability is a direct result of the work related injury;

(E) the ability of the injured employee to return to work; or

(F) issues similar to those described by subparagraphs (A) - (E) of this paragraph; and

(5) be a doctor licensed to practice medicine in Texas that holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);

(A) a dentist that performs dental services under the Act may review dental services that may lawfully be performed within the scope of the dentist's license to practice dentistry; or

(B) a chiropractor that performs chiropractic services under the Act may review chiropractic services that may lawfully be performed within the scope of the chiropractor's license to engage in the practice of chiropractic.

(g) A peer reviewer is a health care provider who performs an administrative review at the insurance carrier's request without a physical examination of the injured employee. The peer reviewer must not have any known conflicts of interest with the injured employee or the health care provider who has proposed or rendered any health care being reviewed.

(1) A peer reviewer who performs a prospective, concurrent, or retrospective review of the medical necessity or reasonableness of health care services (utilization review) is subject to the applicable provisions of the Labor Code; Insurance Code, Chapters 1305 and 4201; and department and division rules. A peer reviewer who performs utilization review must:

(A) be certified or registered as a utilization review agent (URA) by the department or be employed by or under contract with a certified or registered URA to perform utilization review;

(B) hold the appropriate professional license issued by this state; and

(C) hold the appropriate credentials as defined in §180.1 of this title.

(2) A peer reviewer who performs a review for any issue other than medical necessity, such as compensability or an injured employee's ability to return to work, must:

(A) hold the appropriate professional license issued by this state; and

(B) hold the appropriate credentials as defined in §180.1 of this title.

(h) The designated doctor is a doctor assigned by the division to recommend a resolution of a dispute as to the medical condition of an injured employee. At the request of an insurance carrier or an injured employee, or on the commissioner's own order, the commissioner may order a medical examination by a designated doctor in accordance with Labor Code §408.0041 and §408.1225. The credentials, qualifications, and responsibilities of a designated doctor are governed by §180.21 of this title (relating to Division Designated Doctor List), §180.1 of this title that defines "appropriate credentials", applicable provisions of the Act, and other rules providing for use of a designated doctor.

(i) A member of the MQRP is a health care provider chosen by the division's Medical Advisor under Labor Code §413.0512. All eligibilities, terms, responsibilities, and prohibitions shall be prescribed by contract, and the MQRP members shall serve on the MQRP as prescribed by contract. A health care provider must meet the performance standards specified in the contract to be eligible for selection by the Medical Advisor to serve on the MQRP. A member of the medical quality review panel, other than a chiropractor or dentist, who reviews a specific workers' compensation case is subject to Labor Code §408.0043. Doctors seeking membership on the MQRP must hold appropriate credentials as defined in §180.1 of this title. A chiropractor who serves on the MQRP and that reviews a chiropractic service under the Act must be licensed to engage in the practice of chiropractic pursuant to Labor Code §408.0045. A health care provider that serves on the MQRP may only review health care services or treatment that may lawfully be performed within the scope of the health care provider's license.

(j) Independent review organizations (IROs) must comply with the applicable provisions of Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title (relating to Independent Review Organizations; General Medical Provisions; and Monitoring and Enforcement, respectively). The division or the department may initiate appropriate proceedings under applicable provisions of the Insurance Code, Chapter 4201; Labor Code, Title 5; and Chapters 12, 133 and 180 of this title.

*The provisions of this §180.22 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective August 16, 2006, 31 TexReg 6370; amended to be effective January 9, 2011, 35 TexReg 11873.*

**§180.23. Commission Required Training for Doctors/Certification Levels.**

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

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

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

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

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

(B) perform utilization review or peer review functions;

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

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

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

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

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

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

(g) Notwithstanding any other subsection of this section:

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

(A) is licensed in this state,

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

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

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

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

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

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

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

(4) Renewal of a Level 1 Certificate of Registration requires follow-up training every two years and renewal of a Level 2 Certificate of Registration requires follow-up training every four years unless the Certificate provides otherwise, the date is revised by agreed settlement pursuant to §180.26 of this title (relating to Doctor and Insurance Carrier Sanctions) or Texas Government Code §2001.056 (relating to Informal Disposition of Contested Case), Commission order or decision, or the doctor has been removed

from the ADL. Follow-up training will serve as a refresher course but emphasize relevant changes in the Statute and Rules.

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

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

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

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

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

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

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

#### **§180.24. Financial Disclosure.**

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

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

(2) Financial interest means:

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

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

of the health care practitioner and a health care provider.

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

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

(1) If a health care practitioner refers an injured employee to another health care provider in which the health care practitioner, or the health care provider that employs the health care practitioner, has a financial interest, the health care practitioner shall file a disclosure with the division within 30 days of the date the first referral is made unless the disclosure was previously made. This annual disclosure shall be filed for each health care provider to whom an injured employee is referred and shall include the information in paragraph (2) of this subsection.

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

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

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

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

(c) Failure to disclose. In addition to any sanctions provided by the Act and rules, failure to disclose a financial interest by a health care provider is an administrative violation and is subject to a penalty of forfeiture of the right to reimbursement for any services rendered on the claim during the period of noncompliance, regardless of whether the circumstances of the services themselves were subject to disclosure, and regardless of whether the services were medically necessary.

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

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

(3) Rebuttable Presumption. A referral for services to a health care provider by a health care practitioner under circumstances which required a disclosure under this section, but which was not timely disclosed as required, creates a rebuttable presumption that the services were not medically necessary unless one of the statutory and regulatory exceptions that apply to referrals in Title 42, United States Code § 1395nn(b)-(e)

applies to the referral in question. Whenever one of these exceptions is revised and effective, the revised exception shall be effective for referrals made on or after the effective date of the revision.

*The provisions of this §180.24 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873.*

**§180.25. *Improper Inducements, Influence and Threats.***

(a) Pursuant to Labor Code §415.0036, offering, paying, soliciting, or receiving an improper inducement relating to the delivery of benefits to an injured employee is prohibited. Improper attempts to influence the delivery of benefits to an injured employee, including the making of improper threats. This section applies to all system participants in the workers' compensation system who have authority under Labor Code, Title 5 to request the performance of a service affecting the delivery of benefits to an injured employee or who actually performs such a service, including peer reviews, performance of designated doctor examinations, performance of required medical examinations, or case management.

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

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

(A) for the furnishing or arranging for the furnishing of any item, treatment, or service constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.

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

(A) for the furnishing or arranging for the furnishing of any item, treatment or service constituting a medical benefit for which payment may be made in whole or in part under the Labor Code, Title 5 or rules; or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, treatment, or item constituting a medical benefit for which payment may be made in whole or in part under Labor Code, Title 5 or rules.

(3) Providing any financial incentive or promising or threatening to provide injured employee evaluation reports or other medical opinions that could enhance or reduce the injured employee's income benefits or affect the injured employee's work release status as an inducement to have the injured employee treat with or be evaluated by the health care provider or comply with the health care provider's proposed treatment.

(4) Offering or soliciting an inducement in return for selecting a particular health care provider for the furnishing or arranging for the furnishing of any item, treatment, or service (including purchasing or leasing) for which payment may be made in whole or in part under Labor Code, Title 5 or rules; or offering or soliciting an inducement which may reasonably tend to cause a particular health care provider to be selected (excluding a convenience necessary to allow for the provision of health care, such as transportation to and from the health care provider's facility, translator services related to evaluation and treatment, providing claim filing forms or information on rights and responsibilities under the Labor Code,

Title 5 and rules, if generally available to all patients). Such inducement is improper whether offered directly or indirectly, overtly or covertly, in cash or in kind.

(5) Making, presenting, filing, or threatening to make, present, or file any frivolous claim or assertion against a system participant, medical peer reviewer, or any other person performing duties arising under Labor Code, Title 5 or rules, with the division or any licensing, certifying, regulatory, or investigatory body.

(6) Making or causing to be made a threat against life, safety, or property directed to a system participant related to their performance of duties arising under Labor Code, Title 5 or rules.

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

(d) A violation of applicable federal standards that prohibit the payment or acceptance of payment in exchange for health care referrals relating to fraud, abuse, and antikickbacks is an administrative violation.

*The provisions of this §180.25 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective January 9, 2011, 35 TexReg 11873.*

**§180.26. Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies.**

(a) The division may impose sanctions on any system participant if that system participant commits an administrative violation.

(b) The division may impose the following sanctions against a doctor or insurance carrier for any reason listed in Labor Code §408.0231(c) or any other criteria the commissioner considers relevant:

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

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

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

(4) deletion or suspension from the designated doctor list;

(5) restrictions on appointments or reviews;

(6) conditions or restrictions on a insurance carrier regarding actions by insurance carriers under the Act and rules, that are not inconsistent with a memorandum of understanding adopted between the commissioner and the commissioner of insurance regarding the regulation of insurance carriers and utilization review agents as necessary to ensure that appropriate health care decisions are reached under applicable regulations by the department and the division, the Act, and Chapter 4201, Insurance Code; and

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

(c) In addition to a penalty or the other sanctions that may be imposed in accordance with other applicable provisions of the Act, the division may also impose the following sanctions pursuant to Labor Code §415.023(b) against an insurance carrier or its representative, a health care provider, or a representative of an injured employee or legal beneficiary if any of those parties commit an administrative violation as a matter of practice, meaning a

repeated violation of the Act or a rule, order, or decision of the commissioner:

- (1) a reduction or denial of fees;
- (2) public or private reprimand by the commissioner;
- (3) suspension from practice before the division;
- (4) restriction, suspension, or revocation of the right to receive reimbursement under the Act; and
- (5) referral and petition to the appropriate licensing authority for appropriate disciplinary action, including the restriction, suspension, or revocation of the person's license.

(d) In addition to, or in lieu of, the sanctions in subsections (b) and (c) of this section, the division may impose any other sanction or remedy allowed under the Act or division rules, including but not limited to assessing an administrative penalty of up to \$25,000 per violation against a person who commits an administrative violation.

(e) When determining which sanction to impose against a system participant and the severity of that sanction, the division shall consider the factors listed in Labor Code §415.021(c) and other matters that justice may require, including but not limited to:

- (1) Performance Based Oversight (PBO) assessment;
- (2) the promptness and earnestness of actions to prevent future violations;
- (3) self-report of the violation;
- (4) the size of the company or practice;
- (5) the effect of a sanction on the availability of health care; and
- (6) evidence of heightened awareness of the legal duty to comply with the Act and Division rules.

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

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

- (1) include a summary of the duty that the division believes that the charged system participant failed to fulfill or timely fulfill;
- (2) identify the facts that establish that a violation occurred; and
- (3) inform the charged system participant that subsequent noncompliance of the same sort may be deemed to be a repeated administrative violation or matter of practice any of which will be subject to sanction.

(h) The division may, at its discretion, enter into a consent order with the system participant. A consent order may be entered into before or after issuance of a NOV is issued under §180.8 of this title (relating to Notices of Violation; Notices of Hearing; Default Judgments).

*The provisions of this §180.26 adopted to be effective January 9, 2011, 35 TexReg 11873.*

**§180.27. Restoration.**

(a) In accordance with Labor Code §408.0231(d)(2) a doctor, other than a doctor to which Labor Code §408.023(r) applies, may apply for the restoration of a doctor privilege removed under Labor Code §408.0231 by sending a letter of consideration to the Medical Advisor.

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

(1) If, in the Medical Advisor's opinion, the doctor:

(A) has all the appropriate unrestricted licenses/certifications;

(B) has overcome the conditions that resulted in the sanction;

(C) meets all the division's qualification standards and conditions for restoration of some or all of the practice privileges removed; and

(D) is not out of compliance with the Labor Code, Insurance Code, a department rule, or a rule, order, or decision of the commissioner the Medical Advisor may recommend that the commissioner lift the sanction(s) or restore some or all of the privileges removed or restricted by the sanction(s).

(2) If in the Medical Advisor's opinion, the doctor has not met all the requirements for restoration of privileges, the Medical Advisor shall notify the doctor by verifiable means of the intent to recommend to the commissioner that the sanctions not be lifted or that the privileges removed or restricted by the sanction(s) not be restored in whole or in part and the reasons for that recommendation. Within 15 days after receiving the notice, a doctor may file a response that addresses the reasons given in the recommendation to deny lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s). The Medical Advisor shall review the response and make a final recommendation to the commissioner. A copy of the requestor's response to the division shall be provided to the commissioner for consideration.

(c) The commissioner shall consider the matter and shall notify the requestor of the final decision by verifiable means, and may send a copy to the appropriate licensing or certification authority. If the commissioner does not lift the sanction, the commissioner may include in the final decision the conditions that the doctor must meet before the division will reconsider lifting the sanctions including, but not limited to, the amount of time that the doctor must wait prior to re-requesting lifting the sanction(s) or restoration of some or all of the privileges removed or restricted by the sanction(s).

*The provisions of this §180.27 adopted to be effective March 14, 2002, 27 TexReg 1817; amended to be effective September 12, 2004, 29 TexReg 8613; amended to be effective January 9, 2011, 35 TexReg 11873; ; amended to be effective February 14, 2012, 37 TexReg 691.*

**§180.28. Peer Review Requirements, Reporting, and Sanctions.**

(a) A peer reviewer's report, including a report used to deny preauthorization, shall document the objective medical findings and evidence-based medicine that supports the opinion and include:

(1) the peer reviewer's name and professional Texas license number;

(2) certification that the peer reviewer holds the appropriate credentials as defined in §180.1 of this title (relating to Definitions);

(3) a summary of the reviewer's qualifications;

(4) a list of all medical records and other documents reviewed by the peer reviewer, including dates of those documents;

(5) a summary of the clinical history; and

(6) an analysis and explanation for the peer review recommendation, including the findings and conclusions used to support the recommendations.

(b) The insurance carrier shall not request subsequent peer reviews regarding the medical necessity of health care for dates of services for which a peer review report has already been issued unless:

(1) the review is for a different health care service requiring review by a different peer review specialty;

(2) the insurance carrier needs clarification of the peer review opinion based on new medical evidence that has not been presented to the peer reviewer;

(3) the peer reviewer failed to fully address the questions submitted by the insurance carrier; or

(4) for purposes other than determining medical necessity of the health care.

(c) The insurance carrier shall submit a copy of a peer review report to the treating doctor and the health care provider who rendered or requested the health care, as well as the injured employee and injured employee's representative, if any, when the insurance carrier uses the report to deny the compensability or extent of the compensable injury or reduce or deny income or medical benefits of an injured employee.

(d) A peer reviewer and insurance carrier shall maintain accurate records to reflect information regarding requests, reports, and results for peer reviews. The insurance carrier and peer reviewer shall submit such information at the request of the division in the form and manner proscribed by the division. The division will monitor peer review use, activity, and decisions which may result in the initiation of a medical quality review or other division action.

(e) The commissioner may impose sanctions on health care providers performing peer reviews pursuant to §180.26 and §180.27 of this title (relating to Criteria for Imposing, Recommending and Determining Sanctions; Other Remedies; and Sanctions Process/Appeals/Restoration, respectively) and other applicable provisions of the Labor Code and division rules. The commissioner may prohibit a doctor from conducting peer reviews for any of the following:

(1) non-compliance with the provisions of §180.22 of this title (relating to Health Care Provider Roles and Responsibilities), this section, or applicable provisions of the Act, or a rule, order, or decision of the commissioner;

(2) failure to consider all records provided for review;

(3) a history of improper or unjustified decisions regarding the medical necessity of health care reviewed;

(4) failure to hold the appropriate professional license issued by this state;

(5) review of health care without holding the appropriate credentials, as defined in §180.1 of this title, in a health care specialty appropriate to the type of health care reviewed; or

(6) any other violation of the Labor Code or division rules.

(f) In accordance with Labor Code §408.0046, an entity requesting a peer review must obtain and provide to the doctor providing peer review services all relevant and updated medical records.

*The provisions of this §180.28 adopted to be effective August 16, 2006, 31 TexReg 6370; amended to be effective January 9, 2011, 35 TexReg 11873.*

**§180.50. Severability.**

Where any provisions of this chapter are determined by a court of competent jurisdiction to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining provisions of this chapter shall remain in effect.

*The provisions of this §180.50 adopted to be effective January 9, 2011, 35 TexReg 11873.*

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