TEXAS REGISTER

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This month's front cover artwork:

Artist: *Tereena Woods*
9th Grade
Jefferson High School

School children's artwork has decorated the blank filler pages of the *Texas Register* since 1987. Teachers throughout the state submit the drawings for students in grades K-12. The drawings dress up the otherwise gray pages of the *Texas Register* and introduce students to this obscure but important facet of state government.

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ADOPTED RULES

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IN ADDITION

OFFICE OF THE ATTORNEY GENERAL

Under provisions set out in the Texas Constitution, the Texas Government Code. Title 4, §402.042, and numerous statutes, the attorney general is authorized to write advisory opinions for state and local officials. These advisory opinions are requested by agencies or officials when they are confronted with unique or unusually difficult legal questions. The attorney general also determines, under authority of the Texas Open Records Act, whether information requested for release from governmental agencies may be held from public disclosure. Requests for opinions, opinions, and open records decisions are summarized for publication in the ***Texas Register***. The attorney general responds to many requests for opinions and open records decisions with letter opinions. A letter opinion has the same force and effect as a formal Attorney General Opinion, and represents the opinion of the attorney general unless and until it is modified or overruled by a subsequent letter opinion, a formal Attorney General Opinion, or a decision of a court of record. You may view copies of opinions at http://www.oag.state.tx.us. To request copies of opinions, please fax your request to (512) 462-0548 or call (512) 936-1730. To inquire about pending requests for opinions, phone (512) 463-2110.

Request for Opinions

RQ-0469-JC

The Honorable Frank Madla, Chair, Intergovernmental Relations Committee, Texas State Senate, P.O. Box 12068, Austin, Texas 78711

Re: Whether a commissioners court may expend funds to construct or maintain a road that has not been designated a "public road" (Request No. 0469-JC)

Briefs requested by January 10, 2002.

RQ-0470-JC

The Honorable Jack Skeen, Jr., Smith County Criminal District Attorney, 100 North Broadway, Tyler, Texas 75702

Re: Whether a county auditor may participate in an executive session of a commissioners court under the Open Meetings Act, and related questions (Request No. 0470-JC)

Briefs requested by January 11, 2002

RQ-0471-JC

The Honorable Charles A. Rosenthal, Jr., Harris County District Attorney, 1201 Franklin Street, Suite 600, Houston, Texas 77002

Re: Whether a peace officer is required to complete continuing education courses regarding traffic laws, and related questions (Request No. 0471-JC)

Briefs requested by January 7, 2002

RQ-0472-JC

Mr. J. D. Powell, Executive Director, Texas Commission on Human Rights, 6330 Highway 290 East, Suite 250, Austin, Texas 78723

Re: Whether the Employees Retirement System is a "state agency" for purposes of subchapter I of chapter 22 of the Texas Labor Code, which requires every state agency to develop and implement personnel policies and procedures regarding employment discrimination (Request No. 0472-JC)

Briefs requested by January 1l, 2002

For further information, please contact the Opinion Committee at (512) 463-2110 or access the website at www.oag.state.texas.us .

TRD-200107946
Susan D. Gusky
Assistant Attorney General
Office of the Attorney General
Filed: December 14, 2001

♦ ♦ ♦

Request for Opinions

RQ-0473-JC

The Honorable Rick Perry, Governor, Office of the Governor, P.O. Box 12428, Austin, Texas 78711

Re: Clarification of Attorney General Opinion JC-0426: Whether a state university may contract with a bank that employs a member of the board of regents as an officer (Request No. 0473-JC).

Briefs requested by January 18, 2002.

RQ-0474-JC

The Honorable Bill Turner, Brazos District Attorney, 3000 East 26th Street, Suite 31, Bryan, Texas 77803

Re: Whether section 37.123 of the Education Code, which creates the offense of "disruptive activity," requires proof of intent (Request No. 0474-JC).

Briefs requested by January 17, 2002

RQ-0475-JC

The Honorable Juan J. Hinojosa, Chair, Criminal Jurisprudence, Texas House of Representatives, Austin, Texas 78768-2910

Re: Whether the governor may raise the state vehicle registration fee without legislative consent, and related question (Request No. 0475-JC).

Briefs requested by January 17, 2002

RQ-0476-JC

Mr. O.C. "Chet" Robbins, Executive Director, Texas Funeral Service Commission, 510 South Congress, Suite 206, Austin, Texas 78704-1716

Re: Authority of the Texas Funeral Service Commission to regulate certain persons, and related questions (Request No. 0476-JC).

Briefs requested by January 18, 2002

RQ-0477-JC

Mr. O. C. "Chet" Robbins, Executive Director, Texas Funeral Service Commission, 510 South Congress Avenue, Suite 206, Austin, Texas 78704-1716

Re: Whether a casket constitutes "funeral merchandise" for purposes of chapter 651 of the Occupations Code, and related questions (Request No. 0477-JC).

Briefs requested by January 18, 2002

RQ-0478-JC

Mr. Eduardo J. Sanchez, Commissioner of Health, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756-3199

Re: Whether portions of chapters 150 of the Texas Agriculture Code, relating to imported meat, violate federal law and/or the commerce clause of the United States Constitution (Request No. 0478-JC).

Briefs requested by January 18, 2002

For further information, please contact the Opinion Committee at (512) 463-2110 or access the website at www.oag.state.texas.us .

TRD-200108120
Susan D. Gusky
Assistant Attorney General
Office of the Attorney General
Filed: December 19, 2001

PROPOSED RULES

Before an agency may permanently adopt a new or amended section or repeal an existing section, a proposal detailing the action must be published in the ***Texas Register*** at least 30 days before action is taken. The 30-day time period gives interested persons an opportunity to review and make oral or written comments on the section. Also, in the case of substantive action, a public hearing must be granted if requested by at least 25 persons, a governmental subdivision or agency, or an association having at least 25 members.

Symbology in proposed amendments. New language added to an existing section is indicated by the text being underlined. [Brackets] and ~~strike-through~~ of text indicates deletion of existing material within a section.

TITLE 7. BANKING AND SECURITIES

PART 1. FINANCE COMMISSION OF TEXAS

CHAPTER 1. CONSUMER CREDIT COMMISSIONER

SUBCHAPTER Q. CHAPTER 342, PLAIN LANGUAGE CONTRACT PROVISIONS

7 TAC §§1.1201 - 1.1207

The Finance Commission of Texas (the commission) proposes new 7 TAC §§1.1201 - 1.1207, concerning a plain language model contract for Subchapter F contracts. New 7 TAC §§1.1201- 1.1207 includes proposed clauses, disclosures, layout, and font type for Subchapter F plain language contracts.

The purpose of the rules is stated in the purpose clause, §1.1201, and is to implement the provisions of Texas Finance Code §341.502, which requires contracts for consumer loans under Chapter 342, whether in English or in Spanish, to be written in plain language. Use of the model contract is optional; however, should a lender choose not to use the model contract, contracts must be submitted to the agency in accordance with the provisions of 7 TAC §1.841.

Section 1.1202 explains the relationship of federal law to the state requirements. The section describes how any conflicts or inconsistencies shall be resolved.

Section 1.1203 provides definitions in order to ensure consistent treatment and application of defined terms.

Section 1.1204 details the required format, typeface, and font for model plain language Subchapter F contracts. The requirements are necessary to ensure that the contract will be easy for consumers to read and understand.

Section 1.1205 identifies the types of provisions that may be included in a Subchapter F contract.

Section 1.1206 contains the model clauses. These clauses are the agency's interpretation of a plain language version of typical contract provisions.

Section 1.1207 outlines permissible changes that can be made to a contract and still comply with the model provision. This section provides lenders with flexibility in using a model contract.

Leslie L. Pettijohn, Consumer Credit Commissioner, has determined that for the first five-year period the rules are in effect there will be no fiscal implications for state or local government as a result of administering the rules.

Commissioner Pettijohn also has determined that for each year of the first five years the rules are in effect the public benefit anticipated as a result of the new rules will be enhanced compliance with the credit laws, simpler credit contracts, and increased uniformity and consistency in credit contracts. Additional economic costs will be incurred by a person required to comply with this proposal. Because a lender fully complies with the proposal by using the model forms, the additional costs imposed by the proposal are limited to costs associated with copying a contract and costs attributable to loss of obsolete forms inventory. Additional copy costs are estimated to be approximately $0.30 - $0.40 per contract. There will be no adverse effect on small businesses as compared to the effect on large businesses.

Comments on the proposed new rules may be submitted in writing to Leslie L. Pettijohn, Consumer Credit Commissioner, Office of Consumer Credit Commissioner, 2601 North Lamar Boulevard, Austin, Texas 78705-4207.

The new section is proposed under the Texas Finance Code §11.304, which authorizes the Finance Commission to adopt rules to enforce Title 4 of the Texas Finance Code. Additionally, Texas Finance Code §341.502 grants the Finance Commission the authority to adopt rules to govern the form of Subchapter F contracts and to adopt model plain language contracts.

These rules affect Texas Finance Code Chapter 342, Subchapter F.

§1.1201. Purpose.

(a) The purpose of these rules is to provide a model plain language contract in English for Texas Finance Code, Chapter 342, transactions. The establishment of model provisions for these transactions will encourage use of simplified wording that will ultimately benefit consumers by making these contracts easier to understand. The use of the "plain language" model contract by a creditor is not mandatory. The creditor, however, may not use a contract other than a model contract unless the creditor has submitted the contract to the commissioner in compliance with 7 TAC §1.841. The commissioner shall issue an order disapproving the contract if the commissioner determines the contract does not comply with this section or rules adopted under this section. A creditor may not claim the commissioner's failure to disapprove a contract constitutes an approval.

(b) These provisions are intended to constitute a complete plain language Subchapter F contract; however, a creditor is not limited to the contract provisions addressed by these rules.

§1.1202. Relationship with Federal Law.

In the event of an inconsistency or conflict between the disclosure or notice requirements in these provisions and any current or future federal law, regulation, or interpretation, the requirements of the federal law, regulation, or interpretation will control to the extent of the inconsistency. The remainder of the contract will remain in full force and effect.

§1.1203. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Acquisition Charge -- a finance charge assessed for making the loan as authorized under §342.252.

(2) Borrower -- the person or persons who sign the loan agreement.

(3) Collateral -- an interest in personal property which serves as payment or performance of an obligation. See "Security."

(4) Deferment -- an additional period of time beyond a due date for the borrower to make a payment or payments. See "Extension."

(5) Installment Account Handling Charge -- a finance charge assessed on the loan as authorized under §342.252.

(6) Lender -- an authorized lender under Chapter 342 of the Texas Finance Code.

(7) Prepayment -- any whole or partial payment of an amount equal to one or more full installments made by the borrower prior to the date the payment is due.

(8) Security -- an interest in personal property which serves as payment or performance of an obligation. See "Collateral."

§1.1204. Format, Typeface, and Font.

(a) Plain language contracts must be printed in an easily readable font and type size pursuant to Texas Finance Code §341.502(a). This standard is met if the type size and line spacing meet the standards stated in this subsection. If other state or federal law requires a different type size for a specific disclosure or contractual provision, the type size specified by the other law should be used.

(b) The text of the document must be set in a serif typeface. Popular serif typefaces include Times, Scala, Caslon, Century Schoolbook, and Garamond.

(c) A sans serif typeface may be used for titles, headings, subheadings, captions, and illustrative or explanatory tables or sidebars to distinguish between different levels of information or provide emphasis. Popular sans serif typefaces include Scala Sans, Franklin Gothic, Frutinger, Helvetica, Arial, and Univers.

(d) Typeface size is referred to in points (pt). Because different typefaces in the same point size are not of equal size, type face is not strictly defined but is expressed as a minimum size in the Times typeface for visual comparative purposes. Use of a larger typeface is encouraged. The typeface for the federal disclosure box or other disclosures required under federal law must be legible, but no minimum typeface is required. Generally, the typeface for the remainder of the contract must be at least as large as 10pt in the Times typeface, except that the type size must be at least as large as 8 « pt in the Times typeface for:

(1) the section providing for the listing of collateral;

(2) the signature section; and

(3) the complaints and inquiries notice provided by this title.

(e) Spacing must be at least 120% of type size. For example, a 10pt type should be set with 12pt leading (two point of additional leading between the lines).

§1.1205. Contract Provisions.

A Chapter 342, Subchapter F contract may include, but is not limited to, the following contract provisions to the extent not prohibited by law or regulation. If the lender desires to exercise its rights under one of the following provisions, it must include the provision in the contract. A lender who does not desire to apply a provision is not required to include it in the contract. For example, if a lender does not take a security interest in the borrower's personal property, the provisions addressing security interests are not required.

(1) Identification of the parties, including the name and address of each party;

(2) A definition section specifying the pronouns that designate the borrower and the lender;

(3) A promise to pay;

(4) A late charge provision;

(5) A provision for after maturity interest;

(6) A provision specifying that prepayment is permitted;

(7) A provision specifying the finance charge earnings and refund method;

(8) A provision authorizing deferments;

(9) A provision specifying the conditions causing default;

(10) A waiver of notice of intent to accelerate and waiver of notice of acceleration;

(11) A provision contracting for a fee for a dishonored check;

(12) A security agreement;

(13) A signature block;

(14) Security provisions addressing:

(A) a statement that the collateral is free from encumbrances;

(B) the location and restrictions on movement or transfer of the collateral; and

(C) a statement that the borrower will appropriately maintain and use the collateral;

(15) A provision regarding the mailing of notices to the borrower;

(16) Statement of truthful information;

(17) A provision expressing no waiver of lender's rights;

(18) A clause stating that all modifications to the contract must be in writing;

(19) A provision stating Texas and federal law will apply to the contract;

(20) A clause providing for joint liability;

(21) A usury savings clause;

(22) Complaints and inquiries notice;

(23) An integration clause, providing that the contract supersedes prior agreements and statements; and

(24) A clause stating that if any part of the contract is invalid, all other parts remain valid.

§1.1206. Model Clauses.

(a) Generally. These model clauses are the plain language rendition of contract clauses that have typically been stated in technical legal terms.

(1) The model clauses refer to the Borrower as "I" or "me." The Lender is referred to as "you" or "your."

(2) Nothing in this regulation prohibits a contract from including provisions that provide more favorable results for the borrower than those that would result from the use of a model clause.

(b) Promise to Pay. The model clause for the borrower's promise to pay reads: "In return for my loan, I promise to pay the Total of Payments to the order of you, the lender. I will make the payments at your address above. I will make the payments on the dates and in the amounts shown in the Payment Schedule."

(c) Late Charge. The late charge model clause reads: "If I don't pay an entire payment within 10 days after it is due, you can charge me a late charge. The late charge will be 5% of the scheduled payment."

(d) After Maturity Interest. The after maturity interest model clause reads: "If I don't pay all I owe by the date the final payment is due, I will pay interest on the amount that is still unpaid. That interest will be at a rate of 18% per year and will begin the day after the final payment is due."

(e) Prepayment Clause. The model prepayment clause reads: "I can make any payment early."

(f) Finance Charge Earnings and Refund Method. The model finance charge earnings and refund method reads: "The acquisition charge on this loan will not be refunded if I pay off early. If this loan is for more than $30 and I pay off all I owe early, I will save part of the installment account handling charge. You will figure the amount I save by the Sum of the Periodic Balances Method. This method is explained in the Finance Code." You don't have to refund or credit any amount less than $1.

(g) Deferment Clause. The deferment model clause reads: "If I ask for more time to make any payment and you allow me more time, I will pay additional interest to extend the payment. The additional interest will be figured as provided in the Finance Commission rules."

(h) Default Clause. The model default clause reads: "If I break any of my promises in this document, you can demand that I immediately pay all that I owe. You can also do this if you in good faith believe that I am not going to be willing or able to keep any of my promises."

(i) Waiver of Notice of Intent to Accelerate and Waiver of Notice of Acceleration Clause. The waiver of notice of intent to accelerate and waiver of notice of acceleration clause reads: "I agree that you don't have to give me notice that you are demanding or intend to demand immediate payment of all that I owe. You will never charge or collect any unearned interest."

(j) Fee for Dishonored Check Clause. The fee for dishonored check model clause reads: "If I give you a check that isn't paid when sent to my bank or other institution, I agree to pay you a reasonable fee up to $25. You can add the fee to the amount I owe under this agreement or collect it separately."

(k) Security Agreement Clause. The model clause setting out the security agreement in case of default reads: "I give you a security interest in the property listed below to secure what I owe you. The property and anything that becomes attached to it is called the collateral. If I don't keep any of my promises, you can take the collateral. However, you will do this lawfully and without a breach of the peace. If you take my collateral, you will tell me how much I have to pay to get it back. If I don't pay you to get the collateral back, you can sell it. You will send me notice at least 10 days before you sell it. My right to get the collateral back ends when you sell it. You can use the money you get from selling it to pay amounts the law allows, and to reduce the amount I owe. If any money is left, you will pay it to me. If the money from the sale is not enough to pay all I owe, I must pay the rest of what I owe to you. You can charge me interest on the amount still owed at the rate of 18% per year until I pay all I owe."

(l) Security Provisions.

(1) Prohibition on Transfer and Collateral Free of Encumbrance. The model agreement keeping the collateral free from encumbrance and against transferring it reads: "I own the collateral. I won't sell or transfer it without your written permission. I won't allow anyone else to have an interest in the Collateral except you."

(2) Location and Restrictions on Movement or Transfer of Collateral. The model agreement regarding the location of the collateral reads: "I will keep the collateral at my address shown on the reverse side. I will promptly tell you in writing if I change my address. I won't permanently remove the collateral from Texas unless you give me written permission."

(3) Upkeep and Use of Collateral. The model agreement regarding the upkeep and use of the collateral reads: "I will timely pay all taxes and license fees on the collateral. I will keep it in good repair. I won't use the collateral illegally."

(m) Mailing of Notice to Borrower. The model agreement regarding notice to the borrower reads: "You can mail any notice to me at my last address in your records. Your duty to give me notice will be satisfied when you mail it."

(n) Statement of Truthful Information. The following clause is sufficient as the borrower's agreement that the information provided to the lender is true: "I promise that all information I gave you is true."

(o) No Waiver of Lender's Rights. The model agreement regarding the lender's rights reads: "If you don't enforce your rights every time, you can still enforce them later."

(p) Modifications in Writing. The model agreement requiring any change to be in writing reads: "Any change to this agreement has to be in writing. Both you and I have to sign it."

(q) Application of Law. The model clause regarding the law to be applied to the contract reads: "Federal law and Texas law apply to this contract."

(r) Joint Liability. The model joint liability agreement reads: "I will keep all of my promises in this document. If there is more than one Borrower, each Borrower agrees to keep all of the promises in this document, even if the other Borrowers do not."

(s) Usury Savings Clause. The model usury savings clause reads: "I don't have to pay interest or other amounts that are more than the law allows."

(t) Complaints and Inquiries Notice. "This lender is licensed and examined by the State of Texas - Office of Consumer Credit Commissioner. Call the Consumer Credit Hotline or write for credit information or assistance with credit problems. Office of Consumer Credit Commissioner, 2601 North Lamar, Austin, Texas 78705-4207, (512) 936-7611, (800) 538-1579."

§1.1207. Permissible Changes.

Authorized lender may consider making the following types of changes to the model clauses:

(1) The addition of information related to information set forth in the model clauses that is not otherwise prohibited by law.

(2) Substituting another term for "Lender", "Borrower" that has the same meaning, or use of pronouns such as "you", "we" and "us."

(3) The model clauses may be presented in any order, and may be combined or further segregated at the creditor's option.

(4) Inserting descriptive headings or number provisions.

(5) Changing the case of a word if otherwise permitted by the Texas Finance Code.

(6) Other changes which do not affect the substance of the disclosures.

(7) A sample model contract is presented in the following.
Figure 1: 7 TAC §1.1207(7).
Figure 2: 7 TAC §1.1207(7).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107934
Leslie L. Pettijohn
Commissioner
Finance Commission of Texas
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 936-7640

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CHAPTER 1. CONSUMER CREDIT REGULATION
SUBCHAPTER S. MOTOR VEHICLE SALES FINANCE LICENSES
7 TAC §§1.1401 - 1.1410

The Finance Commission of Texas proposes new 7 TAC §§1.1401-1.1410, concerning licensing procedures for motor vehicle sellers and contract holders.

The proposed new rules provide procedures for filing an application for and issuance of a motor vehicle loan license under Chapter 348, Texas Finance Code, procedures for the transfer of a motor vehicle loan license, processing procedures and time frames for applications, procedures for changes in business form or proportionate ownership, procedures for amendments to pending applications, procedures for the relocation of licensed offices, procedures for designating licenses in an active and inactive status, and the fees associated with licensing activities.

Section 1.1401 defines particular terms.

Section 1.1402 describes the procedure for filing a new application for a motor vehicle loan license, including instructions regarding what form to use and what information is necessary on the application and what information must be filed with the application.

Section 1.1403 describes the procedure for filing an application for transfer of a motor vehicle loan license, including the filing requirements.

Section 1.1404 describes how an application for a motor vehicle loan license is processed, including a description of when an application is complete as well as an explanation of what may occur if an applicant fails to complete an application. In addition, this section describes the hearings process that occurs if the applicant contests the denial of its application.

Section 1.1405 describes what action the licensee must take when it changes the proportion of ownership in or the form of the licensed entity that lists the time frame within which the licensee must notify the commissioner.

Section 1.1406 requires each applicant, upon discovery of new or changed information, to supplement its application within 10 days of discovery of the new or changed information.

Section 1.1407 describes the procedures for relocating a licensed office, including deadlines for notification thereof.

Section 1.1408 describes how a licensee may change its license from active to inactive status and how a license may activate an inactive license.

Section 1.1409 sets out the fees for new licenses, license transfers, fingerprint checks, license amendments, license duplication, and cost of hearings.

Section 1.1410 states the implementation provisions including the authority to issue provisional licenses, if necessary.

Leslie L. Pettijohn, Consumer Credit Commissioner has determined that for the first five- year period the rules are in effect, there will be no fiscal implications for state or local government as a result of administering the rules.

Commissioner Pettijohn also has determined that for each year of the first five years the rules are in effect, the public benefit anticipated as a result of the new rules will be enhanced compliance with the credit laws and consistency in credit contracts. A person required to comply with the rules will be responsible for paying the regulatory fees provided in §1.1409 of the proposed rule. No difference will exist between the cost of compliance for small businesses and the cost of compliance for the largest businesses affected by this section.

Comments on the proposed rules may be submitted in writing to Leslie L. Pettijohn, Consumer Credit Commissioner, Office of Consumer Credit Commissioner, 2601 North Lamar Boulevard, Austin, Texas 78705-4207.

The new rules proposed under the Texas Finance Code §11.304 and §348.513, which authorize the Finance Commission to adopt rules to enforce Title 4 and Chapter 348 of the Texas Finance Code.

These rules affect Chapter 348, Texas Finance Code.

§1.1401. Definitions.

Words and terms used in this chapter that are defined in Texas Finance Code, Chapter 348, have the same meanings as defined in Chapter 348. The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Principal Party -- All proprietors and adult individuals with a substantial relationship to the proposed lending business of the applicant. Individuals with a substantial relationship to the proposed lending business of the applicant include but are not limited to:

(1) general partners;

(2) voting members of a limited liability corporation;

(3) corporate officers, to include the chief executive officer or president, the chief operating officer or vice president of operations, and those with substantial responsibility for lending operations or compliance with the Texas Finance Code;

(4) directors of privately-held corporations;

(5) shareholders owning 10% or more of the outstanding voting stock; and

(6) trustees.

§1.1402. Filing of New Application.

An application for issuance of a new motor vehicle sales finance license must be submitted on forms prescribed by the commissioner at the date of filing and in accordance with the commissioner's instructions. The application must include the appropriate fees and the following:

(1) Required Forms. All questions must be answered.

(A) Application for Motor Vehicle Finance License.

(i) Location. A physical street address must be listed for the applicant's proposed operating address. If the address has not yet been determined or the application is for an inactive license, then the application must indicate an application for an inactive license.

(ii) Individual Responsible for Financing Operations. Name the person who is responsible for the day-to-day financing operations of applicant's proposed office, must be named.

(iii) Signature.

(I) If the applicant is a proprietor or a partnership, every proprietor and general partner must sign.

(II) If the applicant is a corporation, two officers must sign unless the corporation only has one officer.

(III) If the applicant is a limited liability company, two authorized members must sign unless the company only has one member.

(IV) If the applicant is a trust or estate, the trustee or executor must sign.

(B) Disclosure of Owners and Principal Parties. If an individual's interest in an entity is community property, then the spouse's community property interest must also be listed. If the business interest is owned by a married individual as separate property, documentation establishing or confirming separate status should be provided.

(i) Sole Proprietorship. An individual owning and operating the business must be named.

(ii) General Partnership. All partners must be listed and the percentage of ownership stated.

(iii) Corporation. The officers and directors' sections on the form must be completed. All shareholders holding voting stock must be named if the corporation is privately held. If a parent corporation is the sole or part owner of the proposed business, a narrative or diagram must be attached that describes each level of ownership and management. This narrative or diagram requires the listing of the names of all officers, directors, and stockholders owning 5% or more stock at each level.

(iv) Limited Liability Partnership. Each partner, general and limited, must be listed and the percentage of ownership stated. If a partner is a business entity and not an individual, a narrative or diagram must be attached that describes each level of ownership. This narrative or diagram requires the listing of the names of all officers, directors, and stockholders owning 5% or more stock at each level.

(v) Limited Liability Company. Each manager, officer, agent, and member, as those terms are used by the Texas Limited Liability Company Act, Texas Civil Statutes, Article 1528n, must be named. If a member is a business entity and not an individual, a narrative or diagram must be attached that describes each level of ownership. This narrative or diagram requires the listing of the names of all officers, directors, and stockholders owning 5% or more stock at each level.

(vi) Trust or Estate. Each trustee or executor must be listed.

(C) Application Questionnaire. All questions must be answered. Questions requiring a yes answer must be accompanied by an explanatory statement and any appropriate documentation requested on the form.

(D) Statutory Agent Disclosure. This form must be completed by each applicant. The statutory agent is the person or entity to whom any legal notice may be delivered. The agent must be a Texas resident and list an address for legal service. If the statutory agent is an individual, the address must be a physical residential address.

(E) Personal Affidavit, Personal Questionnaire, and Employment History. Each individual listed on the application as a principal party or as a person responsible for financing operations must complete this form. The employment history must also include the individual's association with the entity applying for the license.

(F) Fingerprint Card. A complete set of legible fingerprints must be provided for each individual that is a principal party. Individuals who have previously been licensed by the agency and principal parties of entities currently licensed are not required to provide fingerprints. The commissioner may require fingerprints of employees or other persons with some relationship to the applicant if the commissioner believes that the individual's involvement in the lending operation is relevant to the applicant's eligibility for a license. All fingerprints should be submitted on the format provided by the agency and approved by the Department of Public Safety and the Federal Bureau of Investigation.

(2) Other Required Filings.

(A) Contract Forms. The applicant must provide information regarding all retail installment contract forms it intends to use.

(i) Custom Forms. If a custom contract form is to be prepared, a preliminary draft or proof that is complete as to format and content and which indicates the number and distribution of copies to be prepared for each transaction must be submitted.

(ii) Stock Forms. If applicant purchases or plans to purchase stock forms from a supplier, the applicant must attach a statement that includes the supplier's name and address and a list identifying the forms to be used, including the revision date of the form, if any.

(B) Statement of Experience. An applicant should provide information that relates to the applicant's prior experience in the automobile sales finance business in the employment history section of the personal affidavit. If the applicant does not have significant experience in the business, the applicant must provide a written statement explaining the applicant's relevant experience and why the commissioner should find that the applicant has experience.

(C) Statement of Business Operation Plan. An applicant must attach a brief narrative to the application explaining the extent of automobile sales finance activity that is planned. This narrative should discuss whether the applicant will only be arranging or negotiating for another financing entity and, if so, list each entity, and whether the collections will occur at the licensed location and, if not, identify the servicer and state their location.

(D) Entity Documents.

(i) Partnerships. A Partnership applicant must submit a complete copy of the partnership agreement. A limited partnership must submit an acknowledgment of the articles of partnership filed with the secretary of state, and any amendments. This copy from the secretary of state must be signed and dated by all partners.

(ii) Corporations. A corporate applicant, domestic or foreign, must provide the following documents:

(I) an acknowledge-ment from the secretary of state of the filling of the articles of incorporation and any amendments with the secretary of state;

(II) minutes of corporate meetings that record the election of all current officers and directors as listed on the license application; and

(III) a certificate of good standing from the comptroller of public accounts.

(iii) Foreign Corporations. In addition to the items required for corporations, a foreign corporation must also provide the following:

(I) a certificate of authority to do business in Texas; and

(II) a statement of where corporate records and records of Texas transactions will be kept. If these records will be maintained at a location outside of Texas, the applicant must acknowledge responsibility for the travel costs associated with examinations in addition to the usual assessment or agree to make all the records available for examination in Texas.

(iv) Publicly Held Corporations. In addition to the items required for corporations, a publicly held corporation must file the most recent 10K and 10Q for the applicant or for the parent company.

(v) Trusts. A copy of the instrument that created the trust must be filed with the application.

(vi) Estates. A copy of the instrument establishing the estate must be filed with the application.

(3) Subsequent Applications. If the applicant is currently licensed and filing an application for a new office, the applicant must provide any form and other information unique to the new location including the application form. Other information required by this section need not be filed if the information on file with the agency is current and valid.

§1.1403. Transfer of License.

(a) Definition. As used in this section, a "transfer of ownership" occurs whenever an existing owner relinquishes that owner's entire interest in a license or an entirely new person has obtained an ownership interest in the license. This term includes any purchase or acquisition of control over more than 10% of the outstanding voting stock of any licensed corporation, or of any corporation which is the parent or controlling stockholder of a licensed corporation. This term also includes any acquisition of a license by gift, devise, or descent.

(b) Approval of Transfer. No license may be sold, transferred, or assigned without written approval. When a person with no prior ownership interest in the license purchases or acquires control of 10% or more of the voting stock of any licensed corporation, or of any corporation that is the parent or controlling stockholder of a licensed corporation, an application for transfer of the ownership of the license must be filed.

(c) Filing Requirements. An application for transfer of a license must be submitted on forms prescribed by the commissioner and in accordance with the rules and instructions. The application for transfer shall include the appropriate fees and the following:

(1) Application Form. The instructions in §1.1402(1)(A) of this title (relating to Filing of New Application) are applicable to this filing.

(2) Evidence of the Transfer of Ownership. Documentation evidencing the transfer of ownership must be filed with the application and should include one of the following:

(A) a copy of the asset purchase agreement when only the assets have been purchased;

(B) a copy of the stock purchase agreement if 10% or more of the outstanding voting stock of a corporate license has been purchased or otherwise acquired; or

(C) any document that transferred ownership in a license by gift, devise or descent, such as a probated will or a court order.

(d) Permission to Operate. No business under the license shall be conducted by any transferee until the application has been received, all applicable fees have been paid, and a request for permission to operate has been approved. A request for permission to operate during the pendency of the application may be denied.

(e) Purchaser Operating Under Seller's License. A written agreement whereby a seller grants a buyer the authority to operate under the seller's license pending approval of the buyer's new license application may be approved. The agreement must provide that the seller accepts full responsibility and any customer of the licensed business for any acts of the buyer in connection with the operation of the lending business. The written agreement between the seller and the buyer must be submitted with a request to operate under the seller's license not less than three (3) business days after the date of the sale. The agreement

shall be for a limited time as provided in the agreement and in no case may such authority extend beyond 180 calendar days.

(f) Application Filing Deadline. Applications filed in connection with transfers of ownership may be filed in advance but must be filed no later than ten (10) calendar days following the actual transfer.

§1.1404. Processing of Application.

(a) Initial Review. Applications shall be responded to within 14 calendar days of receipt stating that the application is complete and accepted for filing or stating that the application is incomplete and specifying the information required for acceptance.

(b) Complete Application. An application is complete when it:

(1) conforms to the rules and published instructions;

(2) all fees have been paid; and

(3) all requests for additional information have been satisfied.

(c) Failure to Complete Application. If a complete application has not been filed within 30 calendar days after notice of deficiency has been sent to the applicant, the application may be denied.

(d) Hearing. Whenever an application is denied, the affected applicant has 30 calendar days from the date the application was denied to request in writing a hearing to contest the denial. This hearing shall be conducted pursuant to the Administrative Procedure Act, Texas Government Code, Chapter 2001, and §9.1 *et seq*. of this title (relating to Rules of Procedure for Contested Case Hearings, Appeals, and Rulemakings), before an administrative law judge who will recommend a decision to the commissioner. The commissioner will then issue a final decision after review of the recommended decision.

(e) Denial. If an application has been denied, the investigation fee in §1.1409(a) of this title (relating to Fees) shall be forfeited.

(f) Processing time.

(1) A license application shall ordinarily be approved or denied within a maximum of 60 calendar days after the date of filing of a completed application.

(2) When a hearing is requested following an initial license application denial, the hearing shall be held within 60 calendar days after a written request for a hearing is made unless the parties agree to an extension of time. A final decision approving or denying the license application after receipt of the proposal for decision from the administrative law judge shall be made.

(3) Exceptions. More time may be taken where good cause exists, as defined by Texas Government Code, §2005.004, for exceeding the established time periods in paragraphs (1) and (2) of this subsection.

(g) Applications and Notices as Public Records. Once a license application or notice is filed with the agency, it becomes a "state record" under Texas Government Code, §441.180(11), and "public information" under Texas Government Code, §552.002. Under Texas Government Code, §§441.190, 441.191 and 552.004, the original applications and notices must be preserved as "state records" and "public information" unless destroyed with the approval of the director and librarian of the State Archives and Library Commission under Texas Government Code, §441.187. Under Texas Government Code, §441.191, the agency may not return any original documents associated with a license application or notice to the applicant or licensee. An individual may request copies of a state record under the authority of the Texas Government Code, Chapter 552.

§1.1405. Change in Form or Proportionate Ownership.

(a) Organizational Form. When any licensee desires to change the organizational form of its business (e.g., from sole proprietorship to corporation), the licensee must advise the commissioner in writing of the change within ten (10) calendar days by filing the appropriate fees and transfer documents as provided in this title. In addition, the licensee shall submit a copy of the organizational document for the new entity (e.g., the articles of incorporation).

(b) Merger. A merger of a corporate licensee is a change of ownership and requires the filing of a transfer application pursuant to this title. A merger of the parent corporation of a licensee with another corporation that leads to the creation of a new corporate entity requires a transfer application pursuant to this title. A merger of the licensee's parent corporation with another corporation resulting in a different surviving parent corporation requires a transfer application pursuant to this title. Mergers or transfers of other corporations with a beneficial interest beyond the parent corporation level only require notification within ten (10) calendar days.

(c) Proportionate Ownership. A change in the proportion of ownership among the current owners does not require the filing of a transfer application but does require notification no later than ten (10) calendar days following the actual change.

§1.1406. Amendments to Pending Application.

Each applicant shall provide information supplemental to that contained in the applicant's original application documents and attachments. Any action, fact, or information that would require a materially different answer than given in the original license application and which relates to the qualifications for license must be reported within ten (10) calendar days after the person has knowledge of the action, fact, or information.

§1.1407. Relocation of Licensed Offices.

A licensee may move the licensed office from the licensed location to any other location by payment of the appropriate fees and giving notice of intended relocation to the commissioner not less than 30 calendar days prior to the anticipated moving date. The notice must include the present address of the licensed office, the contemplated new address of the licensed office, the approximate date of relocation, and a copy of the notice to consumers who make payments at the approved location.

§1.1408. Designation of Active/Inactive Status.

(a) Inactivation of an Active License. A licensee may cease operating a license by giving notice of the cessation of operations on the appropriate form not less than 30 calendar days prior to the anticipated activation date and remitting the fee for license amendment.

(b) Activation of an Inactive License. A licensee may activate a license by giving notice of the intended activation on the appropriate form not less than 30 calendar days prior to the anticipated activation date and remitting the fee for license amendment.

§1.1409. Fees.

(a) New Licenses. A $100 investigation fee is assessed each time an application for a new license is filed and is non-refundable.

(b) License Transfers. With applications for transfer of a license, the applicant must pay an investigation fee of $100 for the first license transfer and $50 on each additional license transfer sought simultaneously and is non-refundable.

(c) Fingerprint Record Checks. The fee to investigate each applicant's fingerprint record is $40 per set and is non-refundable. This fee must be paid for each set of fingerprints filed with applications for new licenses or license transfers.

(d) License Amendment. A fee of $25 must be paid each time a licensee seeks to amend a license by rendering a license inactive, activating an inactive license, changing the assumed name of the licensee, or relocating an office.

(e) Annual Renewal and Examination Assessment.

(1) An annual renewal fee is required for each licensed location consisting of:

(A) a license fee of $75; and

(B) a variable fee based upon the annual dollar volume of contracts originated or acquired during the preceding calendar year.

(2) The maximum annual assessment for each active license shall be no more than $250.

(f) License Duplicate. The fee for a license duplicate is $10.

(g) Costs of Hearings. The commissioner may assess the costs of an administrative appeal hearing afforded under §1.1404 of this title (relating to Processing of Application), including the cost of the administrative law judge, the court reporter, and agency staff representing the agency at a hearing.

§1.1410. Implementation Provisions of Licensing.

(a) Effective Date. The effective date of the statutory licensing requirement is September 1, 2002. A motor vehicle seller may not engage in any retail installment transactions without a provisional or permanent license granted under this title after September 1, 2002. Any motor vehicle seller engaging in automobile sales finance transactions must comply with the provisions of the Texas Finance Code, Chapter 348 as it existed prior to September 1, 2001, and 7 TAC, Part I, Chapter 1, Subchapter P until September 1, 2002. Failure to comply with required registration provisions is grounds for denial of an application made under §1.1404 of this title (relating to Processing of Application).

(b) Provisional license. The commissioner may issue a provisional license with a specified expiration date if necessary during implementation.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107944
Leslie L. Pettijohn
Commissioner
Finance Commission of Texas
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 936-7640

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TITLE 22. EXAMINING BOARDS

PART 1. TEXAS BOARD OF ARCHITECTURAL EXAMINERS

CHAPTER 1. ARCHITECTS

SUBCHAPTER E. FEES

22 TAC §1.81

The Texas Board of Architectural Examiners proposes an amendment to rule §1.81 for Title 22, Chapter 1, Subchapter E, concerning the establishment, payment, and timely payment of fees established by the Board. The amendment to this rule is intended to clarify the rule's requirements and ensure that they are consistent with governing law. It will require the Board to establish a fee schedule in a public meeting and publish it, designate methods of payment, and describe penalties for paying fees with dishonored checks. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The amendment to this rule is proposed pursuant to Sections 3(b) and 3(h) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and establish fees.

The proposed amendment to this section does not affect any other statutes.

§1.81. General.

(a) All fees shall be established by the Board at a public meeting and shall be published in the *Texas Register.* [~~Certain statutory limits are fixed, within which this board may set certain fees so authorized. These, therefore, are subject to change without notice.~~]

(b) Payment of any fee established by the Board may be made only by check or money order made payable to the Texas Board of Architectural Examiners. [~~Payment shall be made by personal check, money order, or cashier's check made payable to the Texas Board of Architectural Examiners. Notations, explaining the payment remitted, should be on the face of the checks or within cover letters of submittal.~~]

(c) An official postmark from the U.S. Postal Service may be presented to the Board to demonstrate the timely payment of any fee. [~~The board shall accept a postmark date as evidence of intent to remit timely payment of a fee. Proprietary postage meter dates will not be accepted as evidence of intent to make timely payment if contradicted by postal service postmark dates.~~]

(d) If a check is submitted to the Board to pay a fee and the bank upon which the check is drawn refuses to pay the check, the fee shall be considered unpaid and any applicable late fees shall accrue. [~~Any payment submitted to the board and returned as a dishonored check will be charged an administrative penalty fee as prescribed by the board. The payment to replace a dishonored check must be paid with a money order or cashier's check. Any fees paid by dishonored checks are considered unpaid.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108013
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §§1.82 - 1.89

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 1, Subchapter E: §1.82 pertaining to the application, examination and initial registration fees; §1.83 pertaining to the annual record maintenance fee; §1.84 pertaining to the annual registration and renewal fees; §1.85 pertaining to the reinstatement fee; §1.86 pertaining to the reciprocal transfer fee; §1.87 pertaining to the replacement certificate fee; §1.88 pertaining to the emeritus fee; and §1.89 pertaining to the inactive fee.

Simultaneously, the agency is proposing a new rule with section number 1.82 to replace the rules proposed for repeal. Due to the extensive modifications proposed in the new rules, amending the existing rules is less practical than repealing the existing rules and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 1, Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that they will have been replaced with updated rules and that no economic cost to persons who are required to comply with the section is anticipated.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that there will be a clearly stated, efficient procedure for establishing fees and the rules governing fees will be easier to understand.

The repeal is not expected to impact small business significantly.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Sections 3(b) and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§1.82. Application, Examination and Initial Registration Fees.
§1.83. Annual Record Maintenance Fees.
§1.84. Annual Registration and Renewal Fee.
§1.85. Reinstatement Fee.
§1.86. Reciprocal Transfer Fee.
§1.87. Replacement Certificate Fee.
§1.88. Emeritus Fee.
§1.89. Inactive Fee.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §1.82

The Texas Board of Architectural Examiners proposes new rule §1.82 for Title 22, Chapter 1, Subchapter E, concerning annual fees. This rule requires the Board to notify, by mail, each person who must pay an annual fee and requires the annual fee to be paid regardless of whether the notice is received. It requires each registrant to pay the annual renewal fee on or before the designated expiration date and additionally requires the payment of a penalty fee if the renewal payment is late. It states that if the payment for renewal is not made within one year after the designated expiration date, the registrant's certificate of registration may be revoked. It requires the Board to send to the registrant's current address of record a notice of pending revocation if the registrant fails to renew the registration within one year of the expiration date. Due to the proposal of extensive modifications to Subchapter E, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Section 12 of Article 249a, Vernon's Texas Civil Statutes, which governs registration renewal for architects. These proposed sections do not affect any other statutes.

§1.82. Annual Fees.

(a) The Board shall send an annual notice to each person who must pay a fee that is due annually. Each annual notice shall be sent to the intended recipient's current address of record. Every annual fee must be paid regardless of whether an annual notice is received.

(b) Every registrant must pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration. If a registrant fails to pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration, the Board shall require that the registrant pay a penalty fee in addition to the registration renewal fee before the registration may be renewed. A registration certificate shall become invalid on its designated expiration date unless it is renewed.

(c) If a registrant fails to renew his/her certificate of registration within one year after its designated expiration date, the certificate of registration may be revoked by the Board without scheduling a formal hearing before the State Office of Administrative Hearings pursuant to the Administrative Procedure Act. The Board shall send a notice of pending revocation to a registrant who fails to renew his/her certificate of registration within one year after its designated expiration date. The notice shall be sent to the registrant's current address of record.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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SUBCHAPTER J. INTERN DEVELOPMENT TRAINING REQUIREMENT

22 TAC §1.191, §1.192

The Texas Board of Architectural Examiners proposes new rules §1.191 and §1.192 for Title 22, Chapter 1, Subchapter J, concerning intern development training requirements for architectural applicants. Section 1.191 describes the minimum training units required for subjects related to design and construction documents, construction and administration, and management as well as the maximum training units awarded under the various training settings. Section 1.192 sets forth additional criteria that apply to the intern development training requirements. The new rules are being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter J, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits anticipated as a result of the new rule are that the registration requirements will be clearly established and readily accessible.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 3(b), 5(b) and 7 of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and establish registration requirements.

These proposed sections do not affect any other statutes.

§1.191. Description of Experience Required for Registration by Examination.

(a) Pursuant to Section 1.21 of Subchapter B, an Applicant must successfully demonstrate completion of the Intern Development Training Requirement by earning credit for at least 700 Training Units as described in this subchapter.

(b) An Applicant must earn credit for at least 350 Training Units in the areas of design and construction documents in accordance with the following chart:
Figure: 22 TAC §1.191(b)

(c) An Applicant must earn credit for at least seventy (70) Training Units in the areas of construction administration in accordance with the following chart:
Figure: 22 TAC §1.191(c)

(d) An Applicant must earn credit for at least thirty-five (35) Training Units in the area of management in accordance with the following chart:
Figure: 22 TAC §1.191(d)

(e) An Applicant must earn credit for at least ten (10) Training Units in the areas of professional and community service.

(f) An Applicant must earn credit for at least 235 elective Training Units. Credit for elective Training Units may be earned in any of the categories described in Subsections (a) through (e) of this section and/or in teaching, research, a post-professional degree, or other related activities.

(g) An Applicant shall receive credit for Training Units in accordance with the following chart:
Figure: 22 TAC §1.191(g)

§1.192. Additional Criteria.

(a) One Training Unit shall equal eight hours of acceptable experience.

(b) An Applicant may earn credit for Training Units only after satisfactory completion of any one of the following:

(1) three (3) years in a professional program accredited by the National Architectural Accreditation Board (NAAB) or in an architectural education program outside the United States where an evaluation by NAAB or another organization acceptable to the Board has concluded that the program is substantially equivalent to an NAAB-accredited professional program;

(2) the third year of a four-year pre-professional degree program in architecture accepted for direct entry to a two-year NAAB-accredited professional master's degree program;

(3) one (1) year in an NAAB-accredited professional master's degree program following receipt of a non-professional degree; or

(4) Ninety-six (96) semester credit hours as evaluated in accordance with the National Council of Architectural Registration Boards (NCARB) Education Requirement, of which no more than sixty (60) hours can be in the general education category.

(c) In order to earn credit for Training Units in any work setting other than a post-professional degree or teaching or research, an Applicant must:

(1) work at least thirty-five (35) hours per week for a minimum period of ten (10) consecutive weeks; or

(2) work at least twenty (20) hours per week for six (6) or more consecutive months.

(d) To earn credit for Training Units for teaching or research, an Applicant must be employed in the teaching or research position on a full-time basis.

(e) One year in an architectural education program shall equal thirty-two (32) semester credit hours or forty-eight (48) quarter credit hours. An Applicant may not earn credit for Training Units for experience that was counted toward the educational requirements for architectural registration by examination.

(f) Every training activity, the setting in which it took place, and the time devoted to the activity must be verified by the person who supervised the activity.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108015
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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SUBCHAPTER L. HEARINGS--CONTESTED CASES

22 TAC §1.231

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rule for Title 22, Chapter 1, Subchapter L: §1.231 pertaining to the case hearings conducted by State Office of Administrative Hearings.

Simultaneously, the agency is proposing a new rule with section number 1.231 to replace the rule proposed for repeal. Due to the extensive modifications proposed in the new rule, amending the existing rule is less practical than repealing the existing rule and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 1, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that they will have been replaced with updated rules. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering new rules which more clearly define the Board's procedures and are more consistent with governing law.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Sections 3(b), 3(d), and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§1.231. State Office of Administrative Hearings.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108016
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

22 TAC §1.231

The Texas Board of Architectural Examiners proposes new rule §1.231 for Title 22, Chapter 1, Subchapter L, concerning procedures for formal hearings. This rule states that the Administrative Procedure Act applies to all contested cases involving matters under the jurisdiction of the Board and states the Rules of

Procedure of the State Office of Administrative Hearings apply to formal hearings of contested cases conducted for the Board. Due to the proposal of extensive modifications to Subchapter L, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 3(b), 3(d) and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

This proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§1.231. Formal Hearing Procedures.

(a) Unless specifically indicated, the Administrative Procedure Act (APA) applies to all Contested Cases involving matters under the jurisdiction of the Board.

(b) The Rules of Procedure of the State Office of Administrative Hearings (SOAH) apply to formal hearings of Contested Cases conducted for the Board by a SOAH administrative law judge.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
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Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §1.232

The Texas Board of Architectural Examiners proposes an amendment to rule §1.232 for Title 22, Chapter 1, Subchapter L, concerning the board's responsibilities as they pertain to hearings for contested cases. The amendment to this rule will generally describe the Board's procedures for addressing contested cases and ensure that the procedures are consistent with governing law. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter L, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections. economic cost to persons who are required to comply with the section.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The amendment to this rule is proposed pursuant to Sections 3(b), 3(d), and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

The proposed amendment and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§1.232. Board Responsibilities.

(a) The Board shall investigate Contested Case matters and attempt to resolve Contested Cases informally as provided in Subchapter I of the Rules and Regulations of the Board. However, if a Contested Case is not settled informally pursuant to Subchapter I, it shall be referred to SOAH for a formal hearing to determine whether there has been a violation of any of the statutory provisions or rules enforced by the Board.

(b) A formal hearing shall be conducted in accordance with the Rules of Procedure of SOAH.

(c) After a formal hearing of a Contested Case, the SOAH administrative law judge who conducted the formal hearing shall prepare a proposal for decision and submit it to the Board so that the Board may render a final decision with regard to the Contested Case. The proposal for decision shall include findings of fact and conclusions of law.

(d) The Board may change a finding of fact or conclusion of law made by an administrative law judge or may vacate or modify an order issued by an administrative law judge only if the Board determines:

(1) that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions;

(2) that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed; or

(3) that a technical error in a finding of fact should be changed.

(e) If the Board makes a change to a finding of fact or conclusion of law or vacates or modifies an order pursuant to Subsection 1.232(c), the Board must state in writing the specific reason and the legal basis for the change.

(f) The Board shall issue a written order regarding the Board's final decision with regard to a Contested Case that is not settled informally. The written order shall include findings of fact and conclusions of law that are based on the official record of the Contested Case.

(g) Motions for rehearing and appeals may be filed and judicial review of final decisions of the Board may be sought pursuant to the Administrative Procedure Act. [~~The Board will conduct sufficient investigation of complaint matters within its jurisdiction and attempt to resolve cases through authorized informal dispositions. However, when agreements are not reached or approved, the Board must refer contested cases to the State Office of Administrative Hearings for formal hearings. The Board shall not attempt to influence the findings of facts or the judge's application of the law in any contested case other than by proper evidence and legal argument. The Board may, however, change a finding of fact or conclusion of law made by the judge, or vacate or modify an order issued by the judge, only for reasons of policy and must state in writing the reason and legal basis for the change. If a member of the Board finds that he/she should not act on any charge before the Board, he/she may disqualify himself/herself from acting in the proceedings.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §§1.233 - 1.276

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 1, Subchapter L: §1.233 pertaining to jurisdiction and requests for hearings or for An administrative law judge; §1.234 pertaining to filing notices, pleadings, motions, answers, affidavits and all other filings in a contested case; §1.235 pertaining to stipulations and agreements as they concern procedural matters; §1.236 pertaining to the service of documents concerning notices of hearing, default orders, prehearing orders, proposals for decisions, and decisions and orders of the board; §1.237 pertaining to conduct and decorum during proceedings; §1.238 pertaining to the classifications of parties; §1.239 pertaining to appearances in person or by a representative and to waivers and defaults; §1.240 pertaining to classification of pleadings; §1.241 pertaining to form and content of pleadings; §1.242 pertaining to discovery rights; §1.243 pertaining to motions and amendments; §1.244 pertaining to prehearing conferences and orders; §1.245 pertaining to notice of hearings; §1.246 pertaining to certificates of registration; §1.247 pertaining to conduct of hearings; §1.248 pertaining to formal exceptions; §1.249 pertaining to motions for postponement, continuance, withdrawal, or dismissal of matters before the board; §1.250 pertaining to the place and nature of hearings; §1.251 pertaining to powers and authority of the administrative law judge; §1.252 pertaining to the order of proceedings; §1.253 pertaining to reporters and transcript; §1.254 pertaining to telephone hearings; §1.255 pertaining to dismissal or settlement without a hearing; §1.256 pertaining to rules of evidence; §1.257 pertaining to documentary evidence; §1.258 pertaining to official notice of facts; §1.259 pertaining to prepared or prefiled testimony; §1.260 pertaining to limitations on the number of witnesses; §1.261 pertaining to exhibits; §1.262 pertaining to offers of proof; §1.263 pertaining to depositions; §1.264 pertaining to subpoenas; §1.265 pertaining to proposals for decision; §1.266 pertaining to filing exceptions, briefs, and replies; §1.267 pertaining to the form and content of briefs, exceptions, and replies; §1.268 pertaining to oral arguments; §1.269 pertaining to final decisions and orders; §1.270 pertaining to administrative finality; §1.271 pertaining to motions for rehearing; §1.272 pertaining to the rendering of a final decision or order; §1.273 pertaining to the payment of an administrative penalty; §1.274 pertaining to judicial review; §1.275 pertaining to what the record in a contested case shall include; and §1.276 pertaining to complaints.

Simultaneously, the agency is proposing a new rule with section number 1.233 to replace the rules proposed for repeal.

Due to the extensive modifications proposed in the new rule, amending the existing rules is less practical than repealing the existing rules and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 1, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that they will have been replaced with updated rules. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering new rules which more clearly define the Board's procedures and are more consistent with governing law.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Sections 3(b), 3(d), and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§1.233. Jurisdiction; Request for Hearings or Law Judge.
§1.234. Filings.
§1.235. Stipulations; Agreements.

§1.236. Service.
§1.237. Conduct and Decorum.
§1.238. Classification of Parties.
§1.239. Appearances in Person or by Representatives; Waivers; Defaults.
§1.240. Classification of Pleadings.
§1.241. Form and Content of Pleadings.
§1.242. Discovery.
§1.243. Motions; Amendments.
§1.244. Prehearing Conferences and Orders.
§1.245. Notice of Hearing.
§1.246. Certificates of Registration.
§1.247. Conduct of Hearings.
§1.248. Formal Exceptions.
§1.249. Motions for Postponement, Continuance, Withdrawal, or Dismissal of Matters Before the Board.
§1.250. Place and Nature of Hearings.
§1.251. Administrative Law Judge.
§1.252. Order of Proceedings.
§1.253. Reporters and Transcript.
§1.254. Telephone Hearings.
§1.255. Dismissal, Settlement Without Hearing.
§1.256. Rules of Evidence.
§1.257. Documentary Evidence.
§1.258. Official Notice.
§1.259. Prepared or Prefiled Testimony.
§1.260. Limitations on Number of Witnesses.
§1.261. Exhibits.
§1.262. Offer of Proof.
§1.263. Depositions.
§1.264. Subpoenas.
§1.265. Proposals for Decision.
§1.266. Filing of Exceptions, Briefs, and Replies.
§1.267. Form and Content of Briefs, Exceptions, and Replies.
§1.268. Oral Argument.
§1.269. Final Decisions and Orders.
§1.270. Administrative Finality.
§1.271. Motions for Rehearing.
§1.272. Rendering of Final Decision or Order.
§1.273. Administrative Penalty Payment.
§1.274. Judicial Review.
§1.275. The Record.
§1.276. Complaints.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §1.233

The Texas Board of Architectural Examiners proposes new rule §1.233 for Title 22, Chapter 1, Subchapter L, concerning the application and construction of procedures for hearings on contested cases. This rule states that the State Office of Administrative Hearings (SOAH) will conduct formal hearings in accordance with the Administrative Procedure Act and Chapter 155 of the Rules of Procedure of SOAH. It states that the statute will control any conflict between the Board's rules or a prior decision of the Board and any statutory provisions applicable to a contested case. It requires the presiding administrative law judge to consider applicable policy of the Board if an issue is not susceptible to resolution by reference to the APA and other applicable statutes. Due to the proposal of extensive modifications to Subchapter L, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 1, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 3(b), 3(d), and 5(b) of Article 249a, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

The proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§1.233. Application and Construction of Procedures.

(a) SOAH shall conduct formal hearings in accordance with the APA and with Chapter 155 of the Rules of Procedure of SOAH, provided that:

(1) An administrative law judge may, by order, modify the requirements of the Rules of Procedure of SOAH and supplement other procedural requirements of law to promote the fair and efficient handling of a Contested Case; and

(2) An administrative law judge may modify the procedural requirements of the Rules of Procedure of SOAH in appropriate cases to facilitate resolution of issues if doing so does not prejudice any of a party's rights or contravene applicable statutes.

(b) If there is any conflict between the Rules and Regulations of the Board or a prior decision of the Board and any of the statutory provisions applicable to a Contested Case, the statute controls.

(c) Not all contested procedural issues may be susceptible to resolution by reference to the APA and other applicable statutes, the Rules and Regulations of the Board, and case law. When they are not, the presiding administrative law judge shall consider applicable policy of the Board documented in the record in accordance with the Rules of Procedure of SOAH, the Texas Rules of Civil Procedure (TRCP) as interpreted and construed by Texas case law, and persuasive authority established in other forums, in order to issue orders and rulings that are just in the circumstances of the Contested Case.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
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Texas Board of Architectural Examiners
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CHAPTER 3. LANDSCAPE ARCHITECTS
SUBCHAPTER E. FEES

22 TAC §3.81

The Texas Board of Architectural Examiners proposes an amendment to rule §3.81 for Title 22, Chapter 3, Subchapter E, concerning the establishment, payment, and timely payment of fees established by the Board. The amendment to this rule is intended to clarify the rules requirements and ensure that they are consistent with governing law. It will require the Board to establish a fee schedule in a public meeting and publish it, designate methods of payment, and describe penalties for paying fees with dishonored checks. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter E, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the section.

Ms. Hendricks has determined that for the first five-year period the section is in effect the public benefits expected as a result of the amended rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The amendment to this rule is proposed pursuant to Sections 4(a) and (b) of Article 249c, Vernon's Texas Civil Statutes, which provides the Texas Board of Architectural Examiners with authority to promulgate rules and establish fees.

The proposed amendment to this section does not affect any other statutes.

§3.81. General.

(a) All fees shall be established by the Board at a public meeting and shall be published in the *Texas Register*. [~~Certain statutory limits are fixed, within which this board may set certain fees so authorized. These, therefore, are subject to change without notice.~~]

(b) Payment of any fee established by the Board may be made only by check or money order made payable to the Texas Board of Architectural Examiners. [~~Payment shall be made by personal check, money order, or cashier's check made payable to the Texas Board of Architectural Examiners. Notations explaining the payment remitted should be on the face of the checks or within cover letters of submittal.~~]

(c) An official postmark from the U.S. Postal Service may be presented to the Board to demonstrate the timely payment of any fee. [~~The board shall accept a postmark date as evidence of intent to remit timely payment of a fee. Proprietary postage meter dates will not be accepted as evidence of intent to make timely payment if contradicted by postal service postmark dates.~~]

(d) If a check is submitted to the Board to pay a fee and the bank upon which the check is drawn refuses to pay the check, the fee shall be considered unpaid and any applicable late fees shall accrue. [~~Any payment submitted to the board and returned as a dishonored check will be charged an administrative penalty fee as prescribed by the board. The payment to replace a dishonored check must be paid with a money order or cashier's check. Any fees paid by dishonored checks are considered unpaid.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §§3.82 - 3.90

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 3, Subchapter E: §3.82 pertaining to the application and examination fees; §3.83 pertaining to the reexamination fee; §3.84 pertaining to the annual registration and renewal fees; §3.85 pertaining to the reinstatement fees; §3.86 pertaining to the reciprocal transfer fees; §3.87 pertaining to the replacement certificate fees; §3.88 pertaining to the emeritus fees; and §3.89 pertaining to the examination review fee, and §3.90 pertaining to the inactive fee.

Simultaneously, the agency is proposing a new §1.82 to replace the rules proposed for repeal. Due to the extensive modifications proposed in the new rule, amending the existing rules is less practical than repealing the existing rules and publishing a

new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 3, Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the repeal is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Ms. Hendricks has determined that for the first five-year period the repeal is in effect the public benefits expected as a result of repealing the rules are that they will have been replaced with updated rule and that no economic cost to persons who are required to comply with the section is anticipated.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that there will be a clearly stated, efficient procedure for establishing fees and the rules governing fees will be easier to understand.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The repeal is proposed pursuant to Section 4(a) of Article 249(c), Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and includes implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§3.82. Application and Examination Fees.
§3.83. Reexamination Fees.
§3.84. Annual Registration and Renewal Fee.
§3.85. Reinstatement Fee.
§3.86. Reciprocal Transfer Fee.
§3.87. Replacement Certificate Fee.
§3.88. Emeritus Fee.
§3.89. Examination Review Fee.
§3.90. Inactive Fee.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §3.82

The Texas Board of Architectural Examiners proposes new §3.82 for Title 22, Chapter 3, Subchapter E, concerning annual fees. This rule requires the Board to notify, by mail, each person who must pay an annual fee and requires the annual fee to be paid regardless of whether the notice is received. It requires each registrant to pay the annual renewal fee on or before the designated expiration date and additionally requires the payment of a penalty fee if the renewal payment is late. It states that if the payment for renewal is not made within one year after the designated expiration date, the registrant's certificate of registration may be revoked. It requires the Board to send to the registrant's current address of record a notice of pending revocation if the registrant fails to renew the registration within one year of the expiration date. Due to the proposal of extensive modifications to Subchapter E, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter E, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the section.

Ms. Hendricks has determined that for the first five-year period the section is in effect the public benefits expected as a result of the new rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The new rule is proposed pursuant to Section 14 of Article 249c, Vernon's Texas Civil Statutes, which governs registration renewal for landscape architects.

The proposed section does not affect any other statutes.

§3.82. Annual Fees.

(a) The Board shall send an annual notice to each person who must pay a fee that is due annually. Each annual notice shall be sent to the intended recipient's current address of record. Every annual fee must be paid regardless of whether an annual notice is received.

(b) Every registrant must pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration. If a registrant fails to pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration, the Board shall require that the registrant pay a penalty fee in addition to the registration renewal fee before the registration may be renewed. A registration certificate shall become invalid on its designated expiration date unless it is renewed.

(c) If a registrant fails to renew his/her certificate of registration within one year after its designated expiration date, the certificate of registration may be revoked by the Board without scheduling a formal hearing before the State Office of Administrative Hearings pursuant to the Administrative Procedure Act. The Board shall send a notice of pending revocation to a registrant who fails to renew his/her certificate of registration within one year after its designated expiration date. The notice shall be sent to the registrant's current address of record.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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SUBCHAPTER J. TABLE OF EQUIVALENTS FOR EXPERIENCE IN LANDSCAPE ARCHITECTURE

22 TAC §3.191, §3.192

The Texas Board of Architectural Examiners proposes new §3.191 and §3.192 for Title 22, Chapter 3, Subchapter J, concerning the table of equivalents for experience in landscape architecture. Section 3.191 describes the types of experience required and the maximum credit awarded for the various types of experience. Section 3.192 describes how experience other than what is described in §3.191 may be earned. The new rules are being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter J, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Ms. Hendricks has determined that for the first five-year period the sections are in effect the public benefits anticipated as a result of the new rules are that the requirements for registration will be clearly established and readily accessible.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the sections.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The new rules are proposed pursuant to Sections 4(a) and 5 of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and establish registration requirements.

These proposed sections do not affect any other statutes.

§3.191. Description of Experience Required for Registration by Examination.

(a) Pursuant to §3.21 of Subchapter B, an Applicant must successfully demonstrate that he/she has gained at least two years' actual experience in accordance with the following table:
Figure: 22 TAC §3.191(a)

(b) An Applicant must earn at least one year of credit under the conditions described in category LA-1.

(c) In order to earn credit in category LA-1, LA-2, or LA-3, an Applicant must:

(1) work at least 35 hours per week for a minimum of ten consecutive weeks; or

(2) for partial credit, work between 20 and 34 hours per week for a minimum of six consecutive months.

(d) In order to earn credit in category LA-4, an Applicant must teach subjects that are directly related to the practice of landscape architecture. An Applicant may earn one year of credit by teaching for 20 semester credit hours or 30 quarter credit hours.

(e) An Applicant may not earn credit for experience gained prior to the date the Applicant completed the educational requirements for landscape architectural registration by examination in Texas.

§3.192. Other Experience.
An Applicant may earn credit for experience other than under the conditions described in §3.191 of this subchapter if the Board considers such experience to be substantially equivalent to the experience described therein. For purposes of this section, education may be considered as experience.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
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Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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SUBCHAPTER K. HEARINGS--CONTESTED CASES

22 TAC §3.231

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rule for Title 22, Chapter 3, Subchapter K: §3.231 pertaining to the case hearings conducted by the State Office of Administrative Hearings.

Simultaneously, the agency is proposing a new §3.231 to replace the rule proposed for repeal. Due to the extensive modifications proposed in the new rule, amending the existing rule is less practical than repealing the existing rule and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 3, Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Ms. Hendricks has determined that for the first five-year period the new rule is in effect the public benefits expected as a result of the new rule are that they will have been replaced with an updated rule. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering a new rule which more clearly define the Board's procedures and is more consistent with governing law.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The repeal is not expected to impact small business significantly.

The repeal is proposed pursuant to Section 4(a) of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§3.231. State Office of Administrative Hearings.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108025
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §3.231

The Texas Board of Architectural Examiners proposes new §3.231 for Title 22, Chapter 3, Subchapter L, concerning procedures for formal hearings. This rule states that the Administrative Procedure Act applies to all contested cases involving matters under the jurisdiction of the Board and states the Rules of Procedure of the State Office of Administrative Hearings apply to formal hearings of contested cases conducted for the Board. Due to the proposal of extensive modifications to Subchapter L, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Ms. Hendricks has determined that for the first five-year period the section is in effect the public benefits expected as a result of the new section are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, Texas 78711-2337.

The new rule is proposed pursuant to Section 4(a) of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

This proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§3.231. Formal Hearing Procedures.

(a) Unless specifically indicated, the Administrative Procedure Act (APA) applies to all Contested Cases involving matters under the jurisdiction of the Board.

(b) The Rules of Procedure of the State Office of Administrative Hearings (SOAH) apply to formal hearings of Contested Cases conducted for the Board by a SOAH administrative law judge.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §3.232

The Texas Board of Architectural Examiners proposes an amendment to rule §3.232 for Title 22, Chapter 3, Subchapter L, concerning the board's responsibilities as they pertain to hearings for contested cases. The amendment to this rule will generally describe the Board's procedures for addressing contested cases and ensure that the procedures are consistent with governing law. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter L, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The amendment to this rule is proposed pursuant to Section 4(a) of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

The proposed amendment and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§3.232. Board Responsibilities.

(a) The Board shall investigate Contested Case matters and attempt to resolve Contested Cases informally as provided in Subchapter I of the Rules and Regulations of the Board. However, if a Contested Case is not settled informally pursuant to Subchapter I, it shall be referred to SOAH for a formal hearing to determine whether there has been a violation of any of the statutory provisions or rules enforced by the Board. [~~The Board will conduct sufficient investigation of complaint matters within its jurisdiction and attempt to resolve cases through authorized informal dispositions. However, when agreements are not reached or approved, the Board must refer contested cases to the State Office of Administrative Hearings for formal hearings. The Board shall not attempt to influence the findings of facts or the judge's application of the law in any contested case other than by proper evidence and legal argument. The Board may, however, change a finding of fact or conclusion of law made by the judge, or vacate or modify an order issued by the judge, only for reasons of policy and must state in writing the reason and legal basis for the change. If a member of the Board finds that he/she should not act on any charge before the Board, he/she may disqualify himself/herself from acting in the proceedings.~~]

(b) A formal hearing shall be conducted in accordance with the Rules of Procedure of SOAH.

(c) After a formal hearing of a Contested Case, the SOAH administrative law judge who conducted the formal hearing shall prepare a proposal for decision and submit it to the Board so that the Board may render a final decision with regard to the Contested Case. The proposal for decision shall include findings of fact and conclusions of law.

(d) The Board may change a finding of fact or conclusion of law made by an administrative law judge or may vacate or modify an order issued by an administrative law judge only if the Board determines:

(1) that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions;

(2) that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed; or

(3) that a technical error in a finding of fact should be changed.

(e) If the Board makes a change to a finding of fact or conclusion of law or vacates or modifies an order pursuant to Subsection 3.232(c), the Board must state in writing the specific reason and the legal basis for the change.

(f) The Board shall issue a written order regarding the Board's final decision with regard to a Contested Case that is not settled informally. The written order shall include findings of fact and conclusions of law that are based on the official record of the Contested Case.

(g) Motions for rehearing and appeals may be filed and judicial review of final decisions of the Board may be sought pursuant to the Administrative Procedure Act.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108028
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8235

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22 TAC §§3.233 - 3.275

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 3, Subchapter K: §3.233 pertaining to jurisdiction and requests for hearings or for an administrative law judge; §3.234 pertaining to filing notices, pleadings, motions, answers, affidavits and all other filings in a contested case; §3.235 pertaining to stipulations and agreements as they concern procedural matters; §3.236 pertaining to the service of documents concerning notices of hearing, default orders, prehearing orders, proposals for decisions, and decisions and orders of the board; §3.237 pertaining to conduct and decorum during proceedings; §3.238 pertaining to the classifications of parties; §3.239 pertaining to appearances in person or by a representative and to waivers and defaults; §3.240 pertaining to classification of pleadings; §3.241 pertaining to form and content of pleadings; §3.242 pertaining to discovery rights; §3.243 pertaining to motions and amendments; §3.244 pertaining to prehearing conferences and orders; §3.245 pertaining to notices of hearings; §3.246 pertaining to certificates of registration; §3.247 pertaining to conduct of hearings; §3.248 pertaining to formal exceptions; §3.249 pertaining to motions for postponement, continuance, withdrawal, or dismissal of matters before the board; §3.250 pertaining to the place and nature of hearings; §3.251 pertaining to powers and authority of the administrative law judge; §3.252 pertaining to the order of proceedings; §3.253 pertaining to reporters and transcripts; §3.254 pertaining to telephone hearing; §3.255 pertaining to dismissal or settlement without a hearings; §3.256 pertaining to rules of evidence; §3.257 pertaining to documentary evidence; §3.258 pertaining to official notice of facts; §3.259 pertaining to prepared or prefiled testimony; §3.260 pertaining to limitations on the number of witnesses; §3.261 pertaining to exhibits; §3.262 pertaining to offers of proof; §3.263 pertaining to depositions; §3.264 pertaining to subpoenas; §3.265 pertaining to proposals for decision; §3.266 pertaining to filing exceptions, briefs, and replies; §3.267 pertaining to the form and content of briefs, exceptions, and replies; §3.268 pertaining to oral arguments; §3.269 pertaining to final decisions and orders; §3.270 pertaining to administrative finality; §3.271 pertaining to motions for rehearing; §3.272 pertaining to the rendering of a final decision or order; §3.273 pertaining to judicial review; §3.274 pertaining to what the record in a contested case shall include; and §3.275 pertaining to complaints.

Simultaneously, the agency is proposing a new rule with section number §3.233 to replace the rules proposed for repeal.

Due to the extensive modifications proposed in the new rule, amending the existing rules is less practical than repealing the existing rules and publishing a new rule. The modifications are

being made as a result of the agency's review of Title 22, Chapter 3, Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that they will have been replaced with updated rules. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering new rules which more clearly define the Board's procedures and are more consistent with governing law.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Section 4(a) of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§3.233. Jurisdiction; Request for Hearings or Law Judge.
§3.234. Filings.
§3.235. Stipulations; Agreements.
§3.236. Service.
§3.237. Conduct and Decorum.
§3.238. Classification of Parties.
§3.239. Appearances in Person or by Representatives; Waivers; Defaults.
§3.240. Classification of Pleadings.
§3.241. Form and Content of Pleadings.
§3.242. Discovery.
§3.243. Motions; Amendments.
§3.244. Prehearing Conferences and Orders.
§3.245. Notice of Hearing.
§3.246. Certificates of Registration.
§3.247. Conduct of Hearings.
§3.248. Formal Exceptions.
§3.249. Motions for Postponement, Continuance, Withdrawal, or Dismissal of Matters Before the Board.
§3.250. Place and Nature of Hearings.
§3.251. Administrative Law Judge.
§3.252. Order of Proceedings.
§3.253. Reports and Transcript.
§3.254. Telephone Hearings.
§3.255. Dismissal, Settlement Without Hearing.
§3.256. Rules of Evidence.
§3.257. Documentary Evidence.
§3.258. Official Notice.
§3.259. Prepared or Prefiled Testimony.
§3.260. Limitations on Number of Witnesses.
§3.261. Exhibits.
§3.262. Offer of Proof.
§3.263. Depositions.
§3.264. Subpoenas.
§3.265. Proposals for Decision.
§3.266. Filing of Exceptions, Briefs, and Replies.
§3.267. Form and Content of Briefs, Exceptions, and Replies.
§3.268. Oral Argument.
§3.269. Final Decisions and Orders.
§3.270. Administrative Finality.
§3.271. Motions for Rehearing.
§3.272. Rendering of Final Decision or Order.
§3.273. Judicial Review.
§3.274. The Record.
§3.275. Complaints.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

22 TAC §3.233

The Texas Board of Architectural Examiners proposes new rule §3.233 for Title 22, Chapter 3, Subchapter L, concerning the application and construction of procedures for hearings on contested cases. This rule states that the State Office of Administrative Hearings (SOAH) will conduct formal hearings in accordance with the Administrative Procedure Act and Chapter 155 of the Rules of Procedure of SOAH. It states that the statute will control any conflict between the Board's rules or a prior decision of the Board and any statutory provisions applicable to a contested case. It requires the presiding administrative law judge to consider applicable policy of the Board if an issue is not susceptible to resolution by reference to the APA and other applicable statutes. Due to the proposal of extensive modifications to Subchapter L, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 3, Subchapter L, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Section 4(a) of Article 249c, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules.

The proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§3.233. Application and Construction of Procedures.

(a) SOAH shall conduct formal hearings in accordance with the APA and with Chapter 155 of the Rules of Procedure of SOAH, provided that:

(1) an administrative law judge may, by order, modify the requirements of the Rules of Procedure of SOAH and supplement other procedural requirements of law to promote the fair and efficient handling of a Contested Case; and

(2) an administrative law judge may modify the procedural requirements of the Rules of Procedure of SOAH in appropriate cases to facilitate resolution of issues if doing so does not prejudice any of a party's rights or contravene applicable statutes.

(b) If there is any conflict between the Rules and Regulations of the Board or a prior decision of the Board and any of the statutory provisions applicable to a Contested Case, the statute controls.

(c) Not all contested procedural issues may be susceptible to resolution by reference to the APA and other applicable statutes, the Rules and Regulations of the Board, and case law. When they are not, the presiding administrative law judge shall consider applicable policy of the Board documented in the record in accordance with the Rules of Procedure of SOAH, the Texas Rules of Civil Procedure (TRCP) as interpreted and construed by Texas case law, and persuasive authority established in other forums, in order to issue orders and rulings that are just in the circumstances of the Contested Case.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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CHAPTER 5. INTERIOR DESIGNERS
SUBCHAPTER E. FEES

22 TAC §5.91

The Texas Board of Architectural Examiners proposes an amendment to rule §5.91 for Title 22, Chapter 5, Subchapter E, concerning the establishment, payment, and timely payment of fees established by the Board. The amendment to this rule is intended to clarify the rule's requirements and ensure that they are consistent with governing law. It will require the Board to establish a fee schedule in a public meeting and publish it, designate methods of payment, and describe penalties for paying fees with dishonored checks. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 5, Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The amendment to this rule is proposed pursuant to Sections 5(d) and 6 of Article 249e, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and establish law.

The proposed amendment to this section does not affect any other statutes.

§5.91. General.

(a) All fees shall be established by the Board at a public meeting and shall be published in the Texas Register. [~~Certain statutory limits are fixed, within which this board may set certain fees so authorized. These, therefore, are subject to change without notice.~~]

(b) Payment of any fee established by the Board may be made only by check or money order made payable to the Texas Board of Architectural Examiners. [~~Payment shall be made by personal check, money order, or cashier's check made payable to the Texas Board of Architectural Examiners. Notations, explaining the payment remitted, should be on the face of the checks or within cover letters of submittal.~~]

(c) An official postmark from the U.S. Postal Service may be presented to the Board to demonstrate the timely payment of any fee. [~~The board shall accept a postmark date as evidence of intent to remit timely payment of a fee. Proprietary postage meter dates will not be accepted as evidence of intent to make timely payment if contradicted by postal service postmark dates.~~]

(d) If a check is submitted to the Board to pay a fee and the bank upon which the check is drawn refuses to pay the check, the fee shall be considered unpaid and any applicable late fees shall accrue. [~~Any payment submitted to the board and returned as a dishonored check will be charged an administrative penalty fee as prescribed by the board. The payment to replace a dishonored check must be paid with a money order or cashier's check. Any fees paid by dishonored checks are considered unpaid.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §§5.92 - 5.100

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 5, Subchapter E: §5.92 pertaining to the application without examination fee; §5.93 pertaining to the application, examination and initial registration fees; §5.94 pertaining to the reexamination fee; §5.95 pertaining to the annual registration and renewal fees; §5.96 pertaining to the reinstatement fee; §5.97 pertaining to the reciprocal transfer fee; §5.98 pertaining to the replacement certificate fee; §5.99 pertaining to the emeritus fee, and §5.100 pertaining to the inactive fee.

Simultaneously, the agency is proposing a new rule with section number §5.92 to replace the rules proposed for repeal. Due to the extensive modifications proposed in the new rules, amending the existing rules is less practical than repealing the existing rules and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 5 Subchapter E, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that they will have been replaced with updated rules and that no economic cost to persons who are required to comply with the section is anticipated.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that there will be a clearly stated, efficient procedure for establishing fees and the rules governing fees will be easier to understand.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Section 5(a) of Article 249(e), Vernon's Texas Civil Statutes, which provides the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§5.92. Application Without Examination Fees.

§5.93. Application, Examination and Initial Registration Fees.

§5.94. Reexamination Fees.

§5.95. Annual Registration and Renewal Fee.

§5.96. Reinstatement Fee.

§5.97. Reciprocal Transfer Fee.

§5.98. Replacement Certificate Fee.

§5.99. Emeritus Fee.

§5.100. Inactive Fee.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §5.92

The Texas Board of Architectural Examiners proposes new rule §5.92 for Title 22, Chapter 5, Subchapter E, concerning annual fees. This rule requires the Board to notify, by mail, each person who must pay an annual fee and requires the annual fee to be paid regardless of whether the notice is received. It requires each registrant to pay the annual renewal fee on or before the designated expiration date and additionally requires the payment of a penalty fee if the renewal payment is late. It states that if the payment for renewal is not made within one year after the designated expiration date, the registrant's certificate of registration may be revoked. It requires the Board to send to the registrant's current address of record a notice of pending revocation if the registrant fails to renew the registration within one year of the expiration date. Due to the proposal of extensive modifications to Subchapter E, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 5, Subchapter E, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that the rule's requirements will be easier to understand and will be consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Section 14 of Article 249e, Vernon's Texas Civil Statutes, which governs registration renewal for interior designers.

These proposed sections do not affect any other statutes.

§5.92. Annual Fees.

(a) The Board shall send an annual notice to each person who must pay a fee that is due annually. Each annual notice shall be sent to the intended recipient's current address of record. Every annual fee must be paid regardless of whether an annual notice is received.

(b) Every registrant must pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration. If a registrant fails to pay his/her annual renewal fee on or before the designated expiration date of the registrant's certificate of registration, the Board shall require that the registrant pay a penalty fee in addition to the registration renewal fee before the registration may be renewed. A registration certificate shall become invalid on its designated expiration date unless it is renewed.

(c) If a registrant fails to renew his/her certificate of registration within one year after its designated expiration date, the certificate of registration may be revoked by the Board without scheduling a formal hearing before the State Office of Administrative Hearings pursuant to the Administrative Procedure Act. The Board shall send a notice of pending revocation to a registrant who fails to renew his/her certificate of registration within one year after its designated expiration date. The notice shall be sent to the registrant's current address of record.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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SUBCHAPTER J. TABLE OF EQUIVALENTS FOR EDUCATION AND EXPERIENCE IN INTERIOR DESIGN

22 TAC §§5.201 - 5.203

The Texas Board of Architectural Examiners proposes new rules §5.201, §5.202, and §5.203 for Title 22, Chapter 5, Subchapter J, concerning the table of equivalents for education and experience in interior design. Section 5.201 describes the minimum experience required and describes the various approved educational programs. Section 5.202 describes the types of experience required and the maximum credit allowed for the various types of acceptable experience. Section 5.203 sets forth how other education and experience may be earned. The new rules are being proposed as a result of the agency's review of Title 22, Chapter 5, Subchapter J, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that the registration requirements will be clearly stated and readily accessible.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 5(d) and 9 of Article 249e, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and establish registration requirements.

These proposed sections do not affect any other statutes.

§5.201. Description of Approved Education for Registration by Examination.

(a) Pursuant to Section 5.31 of Subchapter B, an Applicant must successfully demonstrate that he/she has a combined total of at least six (6) years of approved interior design education and experience in accordance with the following table:
Figure: 22 TAC §5.201(a)

(b) An Applicant may not earn credit in more than one of categories ID-1 through ID-6.

(c) In order to earn credit in category ID-5 or ID-6, an Applicant must complete all requirements described in that category, including the experiential requirements, and apply for registration by examination on or before August 31, 2010.

§5.202. Description of Approved Experience for Registration by Examination.

(a) An Applicant must successfully demonstrate that he/she has gained the minimum experience required for registration by examination in accordance with the following table:
Figure: 22 TAC §5.202(a)

(b) An Applicant must earn at least one year of experience credit under the conditions described in category ID-7.

(c) In order to earn credit in category ID-7 or ID-8, an Applicant must:

(1) work at least thirty-five (35) hours per week for a minimum of ten (10) consecutive weeks; or

(2) for partial credit, work between twenty (20) and thirty-four (34) hours per week for a minimum of six (6) consecutive months.

(d) In order to earn credit in category ID-9, an Applicant must teach subjects that are directly related to the practice of interior design. An Applicant may earn one year of credit by teaching for twenty (20) semester credit hours or thirty (30) quarter credit hours.

(e) An Applicant may not earn credit for experience gained prior to the date the Applicant completed the educational requirements for interior design registration by examination in Texas.

§5.203. Other Education and Experience.

An Applicant may earn credit for education or experience other than under the conditions described in Sections 5.201 and 5.202 of this subchapter if the Board considers such education or experience to be substantially equivalent to the education and experience described therein. For purposes of this subsection, education may be considered as experience.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108033
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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SUBCHAPTER K. HEARINGS--CONTESTED CASES

22 TAC §5.241

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rule for Title 22, Chapter 5, Subchapter K: §5.241 pertaining to the case hearings conducted by the State Office of Administrative Hearings.

Simultaneously, the agency is proposing a new rule with section number 5.241 to replace the rule proposed for repeal. Due to the extensive modifications proposed in the new rule, amending the existing rule is less practical than repealing the existing rule and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 5, Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that they will have been replaced with updated rules. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering new rules which more clearly define the Board's procedures and are more consistent with governing law.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Section 5(a)of Article 249e, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§5.241. State Office of Administrative Hearings.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108034
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §5.241

The Texas Board of Architectural Examiners proposes new rule §5.241 for Title 22, Chapter 5, Subchapter K, concerning procedures for formal hearings. This rule states that the Administrative Procedure Act applies to all contested cases involving matters under the jurisdiction of the Board and states the Rules of Procedure of the State Office of Administrative Hearings apply to formal hearings of contested cases conducted for the Board. Due to the proposal of extensive modifications to Subchapter K, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 5, Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 5(d) and 5(b) of Article 249e, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

This proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§5.241. Formal Hearing Procedures.

(a) Unless specifically indicated, the Administrative Procedure Act (APA) applies to all Contested Cases involving matters under the jurisdiction of the Board.

(b) The Rules of Procedure of the State Office of Administrative Hearings (SOAH) apply to formal hearings of Contested Cases conducted for the Board by a SOAH administrative law judge.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108035
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §5.242

The Texas Board of Architectural Examiners proposes an amendment to rule §5.242 for Title 22, Chapter 5, Subchapter K, concerning the board's responsibilities as they pertain to hearings for contested cases. The amendment to this rule will generally describe the Board's procedures for addressing contested cases and ensure that the procedures are consistent with governing law. The amendment to the rule is being proposed as a result of the agency's review of Title 22, Chapter 5, Subchapter K, as mandated by Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The amendment to this rule is proposed pursuant to Sections 5(b) and 5(d) of Article 249e, Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

The proposed amendment and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§5.242. Board Responsibilities.

(a) The Board shall investigate Contested Case matters and attempt to resolve Contested Cases informally as provided in Subchapter I of the Rules and Regulations of the Board. However, if a Contested Case is not settled informally pursuant to Subchapter I, it shall be referred to SOAH for a formal hearing to determine whether there has been a violation of any of the statutory provisions or rules enforced by the Board.

(b) A formal hearing shall be conducted in accordance with the Rules of Procedure of SOAH.

(c) After a formal hearing of a Contested Case, the SOAH administrative law judge who conducted the formal hearing shall prepare a proposal for decision and submit it to the Board so that the Board may render a final decision with regard to the Contested Case. The proposal for decision shall include findings of fact and conclusions of law.

(d) The Board may change a finding of fact or conclusion of law made by an administrative law judge or may vacate or modify an order issued by an administrative law judge only if the Board determines:

(1) that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies, or prior administrative decisions;

(2) that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed; or

(3) that a technical error in a finding of fact should be changed.

(e) If the Board makes a change to a finding of fact or conclusion of law or vacates or modifies an order pursuant to Subsection 5.242(c), the Board must state in writing the specific reason and the legal basis for the change.

(f) The Board shall issue a written order regarding the Board's final decision with regard to a Contested Case that is not settled informally. The written order shall include findings of fact and conclusions of law that are based on the official record of the Contested Case.

(g) Motions for rehearing and appeals may be filed and judicial review of final decisions of the Board may be sought pursuant to the Administrative Procedure Act. [~~The Board will conduct sufficient investigation of complaint matters within its jurisdiction and attempt to resolve cases through authorized informal dispositions. However, when agreements are not reached or approved, the Board must refer contested cases to the State Office of Administrative Hearings for formal hearings. The Board shall not attempt to influence the findings of facts or the judge's application of the law in any contested case other than by proper evidence and legal argument. The Board may, however, change a finding of fact or conclusion of law made by the judge, or vacate or modify an order issued by the judge, only for reasons of policy and must state in writing the reason and legal basis for the change. If a member of the Board finds that he/she should not act on any charge before the Board, he/she may disqualify himself/herself from acting in the proceedings.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108037
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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22 TAC §§5.243 - 5.285

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Board of Architectural Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Board of Architectural Examiners proposes the repeal of the following rules for Title 22, Chapter 5 Subchapter K: §5.243 pertaining to jurisdiction and requests for hearings or for an administrative law judge; §5.244 pertaining to filing notices, pleadings, motions, answers, affidavits and all other filings in a contested case; §5.245 pertaining to stipulations and agreements as they concern procedural matters; §5.246 pertaining to the service of documents concerning notices of hearing, default orders, prehearing orders, proposal for decisions, and decisions and orders of the board; §5.247 pertaining to conduct and decorum during proceedings; §5.248 pertaining to the classifications of parties; §5.249 pertaining to appearances in person or by a representative and to waivers and defaults; §5.250 pertaining to classification of pleadings; §5.251 pertaining to form and content of pleadings; §5.252 pertaining to discovery rights; §5.253 pertaining to motions and amendments; §5.254 pertaining to prehearing conferences and orders; §5.255 pertaining to notice of hearing; §5.256 pertaining to certificates of registration; §5.257 pertaining to conduct of hearings; §5.258 pertaining to formal exceptions; §5.259 pertaining to motions for postponement, continuance, withdrawal, or dismissal of matters before the board; §5.260 pertaining to the place and nature of hearings; §5.261 pertaining to powers and authority of the administrative law judge; §5.262 pertaining to the order of proceedings; §5.263 pertaining to reporters and transcript; §5.264 pertaining to telephone hearings; §5.265 pertaining to dismissal or settlement without a hearings; §5.266 pertaining to rules of evidence; §5.267 pertaining to documentary evidence; §5.268 pertaining to official notice of facts; §5.269 pertaining to prepared or prefiled testimony; §5.270 pertaining to limitations on the number of witnesses; §5.271 pertaining to exhibits; §5.272 pertaining to offers of proof; §5.273 pertaining to depositions; §5.274 pertaining to subpoenas; §2.275 pertaining to proposals for decision; §5.276 pertaining to filing exceptions, briefs, and replies; §5.277 pertaining to the form and content of briefs, exceptions, and replies; §5.278 pertaining to oral arguments; §5.279 pertaining to final decisions and orders; §5.280 pertaining to administrative finality; §5.281 pertaining to motions for a rehearing; §5.282 pertaining to the rendering of a final decision or order; §5.283 pertaining to judicial review; §5.284 pertaining to what the record in a contested case shall include; and §5.285 pertaining to complaints.

Simultaneously, the agency is proposing a new rule with section number 5.243 to replace the rules proposed for repeal.

Due to the extensive modifications proposed in the new rule, amending the existing rules is less practical than repealing the existing rules and publishing a new rule. The modifications are being made as a result of the agency's review of Title 22, Chapter 5 Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, there are expected to be no fiscal implications for state or local government as a result of the repeal.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of the new rule are that they will have been replaced with updated rules. She also anticipates there will be no additional economic cost to persons who are required to comply with the section.

Ms. Hendricks has also determined that for each year of the first five years after the repeal, the public benefits anticipated as a result of the repeal will be that the Board will be administering new rules which more clearly define the Board's procedures and are more consistent with governing law.

The repeal is not expected to impact small business significantly.

No economic cost to persons affected by the repeal is expected as a result of the repeal.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The repeal is proposed pursuant to Section 5(a) of Article 249e Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and include implied authority to repeal rules that have been promulgated.

The proposed repeal does not affect any other statutes.

§5.243. Jurisdiction; Request for Hearings or Law Judge.
§5.244. Filings.
§5.245. Stipulations; Agreements.
§5.246. Service.
§5.247. Conduct and Decorum.
§5.248. Classification of Parties.
§5.249. Appearances in Person or by Representatives; Waivers; Defaults.
§5.250. Classification of Pleadings.
§5.251. Form and Content of Pleadings.
§5.252. Discovery.
§5.253. Motions; Amendments.
§5.254. Prehearing Conferences and Orders.
§5.255. Notice of Hearing.
§5.256. Certificates of Registration.
§5.257. Conduct of Hearings.
§5.258. Formal Exceptions.
§5.259. Motions for Postponement, Continuance, Withdrawal, or Dismissal of Matters Before the Board.
§5.260. Place and Nature of Hearings.
§5.261. Administrative Law Judge.
§5.262. Order of Proceedings.
§5.263. Reporters and Transcript.
§5.264. Telephone Hearings.
§5.265. Dismissal, Settlement Without Hearing.
§5.266. Rules of Evidence.
§5.267. Documentary Evidence.
§5.268. Official Notice.
§5.269. Prepared or Prefiled Testimony.
§5.270. Limitations on Number of Witnesses.
§5.271. Exhibits.

§5.272. Offer of Proof.

§5.273. Depositions.

§5.274. Subpoenas.

§5.275. Proposals for Decision.

§5.276. Filing of Exceptions, Briefs, and Replies.

§5.277. Form and Content of Briefs, Exceptions, and Replies.

§5.278. Oral Argument.

§5.279. Final Decisions and Orders.

§5.280. Administrative Finality.

§5.281. Motions for Rehearing.

§5.282. Rendering of Final Decision or Order.

§5.283. Judicial Review.

§5.284. The Record.

§5.285. Complaints.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108036
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
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For further information, please call: (512) 305-8535

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22 TAC §5.243

The Texas Board of Architectural Examiners proposes new rule §5.243 for Title 22, Chapter 5 Subchapter K, concerning the application and construction of procedures for hearings on contested cases. This rule states that the State Office of Administrative Hearings (SOAH) will conduct formal hearings in accordance with the Administrative Procedure Act and Chapter 155 of the Rules of Procedure of SOAH. It states that the statute will control any conflict between the Board's rules or a prior decision of the Board and any statutory provisions applicable to a contested case. It requires the presiding administrative law judge to consider applicable policy of the Board if an issue is not susceptible to resolution by reference to the APA and other applicable statutes. Due to the proposal of extensive modifications to Subchapter K, publishing an amendment to the existing rule is less practical than the alternative of repealing the existing rule and publishing a new rule. The new rule is being proposed as a result of the agency's review of Title 22, Chapter 5 Subchapter K, as mandated by the Legislature.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the section is in effect, no significant fiscal implications for state or local government are expected as a result of enforcing or administering the sections.

Cathy L. Hendricks, Executive Director, Texas Board of Architectural Examiners, has determined that for the first five-year period the sections are in effect the public benefits expected as a result of repealing the rules are that the agency's procedures will be clearly stated and consistent with governing law.

No significant impact on small business is expected. There is expected to be no significant change in the cost to persons required to comply with the section.

Comments may be submitted to Cathy L. Hendricks, ASID/IIDA, Executive Director, Texas Board of Architectural Examiners, P.O. Box 12337, Austin, TX 78711-2337.

The new rule is proposed pursuant to Sections 5(b) and 5(d) of Article 249e Vernon's Texas Civil Statutes, which provide the Texas Board of Architectural Examiners with authority to promulgate rules and take action to enforce them.

The proposed rule and the Administrative Procedure Act, Chapter 2001, Government Code, are interrelated.

§5.243. Application and Construction of Procedures.

(a) SOAH shall conduct formal hearings in accordance with the APA and with Chapter 155 of the Rules of Procedure of SOAH, provided that:

(1) an administrative law judge may, by order, modify the requirements of the Rules of Procedure of SOAH and supplement other procedural requirements of law to promote the fair and efficient handling of a Contested Case; and

(2) an administrative law judge may modify the procedural requirements of the Rules of Procedure of SOAH in appropriate cases to facilitate resolution of issues if doing so does not prejudice any of a party's rights or contravene applicable statutes.

(b) If there is any conflict between the Rules and Regulations of the Board or a prior decision of the Board and any of the statutory provisions applicable to a Contested Case, the statute controls.

(c) Not all contested procedural issues may be susceptible to resolution by reference to the APA and other applicable statutes, the Rules and Regulations of the Board, and case law. When they are not, the presiding administrative law judge shall consider applicable policy of the Board documented in the record in accordance with the Rules of Procedure of SOAH, the Texas Rules of Civil Procedure (TRCP) as interpreted and construed by Texas case law, and persuasive authority established in other forums, in order to issue orders and rulings that are just in the circumstances of the Contested Case.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108038
Cathy L. Hendricks, ASID/IIDA
Executive Director
Texas Board of Architectural Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8535

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PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 161. GENERAL PROVISIONS

The Texas State Board of Medical Examiners proposes the repeal §§161.1-161.5 and new §§161.1-161.13, concerning general provisions. The proposal will outline the purpose and function of the board, clarify its organization and structure, and delineate each committee's responsibilities. The chapter is simultaneously being reviewed elsewhere in this issue of the *Texas Register*.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be an outline of the purpose and function of the board, clarity in its organization and structure, and delineation of each committee's responsibilities. There will be no effect on small businesses. There will be no effect to individuals required to comply with the sections as proposed.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

22 TAC §§161.1 - 161.5

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas State Board of Medical Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeals are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §151.002-.004; 152.001-.010; 152.051-.054; 153.001; 153.005; 153.008; and 164.151-.154 are affected by the repeals.

§161.1. Meetings.

§161.2. Investments.

§161.3. Officers.

§161.4. Rule Changes.

§161.5. Compliance with Non-Discrimination Laws

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108000
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

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22 TAC §§161.1 - 161.13

The new sections are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §151.002-.004; 152.001-.010; 152.051-.054; 153.001; 153.005; 153.008; and 164.151-.154 are affected by the repeals.

§161.1. Introduction.

(a) The Texas State Board of Medical Examiners, referred to as the board, is an agency of the executive branch of state government statutorily empowered to regulate the practice of medicine in Texas.

(b) The board may adopt rules as necessary to govern its own proceedings, perform its duties, regulate the practice of medicine in Texas, and enforce applicable law.

(c) The board may act under its statute and rules through the Executive Director, Executive Committee, or another committee of the board.

§161.2. Purpose and Functions.

(a) The purpose of the board is to protect the public's safety and welfare through the regulation of the practice of medicine. The board fulfills its purpose primarily through the licensure and discipline of physicians and other allied health care providers as mandated by law.

(b) The board's functions include but are not limited to the following:

(1) Establish standards for the practice of medicine by physicians.

(2) Regulate the practice of medicine through the licensure and discipline of physicians.

(3) Provide oversight of the Texas State Board of Physician Assistant Examiners and the Texas State Board of Acupuncture Examiners as specified by law.

(4) Interpret the Medical Practice Act and applicable sections of the Physician Assistant Licensing Act, the Acupuncture Act, the Surgical Assistant Act and the Board Rules to physicians, physician assistants, acupuncturists, surgical assistants, and the public to ensure informed professionals, allied health professionals, and consumers.

(5) Receive complaints and investigate possible violations of the Medical Practice Act and the Board Rules.

(6) Discipline violators through appropriate legal action to enforce the Medical Practice Act and the Board Rules.

(7) Provide a mechanism for public comment with regard to the Board Rules and the Medical Practice Act and the Surgical Assistant Act.

(8) Review and modify the Board Rules when necessary and appropriate.

(9) Examine and license qualified applicants to practice medicine, acupuncture, and surgical assisting in Texas in a manner that ensures that applicable standards are maintained.

(10) Provide recommendations to the legislature concerning appropriate changes to the Medical Practice Act and Surgical Assistant Act to ensure that the acts are current and applicable to changing needs and practices.

(11) Provide informal public information on licensees.

(12) Maintain data concerning the practice of medicine.

§161.3. Organization and Structure.

(a) The board shall consist of 18 members appointed by the Governor with the advice and consent of the Senate.

(b) The board shall consist of the following composition: nine physicians with a degree of doctor of medicine (M.D.) and licensed to practice medicine in Texas for at least three years; three physicians with a degree of doctor of osteopathic medicine (D.O.) and licensed to practice medicine in Texas for three years; and six members who represent the public.

(c) The terms of board members shall be six years in length and shall be staggered so that the terms of not more than one-third of the members shall expire in a single calendar year. Upon completion of a term, a member shall continue to serve until a successor has been appointed. A member may be reappointed to successive terms as permitted by law at the discretion of the Governor.

(d) Each board member shall meet and maintain the qualifications for board membership as set by law.

(e) One ground for removal from the board occurs if a board member is absent from more than half of the regularly scheduled board meetings that the member is eligible to attend during a calendar year. If the executive director of the board has knowledge that a potential ground for removal exists due to a member's failure to attend an adequate number of regularly scheduled board meetings, the executive director shall notify the president of the board of the ground. The president of the board shall then notify the governor's office that a potential ground for removal exists. A board member shall be considered to have been absent from a regularly scheduled board meeting if the member fails to attend at least a portion of either a full board session or a portion of a regularly scheduled committee meeting to which a member is assigned during such board meeting. Any dispute or controversy as to whether or not an absence has occurred shall be submitted to the full board for resolution by a majority vote after giving the purported absentee the opportunity to present information concerning the alleged absences and after allowing discussion by other members of the board.

(f) Each member of the board shall receive per diem as provided by law for each day that the member engages in the business of the board and will be reimbursed for travel expenses incurred in accordance with the state of Texas and board's travel policies.

§161.4. Officers of the Board.

(a) The Governor shall designate a member of the board to serve as the president of the board.

(b) The board shall elect officers from among its members to serve as the vice president and the secretary-treasurer for a term not to extend longer than two years. The election of officers shall be held at least every other year at a regular meeting of the board.

(c) All elections and any other issues requiring a vote of the board shall be decided by a simple majority of the members present and voting.

(d) If more than two candidates are nominated for an office, and no candidate receives a majority on the first ballot, a second ballot will be conducted between the two candidates receiving the highest number of votes.

(e) Duties of the officers.

(1) The duties of the president shall include the following:

(A) approve the agenda for each board meeting;

(B) preside at all meetings of the board;

(C) represent the board in legislative matters and in meetings with related groups;

(D) appoint the members to serve on the standing, ad hoc, and advisory committees of the board;

(E) appoint the chair of each board committee;

(F) perform or designate a member or members of the board to coordinate the annual performance review of the executive director.

(G) perform such other duties as pertain to the office of the president and

(2) The duties of the vice president shall include the following:

(A) function as president in the absence or incapacity of the president;

(B) serve as president if the office of president becomes vacant until another member is named by the Governor; and

(C) perform such other duties that are from time to time assigned by the board.

(3) The duties of the secretary-treasurer shall include the following:

(A) function as president in the absence or incapacity of both the president and vice president;

(B) serve as president if both the offices of president and vice president becomes vacant until another member is elected by the board or named by the Governor; and

(C) perform such other duties as set out by law or such other duties that are from time to time assigned by the board.

(f) In the event of the absence or incapacity of the president, vice president, and secretary-treasurer, the board may elect another person to act as presiding officer of a board meeting or may elect an interim acting president for the duration of the absence or incapacity of the officers.

(g) After the death, resignation, or permanent incapacity of any elected officer, the board shall hold an election to fill the vacant officer position. If any elected officer is elected to another position at these elections, that officer's vacant position shall be filled by election to be held following the creation of the new vacancy.

§161.5. Meetings.

(a) The board shall meet at least four times a year. It shall consider such matters as may be necessary.

(b) Special meetings shall be called by the president or by resolution of the board or upon written request signed by five members of the board.

(c) An agenda for each board meeting and committee meeting shall be posted in accordance with law and copies shall be sent to the board members.

(d) Board and committee meetings shall be conducted pursuant to the provisions of Robert's Rules of Order Newly Revised unless the board by rule adopts a different procedure.

(e) A quorum for transaction of business by the board shall be one more than half the board's membership at the time of the meeting.

(f) The board may act only by majority vote of its members present and voting, with each member entitled to one vote. No proxy vote shall be allowed.

(g) Meetings of the board and of the committees are open to the public unless such meetings are conducted in executive session pursuant to state law.

(h) In order that board and committee meetings may be conducted safely, efficiently, and with decorum, attendees may not engage in disruptive activity that interferes with board proceedings.

(i) Members of the public shall remain within those areas of the board offices and board meeting room designated as open to the public.

(j) Members of the public shall not address or question board members during meetings unless recognized by the board's presiding officer pursuant to a published agenda item.

(k) Journalists have the same right of access to board meetings conducted in open session as other members of the public and are subject to the same requirements.

(l) The board's presiding officer may exclude from a meeting any person who, after being duly warned, persists in disruptive activity that interferes with board proceedings.

(m) Any person may record all or any part of the proceedings of a public board meeting in attendance by means of a tape recorder, video camera, or any other means of sonic or visual reproduction.

(1) The executive director shall direct any individual wishing to record or videotape as to equipment location, placement, and the manner in which the recording is conducted.

(2) The decision will be made so as not to disrupt the normal order and business of the board.

(n) Executive Session.

(1) The board may meet in executive session pursuant to law.

(2) An executive session of the board shall not be held unless a quorum of the board has first been convened in open meeting. If during such open meeting, a motion is passed by the board to hold an executive session, the presiding officer shall publicly announce that an executive session will be held.

(3) The presiding officer of the board shall announce the date and time at the beginning and end of the executive session.

(4) A certified agenda of the executive session shall be prepared.

§161.6. Committees of the Board.

(a) Each board committee shall be composed of board members appointed by the president of the board and shall include at least one physician member who holds the degree of doctor of osteopathic medicine and one public member.

(b) The following are standing and permanent committees of the board. The responsibilities and authority of these committees shall include the following duties and powers, and other responsibilities and charges that the board may from time to time delegate to these committees.

(1) Disciplinary Process Review Committee:

(A) oversee the disciplinary process and give guidance to the board and board staff regarding means to improve the disciplinary process and more effectively enforce the Medical Practice Act;

(B) monitor the effectiveness, appropriateness and timeliness of the disciplinary process and enforcement of the Medical Practice Act;

(C) make recommendations regarding resolution and disposition of specific cases and approve, adopt, modify, or reject recommendations from board staff or board representatives regarding actions to be taken on pending cases.

(D) approve dismissals of complaints and closure of investigations; and

(E) make recommendations to the board staff and the board regarding policies, priorities, budget, and any other matters related to the disciplinary process and enforcement of the Medical Practice Act.

(2) Executive Committee:

(A) ensure records are maintained of all committee actions;

(C) delegate tasks to other committees;

(D) take action on matters of urgency that may arise between board meetings;

(E) assist in the presentation of information concerning the board and the regulation of the practice of medicine to the Legislative and other state officials;

(F) review staff reports regarding finances and the budget;

(G) formulate and make recommendations to the board concerning future board goals and objectives and the establishment of priorities and methods for their accomplishment;

(H) study and make recommendations to the board regarding the role and responsibility of the board offices and committees;

(I) study and make recommendations to the board regarding ways to improve the efficiency and effectiveness of the administration of the board;

(J) study and make recommendations to the board regarding board rules or any area of a board function that, in the judgment of the committee, needs consideration;

(K) make recommendations to the board regarding matters brought to the attention of the executive committee.

(3) Finance Committee:

(A) review staff reports regarding finances and the budget;

(B) assist in the presentation of budget needs to the Legislature and other state officials;

(C) recommend proper fees for the agency to charge;

(D) consider and make recommendations to the board regarding any aspect of board finances.

(4) Legislative Committee:

(A) review and make recommendations to the board regarding proposed legislative changes concerning the Medical Practice Act and the regulation of medicine;

(B) establish communication with members of the Legislature; trade associations, consumer groups, and related groups;

(C) assist in the organization, preparation, and delivery of information and testimony to members of the Legislature committees of the Legislature; and

(D) make recommendations to the board regarding matters brought to the attention of the legislative committee.

(5) Licensure Committee:

(A) review applications for licensure and permits, make a determination of eligibility and report to the board its recommendations as provided by the Medical Practice Act;

(B) review board rules regarding licensure and make recommendations to the board regarding changes or implementation of such rules;

(C) evaluate each examination accepted by the board and develop each examination administered by the board;

(D) investigate and report to the board any problems in the administration of examinations and recommend and implement ways of correcting identified problems;

(E) make recommendations to the board regarding postgraduate training permits and issues concerning physicians in training;

(F) maintain communication with Texas medical schools;

(G) develop rules with regard to international medical schools in the areas of curriculum, faculty, facilities, academic resources, and performance of graduates;

(H) study and make recommendations regarding documentation and verification of records from all applicants for licensure or permits;

(I) review applications for acudetox specialist certification, make a determination of eligibility, and report to the board its recommendations as provided by the Medical Practice Act; and

(J) make recommendations to the board regarding matters brought to the attention of the licensure committee.

(6) Non-Profit Health Organizations Committee:

(A) review applications for approval and certification of non-profit health organizations pursuant to the Medical Practice Act;

(B) review applications and reports for continued approval and certification of non-profit health organizations pursuant to the Medical Practice Act;

(C) make initial determinations and recommendations to the board regarding approval, denial, revocation, decertification, or continued approval and certification of non-profit health organizations pursuant to the Medical Practice Act;

(D) review board rules regarding non-profit health organizations, and make recommendations to the board regarding changes or implementation of such rules; and

(E) make recommendations to the board regarding matters brought to the attention of the non-profit health organizations committee.

(7) Public Information/Physician Profile Committee:

(A) develop information for distribution to the public;

(B) review and make recommendations to the board in regard to press releases, newsletters, web-sites and other publications;

(C) study and make recommendations to the board regarding all aspects of public information or public relations;

(D) receive information from the public concerning the regulation of medicine pursuant to a published agenda item and board rules.

(E) study and make recommendation to the board regarding all aspects of physician profiles; and

(F) make recommendations to the board regarding matters brought to the attention of the public information/physician profile committee.

(8) Standing Orders Committee:

(A) review and make recommendations to the board regarding board rules pertaining to standing orders;

(B) study and make recommendations to the board regarding issues concerning or referred by the Board of Acupuncture Examiners or other acupuncture issues;

(C) study and make recommendations to the board regarding issues concerning or referred by the Board of Physician Assistant Examiners;

(D) study and make recommendations to the board concerning ethical issues related to the practice of medicine; and

(E) make recommendations to the board regarding matters brought to the attention of the standing orders committee.

(9) Telemedicine Committee:

(A) review, study and make recommendations to the board concerning the practice of telemedicine, including but not limited to licensure, regulation, and/or discipline of telemedicine license holders or applicants;

(B) review, study and make recommendations to the board concerning interstate and intrastate telemedicine issues;

(C) review, study and make recommendations to the board concerning board rules regarding or affecting the practice of telemedicine; and

(D) review, study and make recommendations to the board concerning any other issue brought to the attention of the committee.

(c) With statutory or board authorization, the president may appoint, disband, or reconvene standing, ad hoc, or advisory committees as deemed necessary. Such committees shall have and exercise such authority as may be granted by the board.

§161.7. Executive Director.

(a) The board shall determine the qualifications for and employ an executive director who shall be the chief executive officer of the agency.

(b) The duties of the executive director shall be to administer and enforce the applicable law, to assist in conducting meetings of the board, and to carry out other responsibilities as assigned by the board.

(c) The executive director shall have the authority and responsibility for the operations and administration of the agency and such additional powers and duties as prescribed by the board. As chief executive of the agency, the executive director shall be responsible for the management of all aspects of administration of the agency to include personnel, financial and other resources in support of the applicable law, rules, policies, mission and strategic plan of the agency.

(d) The executive director may exercise any responsibilities or authority of the secretary-treasurer of the board unless the board assigns duties or prerogatives exclusively to the secretary-treasurer.

(e) The executive director shall serve as the medical director of the agency if the executive director is a physician licensed to practice in Texas.

§161.8. Deputy Executive Director.

(a) The executive director may determine qualifications for and employ a deputy executive director who shall be responsible for the administrative operations of the agency and the performance of other duties as assigned by the executive director.

(b) Unless the board assigns duties or prerogatives exclusively to the executive director, the deputy executive director may exercise any responsibilities or authority of the executive director except for medical director duties.

(c) The deputy executive director acts under the supervision and at the direction of the executive director.

§161.9. Medical Director.

(a) If the executive director is not a physician licensed to practice in Texas, the executive director shall appoint a medical director who is a physician licensed to practice in Texas.

(b) The medical director shall be responsible for the implementation and maintenance of policies, systems, and measures regarding clinical and professional issues and determinations.

(c) The medical director acts under the supervision and at the direction of the executive director.

(d) In the event of the incapacity, resignation or death of the medical director, members of the board may assume duties of the medical director on an interim basis.

§161.10. General Counsel.

(a) The executive director may employ a general counsel to provide legal advice to the staff of the agency and to the members of the board.

(b) The general counsel shall be licensed by the State Bar of Texas and may not be a lobbyist registered with the Office of the Secretary of State of Texas.

(c) The general counsel acts under the supervision and at the direction of the executive director.

§161.11. Rule Changes.

(a) All rules shall be adopted, repealed, or amended in accordance with the Administrative Procedure Act.

(b) Each adopted rule shall become effective 20 days after it is filed with in the Office of the Secretary of State except as otherwise set out in the Administrative Procedure Act.

§161.12. Compliance with Non-Discrimination Laws.

The board shall ensure non-discrimination in all policies, procedures, and practices as required under state and federal laws relating to race, color, disability, religion, sex, national origin, or age.

§161.13. General Considerations.

(a) A member of the news media may conduct an interview in the reception area of the board's offices or, at the discretion of the board's presiding officer, in the meeting room after recess or adjournment. No interview may be conducted in the hallways of the board's offices.

(b) Access by public visitors to the board's offices is limited to restricted area.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108001
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

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CHAPTER 163. LICENSURE

22 TAC §§163.1 - 163.5, 163.9, 163.10

The Texas State Board of Medical Examiners proposes amendments to §§163.1-163.5, 163.9, and 163.10, regarding the performance and delivery of medical education, examinations, education and documentation requirements, relicensure requirements, and the use of the Federation of State Medical Board's Credentials Verification Service (FCVS).

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be fiscal implications. For those individuals choosing to use the credentialing service, the current cost is approximately $200. This would not be revenue for the state as the fee would be paid directly to the FCVS.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be updated regulations regarding the performance and delivery of medical education, examinations, education and documentation requirements, relicensure requirements, and the use of the Federation of State Medical Board's Credentials Verification Service (FCVS). There will be no effect on small businesses.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §§155.001-.008; 155.051-.058; 155.101-.106; 155.151-.152 is affected by the proposed amendments.

§163.1. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context [~~contents~~] clearly indicate otherwise.

(1) Acceptable approved medical school--A medical school or college located in the United States or Canada that is[~~was~~] approved by the Board [~~at the time the degree was conferred~~].

(2) Acceptable unapproved medical school--A school or college located outside the United States or Canada that is [~~was~~] not approved by the board but is substantially equivalent to a Texas medical school [~~at the time the degree was conferred but whose curriculum~~

~~meets the requirements for an Unapproved medical school as determined by a committee of experts selected by the Texas Higher Education Coordinating Board~~].

(3) Affiliated hospital--Affiliation status of a hospital with a medical school as defined by the Liaison Committee on Medical Education and documented by the medical school in its application for accreditation.

(4) Applicant--One who files an application as defined in this section.

(5) Application--An application is all documents and information necessary to complete an applicant's request for licensure including the following:

(A) forms furnished by the board, completed by the applicant:

(i) all forms and addenda requiring a written response must be printed in ink;

(ii) photographs must meet United States Government passport standards;

(B) a fingerprint card, [~~furnished by the board~~], completed by the applicant, that must be readable by the Texas Department of Public Safety;

(C) all documents required under section 163.5 of this title (relating to Licensure Documentation); and

(D) the required fee, payable by check through a United States bank.

(6) Eligible for licensure in country of graduation--An applicant must be eligible for licensure in the country in which the medical school is located except for any citizenship requirements.

(7) Examinations accepted by the board for licensure.

(A) United States Medical Licensing Examination (USMLE), with a score of 75 or better on each step, all steps must be passed within seven years;

(B) Federation Licensing Examination (FLEX), after July 1985, passage of both components within seven years with a score of 75 or better on each component;

(C) Federation Licensing Examination (FLEX), prior to June 1985, with a FLEX weighted average of 75 or better in one sitting;

(D) National Board of Medical Examiners Examination (NBME) or its successor all steps must be passed within seven years;

(E) National Board of Osteopathic Medical Examiners Examination (NBOME) or its successor all steps must be passed within seven years;

(F) Medical Council of Canada Examination (LMCC) or its successor, all steps must be passed within seven years;

(G) State board examination, before January 1, 1977, (with the exception of Florida, Virgin Islands, Guam, Tennessee Osteopathic Board or Puerto Rico after June 30, 1963); or

(H) One of the following examination combinations with a score of 75 or better on each part, level, component, or step, all parts, levels, components, or steps must be passed within seven years:

(i) FLEX I plus USMLE 3;

(ii) USMLE 1 and USMLE 2, plus FLEX II;

(iii) NBME I or USMLE 1, plus NBME II or USMLE 2, plus NBME III or USMLE 3;

(iv) NBME I or USMLE 1, plus NBME II or USMLE 2, plus FLEX II;

(v) NBOME I, plus NBOME II, plus FLEX II;

(vi) the NBOME Part I or COMLEX Level I and NBOME Part II or COMLEX Level II and NBOME Part III or COMLEX Level III.

(I) An applicant must pass each part of an examination within three attempts, except that an applicant who has passed all but one part of an examination within three attempts may take the remaining part of the examination one additional time.

(J) Notwithstanding subparagraph (I) of this paragraph, an applicant is considered to have satisfied the requirements of this section if the applicant:

(i) passed all but one part of an examination approved by the board within three attempts and passed the remaining part of the examination within five attempts;

(ii) is specialty board certified by a specialty board that:

(I) is a member of the American Board of Medical Specialties; or

(II) is approved by the American Osteopathic Association; and

(iii) completed in this state an additional two years of postgraduate medical training approved by the board.

(K) An applicant who has not passed an examination for licensure in a ten-year period prior to the filing date of the application must:

(i) pass a specialty certification examination or formal evaluation, recertification examination or formal evaluation, or an examination of continued demonstration of qualifications by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists within the preceding ten years;

(ii) obtain through extraordinary circumstances, unique training equal to the training required for specialty certification as determined by a committee of the board and approved by the board, including but not limited to participation for at least six months in a training program approved by the board within twelve months prior to the application for licensure; or

(iii) pass the Special Purpose Examination (SPEX) within the preceding ten years.

(8) Examinations administered by the board for licensure--To be eligible for licensure an Applicant must sit for the Texas medical jurisprudence examination administered by the board and pass. A passing score is 75 or better on the Texas medical jurisprudence examinations. The board shall administer the Texas medical jurisprudence examination in writing at times and places as designated by the board.

~~[(9) Full force--Applicants for licensure who possess a license in another jurisdiction must have it in full force and not restricted for cause, canceled for cause, suspended for cause or revoked. A physician with a license in full force may include a physician who does not have a current, active, valid annual permit in another jurisdiction because:]~~

[(A) that jurisdiction requires the physician to practice in the jurisdiction before the annual permit is current; or]

[(B) that jurisdiction requires the physician, prior to practicing in that jurisdiction, to hold a current professional liability insurance policy before the annual permit is current.]

(9) [(10)] Good professional character--An Applicant for licensure must not be in violation of or committed any act described in the Medical Practice Act, §§164.051 - .053 [§164.051].

(10) [(11)] One-year training program--Applicants who are graduates of acceptable approved medical schools must successfully complete one year of postgraduate training approved by the board that is:

(A) accepted for certification by an American Specialty board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists; or

(B) accredited by one of the following:

(i) the Accreditation Council for Graduate Medical Education, or its predecessor;

(ii) the American Osteopathic Association;

(iii) the Committee on Accreditation of Preregistration Physician Training Programs, Federation of Provincial Medical Licensing Authorities of Canada;

(iv) the Royal College of Physicians and Surgeons of Canada; or

(v) the College of Family Physicians of Canada; or

(C) a postresidency program, usually called fellowship, for additional training in a medical specialty or subspecialty in a program approved by the Texas State Board of Medical Examiners.

(11) [(12)] Sixty (60) semester hours of college courses--60 semester hours of college courses other than in medical school that are acceptable to The University of Texas at Austin for credit on a bachelor of arts degree or a bachelor of science degree; the entire primary, secondary, and premedical education required in the country of medical school graduation, if the medical school is located outside the United States or Canada; or substantially equivalent courses as determined by the board. [Requisite qualifications--An Applicant who is a graduate of an unapproved acceptable medical school who:]

[(A) has for the preceding five years been a licensee of another state or a Canadian province;]

[(B) is not the subject of a sanction imposed by or disciplinary matter pending in any state or Canadian province in which the Applicant is licensed to practice medicine; and]

[(C) is either specialty board certified by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists or successfully passes the Special Purpose Examination (SPEX).]

(12) [(13)] Substantially equivalent to a Texas medical school--A medical school or college located outside the United States or Canada must be an institution of higher learning designed to select and educate medical students; provide students with the opportunity to acquire a sound basic medical education through training in basic sciences and clinical sciences; to provide advancement of knowledge through research; to develop programs of graduate medical education to produce practitioners, teachers, and researchers; and to afford opportunity for postgraduate and continuing medical education. The school must provide resources, including faculty and facilities, sufficient to support a curriculum offered in an intellectual environment that enables the program to meet these standards. The faculty of the school shall actively contribute to the development and transmission of new knowledge. The medical school shall contribute to the advancement of knowledge and to the intellectual growth of its students and faculty through scholarly activity, including research. The medical school shall include, but not be limited to, the following characteristics:

(A) The facilities for basic sciences and clinical training (i.e., laboratories, hospitals, library, etc.) shall be adequate to ensure opportunity for proper education.

(B) The admissions standards shall be substantially equivalent to a Texas medical school.

(C) The basic sciences curriculum shall include the contemporary content of those expanded disciplines that have been traditionally titled anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine, as defined by the Texas Higher Education Coordinating Board.

(D) The fundamental clinical subjects, which shall be offered in the form of required patient-related clerkships, are internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery, as defined by the Texas Higher Education Coordinating Board.

(E) The curriculum shall be of at least 130 weeks in duration.

(F) The school shall provide advancement of knowledge through research.

(G) The school shall develop programs of graduate medical education to produce practitioners, teachers, and researchers.

(H) The school shall provide opportunity for postgraduate and continuing medical education.

(I) Medical education courses must have been centrally organized, integrated and controlled into a continuous program which was conducted, monitored and approved by the medical school which issues the degree.

(J) [(F)] All medical or osteopathic medical education received by the applicant in the United States must be accredited by an accrediting body officially recognized by the United States Department of Education as the accrediting body for medical education leading to the doctor of medicine degree or the doctor of osteopathy degree in the United States. This subsection does not apply to postgraduate medical education or training.

(K) [(G)] An applicant who is unable to comply with the requirements of subparagraph (J)[(F)] of this paragraph is eligible for an unrestricted license if the applicant:

(i) received such medical education in a hospital or teaching institution sponsoring or participating in a program of graduate medical education accredited by the Accrediting Council for Graduate Medical Education, the American Osteopathic Association, or the Texas State Board of Medical Examiners in the same subject as the medical or osteopathic medical education if the hospital or teaching institution has an agreement with the applicant's school; or

(ii) is specialty board certified by a board approved by the Bureau of Osteopathic Specialists or the American Board of Medical Specialties.

(13) [(14)] Three-year training program--Applicants who are graduates of unapproved medical schools must successfully

complete three years of postgraduate training in the United States or Canada:

(A) accredited by one of the following:

(i) the Accreditation Council for Graduate Medical Education;

(ii) the American Osteopathic Association;

(iii) the Committee on Accreditation of Preregistration Physician Training Programs, Federation of Provincial Medical Licensing Authorities of Canada;

(iv) the Royal College of Physicians and Surgeons of Canada;

(v) the College of Family Physicians of Canada; and

(vi) all programs approved by the board after August 25, 1984; or

(B) a board-approved program for which a Faculty Temporary Permit was issued; or

(C) a postresidency program, usually called fellowship, for additional training in a medical specialty or subspecialty in a program approved by the Texas State Board of Medical Examiners.

[~~(15) Unapproved medical school--A school or college located outside the United States or Canada that was not approved by the board at the time the degree was conferred.~~]

§163.2. Licensure for United States/Canadian Medical School Graduates.
An applicant, to be eligible for licensure must:

(1) be 21 years of age;

(2) be of good professional character;

(3) have completed 60 semester hours of college courses other than in medical school [~~, which courses would be acceptable, at the time of completion, to The University of Texas at Austin for credit on a bachelor of arts degree or a bachelor of science degree~~];

(4) be a graduate of an acceptable approved medical school;

(5) have successfully completed a one-year training program of graduate medical training approved by the board;

(6) submit evidence of passing, an examination, acceptable by the board for licensure; and,

(7) pass the Texas Medical Jurisprudence Examination with a score of 75 or better.

§163.3. Licensure for Graduates of Unapproved Medical Schools.
An applicant, to be eligible for licensure must:

(1) be 21 years of age;

(2) be of good professional character;

(3) have completed 60 semester hours of college courses other than in medical school[~~, which courses would be acceptable, at the time of completion, to The University of Texas at Austin for credit on a bachelor of arts degree or a bachelor of science degree~~];

[~~(4) be a graduate of a school whose curriculum meets the requirements for an Acceptable Unapproved medical school as determined by a committee of experts selected by the Texas Higher Education Coordinating Board;~~]

(4) [~~(5)~~] be a graduate of an acceptable unapproved medical school that is substantially equivalent to a Texas medical school;

(5) [~~(6)~~] have successfully completed a three-year training program of graduate medical training in the United States or Canada that was approved by the board on the date the training was completed;

(6) [~~(7)~~] submit evidence of passing, an examination, acceptable by the board for licensure;

(7) [~~(8)~~] pass the Texas Medical Jurisprudence Examination with a score of 75 or better;

(8) [~~(9)~~] be eligible for licensure in country of graduation;

(9) [~~(10)~~] possess a valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG);

(10) [~~(11)~~] have the ability to communicate in the English language; and

(11) [~~(12)~~] have supplied all additional information that the board may require concerning the Applicant's medical school.

§163.4. Procedural Rules for Licensure Applicants.

(a) Applicants for licensure:

(1) If appropriate, applicants are recommended to use the Federation Credentials Verification Service (FCVS) offered by the Federation of State Medical Boards of the United States (FSMB) to verify medical education, postgraduate training, licensure examination history, board action history and identity. [~~whose documentation indicates any name other than the name under which the Applicant has applied must furnish proof of the name change;~~]

(2) whose application for licensure which has been filed with the board office and which is in excess of one years old from the date of receipt, shall be considered inactive. Any fee previously submitted with that application shall be forfeited. Any further application procedure for licensure will require submission of a new application and inclusion of the current licensure fee;

(3) will be allowed to sit for the Texas medical jurisprudence examination only three times. After the third failure of the Texas medical jurisprudence examination, and after each subsequent failure, an applicant for licensure shall be required to appear before a committee of the board to address the applicant's inability to pass the Texas medical jurisprudence examination and to re-evaluate the applicant's eligibility for licensure;

(4) who in any way falsify the application may be required to appear before the board. It will be at the discretion of the board whether or not the applicant will be issued a Texas license;

(5) on whom adverse information is received by the board may be required to appear before the board. It will be at the discretion of the board whether or not the applicant will be issued a Texas license;

(6) shall be required to comply with the board's rules and regulations which are in effect at the time the completed application form and fee are filed with the board;

(7) who have not passed an examination for licensure in a ten-year period prior to the filing date of the application must:

(A) pass a specialty certification examination or formal evaluation, recertification examination or formal evaluation, or an examination of continued demonstration of qualifications by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists within the preceding ten years;

(B) obtain through extraordinary circumstances, unique training equal to the training required for specialty certification as determined by a committee of the board and approved by the board, including but not limited to participation for at least six months in a training program approved by the board within twelve months prior to the application for licensure; or

(C) pass SPEX within the preceding ten years.

(8) may be required to sit for additional oral, written, mental or physical examinations that, in the opinion of the board, are necessary to determine competency and ability of the applicant.

[(7) may be required to sit for additional oral or written examinations that, in the opinion of the board, are necessary to determine competency of the applicant;]

(9) [(8)] must have the application for licensure complete in every detail 20 days prior to the board meeting in which they are considered for licensure. Applicants with complete applications may qualify for a Temporary License prior to being considered by the board for licensure, as required by section §163.7 of this title (relating to Temporary Licensure - Regular);

(10) [(9)] must pass, within seven years all parts of all examinations required for licensure. The board may consider for licensure graduates of simultaneous MD-PhD or DO-PhD programs who have passed all parts of their required examinations no later than two years after their MD or DO degree was awarded.

(b) Applicants for licensure who wish to request reasonable accommodations for the Texas jurisprudence examination, due to a disability, must submit the request upon filing the Application.

(c) Applicants for a license must subscribe to an oath in writing before an officer authorized by law to administer oaths. The written oath is part of the application.

(d) An applicant is not eligible for a license if:

(1) the applicant holds a medical license that is currently restricted for cause, canceled for cause, suspended for cause, or revoked by a state of the United States, a province of Canada, or a uniformed service of the United States;

(2) an investigation or a proceeding is instituted against the applicant for the restriction, cancellation, suspension, or revocation of the applicant's medical license in a state of the United States, a province of Canada, or a uniformed service of the United States; or

(3) a prosecution is pending against the applicant in any state, federal, or Canadian court for any offense that under the laws of this state is a felony or a misdemeanor that involves moral turpitude.

[(c) Applicants for licensure]

[(1) are required to complete an oath swearing that:]

[(A) the license certificate under which the applicant has most recently practiced medicine in the state or Canadian province from which the applicant is transferring to this state or in the uniformed service in which the applicant served is in full force and not restricted, canceled, suspended or revoked;]

[(B) the applicant is the identical person to whom the certificate or diploma was issued;]

[(C) no proceedings have been instituted against the applicant for the restriction, cancellation, suspension, or revocation of the certificate, license, or authority to practice medicine in the state, Canadian province, or uniformed service of the United States in which it was issued; and]

[(D) no prosecution is pending against the applicant in any state, federal, or Canadian court for any offense that under the laws of this state is a felony.]

[(2) who have not been examined for licensure in a ten-year period prior to the filing date of the application must:]

[(A) pass a specialty certification examination or formal evaluation, recertification examination or formal evaluation, or an examination of continued demonstration of qualifications by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists within the preceding ten years;]

[(B) obtain through extraordinary circumstances, unique training equal to the training required for specialty certification as determined by a committee of the board and approved by the board; or]

[(C) pass SPEX within the preceding ten years.]

§163.5. Licensure Documentation.

(a) An applicant must appear for a personal interview at the board offices and present original documents to a representative of the board for inspection. Original documents may include, but are not limited to, those listed in subsections (b)-(e) of this section.

(b) Documentation required of all applicants for licensure.

(1) Birth Certificate/Proof of Age. Each applicant for licensure must provide a copy of a birth certificate and translation if necessary to prove that the applicant is a least 21 years of age. In instances where a birth certificate is not available the applicant must provide copies of a passport or other suitable alternate documentation.

(2) Name Change. Any applicant who submits documentation showing a name other than the name under which the applicant has applied must present copies of marriage licenses, divorce decrees, or court orders stating the name change. In cases where the applicant's name has been changed by naturalization the applicant should send the original naturalization certificate by certified mail to the board office for inspection.

(3) Examination Scores. Each applicant for licensure must have a certified transcript of grades submitted directly from the appropriate testing service to this board for all examinations used in Texas or another state for licensure.

(4) Dean's Certification. Each applicant for licensure must have a certificate of graduation submitted directly from the medical school on a form provided by the board. The applicant shall attach a recent photograph, meeting United States Government passport standards, to the form before submitting to the medical school. The school shall have the Dean of the medical school or designated appointee sign the form attesting to the information on the form and placing the school seal over the photograph.

(5) Medical Diploma. All applicants for licensure must submit a copy of their medical diploma.

(6) Evaluations. All applicants must provide evaluations, on a form provided by the board, of their professional affiliations for the past ten years or since graduation from medical school, whichever is the shorter period.

(7) Premedical School Transcript. Each applicant must submit a copy of the record of their undergraduate education. Transcripts must show courses taken and grades obtained. If determined that the documentation submitted by the applicant is not sufficient to show proof of the completion of 60 semester hours of college courses other than in medical school, [which courses would be acceptable, at the time of completion, to The University of Texas at Austin for

~~credit on a bachelor of arts degree or a bachelor of science degree,~~]the applicant may be requested to contact the Office of Admissions at The University of Texas at Austin for course work verification.

(8) Medical School Transcript. Each applicant must have his or her medical school submit a transcript of courses taken and grades obtained.

(9) National Practitioner Data Bank (NPDB). Each applicant must contact the NPDB and have a report of action submitted directly to the board on the applicant's behalf.

(10) Federation of State Medical Boards History Report. Each applicant must contact the Federation of State Medical Boards and have a history report submitted directly to the board on the applicant's behalf.

(11) Physician's Profile. Each applicant must have a "Physician's Profile" report submitted directly to the board on the applicant's behalf from:

(A) American Medical Association; or

(B) American Osteopathic Association.

(12) Fingerprint Card. Each applicant must complete a fingerprint card and return to the board as part of the application.

(13) Graduate Training Verification. Each applicant must submit a certificate showing successful completion of required training. The certificate must show the beginning and ending dates of the program and state that the program was successfully completed. An applicant may have the Program Director of the program in which the applicant trained submit a letter, addressed to this board, submitted directly to this board stating the beginning and ending dates of the program and attesting to successful completion.

(14) Temporary License Affidavit. Each applicant must submit a completed form, furnished by the board, titled "Temporary License Affidavit" prior to the issuance of a temporary license.

(15) Specialty Board Certification. Each applicant that has obtained certification by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists must submit a copy of the certificate issued by the member showing board certification.

(16) Continuing Medical Education (CME). Each applicant must provide copies of certificates showing completion of at least equal to the number of CME hours required by the endorsing state.

(17) Medical License Verifications. Each applicant will have every state, in which he or she has ever been licensed, regardless of the current status of the license, submit on his or her behalf, directly to this board a letter verifying the status of the license and a description of any sanctions or pending disciplinary matters.

(c) Applicants for licensure who are graduates of unapproved [~~foreign~~] medical schools must furnish all appropriate documentation listed in this subsection, as well as that listed in subsections (a) and (b) of this section.

(1) Educational Commission for Foreign Medical Graduates (ECFMG) Certificate. Applicants must submit a copy of a valid ECFMG certificate unless they have completed a Fifth Pathway program. All Fifth Pathway applicants must submit a copy of their ECFMG interim certificate.

(2) Unique Documentation. The board may request documentation unique to an individual unapproved medical school and additional documentation as needed to verify completion of medical education that is substantially equivalent to a Texas medical school education. This may include but is not limited to:

(A) a copy of the applicant's ECFMG file;

(B) a copy of other states' licensing files;

(C) copies of the applicant's clinical clerkship evaluations; and

(D) a copy of the applicant's medical school file.

(3) Certificate of Registration. Each applicant must provide a copy of his or her certificate to practice in the country in which his or her medical school is located. If a certificate is unavailable, a letter, submitted directly to this board, from the body governing licensure of physicians in the country in which the school is located, will be accepted. The letter must state that the applicant has met all the requirements for licensure in the country in which the school is located. If an applicant is not licensed in the country of graduation due to a citizenship requirement, a letter attesting to this, submitted directly to this board, will be required.

(4) Clinical Clerkship Affidavit. A form, supplied by the board, to be completed by the applicant, is required listing each clinical clerkship that was completed as part of an applicant's medical education. The form will require the name of the clerkship, where the clerkship was located (name of hospital and location of hospital) and dates of the clerkship.

(5) An applicant who is a graduate of a medical school that is located outside the United States and Canada must present satisfactory proof to the board that each medical school attended is substantially equivalent to a Texas medical school. This may include but is not limited to:

(A) a Foreign Educational Credentials Evaluation from the Office of International Education Services of the American Association of Collegiate Registrars and Admissions Officers (AACRAO);

(B) a Board questionnaire, to be completed by the medical school and returned directly to board;

(C) a copy of the medical school's catalog;

(D) verification from the educational agency confirming the validity of school and licensure of applicant;

(E) proof of affiliation agreements between the medical school and the hospitals where clinical clerkships were taught;

(F) proof that the institutions must have a written contract with the medical school if the institutions are not located in a country where the medical school is located;

(G) proof that the faculty of the medical school must have a written contract with the school if the course is taught outside the country where the medical school is located;

(H) proof that the medical education courses taught in the United States must comply the higher education laws of the state in which the courses were taught; and

(I) proof that the faculty of the medical school must be on the faculty of the program of graduate medical education when the course is taught in the United States.

(d) Applicants may be required to submit other documentation, which may include the following.

(1) Translations. Any document that is in a language other than the English language will need to have a certified translation prepared and a copy of the translation will have to be submitted along with the translated document.

(A) An official translation from the medical school (or appropriate agency) attached to the foreign language transcript or other document is acceptable.

(B) If a foreign document is received without a translation, the board will send the applicant a copy of the document to be translated and returned to the board.

(C) Documents must be translated by a translation agency who is a member of the American Translations Association or a United States college or university official.

(D) The translation must be on the translator's letterhead, and the translator must verify that it is a "true word for word translation" to the best of his/her knowledge, and that he/she is fluent in the language translated, and is qualified to translate the document.

(E) The translation must be signed in the presence of a notary public and then notarized. The translator's name must be printed below his/her signature. The notary public must use this phrase: "Subscribed and Sworn to this _____ day of _____, 20___." The notary must then sign and date the translation, and affix his/her Notary Seal to the document.

(2) Arrest Records. If an Applicant has ever been arrested a copy of the arrest and arrest disposition need to be requested from the arresting authority and said authority must submit copies directly to this board.

(3) Malpractice. If an applicant has ever been named in a malpractice claim filed with any medical liability carrier or if an applicant has ever been named in a malpractice suit, the applicant must have the following submitted:

(A) have each medical liability carrier complete a form furnished by this board regarding each claim filed against the applicant's insurance;

(B) for each claim that becomes a malpractice suit have the attorney representing the applicant in each suit submit a letter directly to this board explaining the allegation, dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit, and if any money was paid, the amount of the settlement. If such letter is not available, the Applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(C) a statement, composed by the applicant, explaining the circumstances pertaining to patient care in defense of the allegations.

(4) Inpatient Treatment for Alcohol/Substance Abuse or Mental Illness. Each applicant that has been admitted to an inpatient facility within the last five years for the treatment of alcohol/substance abuse or mental illness must submit the following:

(A) an applicant's statement explaining the circumstances of the hospitalization;

(B) all records, submitted directly from the inpatient facility;

(C) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended;

(D) a copy of any contracts signed with any licensing authority or medical society or impaired physician's committee.

(5) Outpatient Treatment for Alcohol/Substance Abuse or Mental Illness. Each applicant that has been treated on an outpatient basis within the last five years for alcohol/substance abuse or mental illness must submit the following:

(A) an applicant's statement explaining the circumstances of the outpatient treatment;

(B) a statement from the applicant's treating physician/psychotherapist as to diagnosis, prognosis, medications prescribed, and follow-up treatment recommended; and

(C) a copy of any contracts signed with any licensing authority or medical society or impaired physician's committee.

(6) Additional Documentation. Additional documentation as is deemed necessary to facilitate the investigation of any application for medical licensure.

(7) DD214. A copy of the DD214, indicating separation from any branch of the United States military.

(e) The board may, in unusual circumstances, allow substitute documents where proof of exhaustive efforts on the applicant's part to secure the required documents is presented. These exceptions are reviewed by the board's executive director on a case-by-case basis.

§163.9. State Health Agency Temporary License.

An applicant may elect to apply for a state health agency temporary license in lieu of licensure.

(1) The executive director of the board may issue such a temporary license to an applicant:

(A) who holds a valid license in another state or Canadian province on the basis of an examination, that is accepted by the board for licensure;

(B) who has passed the Texas medical jurisprudence examination;

(C) whose application has been filed, processed, and found to be in order. The application shall be complete in every detail with the exception of compliance with §163.4(c)(2) of this title (relating to Procedural Rules for all Licensure Applicants); and

(D) who holds a salaried, administrative, or clinical position with an agency of the State of Texas.

(2) The state health agency temporary license shall be requested by the chief administrative officer of the employing state agency and shall be issued exclusively to that agency. The chief administrative officer shall state whether the temporary license is for a:

(A) clinical position. This temporary license will be valid for a one-year period from the date of issuance and will not be renewable. The temporary license is revocable at any time the board deems necessary. To practice beyond one year, the holder of the temporary license must fully comply with §163.4(c)(2) of this title (relating to Procedural Rules for all Licensure Applicants). During the period that the state health agency clinical temporary license is in effect, the physician will be supervised by a licensed staff physician who will regularly review the temporary license holder's skill and performance. This temporary license will be marked "clinical"; or

(B) administrative non-clinical position. This temporary license will be valid for a one-year period from the date of issuance; however, it is revocable at any time the board deems necessary. The temporary license shall automatically expire one year after the date

of issuance but may be re-issued annually at the request of the chief administrative officer of the employing state agency and at the discretion of the Texas State Board of Medical Examiners. The holder of a state health agency temporary license, not designated as clinical, shall not practice medicine as that term is defined in the Medical Practice Act, Texas Occupations [~~Occ.~~]Code Ann. §151.002(a)(13). This temporary license will be marked "administrative."

§163.10. Relicensure.

(a) If a physician's annual registration permit has been expired for one year due to failure to submit an application for registration and annual registration fee, it is considered to have been canceled, unless an investigation is pending, and the physician may not obtain a new[~~renew the~~] annual registration permit. The physician must apply for relicensure and may obtain a new license by submitting to reexamination and complying with the requirements and procedures for obtaining an original license.

~~[(1) The examinations required by this section are:]~~

~~[(A) the Texas jurisprudence examination; and]~~

~~[(B) SPEX, unless the applicant:]~~

~~*[(i)* has passed a licensure examination or has obtained specialty certification, recertification, or passed an examination of continued demonstration of qualifications by a board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists within the preceding ten years; or]~~

~~*[(ii)* has been in a training program approved by the board within six months prior to application for relicensure.]~~

~~[(2) The additional requirements for this new license shall be as required within the following sections:]~~

~~[(A) Section 163.2 of this title (relating to Licensure for United States and Canadian Medical School Graduates);]~~

~~[(B) Section 163.3 of this title (relating to Licensure for Graduates of Unapproved Medical Schools);]~~

~~[(C) Section 163.4 of this title (relating to Procedural Rules for all Licensure Applicants); and]~~

~~[(D) Section 163.5 of this title (relating to Licensure Documentation).]~~

(b) A person may qualify for a new license [~~renewal of his or her original license~~] without having to take the Texas jurisprudence examination [~~reexamination~~] if that person's license is considered canceled for less than two years.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108002
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

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CHAPTER 171 POSTGRADUATE TRAINING PERMITS

22 TAC §§171.1 - 171.7

The Texas State Board of Medical Examiners proposes amendments to §§171.1-171.7, regarding eligibility and documentation requirements of Physician in Training Permits and Visiting Professor Permits. The sections are being amended for general clean-up of the chapter.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be general clean-up of the chapter. There will be no effect on small businesses. There will be no effect to individuals required to comply with the sections as proposed.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §155.105 is affected by the amendments.

§171.1. Construction.

(a) Permit holders under this chapter shall be subject to the duties, limitations, disciplinary actions, rehabilitation order provisions, and procedures applicable to licensees in the Medical Practice Act and board rules. Permit holders under this chapter shall also be subject to the limitations and restrictions elaborated in this chapter.

(b) Permit holders under this chapter shall cooperate with the board and board staff involved in investigation, review, or monitoring associated with the permit holder's practice of medicine. Such cooperation shall include, but not be limited to, permit holder's written response to the board or board staff written inquiry within 14 days of receipt of such inquiry.

(c) The board may, in its discretion, retain jurisdiction over a permit and the permit holder if the permit is terminated, canceled and/or expires while the permit holder is under investigation.

(d) The issuance of a permit to a physician shall not be construed to obligate the board to issue the physician subsequent permits or licenses. The board reserves the right to investigate, deny a permit or full licensure, and/or discipline a physician regardless of when the information was received by the board.

(e) The director of each approved postgraduate training program shall[~~, as soon as practicable,~~]report in writing to the executive director of the board the following events within seven days of their occurrence:

(1) if an applicant did not begin the training program due to failure to graduate from medical school as scheduled or for any other reason(s);

(2) [~~(1)~~] if a permit holder has been terminated or has resigned from the program and the reason(s) why;

(3) [~~(2)~~] if a permit holder has been or will be absent from the program for more than 30 days and the reason(s) why;

(4) [~~(3)~~] if the program has information that a permit holder has been arrested after the permit holder begins training in the program, and/or

(5) [~~(4)~~] any relevant information relating to the acts of any permit holder if in the opinion of the director of the program the permit holder poses a threat to the public welfare through the practice of medicine.

(f) Failure of any hospital or medical institution to comply with the provisions of this chapter or the Medical Practice Act §§160.002-.003 [~~§2.09(i)~~] may be grounds for the denial of permits to persons seeking permits to practice at that institution.

(g) Board staff shall establish a mechanism by which a medical institution and/or training program may receive information regarding the application status of any physician who has applied with the board for a permit to practice at [~~in~~] that medical institution and/or training program.

(h) A violation of §164.051 [~~3.08~~] or any other provision of the Medical Practice Act is grounds for denial, [~~non-renewal,~~] or cancellation of a permit.

§171.2. Postgraduate Resident Permits

(a) This section applies to all physicians who began [~~will begin~~] postgraduate training in Texas after June 1, 2000. Postgraduate physicians in training for whom any Texas postgraduate training program was issued an institutional permit on the physician's behalf before June 1, 2000, shall be governed by ' §171.3 of this title (relating to Institutional Permits).

(b) Definitions.

(1) Postgraduate Resident: a physician who is in postgraduate training as an intern, resident, or fellow in an approved postgraduate training program.

(2) Approved Postgraduate Training Program: a clearly defined and delineated postgraduate medical education training program, including postgraduate subspecialty training programs, approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Committee on Accreditation of Preregistration Physician Training Programs, the Federation of Provincial Medical Licensing Authorities of Canada (internships prior 1994), the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or the Texas State Board of Medical Examiners.

(3) Basic Postgraduate Resident Permit: permit issued by the board in its discretion to a postgraduate resident who has not previously been issued a permit or license to practice medicine in Texas and is enrolled in an approved postgraduate training program in Texas, regardless of his/her PGY status within the program; the permit shall be effective for a fourteen month period from the date of issuance. The postgraduate resident may apply for two additional 14-month permits. The physician shall not be eligible for another basic postgraduate resident permit after the third permit expires or is terminated. [~~and may be renewed for a fourteen month period twice; at such time as the basic postgraduate resident permit (and its timely renewals) expires the physician shall not be eligible for another basic postgraduate resident permit.~~]

(4) Advanced Postgraduate Resident Permit: permit issued by the board in its discretion to a postgraduate resident whose basic postgraduate resident permit has expired and who is enrolled in an approved postgraduate training program in Texas, regardless of his/her PGY status within the program; the permit shall be effective for a fourteen month period from the date of issuance. The postgraduate resident may apply for four additional 14-month permits[~~and may be renewed for a fourteen month period four times~~].

(c) The board, in its discretion, may grant a postgraduate resident permit to train in an approved postgraduate training program to a physician who qualifies under this subchapter.

(d) A postgraduate resident permit holder is restricted to the supervised practice of medicine that is part of and approved by the training program. The permit does not allow for the practice of medicine, which is outside of the approved program.

(e) Qualifications of Postgraduate Permit Holders.

(1) To be eligible for a postgraduate resident permit, an applicant must present satisfactory proof to the board that the applicant:

(A) is at least 18 years of age;

(B) is of good professional character as elaborated in the Medical Practice Act §§164.051-.053[~~§3.08~~];

(C) has completed:

(i) the entire primary, secondary, and premedical education required in the country of medical school graduation, if the medical school is located outside the United States or Canada; or

(ii) substantially equivalent courses as determined by the board in its discretion[~~.~~] and

(D) is one of the following [~~either~~]:

(i) a graduate of a medical school accepted by the board; [~~or~~]

(ii) a physician who began postgraduate training in Texas before January 1, 2004 and a graduate of a school or college located outside the United States or Canada that was not approved by the board at the time the degree was conferred but whose curriculum meets the requirements for an unapproved medical school as determined by a committee of experts selected by the Texas Higher Education Coordinating Board, unless the they have completed a Fifth Pathway program.

(iii) a physician who began postgraduate training in Texas on or after January 1, 2004 and a graduate of a school or college located outside the United States or Canada that is not approved by the board, but is substantially equivalent to a Texas medical school as defined under section 163.1(13) of this title, unless they have completed a Fifth Pathway Program; or

(iv) a physician who has completed a Fifth Pathway Program. All Fifth Pathway applicants must have completed all of the didactic work of the foreign medical school whose curriculum meets the requirements for an unapproved medical school as determined by a committee of experts selected by the Texas Higher Education Coordinating Board, but has not graduated from an unapproved acceptable medical school.

(2) To be eligible for a postgraduate resident permit, an applicant must not have:

(A) a medical license, permit, or other authority to practice medicine that is currently restricted for cause, cancelled for cause, suspended for cause, revoked or subject to other discipline in a state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(B) an investigation or proceeding pending against the applicant for the restriction, cancellation, suspension, revocation, or other discipline of the applicant's medical license, permit, or authority to practice medicine in a state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(C) a prosecution pending against the applicant in any state, federal, or Canadian court for any offense that under the laws of this state is a felony, a misdemeanor that involves the practice of medicine, or a misdemeanor that involves a crime of moral turpitude;

(3) To be eligible for an advanced postgraduate resident permit, applicants who begin postgraduate training in Texas after June 1, 2002 must not have failed a licensure examination that would prevent the applicant from obtaining an unrestricted physician license in Texas[~~any examination required for full licensure in the Medical Practice Act, 3.05(c) and as construed in board rules, within the limited number of attempts prescribed in those provisions~~].

(f) Application for Postgraduate Resident Permit.

(1) Application Procedures.

(A) Applications for a postgraduate resident permit shall be submitted to the board on or before the following deadlines:

(i) Basic Postgraduate Resident Permit Applications: 60 days prior to the date the applicant begins postgraduate training in Texas; basic postgraduate resident permit applications shall not be deemed incomplete for lack of medical school transcript or diploma until after 100 days from the first day of the resident's training; and

(ii) Advanced Postgraduate Resident Permit Applications 120 [~~90~~] days prior to the date the applicant begins his/her postgraduate training in Texas authorized by an advanced postgraduate resident permit.

(B) The board's executive director may in his/her discretion allow substitute documents where exhaustive efforts have been made to secure the required documents.

(C) For each document presented to the board which is in a foreign language, an official word-for-word translation must be furnished. The board's definition of an official translation is one prepared by a government official, official translation agency, or a college or university official, on official letterhead. The translator must certify that it is a "true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate. [~~"~~]He/she must sign the translation with his/her signature notarized by a Notary Public. The translator's name and title must be typed/printed under the signature.

(D) The board's executive director shall review each application for postgraduate resident permit and shall recommend to the board all applicants eligible to receive a permit. The executive director shall also report to the board the names of all applicants determined to be ineligible to receive a permit, together with the reasons for each recommendation. The executive director may refer any application to a committee of the board for a recommendation concerning eligibility.

(E) An applicant deemed ineligible to receive a permit by the executive director may request review of such recommendation by the Licensure[~~a~~] committee of the board within 20 days of written receipt of such notice from the executive director.

(F) If the committee finds the applicant ineligible to receive a permit, such recommendation together with the reasons for the recommendation, shall be submitted to the board unless the applicant makes a written request for a hearing within 20 days of receipt of notice of the committee's determination. The hearing shall be before an administrative law judge of the State Office of Administrative Hearings and shall comply with the Administrative Procedure Act, the rules of the State Office of Administrative Hearings and the board. The board shall, after receiving the administrative law judge's proposed findings of fact and conclusions of law, determine the eligibility of the applicant to receive a permit. A physician whose application to receive a permit is denied by the board shall receive a written statement containing the reasons for the board's action.

(G) All reports and investigative information received or gathered by the board on each applicant are confidential and are not subject to disclosure under the open records law and the Medical Practice Act §160.006 [~~§4.05(c)~~]. The board may disclose such reports and investigative information to appropriate licensing authorities in other states.

(2) Basic Postgraduate Resident Permit Application: An application for a basic postgraduate resident permit must be on forms furnished by the board and include the following:

(A) the required fee as mandated in the Medical Practice Act, §153.051 [~~§3.05(c)~~] and as construed in board rules, payable by personal check, money order or cashier's check through a United States bank;

(B) a certified copy of the applicant's complete medical school transcript evidencing graduation submitted directly to the board by the school and[~~/or~~] a notarized "true copy" of the applicant's diploma;

(C) a notarized "true copy" of the applicant's valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate, if the applicant is a graduate of a medical school located outside the United States unless the applicant has completed a Fifth Pathway program. All Fifth Pathway applicants must request an ECFMG Certification Status Report be submitted directly to the board by the ECFMG;[~~All Fifth Pathway applicants must submit a notarized copy of the applicant's ECFMG interim certificate;~~]

(D) certification by the director of medical education of the postgraduate training program on a form provided by the board that certifies that:

(i) the program meets the definition of an approved postgraduate training program in subsection (b) of this section;

(ii) the applicant has been accepted into the program; [~~and~~]

(iii) the director has received a letter from the dean of the applicant's medical school which states that the applicant is scheduled to graduate from medical school before the date the applicant plans to begin postgraduate training; this provision applies only to applicants who are not able to provide a certified copy of their transcript or a notarized copy of their diploma by the time of their application to the board for a postgraduate resident permit; and

(iv) if the applicant is completing rotations in Texas as part of the applicant's residency out-of-state training program, the facility at which the rotations are being completed, and the dates the rotations will be completed in Texas;

(E) a certified transcript of exam scores, attempts, and dates sent directly to the board from each appropriate authority[~~a listing of the applicant's licensure exam history on a form provided by the board~~];

(F) information regarding the applicant's criminal and disciplinary history on a form provided by the board;

(G) information regarding the applicant's ability to practice medicine on a form provided by the board;

(H) an oath on a form provided by the board signed by the applicant swearing that:

(i) the applicant's medical license, permit, or authority to practice medicine in another state or territory of the United States, a province of Canada, or a uniformed service of the United States is not restricted for cause, cancelled for cause, suspended for cause, revoked, or subject to other discipline;

(ii) no investigation or proceeding is pending against the applicant for the restriction, cancellation, suspension, revocation, or other discipline of the applicant's medical license, permit, or authority to practice medicine in another state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(iii) no prosecution is pending against the applicant in any state or territory, federal, or Canadian court for any offense that under the laws of this state is a felony, a misdemeanor that involves the practice of medicine, or a misdemeanor that involves a crime of moral turpitude;

(iv) the applicant fully understands that the board's issuance of a postgraduate resident permit to the physician shall not be construed to obligate the board to issue the physician subsequent permits or licenses and that the board reserves the right to discipline, investigate, deny a permit, and/or full licensure to a physician regardless of when the information which serves as the basis for such action was received by the board; and

(v) the applicant has read and is familiar with board rules and the Medical Practice Act; will abide by board rules and the Medical Practice Act in activities permitted by this chapter; and will subject themselves to the disciplinary procedures of the Texas State Board of Medical Examiners; and

(I) such other information or documentation the board and/or the executive director deem necessary to ensure compliance with this chapter, the Medical Practice Act and board rules.

(3) Advanced Postgraduate Resident Permit Application. An application for an advanced postgraduate resident permit must be on forms furnished by the board and include the following:

(A) the required fee as mandated in the Medical Practice Act, §153.051 [~~§3.05(c)~~] and as construed in board rules, payable by personal check, money order or cashier's check through a United States bank;

(B) certification by the director of medical education of the postgraduate training program on a form provided by the board that certifies that:

(i) the program meets the definition of an approved postgraduate training program in subsection (b) of this section; [~~and~~]

(ii) the applicant has been accepted into the program; and

(iii) if the applicant is completing rotations in Texas as part of the applicant's residency training program, the facility at which the rotations are being completed, and the dates the rotations will be completed in Texas;

(C) a Dean's Certification [~~certificate of graduation~~] submitted directly to the board from the applicant's medical school on a form provided by the board; the applicant shall attach to the form a recent photograph, meeting United States Government passport standards, before submitting the form to the medical school;

(D) written evaluations, on forms provided by the board, from each facility and/or training program at which applicant has trained or held staff privileges [~~regarding the applicant's professional affiliations and training~~] in the United States or Canada;

[~~(E) a history report from the Federation of State Medical Boards, on a form provided by the board, requested by the applicant and submitted directly to the board;~~]

(E) [~~(F)~~] a letter of current licensure status or verification submitted directly to the board from every state or territory of the United States, a province of Canada, in which the applicant has ever held a medical license, permit or authority to practice medicine, regardless of the current status of that license, verifying the status of the license, permit or authority to practice medicine, including a description of any sanctions or pending disciplinary matters;

(F) [~~(G)~~] a notarized "true copy" of the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) Search Results obtained from the NPDB/HIPDB [~~report of action regarding the applicant from the National Practitioner Data Bank submitted directly to the board~~];

(G) [~~(H)~~] a notarized "true copy" of the applicant's permanent [~~Educational Commission for Foreign Medical Graduates~~](ECFMG) certificate, if the applicant is a graduate of a medical school located outside the United States unless the applicant has completed a Fifth Pathway program. All Fifth Pathway applicants must request a ECFMG Certification Status Report be submitted directly to the board by the ECFMG [~~All Fifth Pathway applicants must submit a notarized copy of the applicant's ECFMG interim certificate~~];

(H) [~~(I)~~] a notarized "true copy" of the applicant's certificate of registration to practice in the country in which the applicant's medical school is located, if the applicant is a graduate of a medical school located outside of the United States. If a certificate is unavailable, a letter submitted directly to the board from the body governing licensure of physicians in the country in which the school is located will be accepted. The letter must state that the applicant has met all the requirements for licensure in the country in which the school is located. If an applicant is not licensed in the country of graduation due to a citizenship requirement, a letter attesting to this fact will be required to be submitted directly to the board[~~:~~].All letters will be reviewed by the board to determine if acceptable and fulfills requirements;

(I) a certified transcript of exam scores, attempts, and dates sent directly to the board office from each appropriate authority;

(J) a Federation Board Action Data Inquiry Report for applicants who have not taken the FLEX, USMLE or SPEX;

[~~(J) a listing of the applicant's licensure exam history on a form provided by the board~~]

(K) information regarding the applicant's criminal and disciplinary history on a form provided by the board;

(L) information regarding the applicant's ability to practice medicine on a form provided by the board;

(M) a certified pre-medical transcript sent directly to the board office from each college or university the applicant attended to verify the required 60 semester hours of college courses completed other than in medical school;

(N) a certified medical transcript sent directly to the board office from each medical school at which the applicant was enrolled or attended;

(O) [~~(M)~~] an oath on a form provided by the board signed by the applicant swearing that:

(i) the applicant's medical license, permit, or authority to practice medicine in another state or territory of the United States, a province of Canada, or a uniformed service of the United States is not restricted for cause, cancelled for cause, suspended for cause, revoked, or subject to other discipline;

(ii) no investigation or proceeding is pending against the applicant for the restriction for cause, cancellation for cause, suspension for cause, revocation, or other discipline of the applicant's medical license, permit, or authority to practice medicine in another state or territory of the United States, a province of Canada, or a uniformed service of the United States;

(iii) no prosecution is pending against the applicant in any state or territory, federal, or Canadian court for any offense that under the laws of this state is a felony, a misdemeanor that involves the practice of medicine, or a misdemeanor that involves a crime of moral turpitude; [~~and~~]

(iv) the applicant fully understands that the board's issuance of a postgraduate resident permit to the physician shall not be construed to obligate the board to issue the physician subsequent permits or licenses and that the board reserves the right to discipline, investigate, deny a permit, and/or full licensure to a physician regardless of when the information which serves as the basis for such action was received by the board; and

(v) the applicant has read and is familiar with board rules and the Medical Practice Act; will abide by board rules and the Medical Practice Act in activities permitted by this chapter; and will subject themselves to the disciplinary procedures of the Texas State Board of Medical Examiners; and

(P) [~~(N)~~] such other information or documentation the board and/or the executive director deem necessary to ensure compliance with this chapter, the Medical Practice Act and board rules.

(4) Physicians who are applying for an Advanced Postgraduate Resident Permit are recommended to utilize, if appropriate, the Federation Credentials Verification Service (FCVS) offered by the Federation of State Medical Boards of the United States (FSMB) to verify medical education, postgraduate training, licensure examination history, board action history and identity.

(g) [~~Renewal and~~]Expiration of Postgraduate Resident Permit.

(1) Postgraduate resident permits shall be issued with effective dates corresponding with the beginning date[~~first day~~] of the resident's training program.

(2) Basic postgraduate resident permits shall be effective as provisional basic postgraduate resident permits for 100 days from the beginning date[~~first day~~] of the resident's training program in Texas. After 100 days, the provisional basic postgraduate resident permit shall expire but may be extended by the executive director of the board as a full basic postgraduate resident permit. Said extension shall be in the discretion of the executive director of the board contingent upon the applicant fulfilling the qualifications for a postgraduate permit and successfully completing the basic postgraduate resident application. A basic[~~full~~] postgraduate resident permit may be issued at the discretion of the executive director of the board at any time an application is complete. One provisional postgraduate resident permit per application is allowed.

(3) Postgraduate resident permits shall expire on the earlier of:

(A) fourteen months from the date the permit was issued [~~or renewed~~]; or

(B) on the date the physician is terminated or dismissed from the approved training program.

(4) A postgraduate resident who holds an unexpired permit may apply for a new permit for the same training program and same medical specialty in order to avoid a lapse in coverage by completing the designated application form provided by the board, paying the required fee and submitting both the form and fee to the board on or before the expiration date of the resident's current permit [~~permit holder may renew an unexpired postgraduate resident permit by submitting a renewal form, provided by the board, and by paying the required renewal fee to the board on or before the expiration date of the permit~~]. The required form shall include:

(A) information regarding the permit holder's criminal and disciplinary history, mailing address, and place where engaged in training since the permit holder's last application[~~or renewal~~];

(B) an evaluation by the permit holder's program director, on a form provided by the board, regarding the permit holder's training; and

(C) such other information or documentation the board and/or the executive director deem necessary to ensure compliance with this chapter, the Medical Practice Act and board rules.

(5) The executive director of the board may, in his/her discretion, may grant a subsequent [~~renew a~~] postgraduate resident permit for good cause shown.

(h) Board-Approved Postgraduate Training Programs.

(1) The executive director may in his/her discretion, upon written request, approve training programs as referenced in subsection (b)(2) of this section. The initial request must be submitted to the executive director within 90 days prior to the beginning date of the program. Said training programs shall be limited to postgraduate subspecialty programs. If the executive director does not recommend approval, the program's director may appeal to the board for its discretionary consideration of the request.

(2) Approval of training programs shall include but not be limited to the following considerations:

(A) the goals and objectives of the program;

(B) the process by which the program selects subspecialty residents;

(C) whether prior residency training in a related specialty is required of subspecialty residents in the program;

(D) the duties and responsibilities required of subspecialty residents in the program including the number of subspecialty residents to be enrolled each year and when subspecialty residents are required to be permanently licensed;

(E) the formal educational experiences required of subspecialty residents in the program, including grand rounds, seminars and journal club;

(F) the scholarly research required of subspecialty residents in the program, including participation in peer reviewed and funded research which may result in publications or presentations at regional and national scientific meetings;

(G) the type of supervision provided for subspecialty residents by the program;

(H) the curriculum vitae, including academic appointments, of all supervising staff;

(I) the academic affiliation of the program;

(J) the methods for evaluation of subspecialty residents by the program; and

(K) whether a specialty board that is a member of the American Board of Medical Specialties or the Bureau of Osteopathic Specialists gives credit for the program.

(3) All postgraduate training programs approved by the board may be re-evaluated every three years to assure compliance with the above considerations and consideration of continuation of the program. Said re-evaluation shall not be conducted without six months prior notice by board staff to the postgraduate subspecialty training program. Permit holders shall be allowed to complete their training program regardless of continuing program re-evaluation. [~~Training programs approved by the board before June 1, 2000, may be re-evaluated after January 1, 2001.~~]

(i) Temporary Postgraduate Resident Permit.

(1) The executive director of the board may, in his/her discretion, issue a temporary postgraduate resident permit to a physician who has submitted a written request, a $50 fee and is in an approved postgraduate training program with the following limitations:

(A) For a physician whose application for full postgraduate resident permit is pending agency review, the executive director of the board may, in his/her discretion, issue a temporary postgraduate resident permit if the application is complete.

(B) For a physician whose application for full postgraduate resident permit is not complete, the executive director of the board may, in his/her discretion, issue a temporary postgraduate resident permit if the applicant shows good cause for why the application is incomplete.

(2) A temporary postgraduate resident permit is valid for 100 days from the date issued. The executive director, in his/her discretion, may issue additional temporary postgraduate resident permits to an applicant with a maximum of four temporary permits per physician.

§171.3. Institutional Permits.

(a) This section shall apply to all postgraduate physicians in training whose postgraduate training program was issued an institutional permit on the physician's behalf on or before June 1, 2000.

(b) Institutional permits may be issued to postgraduate training programs approved by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Committee on Accreditation of Preregistration Physician Training Programs, the Federation of Provincial Medical Licensing Authorities of Canada (internships prior 1994), the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or the Texas State Board of Medical Examiners for interns, residents, and postresidency fellows.

(1) An intern is a physician who is in a clearly defined and delineated first postgraduate year program.

(2) A resident is a physician who is in a specialized, clearly defined, and delineated postgraduate program.

(3) A postresidency fellow is a physician who is in a specialized, clearly defined, and delineated program, following completion of a delineated residency program, for additional training in a medical specialty or subspecialty delivered in a program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, Committee on Accreditation of Preregistration Physician Training Programs, the Federation of Provincial Medical Licensing Authorities of Canada (internships prior 1994), the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, or in a program approved by the Texas State Board of Medical Examiners.

(c) The executive director may in his/her discretion, upon written request, approve training programs as referenced in §171.2(b)(2) of this chapter. Said training programs shall be limited to postgraduate subspecialty programs. If the executive director does not recommend approval, the program director may appeal to the board for its discretionary consideration of the request.

(d) Approval of training programs shall include but not be limited to the following considerations:

(1) the goals and objectives of the program;

(2) the process by which the program selects fellows;

(3) whether prior residency training in a related specialty is required of fellows in the program;

(4) the duties and responsibilities required of fellows in the program;

(5) the formal educational experiences required of fellows in the program, including grand rounds, seminars and journal club;

(6) the scholarly research required of fellows in the program, including participation in peer reviewed and funded research which may result in publications or presentations at regional and national scientific meetings;

(7) the type of supervision provided for fellows by the program;

(8) the curriculum vitae, including academic appointments, of all supervising staff;

(9) the academic affiliation of the program;

(10) the methods for evaluation of fellows by the program; and

(11) whether a specialty Board gives credit for the program.

(e) All postgraduate training programs approved by the board may be re-evaluated every three years to assure compliance with the above considerations and consideration of continuation of the program. Said re-evaluation shall not be conducted without six months prior notice by board staff to the postgraduate subspecialty training program. Permit holders shall be allowed to complete their training program regardless of continuing program re-evaluation. [~~Training programs approved by the board before June 1, 2000, may be re-evaluated after January 1, 2001.~~]

(f) Applicants who have graduated from a medical school approved by the Liaison Committee on Medical Education, or the American Osteopathic Association must submit:

(1) a completed application and fee 45 days prior to the beginning date of the program; and

(2) certification by the director of medical education of the program that the internship, residency, or fellowship meets the appropriate definition on a form provided by the board.

(g) Applicants who have graduated from a medical school outside the United States or Canada must submit:

(1) a completed application and fee 45 days prior to the beginning date of the program;

(2) a notarized copy of medical school diploma or Fifth Pathway Certificate;

(A) copies should be notarized as being a "true copy" of the original document and the Notary Public must sign, date, and affix his/her notary seal to the document; and

(B) if the document is in a foreign language, an official word-for-word translation must be furnished. The board's definition of an official translation is one prepared by a government official, official translation agency, or a college or university official, on official letterhead. The translator must certify that it is a "true translation to the best of his/her knowledge, that he/she is fluent in the language, and is qualified to translate;" he/she must sign the translation with his/her signature notarized by a Notary Public and the translator's name and title must be typed/printed under the signature;

(3) a notarized copy of a valid ECFMG document;[, ~~or:~~]

[~~(A)~~] proof of an unrestricted license from another state or territory in the United States or Canada; or

[~~(B)~~] proof of citizenship in the United States and residency of the State of Texas prior to entering medical school as provided in Texas Health and Safety Code §311.001;

(4) certification by the director of medical education that the internship, residency, or fellowship program meets the appropriate definition on a form provided by the board; and

(5) certification by the director of medical education, on a form provided by the board that the original medical school diploma, certified medical school transcript from each medical school, valid ECFMG document, and an original Dean's certification has been inspected.

(h) The board's executive director may, on a case by case basis and in his/her discretion, allow substitute documents where exhaustive efforts have been made to secure the required documents.

(i) Initial institutional permits are issued for 14 months; the permit may be renewed for a one-year period up to seven times, depending upon the requirements of the physician's specialty training program.

(j) Physicians holding an institutional permit must confine their practice of medicine to the designated teaching program. The permit may be cancelled if §164.051 [~~§3.08~~] or any other provision of the Medical Practice Act is violated, or if the permit is used to practice medicine outside the teaching program.

(k) If the training is terminated for any reason other than illness or other reasons acceptable to the board, the permit is void and no additional permit will be issued.

(l) Denial of a permanent Texas license is grounds for revoking or not issuing an institutional permit.

(m) Failure of any hospital or medical institution to comply with these provisions shall be grounds for the denial of the institutional permit and any future permits for persons wishing to serve at that institution.

§171.4. Visiting Professor Permit.

The board may issue a permit to practice medicine to a physician appointed as a visiting professor by a Texas medical school in accordance with this section.

(1) The visiting professor permit may be valid for any number of 31-day increments not to exceed 24 increments. The incremental periods wherein the permit is valid need not be contiguous, but rather may be in any arrangement approved by the executive director of the board.

(2) The visiting professor permit shall state on its face the periods during which it will be valid. If all periods of validity are not known at the time of the permit issuance, the permit holder shall request that the executive director of the board endorse the permit with each incremental period of validity as such becomes known. No permit shall be valid at any time when the period of validity is not stated on the permit unless suitable temporary alternative arrangements have been presented to and accepted by the executive director or secretary-treasurer of the board.

(3) The visiting professor permit shall be issued to the institution authorizing the named visiting professor to practice medicine within the teaching confines of the applying medical school as a part of duties and responsibilities assigned by the school to the visiting professor. The visiting professor may participate in the full activities of the department in whichever hospital the appointee's department has full responsibility for clinical, patient care, and teaching activities.

(4) The visiting professor and the school shall file affidavits with the board affirming acceptance of the terms, limitations and conditions imposed by the board on the medical activities of the visiting professor.

(5) The application for visiting professor permit or the renewal thereof shall be presented to the secretary-treasurer or executive director of the board at least 30 days prior to the effective date of the appointment of the visiting professor. The application shall be made by the chairman of the department in which the visiting professor will teach and provide such information and documentation to the board as may be requested. Such application shall be endorsed by the dean of the medical school or by the president of the institution [~~Health Science Center~~].

(6) All applications shall state the date when the visiting professor shall begin performance of duties.

§171.5. National Health Service Corps Permit.

The board may issue a permit to practice medicine to a physician who has contracted with the National Health Service Corps to practice medicine in Texas under the following terms and conditions:

(1) The physician must be a graduate of a medical school approved by the board. An 8 1/2 x11 [~~A~~] notarized true copy of theoriginal medical diploma shall be submitted to the board [~~before the permit is issued~~].

(2) The physician must hold a valid, unrestricted license in another state or territory to practice medicine. A notarized true copy of the license registration certificate shall be submitted to the board [~~before the permit is issued~~]. If the physician is not licensed in another state, he or she must have passed either the United States Medical Licensing Examination (USMLE), within three attempts, with a score of 75 or better on each step, all steps must be passed within seven years, or the National Board of Osteopathic Medical Examiners Examination (NBOME) or its successor, within three attempts, all steps must be passed within seven years, or the National Board of Medical Examiners examination (NBME) within three attempts, all steps must be passed within seven years. A certified transcript of the scores shall be submitted to the board by the appropriate authority[~~before the permit is issued~~].

(3) The physician must have a valid contract with the National Health Service Corps. This permit will expire at the termination

of the contract with the National Health Service Corps. A notarized true copy of the contract shall be submitted to the board [~~before the permit is issued~~].

(4) The permit shall be issued for one year and may be renewed.

(5) The permit allows the physician to practice medicine only within the scope of his or her contract with the National Health Service Corps.

§171.6. Faculty Temporary Permit.

(a) The board may issue a faculty temporary permit to practice medicine to a physician appointed by a Texas medical school in accordance with this section:

(1) The physician must hold a valid medical license is not subject to disciplinary action in another state, territory, or Canadian province; or have completed three years of postgraduate residency training.

(2) The physician must not have failed a licensure examination that would prevent the physician from obtaining an unrestricted physician license in Texas.

(3) The physician must hold a salaried faculty position of assistant professor-level or higher working full-time in one of the following institutions:

(A) University of Texas Medical Branch at Galveston;

(B) University of Texas Southwestern Medical Center at Dallas;

(C) University of Texas Health Science Center at Houston;

(D) University of Texas Health Science Center at San Antonio;

(E) University of Texas Health Center at Tyler;

(F) University of Texas M.D. Anderson Cancer Center;

(G) Texas A&M University College of Medicine;

(H) Texas Tech University School of Medicine;

(I) Baylor College of Medicine; or

(J) University of North Texas Health Science Center at Fort Worth.

(4) The physician must sign an oath on a form provided by the board swearing that the applicant has read and is familiar with Board rules and the Medical Practice Act; will abide by board rules and the Medical Practice Act in activities permitted by this chapter; and will subject themselves to the disciplinary procedures of the Texas State Board of Medical Examiners.

(b) The faculty temporary permit shall be issued for a period of one year, and may, in the discretion of the executive director of the board, be renewed three times.

(c) The faculty temporary permit holder's practice of medicine shall be limited the teaching confines of the applying medical school as a part of duties and responsibilities assigned by the school to the physician.

(d) The physician may participate in the full activities of the department in whichever hospitals the appointee's department has full responsibility for clinical, patient care, and teaching activities.

(e) The physician and the school shall file affidavits with the board affirming acceptance of the terms, limitations, and conditions imposed by the board on the medical activities of the physician.

(f) The application and fee for the faculty temporary permit or the renewal thereof shall be presented to the executive director of the board at least 30 days prior to the effective date of the appointment of the physician.

(g) The application shall be made by the chairman of the department in which the physician will teach and provide such information and documentation to the Board as may be requested.

(h) The application shall be endorsed by the dean of the medical school or by the president of the institution [~~Health Science Center~~].

(i) Three years in a teaching faculty position at any institution listed in subsection (a)(3) of this section may be equivalent to three years of approved postgraduate training if, at the conclusion of this three-year period, the physician presents recommendations in his or her behalf from the chief administrative officer and the president of the institution.

§171.7. Postgraduate Research Permit.

The board may issue a permit to practice medicine to a medical school graduate, who holds a research appointment at a Texas medical school, in a program approved by the board, under the following terms and conditions listed in paragraphs (1)-(6) of this section. .

(1) The research must be in clinical medicine and/or the basic sciences of medicine.

(2) The research must be conducted in the Texas medical school or its affiliated institutions.

(3) The research appointment must be approved by the Dean of the medical school or the president of the institution [~~Medicine or by the President of the Health Science Center~~].

(4) The research appointment must be supervised by a faculty member of the Texas medical school who has an active unrestricted Texas medical license.

(5) The research appointment must be of good professional character as elaborated in the Medical Practice Act.

(6) The Postgraduate Research Permit may be issued for a maximum of one year and is not renewable.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108003
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

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CHAPTER 180. REHABILITATION ORDERS

The Texas State Board of Medical Examiners proposes the repeal and new of §180.1, regarding the purpose of rehabilitation orders and the factors to be considered when proposing and determining eligibility for a rehabilitation order.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be factors to be considered when proposing and determining eligibility for a rehabilitation order. There will be no effect on small businesses. There will be no effect to individuals required to comply with the sections as proposed.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

22 TAC §180.1

(Editor's note: The text of the following section proposed for repeal will not be published. The section may be examined in the offices of the Texas State Board of Medical Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §164.202-.204 is affected the repeal.

§180.1. Rehabilitation Orders.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108004
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

♦ ♦ ♦

22 TAC §180.1

The new section is proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §164.202-.204 is affected the new section.

§180.1. Rehabilitation Orders.

(a) Purpose of chapter. The purpose of this chapter is to establish the process for the board's review and proposal of a nondisciplinary private rehabilitation order ("rehabilitation order") to a licensee or licensure applicant ("applicant") pursuant to the Medical Practice Act ("Act"), Tex. Occ. Code Ann. §§164.202-.204.

(b) Purposes of rehabilitation orders.

(1) To provide an incentive to a licensee or applicant to seek early assistance with drug or alcohol related problems or mental or physical conditions that present a potentially dangerous limitation or inability to practice medicine with reasonable skill and safety.

(2) To protect the public by requiring the impaired licensee or applicant to obtain treatment and/or limit or refrain from the practice of medicine while suffering from an impairment.

(c) Eligibility for rehabilitation order. The board may issue a rehabilitation order for a licensee or applicant, as a prerequisite for issuing a license, for the following reasons:

(1) the licensee or applicant suffers from an addiction caused by treatment;

(2) the licensee or applicant self-reported intemperate use of drugs or alcohol as set out in subsection (f) of this chapter, and has not previously been the subject of a substance abuse-related order of the board;

(3) a court has determined that the licensee or applicant is of unsound mind;

(4) the licensee or applicant has an impairment as determined by a mental or physical examination; or

(5) an admission by the licensee or applicant of an illness or a physical or mental condition that limits or prevents the person's practice of medicine with reasonable skill and safety.

(d) Factors for board consideration in proposing a rehabilitation order.

(1) General. In determining whether to recommend a rehabilitation order to an otherwise eligible licensee or applicant, the board shall consider all relevant factors.

(2) Federal and state drug and alcohol laws. Absent a showing of good cause by the licensee or applicant, the board may not grant a rehabilitation order if any of the following factors exist:

(A) the licensee or applicant has been found guilty, pled guilty, or received deferred adjudication of any felony or misdemeanor related to the intemperate use of drugs or alcohol at issue;

(B) the licensee or applicant was required to or voluntarily surrendered his/her drug license(s) or certification(s) issued by the Federal Drug Enforcement Administration (DEA), Texas Department of Public Safety (DPS) or comparable authority of another state in connection with a criminal investigation related to the intemperate use of drugs or alcohol at issue; and

(C) the licensee's or applicant's intemperate use of drugs or alcohol led to a violation of Sections 481 and 483 of the Texas Health and Safety Code or a violation of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Section 801 et seq.).

(3) Additional factors to be established by a licensee or applicant. Licensees or applicants otherwise eligible for a rehabilitation order should provide evidence of the following factors to be considered by the board prior to the board proposing a rehabilitation order:

(A) steps taken to prevent potential future harm to the public that may include a treatment and monitoring plan;

(B) existence of rehabilitative potential;

(C) a clinical diagnosis of a physical or mental condition and supporting medical records; and

(D) that the licensee or applicant cooperated with board staff during the course of the investigation.

(4) Additional factors to be established by board staff. If applicable, board staff shall present evidence of the following factors to be considered by the board prior to the board proposing a rehabilitation order:

(A) licensee or applicant caused patient harm;

(B) licensee or applicant caused economic harm to any individual or entity;

(C) licensee or applicant has a disciplinary history, including criminal convictions, disciplinary orders with board or other state medical boards, disciplinary actions by other state or federal regulatory agencies, and peer review actions by hospitals or medical societies;

(D) licensee or applicant inappropriately self-treated or self-prescribed; and

(E) licensee or applicant violated provisions of the Act other than §§164.051(a)(4), (a)(5) and 164.052(a)(5).

(e) Concurrent public agreed order. The board may recommend a public agreed order for a licensee or applicant in addition to, or in lieu of, a confidential rehabilitation order, for violations of the Act or board rules.

(f) Guidelines for self-reports.

(1) Procedure. Self-reports of intemperate use of drugs or alcohol by licensees or applicants shall be made through one or more of the following methods:

(A) a hand-written or typed statement submitted to the board or board staff by mail, messenger, telefacsimile transmission, or hand-delivery which has been signed by the licensee or applicant and may include responses provided as part of an application for a license or a writing submitted for purposes of licensure renewal; or

(B) a hand-written or typed statement submitted to the board or board staff by mail, messenger, telefacsimile transmission, or hand-delivery which has been signed by an authorized agent of the licensee or applicant with the prior approval of the licensee or applicant.

(2) Contents of Self-report. Prior to the board considering whether to propose a rehabilitation order, the licensee or applicant shall provide a complete self-report of the intemperate use of alcohol or drugs that includes, but is not limited to, the following information:

(A) the approximate dates of intemperate use;

(B) the extent of intemperate use;

(C) the substance(s) used;

(D) the method(s) of ingestion; and

(E) all history of substance abuse treatment to include approximate dates of treatment and the specific locations where treatment was received.

(3) Timing of self-report. To be considered a self-report, the notice given to the board by the licensee or applicant must:

(A) be given within five years from the last commission of intemperate use of drugs or alcohol; and

(B) be given prior to the board receiving a complaint regarding a licensee's or applicant's alleged intemperate use.

(g) Guidelines for determination of a mental or physical condition.

(1) Mental condition. Absent a showing of good cause, a licensee or applicant suffering from a mental condition should provide evidence to the board, including medical records, of a clinical diagnosis by a physician or mental health care provider of a condition listed under DSM-IV.

(2) Physical condition. Absent a showing of good cause, a licensee or applicant suffering from a physical condition should provide evidence to the board, including medical records, of a clinical diagnosis by a physician.

(3) Additional factors for consideration. A licensee's or applicant's diagnosis shall be considered along with the licensee's or applicant's:

(A) current and past levels of functioning;

(B) concurrent medical disorders;

(C) complicating factors such as substance-related disorders;

(D) compliance with treatments;

(E) response to treatment;

(F) prognosis; and

(G) stage of recovery from the illness.

(4) Hearing. An informal show compliance proceeding shall be considered an evidentiary hearing for of the purposes of this subsection and in accordance with §164.202 of the Act.

(h) Confidentiality. Consideration of proposed agreed rehabilitation orders shall be conducted so as to keep the identity of the licensee or applicant confidential.

(1) Confidentiality may be preserved through one or more of the following:

(A) confidential informal show compliance proceedings;

(B) confidential modification and termination requests and proceedings;

(C) executive sessions by the board and board committee; and/or

(D) redaction of identifying information when such orders are considered in open session.

(2) The board, board staff, and agents of the board will attempt in good faith to ensure that the terms and conditions of a rehabilitation order remain confidential. However, in order to ensure compliance with a rehabilitation order, it may be necessary to disrupt the activities of a licensee or applicant and to contact the licensee or applicant, including but not limited to telephone calls, mail, or unannounced visits to the licensee's or applicant's place of employment or residence.

(3) Upon a determination by the board that licensee or applicant has violated a rehabilitation order, the rehabilitation order will become a public document and subject to the Texas Public Information Act.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200108005

Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-7016

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CHAPTER 181. CONTACT LENS PRESCRIPTIONS

22 TAC §§181.1 - 181.3, 181.5 - 181.7

The Texas State Board of Medical Examiners proposes amendments to §§181.1-181.3, 181.5-181.7, concerning contact lens prescriptions. The sections are being amended for general clean-up of the chapter and to update Occupation Code cites. This chapter is being proposed for review elsewhere in this issue of the *Texas Register*.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be general clean-up of the chapter. There will be no effect on small businesses. There will be no effect to individuals required to comply with the sections as proposed.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, Title 3, Subtitle B and Title 3, Subtitle F, Chapter 353 are affected by the amendments.

§181.1. Purpose.

These rules are promulgated under the authority of the Medical Practice Act, Texas Occupations Code Ann., Title 3, Subtitle B, [~~Article 4495b,~~] and the Texas Contact Lens Prescription Act, Texas Occupations Code Ann., Title 3, Subtitle F, Chapter 353, [~~Chapter 1345, 75th Legislature Regular Session,~~]to set forth the criteria under which a patient may request and receive a contact lens prescription and under which a physician shall provide such prescription.

§181.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the contents clearly indicate otherwise.

(1) Contact lens prescription--a written prescription that contains the following information:

(A) the [~~The~~] patient's name;

(B) the [~~The~~] date the prescription was issued;

(C) the [~~The~~] contact lens manufacturer, if needed;

(D) the [~~The~~] expiration date of the prescription, which shall be one year or more unless the health of the patient requires an earlier expiration date;

(E) the [~~The~~] original signature of the physician;

(F) the [~~The~~] total number of [~~disposal~~] lenses authorized and recommended replacement intervals if the prescription is for disposable contact lenses;

(G) the [~~The~~] brand name or model type of the lens prescribed;

(H) the [~~The~~] lens power;

(I) the [~~The~~] base curve measurements; and

(J) the [~~The~~] diameter.

(2) Disposable contact lenses--soft contact lenses that:

(A) are [~~Are~~] dispensed in sealed packages;

(B) are [~~Are~~] sterilized and sealed by the manufacturer; and

(C) according [~~According~~] to the wearing instructions suggest the lenses be replaced at an interval of less than three months.

§181.3. Release of Contact Lens Prescription.

(a) Except as provided in subsection (d) of this section, each physician who performs an eye examination and fits a patient for contact lenses shall, on request, prepare and give a contact lens prescription to the patient. The physician may exclude categories of contact lenses if the exclusion is clinically indicated. The physician may not charge the patient a fee for providing the contact lens prescription but may charge a fee for examination and a fee for fitting of contact lenses as a condition for giving a contact lens prescription to the patient.

(b) If a patient requests a contact lens prescription during an initial or annual examination, the physician must prepare and give the contact lens prescription to the patient at the time the physician determines all of the parameters of the contact lens prescription, as that term is defined in section 181.2 of this title (relating to definitions). If the physician has delegated the fitting of the contact lens as authorized by the Texas Contact Lens Prescription Act, [~~Texas Revised Civil Statutes, Article 4552-A,~~]the physician is not required to provide the prescription for the patient.

(c) If the patient does not request or receive an original contact lens prescription during the patient's initial or annual examination, the patient may request the patient's contact lens prescription at any time during which the prescription is valid. On receipt of a request, the physician shall provide the patient with a contact lens prescription if the physician has fit the patient. If the patient requests the physician to deliver the prescription to the patient or to another person, the physician may charge the cost of delivery to the patient.

(d) A physician may refuse to give a contact lens prescription to a patient if:

(1) the [~~The~~] patient's ocular health presents a contraindication for contact lenses;

(2) refusal [~~Refusal~~] is warranted due to potential harm to the patient's ocular health;

(3) the [~~The~~] patient has not paid for the examination and [~~for the~~] fitting, or has not paid [~~for~~] other financial obligations to the physician if the patient would have been required to make an immediate or similar payment if the examination revealed that ophthalmic goods were not required;

(4) the [~~The~~] patient has an existing medical condition that indicates that the patient's ocular health would be damaged if the prescription were released to the patient, or if further monitoring of the patient is needed; or

(5) the [~~The~~] request is made after the first anniversary date of the patient's last eye examination.

(e) Subsection (d) of this section does not prohibit a physician from giving a patient the patient's contact lens prescription.

(f) A physician may not condition the availability to a patient of an eye examination, a fitting for contact lenses, the issuance of a contact lens prescription, or any combination of these services on a requirement that the patient agree to purchase contact lenses or other ophthalmic goods from the physician.

(g) Unless a shorter prescription period is warranted by the patient's ocular health or by a potential harm to the patient's ocular health, a physician may not issue a contact lens prescription that expires before the first anniversary of the date the person's prescription parameters are determined. The physician may extend the expiration date of the prescription without completing another eye examination or may require the patient to undergo another eye examination.

(h) If a physician refuses to give a patient the patient's contact lens prescription for a reason permitted under subsection (d) of this section or writes the prescription for a period of less than one year, the physician must:

(1) give the patient a verbal explanation of the reason for the action at the time of the action; and

(2) maintain in the patient's records a written explanation of the reason.

§181.5. Contact Lens Dispensing Permit Not Required of Physician or Physician's Employees.

Neither a physician nor an employee of a physician is required to obtain a permit [~~under this act~~] if the employee performs contact lens dispensing services under the direct supervision and control of the physician.

§181.6. Physician's Prescriptions: Delegation.

(a) These rules shall not be interpreted to prevent, limit, or restrict a physician from treating or prescribing for the physician's patients or from directing or instructing others under the physician's control, supervision or instruction who assists those patients according to specific directions, orders, instructions, or prescriptions.

(b) If a physician's directions, instructions, orders, or prescriptions are to be performed or filled by an optician who is independent of the physician's office, the directions, instructions, orders or prescriptions must be:

(1) in [~~In~~] writing;

(2) of [~~Of~~] a scope and content and communicated to the optician in a form and manner that in the professional judgment of the physician best serves the health, safety, and welfare of the physician's patients; and

(3) in [~~In~~] form in detail consistent with the particular optician's skill and knowledge.

(c) A person holding a contact lens dispensing permit [~~under this act~~] may take measurements of the eye or cornea and may evaluate the physical fit of the lenses for a particular patient of the physician and may instruct the patient in the use and care of the contact lenses if the physician has delegated in writing those responsibilities with regard to that specific patient to the contact lens dispenser.

§181.7. Liability.

(a) A contact lens prescription may not contain, and a physician may not require a patient to sign a form or notice that waives or disclaims the liability of the physician for the accuracy of:

(1) the [~~The~~] eye examination on which the contact lens prescription furnished to the patient is based; or

(2) the [~~The~~] contact lens prescription provided to the patient.

(b) A physician is not liable for any subsequent use of a contact lens prescription by a patient if the physician does not reexamine the patient and the patient's condition, age, general health, and susceptibility to an adverse reaction caused by or related to the use of contact lenses or other factors result in patient no longer being a proper candidate for the contact lens or lenses prescribed.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Donald W. Patrick, MD, JD
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Texas State Board of Medical Examiners
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For further information, please call: (512) 305-7016

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CHAPTER 185. PHYSICIAN ASSISTANTS

22 TAC §185.4, §185.9

The Texas State Board of Medical Examiners proposes amendments to §185.4 and §185.9, regarding physician assistants not currently in active practice and reactivation of an inactive license.

Michele Shackelford, General Counsel, Texas State Board of Medical Examiners, has determined that for the first five-year period the sections are in effect there will be no fiscal implications to state or local government as a result of enforcing the rules as proposed.

Ms. Shackelford also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be updated rules regarding physician assistants not currently in active practice and reactivation of an inactive license. There will be no effect on small businesses. There will be no effect to individuals required to comply with the sections as proposed.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018. A public hearing will be held at a later date.

The amendments are proposed under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

The Occupations Code, §204.157 is affected by the amendments.

§185.4. Procedural Rules for Licensure Applicants.

(a) Except as otherwise provided in this section, an individual shall be licensed by the board before the individual may function as a physician assistant. A license shall be granted to an applicant who:

(1) submits an application on forms approved by the board;

(2) pays the appropriate application fee as prescribed by the board;

(3) has successfully completed an educational program for physician assistants or surgeon assistants accredited by the Commission on Accreditation of Allied Health Education Programs, or by that committee's predecessor or successor entities, and holds a valid and current certificate issued by the National Commission on Certification of Physician Assistants;

(4) certifies that the applicant is mentally and physically able to function safely as a physician assistant;

(5) does not have a license, certification, or registration as a physician assistant in this state or from any other licensing authority that is currently revoked or on suspension or the applicant is not subject to probation or other disciplinary action for cause resulting from the applicant's acts as a physician assistant, unless the board takes that fact into consideration in determining whether to issue the license;

(6) is of good moral character;

(7) submits to the board any other information the board considers necessary to evaluate the applicant's qualifications; and

(8) meets any other requirement established by rules adopted by the board.

(b) The following documentation shall be submitted as a part of the licensure process:

(1) Name Change. Any applicant who submits documentation showing a name other than the name under which the applicant has applied must present certified copies of marriage licenses, divorce decrees, or court orders stating the name change. In cases where the applicant's name has been changed by naturalization the applicant should send the original naturalization certificate by certified mail to the board for inspection.

(2) Certification. Each applicant for licensure must submit:

(A) a valid and current certificate from the National Commission on Certification of Physician Assistants ("NCCPA") directly from NCCPA on a form provided by the board, and

(B) a certificate of successful completion of an educational program submitted directly from the program on a form provided by the board.

(3) Fingerprint Card. Each applicant must complete and submit a fingerprint card. This fingerprint card must be completed through an agency trained in taking fingerprints.

(4) Verification from other states. Each applicant for licensure who is licensed, registered, or certified in another state must have that state submit directly to the board, on a form provided by the board, that the physician assistant's license, registration, or certification is current and in full force and that the license, registration, or certification has not been restricted, canceled, suspended, or revoked. The other state shall also include a description of any sanctions imposed by or disciplinary matters pending in the state.

(5) State License Registration. Each applicant, if licensed, registered, or certified in another state as a physician assistant, must submit a copy of the license registration certificate to the board. The license, registration, or certificate number and the date of expiration must be visible on the copy.

(6) Arrest Records. If an applicant has ever been arrested, a copy of the arrest and arrest disposition needs to be requested from the arresting authority and that authority must submit copies directly to the board.

(7) Malpractice. If an applicant has ever been named in a malpractice claim filed with any liability carrier or if an applicant has ever been named in a malpractice suit, the applicant must:

(A) have each liability carrier complete a form furnished by this board regarding each claim filed against the applicant's insurance;

(B) for each claim that becomes a malpractice suit, have the attorney representing the applicant in each suit submit a letter directly to the board explaining the allegation, dates of the allegation, and current status of the suit. If the suit has been closed, the attorney must state the disposition of the suit, and if any money was paid, the amount of the settlement. If such letter is not available, the applicant will be required to furnish a notarized affidavit explaining why this letter cannot be provided; and

(C) provide a statement, composed by the applicant, explaining the circumstances pertaining to patient care in defense of the allegations.

(8) Additional Documentation. Additional documentation as is deemed necessary to facilitate the investigation of any application for licensure must be submitted.

(c) The executive director shall review each application for licensure and shall recommend to the board all applicants eligible for licensure. The executive director also shall report to the board the names of all applicants determined to be ineligible for licensure, together with the reasons for each recommendation. An applicant deemed ineligible for licensure by the executive director may request review of such recommendation by a committee of the board within 20 days of receipt of such notice, and the executive director may refer any application to said committee for a recommendation concerning eligibility. If the committee finds the applicant ineligible for licensure, such recommendation, together with the reasons therefor, shall be submitted to the board unless the applicant requests a hearing within 20 days of receipt of notice of the committee's determination. The hearing shall be before an administrative law judge of the State Office of Administrative Hearings and shall comply with the Administrative Procedure Act and its subsequent amendments and the rules of the State Office of Administrative Hearings and the board. The committee may refer any application for determination of eligibility to the full board. The board shall, after receiving the administrative law judge's proposed findings of fact and conclusions of law, determine the eligibility of the applicant for licensure. A physician assistant whose application for licensure is denied by the board shall receive a written statement containing the reasons for the board's action. All reports received or gathered by the board on each applicant are confidential and are not subject to disclosure under the Open Records Law. The board may disclose such reports to appropriate licensing authorities in other states.

(d) All physician assistant applicants shall provide sufficient documentation to the board that the applicant has, on a full-time basis, actively practiced as a physician assistant, [~~or~~] has been a student at an acceptable approved physician assistant program, or has been on the active teaching faculty of an acceptable approved physician assistant program, within either[~~each~~] of the last two years preceding receipt of an application for licensure. The term "full-time basis," for purposes of

this section, shall mean at least 20 hours per week for 40 weeks duration during a given year. Applicants who do not meet the requirements of subsections (a) and (b) of this section may, in the discretion of the board, be eligible for an unrestricted license or a restricted license subject to one or more of the following conditions or restrictions as set forth in paragraphs (1)-(5)[~~(4)~~] of this subsection:

(1) current certification by the National Commission on the Certification of Physician Assistants;

(2) completion of specified continuing medical education hours approved for Category 1[~~I~~] credits by a CME sponsor approved by the American Academy of Physician Assistants;

(3) limitation and/or exclusion of the practice of the applicant to specified activities of the practice as a physician assistant;

(4) remedial education;and

(5) such other remedial or restrictive conditions or requirements which, in the discretion of the board, are necessary to ensure protection of the public and minimal competency of the applicant to safely practice as a physician assistant.

(e) Applicants for licensure:

(1) whose documentation indicates any name other than the name under which the applicant has applied must furnish proof of the name change;

(2) whose application for licensure which has been filed with the board office and which is in excess of two years old from the date of receipt, shall be considered inactive. Any fee previously submitted with the application shall be forfeited. Any further application procedure for licensure will require submission of a new application and inclusion of the current licensure fee;

(3) who in any way falsify the application may be required to appear before the board;

(4) on whom adverse information is received by the board may be required to appear before the board;

(5) shall be required to comply with the board's rules and regulations which are in effect at the time the completed application form and fee are filed with the board;

(6) may be required to sit for additional oral or written examinations that, in the opinion of the board, are necessary to determine competency of the applicant;

(7) must have the application of licensure complete in every detail 20 days prior to the board meeting in which they are considered for licensure. Applicants may qualify for a Temporary License prior to being considered by the board for licensure, as required by § 185.7 of this title (relating to Temporary License);

(8) who previously held a Texas health care provider license may be required to complete additional forms as required.

§185.9. Inactive License.

(a) A license holder may have the license holder's license placed on inactive status by applying to the board. A physician assistant with an inactive license is excused from paying renewal fees on the license and may not practice as a physician assistant in Texas.

(b) In order for a license holder to be placed on inactive status, the license holder must have a current annual registration permit.

(c) A license holder who practices as a physician assistant while on inactive status is considered to be practicing without a license.

(d) A physician assistant may return to active status by applying to the board, paying the license renewal fee, penalty fees,[~~and~~] complying with the requirements for license renewal under the Physician Assistant Licensing Act and complying with subsection (e) of this section.

(e) All physician assistant applicants applying to return to active status shall provide sufficient documentation to the board that the applicant has, on a full-time basis as defined in §185.4(d) of this Chapter, actively practiced as a physician assistant or has been on the active teaching faculty of an acceptable approved physician assistant program, within either of the two years preceding receipt of an application for reactivation. Applicants who do not meet this requirement may, in the discretion of the board, be eligible for the reactivation of a license subject to one or more of the following conditions or restrictions as set forth in paragraphs (1)-(5) of this subsection:

(1) current certification by the National Commission on the Certification of Physician Assistants;

(2) completion of specified continuing medical education hours approved for Category 1 credits by a CME sponsor approved by the American Academy of Physician Assistants;

(3) limitation and/or exclusion of the practice of the applicant to specified activities of the practice as a physician assistant;

(4) remedial education; and

(5) such other remedial or restrictive conditions or requirements which, in the discretion of the board are necessary to ensure protection of the public and minimal competency of the applicant to safely practice as a physician assistant.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
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For further information, please call: (512) 305-7016

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PART 14. TEXAS OPTOMETRY BOARD

CHAPTER 273. GENERAL RULES

22 TAC §273.12

The Texas Optometry Board proposes new rule §273.12 to comply with Tex. Gov't Code §2054.2606, which requires to the Board to collect profile information from its licensees and post the information on the Internet.

Chris Kloeris, executive director of the Texas Optometry Board, has determined that for the first five-year period the new rule is in effect, there will be no fiscal implications for state and local governments as a result of enforcing or administering the new rule since the Board's license fees have previously been increased through amendment to §273.4 by $5.00 per licensee.

Chris Kloeris also has determined that for each of the first five years the new rule is in effect, the public benefit anticipated as a

result of enforcing the rule is that the public will have a method to quickly and easily access information concerning the Board's licensees. It has also been determined that the statutory profile requirements requiring profile information impose a $5.00 fee added to license renewal fees for each of the first five years the new rule is in effect. No disparate costs are foreseen for small or micro business. Comments are invited concerning disparate costs for such businesses.

Comments on the proposal may be submitted to Chris Kloeris, Executive Director, Texas Optometry Board, 333 Guadalupe Street, Suite 2-420, Austin, Texas 78701-3942. The deadline for furnishing comments is thirty days after publication in the *Texas Register.*

The new rule is proposed under the Texas Optometry Act, Texas Occupations Code, §351.151 and Senate Bill 187, 77th Legislature.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession. The Board interprets Senate Bill 187, 77th Legislature, as requiring the Board to adopt rules on a profile system and to collect and remit fees for the costs. No other sections are affected.

§273.12. Profile Information.

(a) All licensees shall provide, on each application for renewal of license, the information listed in subsection (b). New licensees shall provide the information listed in subsection (b) prior to receiving a license.

(b) Each license holder is required to furnish:

(1) the name of the license holder and the address and telephone number of the license holder's primary practice location;

(2) whether the license holder's patient service areas, as applicable, are accessible to disabled persons, as defined by federal law;

(3) the type of language translating services, including translating services for a person with impairment of hearing, that the license holder provides for patients, clients, users, customers, or consumers, as applicable;

(4) if applicable, insurance information, including whether the license holder participates in the state child health plan under Chapter 62, Health and Safety Code, or the Medicaid program;

(5) the education and training received by the license holder, as required by the licensing entity;

(6) any specialty certification held by the license holder;

(7) the number of years the person has practiced as a license holder; and

(8) if applicable, any hospital affiliation of the license holder.

(c) The information listed in subsection (b) shall be furnished when requested by the Board on the license renewal form or, in the case of a new applicant, when requested by letter from the Board.

(d) The Board shall make the information available to the public, including posting the information on the Board's Internet website.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Chris Kloeris
Executive Director
Texas Optometry Board
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For further information, please call: (512) 305-8500

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CHAPTER 275. CONTINUING EDUCATION

22 TAC §275.2

The Texas Optometry Board proposes amendments to rule §275.2 in order to allow optometrists and therapeutic optometrists to combine the credit hours for on-line courses and correspondence courses so that any combination of eight hours may be submitted. A citation correction is also being made.

Chris Kloeris, executive director of the Texas Optometry Board, has determined that for the first five-year period the amendments are in effect, there will be no fiscal implications for state and local governments as a result of enforcing or administering the amendments.

Chris Kloeris also has determined that for each of the first five years the amendments are in effect, the public benefit anticipated as a result of enforcing the amendments is that licensees will have access to the most current continuing education and will be able take advantage of more numerous course offerings on the Internet. It has also been determined that the amendments will not impose any additional costs to the persons affected by the rule. No additional costs are foreseen for small or micro business.

Comments on the proposal may be submitted to Chris Kloeris, Executive Director, Texas Optometry Board, 333 Guadalupe Street, Suite 2-420, Austin, Texas, 78701-3942. The deadline for furnishing comments is thirty days after publication in the *Texas Register.*

The amendment is proposed under the Texas Optometry Act, Texas Occupations Code, §351.151 and §351.308.

The Texas Optometry Board interprets §351.151 as authorizing the adoption of procedural and substantive rules for the regulation of the optometric profession. The Board interprets §351.308 as setting the requirements for continuing education. No other sections are affected.

§275.2. Required Education.

(a)-(c) (No change.)

(d) Continuing education courses. See [~~subsection~~] §275.1(b) of this title [~~section~~].

[~~(e) Correspondence courses. A maximum of four hours of credit per calendar year for correspondence courses sponsored and graded by accredited optometry colleges.~~]

(e) [~~(f)~~] Clinical rotations or rounds. One hour of continuing education credit will be given for each two clock hours spent on clinical rounds, for a maximum of four hours per calendar year. Sponsoring organizations and universities must submit information regarding scheduled rounds and certify to the board at least on a quarterly basis the number of continuing education hours obtained.

(f) [~~(g)~~] Credit will be given for a maximum of eight hours of the combined total of correspondence course hours and on-line computer course hours per calendar year. On-line computer courses are those courses [~~A maximum of four hours of credit per calendar year for on-line computer courses as~~] described in §275.1(b)(8) of this title (relating to General Requirements). Correspondence courses must be sponsored and graded by accredited optometry colleges.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Chris Kloeris
Executive Director
Texas Optometry Board
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PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 291. PHARMACIES

SUBCHAPTER B. COMMUNITY PHARMACY (CLASS A)

22 TAC §§291.33, 291.34, 291.36

The Texas State Board of Pharmacy proposes amendments to §291.33, concerning Operational Standards, §291.34, concerning Records, and §291.36, concerning Class A Pharmacies Compounding Sterile Pharmaceuticals. The amendments, if adopted, will (1) implement the provisions of the Occupations Code §562.015, as added by SB 768, Texas Legislature, 77th Session, by referencing a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists; and (2) update citations to the new codified Texas Pharmacy Act as a result of the rule review process.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the amendments are in effect, there will be fiscal implications for state government as a result of enforcing or administering the amendments. There are no anticipated fiscal implications for local government. Fiscal implications for state government will be the costs to the Texas State Board of Pharmacy to notify affected practitioners of the new requirements. The estimated cost to the Texas State Board of Pharmacy for the next five years will be: FY2002--$20,730.01; FY2003--$0; FY2004--$0; FY2005--$0; and FY2006--$0.

Ms. Dodson has determined that, for each year of the first five-year period the amendments will be in effect, the public benefit anticipated as a result of enforcing the amendments will be to allow easier patient access to lower cost generically equivalent drugs. A May 2001 study by The Center for Pharmacoeconomic Studies at the University of Texas at Austin estimates potential savings to patient and pharmacy benefit plans by increasing generic substitution of multi-source brand name prescription products in Texas to be $223,553,992.

Although not absolutely necessary, practitioners licensed to prescribe prescription drugs are encouraged to reprint their prescription forms to facilitate compliance with these new requirements. Cost to replace prescription forms is estimated to cost approximately $48.00 per 1000 forms. There is no additional fiscal impact anticipated for small or large businesses.

Written comments on the proposed amendments may be submitted to Steve Morse, R.Ph., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Box 21, Austin, Texas, 78701-3942, FAX (512) 305-8082. Comments must be received by 5 p.m., January 31, 2002. A public hearing to receive verbal comments will be held at 9:00 a.m. on Tuesday, February 5, 2002, in Room 2-225 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Persons presenting verbal testimony are asked to bring 15 copies of their comments to the hearing.

The amendments are proposed under §§551.002, 554.051, and 562.015 (as amended by SB 768, Acts of the 77th Texas Legislature) of the Texas Pharmacy Act (Chapters 551 - 566, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §562.015 as authorizing the agency to establish a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists.

The statutes affected by the rules: Chapters 551 - 566, Texas Occupations Code.

§291.33. Operational Standards.

(a) - (b) (No change.)

(c) Prescription dispensing and delivery.

(1) - (2) (No change.)

(3) Generic Substitution.

(A) General requirements.

(i) In accordance with Chapter 562 of the Act, a pharmacist may dispense a generically equivalent drug product if:

(I) the generic product costs the patient less than the prescribed drug product;

(II) the patient does not refuse the substitution; and

(III) the practitioner does not certify on the prescription form that a specific prescribed brand is medically necessary as specified in a dispensing directive described in subparagraph (C) of this paragraph.

(ii) If the practitioner has prohibited substitution through a dispensing directive in compliance with subparagraph (C) of this paragraph, a pharmacist shall not substitute a generically equivalent drug product unless the pharmacist obtains verbal or written authorization from the practitioner and notes such authorization on the original prescription drug order.

(B) Prescription format for written prescription drug orders.

(i) A written prescription drug order issued in Texas shall:

(I) be on a form containing a single signature line for the practitioner; and

(II) contain the following reminder statement on the face of the prescription: "A generically equivalent drug product will be dispensed unless the practitioner hand writes the words 'Brand Necessary' or 'Brand Medically Necessary' on the face of the prescription."

(ii) A pharmacist may dispense a prescription that is not issued on the form specified in clause (i) of this subparagraph, however, the pharmacist may dispense a generically equivalent drug product unless the practitioner has prohibited substitution through a dispensing directive in compliance with subparagraph (C)(i) of this paragraph.

(iii) The prescription format specified in clause (i) of this subparagraph does not apply to the following types of prescription drug orders:

(I) prescription drug orders issued by a practitioner in a state other than Texas;

(II) prescriptions for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; or

(III) prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.

(C) Dispensing directive.

(i) Written prescriptions.

(I) A practitioner may prohibit the substitution of a generically equivalent drug product for a brand name drug product in the manner authorized by 42 C.F.R. §447.331(c) which specifies that the practitioner shall write across the face of the written prescription, in his or her own handwriting, the phrase "brand necessary" or "brand medically necessary."

(II) The dispensing directive shall:

(-a-) be in a format that protects confidentiality as required by the Health Insurance Portability and Accountability Act of 1996 (29 U.S.C. §1181 et seq.) and its subsequent amendments; and

(-b-) comply with federal and state law, including rules, with regard to formatting and security requirements.

(III) The dispensing directive specified in this paragraph may not be preprinted, rubber stamped, or otherwise reproduced on the prescription form.

(IV) After, June 1, 2002, a practitioner may prohibit substitution on a written prescription only by following the dispensing directive specified in this paragraph. Two-line prescription forms, check boxes, or other notations on an original prescription drug order which indicate "substitution instructions" are not valid methods to prohibit substitution, and a pharmacist may substitute on these types of written prescriptions.

(V) A written prescription drug order issued prior to June 1, 2002, but presented for dispensing on or after June 1, 2002, shall follow the substitution instructions on the prescription.

(ii) Verbal Prescriptions.

(I) If a prescription drug order is transmitted to a pharmacist orally, the practitioner or practitioner's agent shall prohibit substitution by specifying "brand necessary" or "brand medically necessary." The pharmacists shall note any substitution instructions by the practitioner or practitioner's agent, on the file copy of the prescription drug order. Such file copy may follow the one-line format indicated in subparagraph (B)(i) of this paragraph, or any other format that clearly indicates the substitution instructions.

(II) If the practitioner's or practitioner's agent does not clearly indicate that the brand name is medically necessary, the pharmacist may substitute a generically equivalent drug product.

(III) To prohibit substitution on a verbal prescription reimbursed through the medical assistance program specified in 42 C.F.R., §447.331:

(-a-) the practitioner or the practitioner's agent shall verbally indicate that the brand is medically necessary; and

(-b-) the practitioner shall mail or fax a written prescription to the pharmacy which complies with the dispensing directive for written prescriptions specified in clause (i) of this subparagraph within 30 days.

(iii) Electronic prescription drug orders.

(I) To prohibit substitution, the practitioner or practitioner's agent shall note "brand necessary" or "brand medically necessary" on the electronic prescription drug order.

(II) If the practitioner or practitioner's agent does not clearly indicate on the electronic prescription drug order that the brand is medically necessary, the pharmacist may substitute a generically equivalent drug product.

(III) To prohibit substitution on an electronic prescription drug order reimbursed through the medical assistance program specified in 42 C.F.R., §447.331, the practitioner shall fax a copy of the original prescription drug order which complies with the requirements of a written prescription drug order specified in clause (i) of this subparagraph.

(iv) Compliance with federal law or rules. Should the requirements regarding substitution in 42 C.F.R., §447.331(c) change, the new requirements will be applicable to Texas prescriptions.

(v) Prescriptions issued by out-of-state, Mexican, Canadian, or federal facility practitioners.

(I) The dispensing directive specified in this subsection does not apply to the following types of prescription drug orders:

(-a-) prescription drug orders issued by a practitioner in a state other than Texas;

(-b-) prescriptions for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; or

(-c-) prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.

(II) A pharmacist may not substitute on prescription drug orders identified in subclause (I) of this clause unless the practitioner has authorized substitution on the prescription drug order. If the practitioner has not authorized substitution on the written prescription drug order, a pharmacist shall not substitute a generically equivalent drug product unless:

(-a-) the pharmacist obtains verbal or written authorization from the practitioner (such authorization shall be noted on the original prescription drug order); or

(-b-) the pharmacist obtains written documentation regarding substitution requirements from the State Board of Pharmacy in the state, other than Texas, in which the prescription

drug order was issued. The following is applicable concerning this documentation.

(-1-) The documentation shall state that a pharmacist may substitute on a prescription drug order issued in such other state unless the practitioner prohibits substitution on the original prescription drug order.

(-2-) The pharmacist shall note on the original prescription drug order the fact that documentation from such other state board of pharmacy is on file.

(-3-) Such documentation shall be updated yearly.

(D) Refills.

(i) Original substitution instructions. All refills, including prescriptions issued prior to June 1, 2001, shall follow the original substitution instructions or dispensing directive, unless otherwise indicated by the practitioner or practitioner's agent.

(ii) Narrow therapeutic index drugs.

(I) The board, in consultation with the Texas State Board of Medical Examiners, has determined that no drugs shall be included on a list of narrow therapeutic index drugs as defined in §562.013, Occupations Code. The board has specified in §309.7 of this title (relating to Dispensing Responsibilities) that pharmacist shall use as a basis for determining generic equivalency, Approved Drug Products with Therapeutic Equivalence Evaluations and current supplements published by the Federal Food and Drug Administration, within the limitations stipulated in that publication.

(-a-) Pharmacists may only substitute products that are rated therapeutically equivalent in the Approved Drug Products with Therapeutic Equivalence Evaluations and current supplements.

(-b-) Practitioners may prohibit substitution through a dispensing directive in compliance with subparagraph (C) of this paragraph.

(II) The board shall reconsider the contents of the list if the Federal Food and Drug Administration determines a new equivalence classification which indicates that certain drug products are equivalent but special notification to the patient and practitioner is required when substituting these products.

(4) Substitution of dosage form.

(A) As specified in §562.002 of the Act, a pharmacist may dispense a dosage form of a drug product different from that prescribed, such as a tablet instead of a capsule or liquid instead of tablets, provided:

(i) the patient consents to the dosage form substitution;

(ii) the pharmacist notifies the practitioner of the dosage form substitution; and

(iii) the dosage form so dispensed:

(I) contains the identical amount of the active ingredients as the dosage prescribed for the patient;

(II) is not an enteric-coated or time release product;

(III) does not alter desired clinical outcomes;

(B) Substitution of dosage form may not include the substitution of a product that has been compounded by the pharmacist unless the pharmacist contacts the practitioner prior to dispensing and obtains permission to dispense the compounded product.

(5) [~~(3)~~] Prescription containers.

(A) A drug dispensed pursuant to a prescription drug order shall be dispensed in a child-resistant container unless:

(i) the patient or the practitioner requests the prescription not be dispensed in a child-resistant container; or

(ii) the product is exempted from requirements of the Poison Prevention Packaging Act of 1970.

(B) A drug dispensed pursuant to a prescription drug order shall be dispensed in an appropriate container as specified on the manufacturer's container.

(C) Prescription containers or closures shall not be re-used.

(6) [~~(4)~~] Labeling.

(A) At the time of delivery of the drug, the dispensing container shall bear a label with at least the following information:

(i) name, address and phone number of the pharmacy;

(ii) unique identification number of the prescription;

(iii) date the prescription is dispensed;

(iv) initials or an identification code of the dispensing pharmacist;

(v) name of the prescribing practitioner;

(vi) name of the patient or if such drug was prescribed for an animal, the species of the animal and the name of the owner;

(vii) instructions for use;

(viii) quantity dispensed;

(ix) appropriate ancillary instructions such as storage instructions or cautionary statements such as warnings of potential harmful effects of combining the drug product with any product containing alcohol;

(x) if the prescription is for a Schedule II-IV controlled substance, the statement "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed";

(xi) if the pharmacist has selected a generically equivalent drug pursuant to the provisions of the Act, Chapters 562 and 563, the statement "Substituted for Brand Prescribed" or "Substituted for 'Brand Name'" where "Brand Name" is the actual name of the brand name product prescribed;

(xii) the name of the advanced practice nurse or physician assistant, if the prescription is carried out or signed by an advanced practice nurse or physician assistant in compliance with Subtitle B, Chapter 157, Occupations Code; and

(xiii) the name and strength of the actual drug product dispensed, unless otherwise directed by the prescribing practitioner.

(I) The name shall be either:

(-a-) the brand name; or

(-b-) if no brand name, then the generic name and name of the manufacturer or distributor of such generic drug. (The name of the manufacturer or distributor may be reduced to an abbreviation or initials, provided the abbreviation or initials are sufficient to identify the manufacturer or distributor. For combination drug products or non-sterile compounded drug products having no brand name, the principal active ingredients shall be indicated on the label.)

(II) Except as provided in clause (xi) of this subparagraph, the brand name of the prescribed drug shall not appear on the prescription container label unless it is the drug product actually dispensed.

(B) The dispensing container is not required to bear the label specified in subparagraph (A) of this paragraph if:

(i) the drug is prescribed for administration to an ultimate user who is institutionalized in a licensed health care institution (e.g., nursing home, hospice, hospital);

(ii) no more than a 34-day supply or 100 dosage units, whichever is less, is dispensed at one time;

(iii) the drug is not in the possession of the ultimate user prior to administration;

(iv) the pharmacist-in-charge has determined that the institution:

(I) maintains medication administration records which include adequate directions for use for the drug(s) prescribed;

(II) maintains records of ordering, receipt, and administration of the drug(s); and

(III) provides for appropriate safeguards for the control and storage of the drug(s); and

(v) the system employed by the pharmacy in dispensing the prescription drug order adequately:

(I) identifies the:

(-a-) pharmacy by name and address;

(-b-) unique identification number of the prescription;

(-c-) name and strength of the drug dispensed;

(-d-) name of the patient;

(-e-) name of the prescribing practitioner; and

(II) sets forth the directions for use and cautionary statements, if any, contained on the prescription drug order or required by law.

(d) - (j) (No change.)

§291.34. Records.

(a) (No change.)

(b) Prescriptions.

(1) (No change.)

(2) Written prescription drug orders.

(A) (No change.)

~~[(B) Required prescription drug order format.]~~

~~*[(i)* A pharmacist may not dispense a written prescription drug order issued in Texas unless it is ordered on a form containing two signature lines of equal prominence, side by side, at the bottom of the form. Under either signature line shall be printed clearly the words "product selection permitted," and under the other signature line shall be printed clearly the words "dispense as written."]~~

~~*[(ii)* The two signature line requirement does not apply to the following types of prescription drug orders:]~~

~~*[(I)* prescription drug orders issued by a practitioner in a state other than Texas;]~~

~~*[(II)* prescription drug orders for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; and]~~

~~*[(III)* prescription drug orders issued by a practitioner practicing in a federal facility provided they are acting in the scope of their employment.]~~

~~[(C) Preprinted prescription drug order forms. No prescription drug order form furnished to a practitioner shall contain a preprinted order for a drug product by brand name, generic name, or manufacturer.]~~

(B) [~~(D)~~] Prescription drug orders written by practitioners in another state.

(i) Dangerous drug prescription orders. A pharmacist may dispense a prescription drug order for dangerous drugs issued by practitioners in a state other than Texas in the same manner as prescription drug orders for dangerous drugs issued by practitioners in Texas are dispensed.

(ii) Controlled substance prescription drug orders.

(I) A pharmacist may dispense prescription drug order for controlled substances in Schedule II issued by a practitioner in another state provided:

(-a-) the prescription is filled in compliance with a written plan approved by the Director of the Texas Department of Public Safety in consultation with the Board, which provides the manner in which the dispensing pharmacy may fill a prescription for a Schedule II controlled substance;

(-b-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule II controlled substances in such other state; and

(-c-) the prescription drug order is not dispensed after the end of the seventh day after the date on which the prescription is issued.

(II) A pharmacist may dispense prescription drug orders for controlled substances in Schedule III, IV, or V issued by a practitioner in another state provided:

(-a-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule III, IV, or V controlled substances in such other state;

(-b-) the prescription drug order is not dispensed or refilled more than six months from the initial date of issuance and may not be refilled more than five times; and

(-c-) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order is obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(C) [~~(E)~~] Prescription drug orders written by practitioners in the United Mexican States or the Dominion of Canada.

(i) Controlled substance prescription drug orders. A pharmacist may not dispense a prescription drug order for a Schedule II, III, IV, or V controlled substance issued by a practitioner in the Dominion of Canada or the United Mexican States.

(ii) Dangerous drug prescription drug orders. A pharmacist may dispense a dangerous drug prescription issued by a person licensed in the Dominion of Canada or the United Mexican States as a physician, dentist, veterinarian, or podiatrist provided:

(I) the prescription drug order is an original written prescription; and

(II) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of dangerous drugs.

(D) [~~(F)~~] Prescription drug orders carried out or signed by an advanced practice nurse or physician assistant.

(i) A pharmacist may dispense a prescription drug order for a dangerous drug which is carried out or signed by an advanced practice nurse or physician assistant provided:

(I) the prescription is for a dangerous drug and not for a controlled substance; and

(II) the advanced practice nurse or physician assistant is practicing in accordance with Subtitle B, Chapter 157, Occupations Code.

(ii) Each practitioner shall designate in writing the name of each advanced practice nurse or physician assistant authorized to carry out or sign a prescription drug order pursuant to Subtitle B, Chapter 157, Occupations Code. A list of the advanced practice nurses or physician assistants designated by the practitioner must be maintained in the practitioner's usual place of business. On request by a pharmacist, a practitioner shall furnish the pharmacist with a copy of the written authorization for a specific advanced practice nurse or physician assistant.

(E) [~~(G)~~] Prescription drug orders for Schedule II controlled substances. No Schedule II controlled substance may be dispensed without a written prescription drug order of a practitioner on an official prescription form as required by the Texas Controlled Substances Act, §481.075.

(3) Verbal prescription drug orders.

(A) - (B) (No change.)

[~~(C) If a prescription drug order is transmitted to a pharmacist verbally, the pharmacist shall note any substitution instructions by the practitioner or practitioner's agent on the file copy of the prescription drug order. Such file copy may follow the two-line format indicated in paragraph (2)(B) of this subsection, or any other format that clearly indicates the substitution instructions.~~]

(C) [~~(D)~~] A pharmacist may not dispense a verbal prescription drug order for a Schedule III, IV, or V controlled substance issued by a practitioner licensed in another state unless the practitioner is also registered under the Texas Controlled Substances Act.

(D) [~~(E)~~] A pharmacist may not dispense a verbal prescription drug order for a dangerous drug or a controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(4) Electronic prescription drug orders. For the purpose of this subsection, prescription drug orders shall be considered the same as verbal prescription drug orders.

(A) - (B) (No change.)

(C) A pharmacist may not dispense an electronic prescription drug order for a:

(i) Schedule II controlled substance, except as authorized for faxed prescriptions in §481.074, Health and Safety Code;

(ii) - *(iii)* (No change.)

[~~(D) The practitioner or practitioner's agent shall note any substitution instructions on the electronic prescription drug order. Such electronic prescription drug order may follow the two-line format indicated in paragraph (2)(B) of this subsection, or any other format that clearly indicates the substitution instructions.~~]

[~~(5) Authorization for substitution.~~]

[~~(A) Generic substitution.~~]

~~*[(i)* A pharmacist may dispense a generically equivalent drug product if:~~]

~~*[(I)* the generic product cost the patient less than the prescribed drug product;~~]

~~*[(II)* the patient does not refuse the substitution; and~~]

~~*[(III)* the prescribing practitioner authorizes the substitution of a generically equivalent product; or~~]

~~*[(IV)* the practitioner or practitioner's agent does not clearly indicate that the verbal or electronic prescription drug order shall be dispensed as ordered.~~]

~~*[(ii)* Practitioners shall indicate their dispensing instructions by signing on either the "Dispense as Written" or "Product Selection Permitted" line on the prescription drug order. If the practitioner's signature does not clearly indicate the prescription drug order shall be dispensed as written, the pharmacist may substitute a generically equivalent drug product.~~]

~~*[(iii)* A pharmacist may not substitute on prescription drug orders identified in paragraph (2)(B)(ii) of this subsection unless the practitioner has authorized substitution on the prescription drug order.~~]

~~*[(iv)* If the practitioner has not authorized substitution on the written prescription drug order, a pharmacist shall not substitute a generically equivalent drug product unless:~~]

~~*[(I)* the pharmacist obtains verbal or written authorization from the practitioner (such authorization shall be noted on the original prescription drug order); or~~]

~~*[(II)* the pharmacist obtains written documentation regarding substitution requirements from the state board of pharmacy in the state, other than Texas, in which the prescription drug order was issued. The following is applicable concerning this documentation.~~]

[~~(-a-) The documentation shall state that a pharmacist may substitute on a prescription drug order issued in such~~

other state unless the practitioner prohibits substitution on the original prescription drug order.]

[(-b-) The pharmacist shall note on the original prescription drug order the fact that documentation from such other state board of pharmacy is on file.]

[(-c-) Such documentation shall be updated yearly.]

[(B) Substitution of dosage form.]

[(i) A pharmacist may dispense a dosage form of a drug product different from that prescribed, such as a tablet instead of a capsule or liquid instead of tablets, provided:]

[(I) the patient consents to the dosage form substitution;]

[(II) the pharmacist notifies the practitioner of the dosage form substitution; and]

[(III) the dosage form so dispensed:]

[(-a-) contains the identical amount of the active ingredients as the dosage prescribed for the patient;]

[(-b-) is not an enteric-coated or time release product;]

[(-c-) does not alter desired clinical outcomes;]

[(ii) Substitution of dosage form may not include the substitution of a product that has been compounded by the pharmacist unless the pharmacist contacts the practitioner prior to dispensing and obtains permission to dispense the compounded product.]

[(6) Therapeutic Drug Interchange. A switch to a drug providing a similar therapeutic response to the one prescribed shall not be made without prior approval of the prescribing practitioner. This paragraph does not apply to generic substitution. For generic substitution, see the requirements of paragraph (5) of this subsection.]

[(A) The patient shall be notified of the therapeutic drug interchange prior to, or upon delivery, of the dispensed prescription to the patient. Such notification shall include:]

[(i) a description of the change;]

[(ii) the reason for the change;]

[(iii) whom to notify with questions concerning the change; and]

[(iv) instructions for return of the drug if not wanted by the patient.]

[(B) The pharmacy shall maintain documentation of patient notification of therapeutic drug interchange which shall include:]

[(i) the date of the notification;]

[(ii) the method of notification;]

[(iii) a description of the change; and]

[(iv) the reason for the change.]

(5) [(7)] Original prescription drug order records.

(A) Original prescriptions shall be maintained by the pharmacy in numerical order and remain legible for a period of two years from the date of filling or the date of the last refill dispensed.

(B) If an original prescription drug order is changed, such prescription order shall be invalid and of no further force and effect; if additional drugs are to be dispensed, a new prescription drug order with a new and separate number is required.

(C) Original prescriptions shall be maintained in three separate files as follows:

(i) prescriptions for controlled substances listed in Schedule II;

(ii) prescriptions for controlled substances listed in Schedule III-V; and

(iii) prescriptions for dangerous drugs and nonprescription drugs.

(D) Original prescription records other than prescriptions for Schedule II controlled substances may be stored on microfilm, microfiche, or other system which is capable of producing a direct image of the original prescription record, e.g., digitalized imaging system. If original prescription records are stored in a direct imaging system, the following is applicable:

(i) the record of refills recorded on the original prescription must also be stored in this system;

(ii) the original prescription records must be maintained in numerical order and separated in three files as specified in subparagraph (C) of this paragraph; and

(iii) the pharmacy must provide immediate access to equipment necessary to render the records easily readable.

(6) [(8)] Prescription drug order information.

(A) All original prescriptions shall bear:

(i) name of the patient, or if such drug is for an animal, the species of such animal and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient; and

(viii) date of issuance.

(B) All original electronic prescription drug orders shall bear:

(i) name of the patient, if such drug is for an animal, the species of such animal, and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) indications for use, unless the practitioner determines the furnishing of this information is not in the best interest of the patient;

(viii) date of issuance;

(ix) a statement which indicates that the prescription has been electronically transmitted, (e.g., Faxed to or electronically transmitted to:);

(x) name, address, and electronic access number of the pharmacy to which the prescription was transmitted;

(xi) telephone number of the prescribing practitioner;

(xii) date the prescription drug order was electronically transmitted to the pharmacy, if different from the date of issuance of the prescription; and

(xiii) if transmitted by a designated agent, the full name of the designated agent.

(C) All original written prescriptions for dangerous drugs carried out or signed by an advanced practice nurse or physician assistant in accordance with Subtitle B, Chapter 157, Occupations Code, shall bear:

(i) name and address of the patient;

(ii) name, address, and telephone number of the supervising practitioner;

(iii) name, identification number, and original signature of the advanced practice nurse or physician assistant;

(iv) address and telephone number of the clinic at which the prescription drug order was carried out or signed;

(v) name, strength, and quantity of the dangerous drug;

(vi) directions for use;

(vii) indications for use, if appropriate;

(viii) date of issuance; and

(ix) number of refills authorized.

(D) At the time of dispensing, a pharmacist is responsible for the addition of the following information to the original prescription:

(i) unique identification number of the prescription drug order;

(ii) initials or identification code of the dispensing pharmacist;

(iii) quantity dispensed, if different from the quantity prescribed;

(iv) date of dispensing, if different from the date of issuance; and

(v) brand name or manufacturer of the drug product actually dispensed, if the drug was prescribed by generic name or if a drug product other than the one prescribed was dispensed pursuant to the provisions of the Act, Chapters 562 and 563.

(7) [~~(9)~~] Refills.

(A) Refills may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order.

(B) If there are no refill instructions on the original prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original prescription drug order have been dispensed, authorization from the prescribing practitioner shall be obtained prior to dispensing any refills.

(C) Refills of prescription drug orders for dangerous drugs or nonprescription drugs.

(i) Prescription drug orders for dangerous drugs or nonprescription drugs may not be refilled after one year from the date of issuance of the original prescription drug order.

(ii) If one year has expired from the date of issuance of an original prescription drug order for a dangerous drug or nonprescription drug, authorization shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of the drug.

(D) Refills of prescription drug orders for Schedule III-V controlled substances.

(i) Prescription drug orders for Schedule III-V controlled substances may not be refilled more than five times or after six months from the date of issuance of the original prescription drug order, whichever occurs first.

(ii) If a prescription drug order for a Schedule III, IV, or V controlled substance has been refilled a total of five times or if six months have expired from the date of issuance of the original prescription drug order, whichever occurs first, a new and separate prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(E) A pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(i) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(ii) either:

(I) a natural or manmade disaster has occurred which prohibits the pharmacist from being able to contact the practitioner; or

(II) the pharmacist is unable to contact the practitioner after a reasonable effort;

(iii) the quantity of prescription drug dispensed does not exceed a 72-hour supply;

(iv) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(v) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(vi) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection;

(vii) the pharmacist affixes a label to the dispensing container as specified in §291.33(c)(6) [~~§291.33(c)(4)~~] of this title (relating to Operational Standards); and

(viii) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(I) the patient has the prescription container, label, receipt or other documentation from the other pharmacy which contains the essential information;

(II) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(III) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of clauses (i) and (ii) of this subparagraph; and

(IV) the pharmacist complies with the requirements of clauses (iii) - (v) of this subparagraph.

(c) (No change.)

(d) Prescription drug order records maintained in a manual system.

(1) Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(C) [~~(b)(6)(D)~~] of this section.

(2) - (5) (No change.)

(e) Prescription drug order records maintained in a data processing system.

(1) General requirements for records maintained in a data processing system.

(A) (No change.)

(B) Original prescriptions. Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(C) [~~(b)(6)(D)~~] of this section.

(C) - (E) (No change.)

(2) - (6) (No change.)

(f) - (k) (No change.)

§291.36. Class A Pharmacies Compounding Sterile Pharmaceuticals.

(a) - (c) (No change.)

(d) Operational standards.

(1) - (2) (No change.)

(3) Prescription dispensing and delivery.

(A) (No change.)

(B) Generic Substitution. A pharmacist may substitute on a prescription drug order issued for a brand name product provided the substitution is authorized and performed in compliance with Chapter 309 of this title (relating to Generic Substitution).

(C) [~~(B)~~] Prescription containers.

(i) A drug dispensed pursuant to a prescription drug order shall be dispensed in an appropriate container as specified on the manufacturer's container.

(ii) Prescription containers or closures shall not be re-used.

(D) [~~(C)~~] Labeling.

(i) At the time of delivery of the drug, the dispensing container of a sterile pharmaceutical shall bear a label with at least the following information:

(I) name, address and phone number of the pharmacy, including a phone number which is answered 24 hours a day;

(II) date dispensed;

(III) name of prescribing practitioner;

(IV) name of patient;

(V) directions for use, including infusion rate and directions to the patient for the addition of additives, if applicable;

(VI) unique identification number of the prescription;

(VII) name and amount of the base solution and of each drug added unless otherwise directed by the prescribing practitioner;

(VIII) initials or identification code of the person preparing the product and the pharmacist who checked and released the final product;

(IX) expiration date of the preparation based on published data;

(X) appropriate ancillary instructions, such as storage instructions or cautionary statements, including cytotoxic/biohazardous warning labels where applicable;

(XI) if the prescription is for a Schedule II-IV controlled substance, the statement "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed";

(XII) if the pharmacist has selected a generically equivalent drug pursuant to the provisions of the Act, Chapters 562 and 563, the statement "Substituted for Brand Prescribed" or "Substituted for 'Brand Name'" where "Brand Name" is the actual name of the brand name product prescribed; and

(XIII) the name of the advanced practice nurse or physician assistant, if the prescription is carried out by an advanced practice nurse or physician assistant in compliance with Subtitle B, Chapter 157, Occupations Code.

(ii) The dispensing container is not required to bear the label specified in clause (i) of this subparagraph [~~subparagraph (A) of this paragraph~~] if:

(I) the drug is prescribed for administration to an ultimate user who is institutionalized in a licensed health care facility (e.g., nursing home, hospice, hospital);

(II) no more than a 34-day supply or 100 dosage units, whichever is less, is dispensed at one time;

(III) the drug is not in the possession of the ultimate user prior to administration;

(IV) the pharmacist-in-charge has determined that the institution:

(-a-) maintains medication administration records which include adequate directions for use for the drug(s) prescribed;

(-b-) maintains records of ordering, receipt, and administration of the drug(s); and

(-c-) provides for appropriate safeguards for the control and storage of the drug(s);

(V) the system employed by the pharmacy in dispensing the prescription drug order adequately identifies the:

(-a-) pharmacy by name and address;

(-b-) unique identification number of the prescription;

(-c-) name and strength of the drug dispensed;

(-d-) the name of the patient;

(-e-) name of the prescribing practitioner; and

(VI) the system employed by the pharmacy in dispensing the prescription drug order adequately sets forth the directions for use and cautionary statements, if any, contained on the prescription drug order or required by law.

(4) - (9) (No change.)

(e) Records.

(1) (No change.)

(2) Prescriptions.

(A) (No change.)

(B) Written prescription drug orders.

(i) (No change.)

~~*[(ii)* Required prescription drug order format.]~~

~~*[(I)* A pharmacist may not dispense a written prescription drug order issued in Texas unless it is ordered on a form containing two signature lines of equal prominence, side by side, at the bottom of the form. Under either signature line shall be printed clearly the words "product selection permitted," and under the other signature line shall be printed clearly the words "dispense as written."]~~

~~*[(II)* The two signature line requirement does not apply to the following types of prescriptions drug orders:]~~

~~[(-a-) prescription drug orders issued by a practitioner in a state other than Texas;]~~

~~[(-b-) prescription drug orders for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; and]~~

~~[(-c-) prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.]~~

~~*[(iii)* Preprinted prescription drug order forms. No prescription drug order form furnished to a practitioner shall contain a preprinted order for a drug product by brand name, generic name, or manufacturer.]~~

(ii) [~~(iv)~~] Prescription drug orders written by practitioners in another state.

(I) Dangerous drug prescription orders. A pharmacist may dispense a prescription drug order for dangerous drugs issued by practitioners in a state other than Texas in the same manner as prescription drug orders for dangerous drugs issued by practitioners in Texas are dispensed.

(II) Controlled substance prescription drug orders.

(-a-) A pharmacist may dispense prescription drug order for controlled substances in Schedule II issued by a practitioner in another state provided:

(-1-) the prescription is filled in compliance with a written plan approved by the Director of the Texas Department of Public Safety in consultation with the Board, which provides the manner in which the dispensing pharmacy may fill a prescription for a Schedule II controlled substance;

(-2-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule II controlled substances in such other state; and

(-3-) the prescription drug order is not dispensed after the end of the seventh day after the date on which the prescription is issued.

(-b-) A pharmacist may dispense prescription drug orders for controlled substances in Schedule III, IV, or V issued by a practitioner in another state provided:

(-1-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration registration number, and who may legally prescribe Schedule III, IV, or V controlled substances in such other state;

(-2-) the prescription drug order is not dispensed or refilled more than six months from the initial date of issuance and may not be refilled more than five times; and

(-3-) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order is obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(iii) [~~(v)~~] Prescription drug orders written by practitioners in the United Mexican States or the Dominion of Canada.

(I) Controlled substance prescription drug orders. A pharmacist may not dispense a prescription drug order for a Schedule II, III, IV, or V controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States.

(II) Dangerous drug prescription drug orders. A pharmacist may dispense a dangerous drug prescription issued by a person licensed in the Dominion of Canada or the United Mexican States as a physician, dentist, veterinarian, or podiatrist provided:

(-a-) the prescription drug order is an original written prescription; and

(-b-) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of dangerous drugs.

(iv) [~~(vi)~~] Prescription drug orders carried out or signed by an advanced practice nurse or physician assistant.

(I) A pharmacist may dispense a prescription drug order for a dangerous drug which is carried out or signed by an advanced practice nurse or physician assistant provided:

(-a-) the prescription is for a dangerous drug and not for a controlled substance; and

(-b-) the advanced practice nurse or physician assistant is practicing in accordance with Subtitle B, Chapter 157, Occupations Code.

(II) Each practitioner shall designate in writing the name of each advanced practice nurse or physician assistant authorized to carry out or sign a prescription drug order pursuant to Subtitle

B, Chapter 157, Occupations Code. A list of the advanced practice nurses or physician assistants designated by the practitioner must be maintained in the practitioner's usual place of business. On request by a pharmacist, a practitioner shall furnish the pharmacist with a copy of the written authorization for a specific advanced practice nurse or physician assistant.

(v) [~~(vii)~~] Prescription drug orders for Schedule II controlled substances. No Schedule II controlled substance may be dispensed without a written prescription drug order of a practitioner on an official prescription form as required by the Texas Controlled Substances Act, §481.075.

(C) Verbal prescription drug orders.

(i) - (ii) (No change.)

~~*[(iii)*~~ ~~If a prescription drug order is transmitted to a pharmacist verbally, the pharmacist shall note any substitution instructions by the practitioner or practitioner's agent on the file copy of the prescription drug order. Such file copy may follow the two-line format indicated in subparagraph (B)(ii) of this paragraph, or any other format that clearly indicates the substitution instructions.]~~

(iii) [~~(iv)~~] A pharmacist may not dispense a verbal prescription drug order for a Schedule III, IV, or V controlled substance issued by a practitioner licensed in another state unless the practitioner is also registered under the Texas Controlled Substances Act.

(iv) [~~(v)~~] A pharmacist may not dispense a verbal prescription drug order for a dangerous drug or a controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(D) Electronic prescription drug orders. For the purpose of this subparagraph, electronic prescription drug orders shall be considered the same as verbal prescription drug orders.

(i) - (ii) (No change.)

(iii) A pharmacist may not dispense an electronic prescription drug order for a:

(I) Schedule II controlled substance except as authorized for faxed prescriptions in §481.074, Health and Safety Code;

(II) - (III) (No change.)

~~*[(iv)*~~ ~~The practitioner or practitioner's agent shall note any substitution instructions on the electronic prescription drug order. Such electronic prescription drug order may follow the two-line format indicated in subparagraph (B)(ii) of this paragraph or any other format that clearly indicated the substitution instructions.]~~

~~[(E) Authorization for generic substitution.]~~

~~*[(i)*~~ ~~A pharmacist may dispense a generically equivalent drug product if:]~~

~~*[(I)*~~ ~~the generic product cost the patient less than the prescribed drug product;]~~

~~*[(II)*~~ ~~the patient does not refuse the substitution; and]~~

~~*[(III)*~~ ~~the prescribing practitioner authorizes the substitution of a generically equivalent product; or]~~

~~*[(IV)*~~ ~~the practitioner or practitioner's agent does not clearly indicate that the verbal or electronic prescription drug order shall be dispensed as ordered.]~~

~~*[(ii)*~~ ~~Practitioners shall indicate their dispensing instructions by signing on either the "Dispense as Written" or "Product Selection Permitted" line on the prescription drug order. If the practitioner's signature does not clearly indicate the prescription drug order shall be dispensed as written, the pharmacist may substitute a generically equivalent drug product.]~~

~~*[(iii)*~~ ~~A pharmacist may not substitute on prescription drug orders identified in subparagraph (B)(iv) and (v) of this paragraph unless the practitioner has authorized substitution on the prescription drug order.]~~

~~*[(iv)*~~ ~~If the practitioner has not authorized substitution on the written prescription drug order, a pharmacist shall not substitute a generically equivalent drug product unless:]~~

~~*[(I)*~~ ~~the pharmacist obtains verbal or written authorization from the practitioner (such authorization shall be noted on the original prescription drug order); or]~~

~~*[(II)*~~ ~~the pharmacist obtains written documentation regarding substitution requirements from the State Board of Pharmacy in the state, other than Texas, in which the prescription drug order was issued. The following is applicable concerning this documentation.]~~

~~[(-a-) The documentation shall state that a pharmacist may substitute on a prescription drug order issued in such other state unless the practitioner prohibits substitution on the original prescription drug order.]~~

~~[(-b-) The pharmacist shall note on the original prescription drug order the fact that documentation from such other state board of pharmacy is on file.]~~

~~[(-c-) Such documentation shall be updated yearly.]~~

~~[(F) Substitution of dosage form.]~~

~~*[(i)*~~ ~~A pharmacist may dispense a dosage form of a drug product different from that prescribed, such as a tablet instead of a capsule or liquid instead of tablets, provided:]~~

~~*[(I)*~~ ~~the patient consents to the dosage form substitution;]~~

~~*[(II)*~~ ~~the pharmacist notifies the practitioner of the dosage form substitution; and]~~

~~*[(III)*~~ ~~the dosage form so dispensed:]~~

~~[(-a-) contains the identical amount of the active ingredients as the dosage prescribed for the patient;]~~

~~[(-b-) is not an enteric-coated or time release product; and]~~

~~[(-c-) does not alter desired clinical outcomes.]~~

~~*[(ii)*~~ ~~Substitution of dosage form may not include the substitution of a product that has been compounded by the pharmacist unless the pharmacist contacts the practitioner prior to dispensing and obtains permission to dispense the compounded product.]~~

~~[(G) Therapeutic Drug Interchange. A switch to a drug providing a similar therapeutic response to the one prescribed shall not be made without prior approval of the prescribing practitioner. This subparagraph does not apply to generic substitution. For generic substitution, see the requirements of subparagraphs (E) and (F) of this paragraph.]~~

~~*[(i)*~~ ~~The patient shall be notified of the therapeutic drug interchange prior to, or upon delivery, of the dispensed prescription to the patient. Such notification shall include:]~~

~~*[(I)*~~ ~~a description of the change;]~~

~~[(II)~~ ~~the reason for the change;]~~

~~[(III)~~ ~~whom to notify with questions concerning the change; and]~~

~~[(IV)~~ ~~instructions for return of the drug if not wanted by the patient.]~~

~~[(ii)~~ ~~The pharmacy shall maintain documentation of patient notification of therapeutic drug interchange which shall include:]~~

~~[(I)~~ ~~the date of the notification;]~~

~~[(II)~~ ~~the method of notification;]~~

~~[(III)~~ ~~a description of the change; and]~~

~~[(IV)~~ ~~the reason for the change.]~~

(E) [~~(II)~~] Original prescription drug order records.

(i) Original prescriptions shall be maintained by the pharmacy in numerical order and remain legible for a period of two years from the date of filling or the date of the last refill dispensed.

(ii) If an original prescription drug order is changed, such prescription order shall be invalid and of no further force and effect; if additional drugs are to be dispensed, a new prescription drug order with a new and separate number is required.

(iii) Original prescriptions shall be maintained in one of the following formats:

(I) in three separate files as follows:

(-a-) prescriptions for controlled substances listed in Schedule II;

(-b-) prescriptions for controlled substances listed in Schedule III - V; and

(-c-) prescriptions for dangerous drugs and nonprescription drugs; or

(II) within a patient medication record system provided that original prescriptions for controlled substances are maintained separate from original prescriptions for noncontrolled substances and official prescriptions for Schedule II controlled substances are maintained separate from all other original prescriptions.

(iv) Original prescription records other than prescriptions for Schedule II controlled substances may be stored on microfilm, microfiche, or other system which is capable of producing a direct image of the original prescription record, e.g., digitalized imaging system. If original prescription records are stored in a direct imaging system, the following is applicable.

(I) The record of refills recorded on the original prescription must also be stored in this system.

(II) The original prescription records must be maintained in numerical order and as specified in clause (iii) of this subparagraph.

(III) The pharmacy must provide immediate access to equipment necessary to render the records easily readable.

(F) [~~(I)~~] Prescription drug order information.

(i) All original prescriptions shall bear:

(I) name of the patient;

(II) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(III) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(IV) name and strength of the drug prescribed;

(V) quantity prescribed;

(VI) directions for use;

(VII) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient;

(VIII) date of issuance; and

(IX) if telephoned to the pharmacist by a designated agent, the full name of the designated agent.

(ii) All original prescriptions for dangerous drugs carried out by an advanced practice nurse or physician assistant in accordance with Subtitle B, Chapter 157, Occupations Code, shall bear:

(I) name and address of the patient;

(II) name, address, and telephone number of the practitioner;

(III) name, address, telephone number, identification number, and original signature of the advanced practice nurse or physician assistant;

(IV) name, strength, and quantity of the dangerous drug;

(V) directions for use;

(VI) the intended use of the drug, if appropriate;

(VII) date of issuance; and

(VIII) number of refills authorized.

(iii) All original electronic prescription drug orders shall bear:

(I) name of the patient;

(II) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as patient medication records;

(III) name and strength of the drug prescribed;

(IV) quantity prescribed;

(V) directions for use;

(VI) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient;

(VII) date of issuance;

(VIII) a statement which indicates that the prescription has been electronically transmitted (e.g., Faxed to or electronically transmitted to:);

(IX) name, address, and electronic access number of the pharmacy to which the prescription was transmitted;

(X) telephone number of the prescribing practitioner;

(XI) date the prescription drug order was electronically transmitted to the pharmacy, if different from the date of issuance of the prescription; and

(XII) if transmitted by a designated agent, the full name of the designated agent.

(iv) At the time of dispensing, a pharmacist is responsible for the addition of the following information to the original prescription:

(I) unique identification number of the prescription drug order;

(II) initials or identification code of the person who compounded the sterile pharmaceutical and the pharmacist who checked and released the product;

(III) name, quantity, lot number, and expiration date of each product used in compounding the sterile pharmaceutical; and

(IV) date of dispensing, if different from the date of issuance.

(G) [~~(J)~~] Refills.

(i) Refills may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order. Such refills may be indicated as authorization to refill the prescription drug order a specified number of times or for a specified period of time period, such as the duration of therapy.

(ii) If there are no refill instructions on the original prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original prescription drug order have been dispensed, authorization from the prescribing practitioner shall be obtained prior to dispensing any refills.

(iii) Refills of prescription drug orders for dangerous drugs or nonprescription drugs shall be dispensed as follows.

(I) Prescription drug orders for dangerous drugs or nonprescription drugs may not be refilled after one year from the date of issuance of the original prescription order.

(II) If one year has expired from the date of issuance of an original prescription drug order for a dangerous drug or nonprescription drug, authorization shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of the drug.

(iv) Refills of prescription drug orders for Schedule III - V controlled substances shall be dispensed as follows.

(I) Prescription drug orders for Schedule III - V controlled substances may not be refilled more than five times or after six months from the date of issuance of the original prescription drug order, whichever occurs first.

(II) If a prescription drug order for a Schedule III, IV, or V controlled substance has been refilled a total of five times or if six months have expired from the date of issuance of the original prescription drug order, whichever comes first, a new and separate prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(v) A pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(I) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(II) either:

(-a-) a natural or manmade disaster has occurred which prohibits the pharmacist from being able to contact the practitioner; or

(-b-) the pharmacist is unable to contact the practitioner after a reasonable effort;

(III) the quantity of prescription drug dispensed does not exceed a 72-hour supply;

(IV) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(V) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(VI) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this paragraph;

(VII) the pharmacist affixes a label to the dispensing container as specified in this paragraph; and

(VIII) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(-a-) the patient has the prescription container, label, receipt or other documentation from the other pharmacy which contains the essential information;

(-b-) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(-c-) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of subclauses (I) and (II) of this clause; and

(IX) the pharmacist complies with the requirements of subclauses (III) - (V) of this clause.

(3) Prescription drug order records maintained in a manual system.

(A) Original prescriptions. Original prescriptions shall be maintained in three files as specified in paragraph (2)(E)(iii) [~~(2)(H)(iii)~~] of this subsection.

(B) - (E) (No change.)

(4) Prescription drug order records maintained in a data processing system.

(A) General requirements for records maintained in a data processing system.

(i) (No change.)

(ii) Original prescriptions. Original prescriptions shall be maintained as specified in paragraph (2)(E)(iii) [~~(2)(F)(iii)~~] of this subsection.

(iii) - (v) (No change.)

(B) - (F) (No change.)

(5) - (11) (No change.)

(f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 11, 2001.

TRD-200107733
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8028

♦ ♦ ♦

SUBCHAPTER C. NUCLEAR PHARMACY (CLASS B)

22 TAC §§291.52, 291.54, 291.55

The Texas State Board of Pharmacy proposes amendments to §291.52, concerning Definitions, §291.54, concerning Operational Standards, and §291.55, concerning Records. The amendments, if adopted, will (1) implement the provisions of the Occupations Code §562.015, as added by SB 768, Texas Legislature, 77th Session, by referencing a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists; and (2) update citations to the new codified Texas Pharmacy Act as a result of the rule review process.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the amendments are in effect, there will be fiscal implications for state government as a result of enforcing or administering the amendments. There are no anticipated fiscal implications for local government. Fiscal implications for state government will be the costs to the Texas State Board of Pharmacy to notify affected practitioners of the new requirements. The estimated cost to the Texas State Board of Pharmacy for the next five years will be: FY2002--$20,730.01; FY2003--$0; FY2004--$0; FY2005--$0; and FY2006--$0.

Ms. Dodson has determined that, for each year of the first five-year period the amendments will be in effect, the public benefit anticipated as a result of enforcing the amendments will be to allow easier patient access to lower cost generically equivalent drugs. A May 2001 study by The Center for Pharmacoeconomic Studies at the University of Texas at Austin estimates potential savings to patient and pharmacy benefit plans by increasing generic substitution of multi-source brand name prescription products in Texas to be $223,553,992.

Although not absolutely necessary, practitioners licensed to prescribe prescription drugs are encouraged to reprint their prescription forms to facilitate compliance with these new requirements. Cost to replace prescription forms is estimated to cost approximately $48.00 per 1000 forms. There is no additional fiscal impact anticipated for small or large businesses.

Written comments on the proposed amendments may be submitted to Steve Morse, R.Ph., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Box 21, Austin, Texas, 78701-3942, FAX (512) 305-8082. Comments must be received by 5 p.m., January 31, 2002. A public hearing to receive verbal comments will be held at 9:00 a.m. on Tuesday, February 5, 2002, in Room 2-225 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Persons presenting verbal testimony are asked to bring 15 copies of their comments to the hearing.

The amendments are proposed under §§551.002, 554.051, and 562.015 (as amended by SB 768, Acts of the 77th Texas Legislature) of the Texas Pharmacy Act (Chapters 551 - 566, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §562.015 as authorizing the agency to establish a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists.

The statutes affected by the rules: Chapters 551 - 566, Texas Occupations Code.

§291.52. Definitions.

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise. Any term not defined in this section shall have the definition set forth in the Act, §551.003 [~~§5~~].

(1) Act--The Texas Pharmacy Act, Chapters 551-566, Occupations Code [~~Texas Civil Statutes, Article 4542a-1~~], as amended.

(2) Accurately as prescribed--Dispensing, delivering, and/or distributing a prescription drug order or radioactive prescription drug order:

(A) to the correct patient (or agent of the patient) for whom the drug or device was prescribed;

(B) with the correct drug in the correct strength, quantity, and dosage form ordered by the practitioner; and

(C) with correct labeling (including directions for use) as ordered by the practitioner. Provided, however, that nothing herein shall prohibit pharmacist substitution if substitution is conducted in strict accordance with applicable laws and rules, including Subchapter A, Chapter 562 [~~§40~~] of the Texas Pharmacy Act.

(3) - (16) (No change.)

(17) Dangerous drug--A device, drug, or radioactive drug that is unsafe for self medication and that is not included in Penalty Groups I through IV of Chapter 481 (Texas Controlled Substances Act). The term includes a device, drug, or radiopharmaceutical that bears or is required to bear the legend:

(A) "Caution: Federal Law Prohibits Dispensing Without a Prescription" or "Rx only" or another legend that complies with federal law; or

(B) "Caution: Federal Law Restricts This Drug To Be Used By or on the Order of a Licensed Veterinarian."

(18) - (40) (No change.)

§291.54. Operational Standards.

(a) Licensing requirements.

(1) - (9) (No change.)

(10) A Class B pharmacy, licensed under the provisions of the Act, §560.051(a)(2) [~~§29(b)(2)~~], which also operates another type of pharmacy which would otherwise be required to be licensed under the Act, §560.051(a)(1) [~~§29(b)(1)~~], concerning community pharmacy (Class A), is not required to secure a license for such other type of pharmacy; provided, however, such licensee is required to comply with the provisions of §291.31 of this title (relating to Definitions); §291.32 of this title (relating to Personnel); §291.33 of this title (relating to Operational Standards); §291.34 of this title (relating to Records); §291.35 of this title (relating to Triplicate Prescription Requirements);

and §291.36 of this title (relating to Class A Pharmacies Dispensing Compounded Sterile Parenteral and/or Enteral Products), contained in Community Pharmacy (Class A), to the extent such rules are applicable to the operation of the pharmacy.

(11) (No change.)

(b) (No change.)

(c) Prescription dispensing and delivery.

(1) Generic Substitution. A pharmacist may substitute on a prescription drug order issued for a brand name product provided the substitution is authorized and performed in compliance with Chapter 309 of this title (relating to Generic Substitution).

(2) [~~(1)~~] Prescription containers (immediate inner containers).

(A) A drug dispensed pursuant to a radioactive prescription drug order shall be dispensed in an appropriate immediate inner container as follows.

(i) If a drug is susceptible to light, the drug shall be dispensed in a light-resistant container.

(ii) If a drug is susceptible to moisture, the drug shall be dispensed in a tight container.

(iii) The container should not interact physically or chemically with the drug product placed in it so as to alter the strength, quality, or purity of the drug beyond the official requirements.

(B) Immediate inner prescription containers or closures shall not be re-used.

(3) [~~(2)~~] Delivery containers (outer containers).

(A) Prescription containers may be placed in suitable containers for delivery which will transport the radiopharmaceutical safely in compliance with all applicable laws and regulations.

(B) Delivery containers may be re-used provided they are maintained in a manner to prevent cross contamination.

(4) [~~(3)~~] Labeling.

(A) The immediate inner container of a radiopharmaceutical shall be labeled with:

(i) standard radiation symbol;

(ii) the words "caution-radioactive material";

(iii) the name of the radiopharmaceutical; and

(iv) the unique identification number of the prescription.

(B) The outer container of a radiopharmaceutical shall be labeled with:

(i) the name, address, and phone number of the pharmacy;

(ii) the date dispensed;

(iii) the directions for use, if applicable;

(iv) the unique identification number of the prescription;

(v) the name of the patient if known, or the statement, "for physician use" if the patient is unknown;

(vi) the standard radiation symbol;

(vii) the words "caution-radioactive material";

(viii) the name of the radiopharmaceutical;

(ix) the amount of radioactive material contained in millicuries (mCi), microcuries (uCi), or bequerels (Bq) and the corresponding time that applies to this activity, if different from the requested calibration date and time;

(x) the name or initials of the person preparing the product and the authorized nuclear pharmacist who checked and released the final product unless documents are maintained in the pharmacy identifying these individuals for each prescription dispensed;

(xi) if a liquid, the volume in milliliters;

(xii) the requested calibration date and time; and

(xiii) the expiration date and/or time.

(C) The amount of radioactivity shall be determined by radiometric methods for each individual preparation immediately at the time of dispensing and calculations shall be made to determine the amount of activity that will be present at the requested calibration date and time, due to radioactive decay in the intervening period, and this activity and time shall be placed on the label per requirements set out in paragraph (4) [~~(2)~~] of this subsection.

(d) Pharmaceutical Care Services.

(1) (No change.)

(2) Other pharmaceutical care services which may be provided by authorized nuclear pharmacists include, but are not limited to, the following:

(A) managing drug therapy as delegated by a practitioner as allowed under the provisions of the Medical Practice Act [~~, §3.061 or §3.06(d)~~];

(B) - (D) (No change.)

(e) - (i) (No change.)

§291.55. Records.

(a) (No change.)

(b) Prescriptions.

(1) (No change.)

(2) Verbal radioactive prescription drug orders.

(A) - (B) (No change.)

[~~(C) If a radioactive prescription drug order is transmitted to an authorized nuclear pharmacist verbally, the pharmacist shall note any substitution instructions by the practitioner or practitioner's agent on the file copy of the prescription drug order. Such file copy may follow the two-line format indicated in paragraph (3)(B) of this subsection, or any other format that clearly indicates the substitution instructions.~~]

(C) [~~(D)~~] A pharmacist may not dispense a verbal radioactive prescription drug order for a Schedule III, IV, or V controlled substance issued by a practitioner licensed in another state unless the practitioner is also registered under the Texas Controlled Substances Act.

(D) [~~(E)~~] A pharmacist may not dispense a verbal radioactive prescription drug order for a dangerous drug or a controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(3) Written radioactive prescription drug orders.

(A) (No change.)

~~[(B) Required radioactive prescription drug order format.]~~

~~*[(i)* A pharmacist may not dispense a written radioactive prescription drug order issued in Texas unless it is ordered on a form containing two signature lines of equal prominence, side by side, at the bottom of the form. Under either signature line shall be printed clearly the words "product selection permitted," and under the other signature line shall be printed clearly the words "dispense as written."]~~

~~*[(ii)* The two signature line requirement does not apply to the following types of radioactive prescriptions drug orders:]~~

~~*[(I)* radioactive prescription drug orders issued by a practitioner in a state other than Texas;]~~

~~*[(II)* radioactive prescription drug orders for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; and]~~

~~*[(III)* radioactive prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.]~~

~~[(C) Preprinted radioactive prescription drug order forms. No radioactive prescription drug order form furnished to a practitioner shall contain a preprinted order for a radiopharmaceutical by brand name, generic name, or manufacturer.]~~

(B) [~~(D)~~] Radioactive prescription drug orders written by practitioners in another state.

(i) Dangerous drug prescription orders. A pharmacist may dispense a radioactive prescription drug order for dangerous drugs issued by practitioners in a state other than Texas in the same manner as radioactive prescription drug orders for dangerous drugs issued by practitioners in Texas are dispensed.

(ii) Controlled substance prescription drug orders. A pharmacist may dispense radioactive prescription drug orders for controlled substances in Schedule III, IV, or V issued by a practitioner in another state provided:

(I) the radioactive prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration registration number, and who may legally prescribe Schedule III, IV, or V controlled substances in such other state;

(II) the radioactive prescription drug order is not dispensed or refilled more than six months from the initial date of issuance and may not be refilled more than five times; and

(III) if there are no refill instructions on the original written radioactive prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written radioactive prescription drug order have been dispensed, a new written radioactive prescription drug order is obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(C) [~~(E)~~] Radioactive prescription drug orders written by practitioners in the United Mexican States or the Dominion of Canada.

(i) Controlled substance prescription drug orders. A pharmacist may not dispense a radioactive prescription drug order for a Schedule II, III, IV, or V controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States.

(ii) Dangerous drug prescription drug orders. A pharmacist may dispense a radioactive prescription drug order for a dangerous drug issued by a person licensed in the Dominion of Canada or the United Mexican States as a physician, dentist, veterinarian, or podiatrist provided:

(I) the radioactive prescription drug order is an original written prescription; and

(II) if there are no refill instructions on the original written radioactive prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written radioactive prescription drug order have been dispensed, a new written radioactive prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of dangerous drugs.

(iii) Prescription drug orders for Schedule II controlled substances. No Schedule II controlled substance may be dispensed without a written prescription drug order of a practitioner on a official [~~triplicate~~] prescription form as required by the Texas Controlled Substances Act, §481.075.

(4) Electronic radioactive prescription drug orders. For the purpose of this paragraph, electronic radioactive prescription drug orders shall be considered the same as verbal radioactive prescription drug orders.

(A) - (B) (No change.)

(C) A pharmacist may not dispense an electronic radioactive prescription drug order for a:

(i) Schedule II controlled substance except as authorized for faxed prescriptions in §481.074, Health and Safety Code;

(ii) - *(iii)* (No change.)

~~[(D) The practitioner or practitioner's agent shall note any substitution instructions on the electronic radioactive prescription drug order. Such electronic radioactive prescription drug order may follow the two-line format indicated in paragraph (3)(B) of this subsection or any other format that clearly indicated the substitution instructions.]~~

~~[(5) Authorization for generic substitution.]~~

~~[(A) A pharmacist may dispense a generically equivalent drug product if:]~~

~~*[(i)* the generic product cost the patient less than the prescribed drug product;]~~

~~*[(ii)* the patient does not refuse the substitution; and]~~

~~*[(iii)* the prescribing practitioner authorizes the substitution of a generically equivalent product; or]~~

~~*[(iv)* the practitioner or practitioner's agent does not clearly indicate that the verbal or electronic prescription drug order shall be dispensed as ordered.]~~

~~[(B) Practitioners shall indicate their dispensing instructions by signing on either the "Dispense as Written" or "Product Selection Permitted" line on the radioactive prescription drug order. If the practitioner's signature does not clearly indicate the radioactive prescription drug order shall be dispensed as written, the pharmacist may substitute a generically equivalent drug product.]~~

~~[(C) A pharmacist may not substitute on radioactive prescription drug orders identified in paragraph (3)(D) and (E) of this~~

~~subsection unless the practitioner has authorized substitution on the radioactive prescription drug order.]~~

~~[(D) If the practitioner has not authorized substitution on the written radioactive prescription drug order, a pharmacist shall not substitute a generically equivalent drug product unless:]~~

~~*[(i)* the pharmacist obtains verbal or written authorization from the practitioner (such authorization shall be noted on the original radioactive prescription drug order); or]~~

~~*[(ii)* the pharmacist obtains written documentation regarding substitution requirements from the State Board of Pharmacy in the state, other than Texas, in which the radioactive prescription drug order was issued. The following is applicable concerning this documentation.]~~

~~*[(I)* The documentation shall state that a pharmacist may substitute on a prescription drug order issued in such other state unless the practitioner prohibits substitution on the original prescription drug order.]~~

~~*[(II)* The pharmacist shall note on the original radioactive prescription drug order the fact that documentation from such other state board of pharmacy is on file.]~~

~~*[(III)* Such documentation shall be updated yearly.]~~

(5) [~~(6)~~] Original prescription drug order records.

(A) Original prescriptions shall be maintained by the pharmacy in numerical order and remain legible for a period of two years from the date of filling or the date of the last refill dispensed.

(B) If an original prescription drug order is changed, such prescription order shall be invalid and of no further force and effect; if additional drugs are to be dispensed, a new prescription drug order with a new and separate number is required.

(C) Original prescriptions shall be maintained in one of the following formats:

(i) in three separate files as follows:

(I) prescriptions for controlled substances listed in Schedule II;

(II) prescriptions for controlled substances listed in Schedule III-V; and

(III) prescriptions for dangerous drugs and nonprescription drugs; or

(ii) within a patient medication record system provided that original prescriptions for controlled substances are maintained separate from original prescriptions for noncontrolled substances and triplicate prescriptions for Schedule II controlled substances are maintained separate from all other original prescriptions.

(D) Original prescription records other than triplicate prescriptions may be stored on microfilm, microfiche, or other system which is capable of producing a direct image of the original prescription record, e.g., digitalized imaging system. If original prescription records are stored in a direct imaging system, the following is applicable.

(i) The record of refills recorded on the original prescription must also be stored in this system.

(ii) The original prescription records must be maintained in numerical order and as specified in subparagraph (C) of this paragraph.

(iii) The pharmacy must provide immediate access to equipment necessary to render the records easily readable.

(6) [~~(7)~~] Prescription drug order information.

(A) All original radioactive prescription drug orders shall bear:

(i) name of the patient, if applicable at the time of the order;

(ii) name of the institution;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner

(iv) name of the radiopharmaceutical;

(v) amount of radioactive material contained in millicuries (mCi), microcuries (uCi), or bequerels (Bq) and the corresponding time that applies to this activity, if different than the requested calibration date and time;

(vi) date and time of calibration;

(vii) if a liquid, the volume in milliliters;

(viii) date of issuance; and

(ix) if telephoned to the pharmacy by a designated agent, the full name of the designated agent.

(B) All original electronic radioactive prescription drug orders shall bear:

(i) name of the patient, if applicable at the time of the order;

(ii) name of the institution;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name of the radiopharmaceutical;

(v) amount of radioactive material contained in millicuries (mCi), microcuries (uCi), or bequerels (Bq) and the corresponding time that applies to this activity, if different than the requested calibration date and time;

(vi) date and time of calibration;

(vii) if a liquid, the volume in milliliters;

(viii) a statement which indicates that the prescription has been electronically transmitted (e.g., Faxed to or electronically transmitted to:);

(ix) name, address, and electronic access number of the pharmacy to which the prescription was transmitted;

(x) telephone number of the prescribing practitioner;

(xi) date the prescription drug order was electronically transmitted to the pharmacy, if different from the date of issuance of the prescription;

(xii) date of issuance; and

(xiii) if telephoned to the pharmacy by a designated agent, the full name of the designated agent.

(C) At the time of dispensing, a pharmacist is responsible for the addition of the following information to the original prescription:

(i) unique identification number of the prescription drug order;

(ii) initials or identification code of the person who compounded the sterile radiopharmaceutical and the pharmacist who checked and released the product;

(iii) name, quantity, lot number, and expiration date of each product used in compounding the sterile radiopharmaceutical; and

(iv) date of dispensing, if different from the date of issuance.

(7) [~~(8)~~] Refills. A radioactive prescription drug order must be filled from an original prescription which may not be refilled.

(c) - (f) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 11, 2001.

TRD-200107734
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8028

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CHAPTER 309. GENERIC SUBSTITUTION

The Texas State Board of Pharmacy proposes a repeal of §§309.1 - 309.8, concerning Generic Substitution and simultaneously proposes new §§309.1 - 309.8, concerning Generic Substitution. The new rule, if adopted, will (1) implement the provisions of the Occupations Code §562.015, as added by SB 768, Texas Legislature, 77th Session, by establishing a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists; and (2) update citations to the new codified Texas Pharmacy Act as a result of the rule review process.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rules are in effect, there will be fiscal implications for state government as a result of enforcing or administering the rules. There are no anticipated fiscal implications for local government. Fiscal implications for state government will be the costs to the Texas State Board of Pharmacy to notify affected practitioners of the new requirements. The estimated cost to the Texas State Board of Pharmacy for the next five years will be: FY2002--$20,730.01; FY2003--$0; FY2004--$0; FY2005--$0; and FY2006--$0.

Ms. Dodson has determined that, for each year of the first five-year period the rules will be in effect, the public benefit anticipated as a result of enforcing the rules will be to allow easier patient access to lower cost generically equivalent drugs. A May 2001 study by The Center for Pharmacoeconomic Studies at the University of Texas at Austin estimates potential savings to patient and pharmacy benefit plans by increasing generic substitution of multi-source brand name prescription products in Texas to be $223,553,992.

Although not absolutely necessary, practitioners licensed to prescribe prescription drugs are encouraged to reprint their prescription forms to facilitate compliance with these new requirements. Cost to replace prescription forms is estimated to cost approximately $48.00 per 1000 forms. There is no additional fiscal impact anticipated for small or large businesses.

Written comments on the proposed rules may be submitted to Steve Morse, R.Ph., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Box 21, Austin, Texas, 78701-3942, FAX (512) 305-8082. Comments must be received by 5 p.m., January 31, 2002. A public hearing to receive verbal comments will be held at 9:00 a.m. on Tuesday, February 5, 2002, in Room 2-225 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Persons presenting verbal testimony are asked to bring 15 copies of their comments to the hearing.

22 TAC §§309.1 - 309.8

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas State Board of Pharmacy or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under §§551.002, 554.051, and 562.015 (as amended by SB 768, Acts of the 77th Texas Legislature) of the Texas Pharmacy Act (Chapters 551 - 566, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §562.015 as authorizing the agency to establish a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists.

The statutes affected by the repeal: Chapters 551 - 566, Texas Occupations Code.

§309.1. Objective.
§309.2. Definitions.
§309.3. Prescription Drug Orders.
§309.4. Patient Notification.
§309.5. Labeling Requirements.
§309.6. Records.
§309.7. Dispensing Responsibilities.
§309.8. Advertising of Generic Drugs by Pharmacies.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 11, 2001.

TRD-200107735
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8028

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22 TAC §§309.1 - 309.8

The new rules are proposed under §§551.002, 554.051, and 562.015 (as amended by SB 768, Acts of the 77th Texas Legislature) of the Texas Pharmacy Act (Chapters 551 - 566, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §562.015 as authorizing the agency to establish a "dispensing directive" for the communication of substitution instructions from practitioners to pharmacists.

The statutes affected by this rule: Chapters 551 - 566, Texas Occupations Code.

§309.1. Objective.

These sections govern the substitution of lower-priced generically equivalent drug products for certain brand name drug products.

§309.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Any term not defined in this section shall have the definition set out in the Act, §551.003 and Chapter 562.

(1) Act--The Texas Pharmacy Act, Occupations Code, Subtitle J, as amended.

(2) Data communication device--An electronic device that receives electronic information from one source and transmits or routes it to another (e.g., bridge, router, switch, or gateway).

(3) Electronic prescription drug order--A prescription drug order which is transmitted by an electronic or facsimile device to the receiver (pharmacy). Electronic prescription drug order includes computer to computer transmission.

(4) Generically equivalent--A drug that is pharmaceutically equivalent and therapeutically equivalent to the drug prescribed.

(5) Pharmaceutically equivalent Drug products that have identical amounts of the same active chemical ingredients in the same dosage form and that meet the identical compendial or other applicable standards of strength, quality, and purity according to the United States Pharmacopoeia or another nationally recognized compendium.

(6) Therapeutically equivalent--Pharmaceutically equivalent drug products that, if administered in the same amounts, will provide the same therapeutic effect, identical in duration and intensity.

(7) Original prescription--The:

(A) original written prescription drug orders; or

(B) original verbal or electronic prescription drug orders reduced to writing either manually or electronically by the pharmacist.

(8) Practitioner--

(A) A person licensed or registered to prescribe, distribute, administer, or dispense a prescription drug or device in the course of professional practice in this state, including a physician, dentist, podiatrist, or veterinarian but excluding a person licensed under this subtitle;

(B) A person licensed by another state, Canada, or the United Mexican States in a health field in which, under the law of this state, a license holder in this state may legally prescribe a dangerous drug; or

(C) A person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration registration number and who may legally prescribe a Schedule II, III, IV, or V controlled substance, as specified under Chapter 481, Health and Safety Code, in that other state; or

(D) An advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders under §§157.052, 157.053, 157.054, 157.0541, or 157.0542, Occupations Code.

§309.3. Generic Substitution.

(a) General requirements.

(1) In accordance with Chapter 562 of the Act, a pharmacist may dispense a generically equivalent drug product if:

(A) the generic product costs the patient less than the prescribed drug product;

(B) the patient does not refuse the substitution; and

(C) the practitioner does not certify on the prescription form that a specific prescribed brand is medically necessary as specified in a dispensing directive described in subsection (c) of this section.

(2) If the practitioner has prohibited substitution through a dispensing directive in compliance with subsection (c) of this section, a pharmacist shall not substitute a generically equivalent drug product unless the pharmacist obtains verbal or written authorization from the practitioner and notes such authorization on the original prescription drug order.

(b) Prescription format for written prescription drug orders.

(1) A written prescription drug order issued in Texas shall:

(A) be on a form containing a single signature line for the practitioner; and

(B) contain the following reminder statement on the face of the prescription: "A generically equivalent drug product will be dispensed unless the practitioner hand writes the words 'Brand Necessary' or 'Brand Medically Necessary' on the face of the prescription."

(2) A pharmacist may dispense a prescription that is not issued on the form specified in paragraph (1) of this subsection, however, the pharmacist may dispense a generically equivalent drug product unless the practitioner has prohibited substitution through a dispensing directive in compliance with subsection (c)(1) of this section.

(3) The prescription format specified in paragraph (1) of this subsection does not apply to the following types of prescription drug orders:

(A) prescription drug orders issued by a practitioner in a state other than Texas;

(B) prescriptions for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; or

(C) prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.

(c) Dispensing directive.

(1) Written prescriptions.

(A) A practitioner may prohibit the substitution of a generically equivalent drug product for a brand name drug product in the manner authorized by 42 C.F.R. §447.331(c) which specifies that the practitioner shall write across the face of the written prescription, in his or her own handwriting, the phrase "brand necessary" or "brand medically necessary."

(B) The dispensing directive shall:

(i) be in a format that protects confidentiality as required by the Health Insurance Portability and Accountability Act of 1996 (29 U.S.C. §1181 et seq.) and its subsequent amendments; and

(ii) comply with federal and state law, including rules, with regard to formatting and security requirements.

(C) The dispensing directive specified in this paragraph may not be preprinted, rubber stamped, or otherwise reproduced on the prescription form.

(D) After, June 1, 2002, a practitioner may prohibit substitution on a written prescription only by following the dispensing directive specified in this paragraph. Two-line prescription forms, check boxes, or other notations on an original prescription drug order which indicate "substitution instructions" are not valid methods to prohibit substitution, and a pharmacist may substitute on these types of written prescriptions.

(E) A written prescription drug order issued prior to June 1, 2002, but presented for dispensing on or after June 1, 2002, shall follow the substitution instructions on the prescription.

(2) Verbal Prescriptions.

(A) If a prescription drug order is transmitted to a pharmacist orally, the practitioner or practitioner's agent shall prohibit substitution by specifying "brand necessary" or "brand medically necessary." The pharmacists shall note any substitution instructions by the practitioner or practitioner's agent, on the file copy of the prescription drug order. Such file copy may follow the one-line format indicated in subsection (b)(1) of this section, or any other format that clearly indicates the substitution instructions.

(B) If the practitioner's or practitioner's agent does not clearly indicate that the brand name is medically necessary, the pharmacist may substitute a generically equivalent drug product.

(C) To prohibit substitution on a verbal prescription reimbursed through the medical assistance program specified in 42 C.F.R., §447.331:

(i) the practitioner or the practitioner's agent shall verbally indicate that the brand is medically necessary; and

(ii) the practitioner shall mail or fax a written prescription to the pharmacy which complies with the dispensing directive for written prescriptions specified in paragraph (1) of this subsection within 30 days.

(3) Electronic prescription drug orders.

(A) To prohibit substitution, the practitioner or practitioner's agent shall note "brand necessary" or "brand medically necessary" on the electronic prescription drug order.

(B) If the practitioner or practitioner's agent does not clearly indicate on the electronic prescription drug order that the brand is medically necessary, the pharmacist may substitute a generically equivalent drug product.

(C) To prohibit substitution on an electronic prescription drug order reimbursed through the medical assistance program specified in 42 C.F.R., §447.331, the practitioner shall fax a copy of the original prescription drug order which complies with the requirements of a written prescription drug order specified in paragraph (1) of this subsection.

(4) Compliance with federal law or rules. Should the requirements regarding substitution in 42 C.F.R., §447.331(c) change, the new requirements will be applicable to Texas prescriptions.

(5) Prescriptions issued by out-of-state, Mexican, Canadian, or federal facility practitioners.

(A) The dispensing directive specified in this subsection does not apply to the following types of prescription drug orders:

(i) prescription drug orders issued by a practitioner in a state other than Texas;

(ii) prescriptions for dangerous drugs issued by a practitioner in the United Mexican States or the Dominion of Canada; or

(iii) prescription drug orders issued by practitioners practicing in a federal facility provided they are acting in the scope of their employment.

(B) A pharmacist may not substitute on prescription drug orders identified in subparagraph (A) of this paragraph unless the practitioner has authorized substitution on the prescription drug order. If the practitioner has not authorized substitution on the written prescription drug order, a pharmacist shall not substitute a generically equivalent drug product unless:

(i) the pharmacist obtains verbal or written authorization from the practitioner (such authorization shall be noted on the original prescription drug order); or

(ii) the pharmacist obtains written documentation regarding substitution requirements from the State Board of Pharmacy in the state, other than Texas, in which the prescription drug order was issued. The following is applicable concerning this documentation.

(I) The documentation shall state that a pharmacist may substitute on a prescription drug order issued in such other state unless the practitioner prohibits substitution on the original prescription drug order.

(II) The pharmacist shall note on the original prescription drug order the fact that documentation from such other state board of pharmacy is on file.

(III) Such documentation shall be updated yearly.

(d) Substitution of dosage form.

(1) As specified in §562.012 of the Act, a pharmacist may dispense a dosage form of a drug product different from that prescribed, such as tablets instead of capsules or liquid instead of tablets, provided:

(A) the patient consents to the dosage form substitution;

(B) the pharmacist notifies the practitioner of the dosage form substitution; and

(C) the dosage form so dispensed:

(i) contains the identical amount of the active ingredients as the dosage prescribed for the patient;

(ii) is not an enteric-coated or time release product; and

(iii) does not alter desired clinical outcomes;

(2) Substitution of dosage form may not include the substitution of a product that has been compounded by the pharmacist unless the pharmacist contacts the practitioner prior to dispensing and obtains permission to dispense the compounded product.

(e) Refills.

(1) Original substitution instructions.

(A) All refills, shall follow the original substitution instructions, unless otherwise indicated by the practitioner or practitioner's agent

(B) Prescriptions issued prior to June 1, 2002, on the two-line form shall follow the substitution instructions on the form.

(2) Narrow therapeutic index drugs.

(A) The board, in consultation with the Texas State Board of Medical Examiners, has determined that no drugs shall be included on a list of narrow therapeutic index drugs as defined in §562.013, Occupations Code. The board has specified in §309.7 of this title (relating to Dispensing Responsibilities) that pharmacist shall use as a basis for determining generic equivalency, Approved Drug Products with Therapeutic Equivalence Evaluations and current supplements published by the Federal Food and Drug Administration, within the limitations stipulated in that publication.

(i) Pharmacists may only substitute products that are rated therapeutically equivalent in the Approved Drug Products with Therapeutic Equivalence Evaluations and current supplements.

(ii) Practitioners may prohibit substitution through a dispensing directive in compliance with subsection (c) of this section.

(B) The board shall reconsider the contents of the list if the Federal Food and Drug Administration determines a new equivalence classification which indicates that certain drug products are equivalent but special notification to the patient and practitioner is required when substituting these products.

§309.4. Patient Notification.

(a) Substitution notification. A pharmacist who selects a generically equivalent drug product as authorized by Subchapter A, Chapter 562 of the Act shall:

(1) personally, or through his or her agent or employee and prior to delivery of a generically equivalent drug product, inform the patient or the patient's agent that a less expensive generically equivalent drug product has been substituted for the brand prescribed and the patient's or the patient's agent's right to refuse such substitution; or

(2) cause to be displayed, in a prominent place that is in clear public view where prescription drugs are dispensed, a sign in block letters not less than one inch in height that reads, in both English and Spanish: TEXAS LAW ALLOWS A LESS EXPENSIVE GENERICALLY EQUIVALENT DRUG TO BE SUBSTITUTED FOR CERTAIN BRAND NAME DRUGS UNLESS YOUR PHYSICIAN DIRECTS OTHERWISE. YOU HAVE A RIGHT TO REFUSE SUCH SUBSTITUTION. CONSULT YOUR PHYSICIAN OR PHARMACIST CONCERNING THE AVAILABILITY OF A SAFE, LESS EXPENSIVE DRUG FOR YOUR USE (LAS LEYES DE TEXAS PERMITEN QUE SE SUSTITUYA UNA MEDICINA GENERICAMENTE EQUIVALENTE Y MENOS CARA POR CIERTAS MEDICINAS DE MARCA RECONOCIDA A MENOS QUE SU MEDICO INSTRUYA DE OTRA MANERA. UD. TIENE EL DERECHO DE REHUSAR DICHA SUSTITUCION. CONSULTE A SU MEDICO O FARMACEUTICO CON REFERENCIA A LA DISPONIBILIDAD DE UNA MEDICINA SEGURA Y MENOS CARA PARA SU USO). By the display of a sign as set out in this paragraph, a pharmacy shall be deemed in compliance with this subsection.

(3) A pharmacist complies with the requirements of this subsection if an employee or agent of the pharmacist notifies a purchaser as required by paragraph (1) of this subsection. The patient or patient's agent shall have the right to refuse substitution.

(b) Inpatient notification exemption. Institutional pharmacies shall be exempt from the labeling provisions and patient notification requirements of §562.006 and §562.009 of the Act, as respects drugs distributed pursuant to medication orders.

§309.5. Labeling Requirements.

At the time of delivery of the drug, the dispensing container shall bear a label with at least the following information:

(1) unique identification number of the prescription;

(2) name, address, and phone number of the pharmacy;

(3) the name of the patient, or if such drug was prescribed for an animal, the species of the animal and the name of its owner;

(4) the name of the prescribing practitioner;

(5) the date the prescription is dispensed;

(6) name or initials of the dispensing pharmacist;

(7) instructions for use;

(8) quantity dispensed;

(9) appropriate ancillary instructions such as storage instructions or cautionary statements such as warnings of potential harmful effect of combining the drug product with any product containing alcohol;

(10) if the prescription drug order is for a Schedule II-IV controlled substance, the statement "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed.";

(11) if the pharmacist has selected a generically equivalent drug pursuant to the provisions of Subchapter A, Chapter 562 of the Act, the statement "Substituted for Brand Prescribed" or "Substituted for 'Brand Name'" where "Brand Name" is the actual name of the brand name product prescribed;

(12) the name of the registered nurse or physician assistant, if the prescription is carried out by a registered nurse or physician assistant in compliance with Subtitle B, Chapter 157, Occupations Code; and

(13) unless otherwise directed by the prescribing practitioner, the name and strength of the actual drug product dispensed.

(A) The name shall be either:

(i) the brand name; or

(ii) if no brand name, then the generic name and name of the manufacturer or distributor of such generic drug. (The name of the manufacturer or distributor may be reduced to an abbreviation or initials, provided the abbreviation or initials are sufficient to identify the manufacturer or distributor. For combination drug products or nonsterile compounded drug products having no brand name, the principal active ingredients shall be indicated on the label.)

(B) Except as provided in paragraph (11) of this subsection, the brand name of the prescribed drug shall not appear on the prescription container unless it is the drug product actually dispensed.

§309.6. Records.

(a) When the pharmacist dispenses a generically equivalent drug pursuant to the Subchapter A, Chapter 562 of the Act, the following information shall be noted on the original written or hard-copy of the oral prescription drug order:

(1) any substitution instructions communicated orally to the pharmacist by the practitioner or practitioner's agent or a notation that no substitution instructions were given; and]

(2) the name and strength of the actual drug product dispensed shall be noted on the original or hard-copy prescription drug order. The name shall be either.

(A) the brand name and strength; or

(B) the generic name, strength, and name of the manufacturer or distributor of such generic drug. (The name of the manufacturer or distributor may be reduced to an abbreviation or initials, provided the abbreviation or initials are sufficient to identify the manufacturer or distributor. For combination drug products having no brand name, the principal active ingredients shall be indicated on the prescription.)

(b) If a pharmacist refills a prescription drug order with a generically equivalent product from a different manufacturer or distributor than previously dispensed, the pharmacist shall record on the prescription drug order the information required in subsection (a) of this section for the product dispensed on the refill.

(c) If a pharmacy utilizes patient medication records for recording prescription information, the information required in subsections (a) and (b) of this section shall be recorded on the patient medication records.

(d) The National Drug Code (NDC) of a drug or any other code may be indicated on the prescription drug order at the discretion of the pharmacist, but such code shall not be used in place of the requirements of subsections (a) and (b) this section.

§309.7. Dispensing Responsibilities.

(a) The determination of the drug product to be substituted as authorized by the Subchapter A, Chapter 562 of the Act, is the professional responsibility of the pharmacist, and the pharmacist may not dispense any product that does not meet the requirements of the Subchapter A, Chapter 562 of the Act.

(b) Pharmacists shall utilize as a basis for the determination of generic equivalency as defined in the Subchapter A, Chapter 562 of the Act, Approved Drug Products With Therapeutic Equivalence Evaluations (Orange Book) and current supplements published by the Federal Food and Drug Administration, within the limitations stipulated in that publication.

(c) Pharmacists may only substitute products that are rated therapeutically equivalent in the Orange Book and have an "A" rating. "A" rated drug products include but are not limited to, those designated AA, AB, AN, AO, AP, or AT in the Orange Book.

§309.8. Advertising of Generic Drugs by Pharmacies.

Prescription drug advertising comparing generic and brand name drugs is subject to the §554.054 of the Act and in compliance with federal law.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200108040

Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 305-8028

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TITLE 25. HEALTH SERVICES

PART 2. TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

CHAPTER 403. OTHER AGENCIES AND THE PUBLIC

SUBCHAPTER B. CHARGES FOR COMMUNITY-BASED SERVICES

25 TAC §§403.41 - 403.53

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Mental Health and Mental Retardation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The Texas Department of Mental Health and Mental Retardation (TDMHMR) proposes the repeals of §§403.41 - 403.53 of Chapter 403, Subchapter B, concerning charges for community-based services. New §§412.101 - 412.115 of Chapter 412, Subchapter C, concerning charges for community services, which would replace the repealed sections, are contemporaneously proposed in this issue of the *Texas Register*.

The repeals would allow for the adoption of new and more current rules governing the same matters.

Cindy Brown, chief financial officer, has determined that for each year of the first five years the proposed repeals are in effect, the proposed repeals do not have foreseeable implications relating to costs or revenues of the state or local governments.

Sam Shore, director, Behavioral Health Services, has determined that, for each year of the first five years the proposed repeals are in effect, the public benefit expected is the adoption of new and more current rules governing the same matters. It is anticipated that there would be no economic cost to persons required to comply with the proposed repeals.

It is not anticipated that the proposed repeals will affect a local economy.

It is not anticipated that the proposed repeals will have an adverse economic effect on small businesses or micro-businesses because the proposed repeals do not place requirements on small businesses or micro-businesses.

Written comments on the proposed repeals may be sent to Linda Logan, director, Policy Development, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 30 days of publication.

These rules are proposed for repeal under the Texas Health and Safety Code, §532.015, which provides the Texas Board of Mental Health and Mental Retardation (board) with broad rulemaking authority, and §534.067, which requires TDMHMR to establish a

uniform fee collection policy for all local authorities that is equitable, provides for collections, and maximizes contributions to local revenue.

The proposal would affect the Texas Health and Safety Code, §534.067.

§403.41. Purpose.
§403.42. Application.
§403.43. Definitions.
§403.44. Principles.
§403.45. Financial Assessment.
§403.46. Determination of Ability to Pay.
§403.47. Rates.
§403.48. Billing Procedures.
§403.49. Monthly Ability-to-Pay Fee Schedule.
§403.50. Training.
§403.51. Information for Persons.
§403.52. References.
§403.53. Distribution.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107950
Andrew Hardin
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 206-5216

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CHAPTER 412. LOCAL AUTHORITY RESPONSIBILITIES
SUBCHAPTER C. CHARGES FOR COMMUNITY SERVICES

25 TAC §§412.101 - 412.115

The Texas Department of Mental Health and Mental Retardation (TDMHMR) proposes new §§412.101 - 412.115 of new Chapter 412, Subchapter C, concerning charges for community services. The repeals of §§403.41 - 403.53 of Chapter 403, Subchapter B, concerning charges for community-based services, which the new sections would replace, are contemporaneously proposed in this issue of the *Texas Register*.

The proposed new rules describe TDMHMR's uniform fee collection policy for all local authorities that is equitable, provides for collections, and maximizes contributions to local revenue as required by the Texas Health and Safety Code, §534.067.

Similar rules governing charges for community services were proposed for public comment in the October 19, 2001, issue of the *Texas Register*. Public comment received on the proposal prompted TDMHMR to reconsider its proposed policy for billing persons with third-party coverage that is not income-based public insurance (i.e., Childrens Health Insurance Program (CHIP) and Medicaid). The previous proposal would have applied all charges for non-covered services and all applicable co-payments, co-insurance, and deductibles toward the person's maximum monthly fee (MMF). If the total amount exceeded the MMF, the total amount would be reduced to equal the MMF and the person would be billed the MMF. Several commenters stated that the proposed policy would place local authorities at risk of being in violation of their contractual obligations with third party payers. The commenters, as well as the Texas Department of Insurance, expressed concern that the policy could discourage private insurers from contracting with a local authority, which would have a negative impact on the local authority's ability to maximize contributions to local revenue. The previous proposal has been withdrawn as a result of TDMHMR's reconsideration. These new rules are proposed because the changes TDMHMR intended to make to the previous proposal were too significant to make upon adoption.

Because these proposed rules meet the criteria in federal regulations for waiving Medicare co-payments, co-insurance, and deductibles, the rules would differentiate between the billing procedures for persons with Medicare third-party coverage and the billing procedures for persons with non-Medicare third-party coverage. Persons with Medicare would be billed as provided for in the previous proposal (i.e., charges for non-covered services and all applicable co-payments, co-insurance, and deductibles are applied toward the person's maximum monthly fee (MMF); If the total amount exceeded the MMF, the total amount is reduced to equal the MMF and the person is billed the MMF). Persons with non-Medicare third-party coverage would be billed all applicable co-payments, co-insurance, and deductibles even if the total amount exceeded the MMF. Although this proposed policy could result in a person being charged an amount that exceeds his/her MMF, the proposal also contains a provision that would require the local authority to defer a portion of the charges if the person states that financial hardship prevents prompt payment of all charges owed. The local authority defers a portion of the charges by arranging for the person to pay a lesser amount each month in accordance with prescribed parameters.

The proposed new rules would add several new requirements for local authorities and others, with the exception of the billing procedures for persons with third-party coverage, but the overall policies for charging for community services in the proposed new rules are not significantly different from the policies contained in the rules proposed for repeal. A substantive new provision is the requirement for parents of minor children seeking or receiving services to enroll their children in Medicaid or the Childrens Health Insurance Program (CHIP), or provide documentation that they have been denied Medicaid/CHIP or that their Medicaid/CHIP enrollment is pending. Another substantive new provision is the requirement for adults seeking or receiving services to apply for Supplemental Security Income (SSI) in order to become eligible for Medicaid or provide documentation that they have been denied SSI or that their SSI application is pending.

A new provision that would affect persons receiving services as well as local authorities is the process for referring persons to their third-party coverage when their third-party coverage will not pay the local authority for services because the local authority does not have an approved provider on its network. The process includes notifying the person of the local authority's intent to refer and providing the person with an opportunity to appeal. The person is also offered the opportunity to request a review of the appeal decision. Another new provision that would affect persons receiving services and local authorities is the process that allows the local authority to involuntarily reduce or terminate a

person's services for non-payment. The process provides safeguards and includes the same prior notification, and appeal and review opportunities as the process for referring persons to their third-party coverage.

The proposed new rules contain extensive clarification of TDMHMR's policies for charging for community services. The rules address principles supported by TDMHMR, including the principles that earned revenues are optimized and TDMHMR is the payer of last resort. The rules would require local authorities to identify and access, and to assist persons (and parents) in identifying and accessing, available funding sources other than TDMHMR. They also describe the process for billing third-parties and persons (and parents). The rules state that persons (and parents) are responsible for paying all charges owed and that local authorities are responsible for making reasonable efforts to collect payments from all available funding sources.

Although the subchapter proposed for repeal states that the Monthly Ability-To-Pay Fee Schedule is based on 150% of the current Federal Poverty Guidelines (FPG), the current fee schedule actually *begins charging for services* at 150% of the current FPG *for a family of one person*. This current calculation results in families of two or more being charged a higher percentage of their income than families of one. These proposed new rules would continue to state that the Monthly Ability-To-Pay Fee Schedule is based on 150% of the current FPG; however, the fee schedule calculation would be revised to begin charging for services at 150% of the current FPG for a family of two persons, three persons, four persons, and so on. For example, 150% of the 2001 FPG for a family of two is $17,415. A family of two whose annual income is less than $17,415 would have a maximum monthly fee of zero. A family of two whose annual income is more than $17,415 would have a maximum monthly fee of greater than zero. The revised fee schedule would also be calculated using slightly smaller increments between each annual/monthly gross income level. Each increment is one-half of the increment used by the FPG between family sizes. The change in increment amount makes apparent that each family size is first charged for services at exactly 150% of FPG.

Cindy Brown, chief financial officer, has determined that for each year of the first five years the proposed new sections are in effect, enforcing or administering the sections does not have foreseeable implications relating to costs or revenues of the state government. There will be some impact to revenues of local governments (i.e., local mental health and mental retardation authorities) due to revisions in the fee schedule's calculation; however, the extent of the impact cannot be determined because TDMHMR does not require local authorities to report consumer fee collection data based on income levels. Although the revised fee schedule has slightly smaller increments between each monthly gross income level, the maximum monthly fee amounts for a family size of one closely resemble the fee amounts for a family size of one at the same income level in the existing fee schedule. Additionally, in the existing fee schedule the same fee amounts that are calculated for a family size of one are applied to a family size of two, except the column of amounts shifts down one row to begin charging at the next higher income level, and the process continues for a family size of three, family size of four, and so on. In the revised fee schedule, the family size of one fee amounts are also applied to all other family sizes except the column of amounts shifts down *three* rows to begin charging at the income level that represents 150% of FPG for that family size. While the revised calculation could have a negative fiscal impact on the revenues of local governments, because families of two or more persons will not be charged a fee until family income is 150% of FPG, other provisions in the proposed new rules would offset the negative impact. Provisions in the proposed new rules that would offset the negative impact include requiring parents to enroll their children in Medicaid or CHIP; requiring adults to apply for Supplemental Security Income (SSI); stating that persons (and parents) are responsible for paying all charges owed and that local authorities are responsible for making reasonable efforts to collect payments from all available funding sources; and requiring local authorities to identify and access, and assist persons (and parents) in identifying and accessing, available funding sources other than TDMHMR.

Sam Shore, director, Behavioral Health Services, has determined that, for each year of the first five years the proposed rules are in effect, the public benefit expected is the implementation of a uniform fee collection policy for all local authorities that is equitable, provides for collections, and maximizes contributions to local revenue. The economic cost to persons required to comply with the rules as proposed is expected to be less, but in no case greater, than if those persons received community services from a private provider.

It is not anticipated that the proposed sections will affect a local economy.

It is not anticipated that the proposed sections will have an adverse economic effect on small businesses or micro-businesses because the sections do not place additional requirements on small or micro-businesses than those in the sections proposed for repeal.

Written comments on the proposed sections may be sent to Linda Logan, director, Policy Development, Texas Department of Mental Health and Mental Retardation, P.O. Box 12668, Austin, Texas 78711-2668, within 30 days of publication.

These new sections are proposed under the Texas Health and Safety Code, §532.015, which provides the Texas Board of Mental Health and Mental Retardation (board) with broad rulemaking authority, and §534.067, which requires TDMHMR to establish a uniform fee collection policy for all local authorities that is equitable, provides for collections, and maximizes contributions to local revenue.

The proposed sections would affect the Texas Health and Safety Code, §534.067.

§412.101. Purpose.

The purpose of this subchapter is to comply with the Texas Health and Safety Code, §534.067, by establishing a uniform fee collection policy for local authorities that:

(1) is equitable;

(2) provides for collections; and

(3) maximizes contributions to local revenue.

§412.102. Application.

(a) This subchapter applies to all local authorities for community services contracted for through the performance contract that the authority provides directly or through subcontractors to members of the priority population. This subchapter also applies to persons in the priority population, and parents of persons under age 18 years in the priority population, who are seeking or receiving services.

(b) This subchapter does not apply to:

(1) programs and services that are prohibited by statute or regulation from charging fees to persons served (e.g., Early Childhood Intervention Program);

(2) the TDMHMR In-Home and Family Support Program;

(3) inpatient services in a state MH facility and non-crisis residential services as described in the performance contract; and

(4) specialized services mandated by the Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended by OBRA 90, for preadmission screening and annual resident reviews (PASARR) provided to non-Medicaid eligible persons.

(c) In this subchapter all references to a parent means the requirement is applicable to the parent of a person under age 18 years who is in the priority population and who is seeking or receiving services.

§412.103. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise.

(1) Ability to pay -- The person has third-party coverage that will pay for needed services, the person's maximum monthly fee is greater than zero, or the person has identified payment for a needed service or services in an approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*).

(2) Community services or services -- Except for inpatient services in a state MH facility and non-crisis residential services, the required and optional mental health and mental retardation services described in the performance contract, including:

(A) 24-hour emergency screening and rapid crisis stabilization services;

(B) community-based crisis residential services or inpatient services in a mental health facility that is not a state MH facility;

(C) community-based assessments, including the development of interdisciplinary treatment plans, and diagnosis and evaluation services;

(D) family support services, including respite care;

(E) case management services (service coordination);

(F) medication-related services, including medication clinics, laboratory monitoring, medication education, mental health maintenance education, and the provision of medication; and

(G) psychosocial rehabilitation programs, including social support activities, independent living skills, and vocational training.

(3) Extraordinary expenses -- Major medical or health related expenses, major casualty losses, and child care expenses for the previous year or projections for the next year.

(4) Family members --

(A) For an unmarried person under the age of 18 years - The person, the person's parents, and the dependents of the parents, if residing in the same household;

(B) For an unmarried person age 18 years or older - The person and his/her dependents;

(C) For a married person of any age - The person, his/her spouse, and their dependents.

(5) Gross income -- Revenue from all sources before taxes and other payroll deductions. The term does not include child support received.

(6) Inability to pay -- The person's maximum monthly fee is zero and the person:

(A) does not have third-party coverage;

(B) has third-party coverage, but has exceeded the maximum benefit of the covered service(s) or the third-party coverage will not pay because the services needed by the person are not covered services; or

(C) has not identified payment for a needed service or services in an approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*).

(7) Income-based public insurance -- Government funded third-party coverage that bases eligibility on income (i.e., CHIP and Medicaid).

(8) Local authority -- An entity designated by the TDMHMR commissioner in accordance with the Texas Health and Safety Code, §533.035(a).

(9) Performance contract -- A written agreement between TDMHMR and a local authority for the provision of one or more functions as described in the Texas Health and Safety Code, §533.035(a).

(10) Person -- A person in the priority population who is seeking or receiving services through a local authority.

(11) Priority population -- Those groups of persons with mental illness or mental retardation identified in TDMHMR's current strategic plan as being most in need of mental health and mental retardation services.

(12) Standard charge -- A fixed price for a community service or unit of service.

(13) State MH facility -- A state hospital or a state center with an inpatient component.

(14) Team -- The interdisciplinary team, multidisciplinary team, or treatment team.

(15) Third-party coverage -- A public or private payer of community services for a specific person that is not the person (e.g., Medicaid, Medicare, private insurance, CHIP, TRICARE).

§412.104. Principles.

TDMHMR supports the following principles:

(1) Persons are charged for services based on their ability to pay.

(2) Procedures for determining ability to pay are fair, equitable, and consistently implemented.

(3) Paying for services in accordance with his/her ability to pay reinforces the role of the person as a customer.

(4) Earned revenues are optimized.

(5) TDMHMR is the payer of last resort.

§412.105. Accountability.

(a) Prohibition from denying services. Local authorities are prohibited from denying services to a person:

(1) because of the person's inability to pay for the services;

(2) in crisis because:

(A) a financial assessment has not been completed;

(B) financial responsibility has not been determined;

(C) the person has a past-due account; or

(D) the person had his/her services involuntarily reduced or terminated for non-payment under §412.109(d) of this title (relating to Payments, Collections, and Non-payment); or

(3) pending resolution of an issue relating solely to payment for services, including failure of the person (or parent) to comply with any requirement in subsections (c), (d), (e), and (g) of this section.

(b) Identifying funding sources. Local authorities are responsible for identifying and accessing available funding sources other than TDMHMR, and for assisting persons (and parents) in identifying and accessing available funding sources other than TDMHMR, to pay for services. Available funding sources may include third-party coverage, state and/or local governmental agency funds (e.g., crime victims fund), indigent pharmaceutical programs, or a trust that provides for the person's healthcare and rehabilitative needs.

(c) Requirement for parents to enroll their children in income-based public insurance. Parents of children who may be eligible for Medicaid or the Childrens Health Insurance Program (CHIP) must enroll their children in Medicaid or CHIP or provide documentation that they have been denied Medicaid or CHIP benefits or that their Medicaid or CHIP enrollment is pending. The local authority shall provide assistance as needed to facilitate the enrollment process.

(d) Financial documentation. If requested by the local authority, persons (or parents) must provide the following financial documentation:

(1) annual or monthly gross income/earnings, if any;

(2) extraordinary expenses (as defined) paid during the past 12 months or projected for the next 12 months;

(3) number of family members (as defined); and

(4) proof of any third-party coverage.

(e) Authorizing third-party coverage payment to the local authority. Persons (and parents) with third-party coverage must execute an assignment of benefits authorizing third-party coverage payment to the local authority.

(f) Failure to comply.

(1) Except as provided by paragraph (2) of this subsection, if the person (or parent) fails to comply with any requirement in subsections (c)-(e) of this section, then the local authority will charge the person (or parent) the standard charge(s) for services. If, within 30 days after the person (or parent) initially failed to comply, the person (or parent) complies with the requirements, then the local authority will adjust the person's account to retroactively reflect compliance.

(2) The local authority will not charge the person the standard charge(s) for services if the local authority makes a decision, based on a clinical determination that is documented and includes input from the person's team, that the person's failure to comply is related to the person's mental illness or mental retardation. The clinical determination must be reassessed at least every three months. If the local authority decides that a person's failure to comply is related to the person's mental illness or mental retardation, then the local authority must develop and implement a plan to reduce or eliminate the barriers related to the person's failure to comply.

(g) Requirement for adult persons to apply for SSI to become eligible for Medicaid. Adult persons who may be eligible for Medicaid must apply for Supplemental Security Income (SSI) or provide documentation that they have been denied SSI or that their SSI application is pending. The local authority shall provide assistance as needed to facilitate all aspects of the application process. If the adult person is unable to act in accordance with the requirement because of the person's mental illness or mental retardation, then the local authority must develop and implement a plan to reduce or eliminate the barriers related to the person's inability to act in accordance with the requirement.

§412.106. Determination of Ability to Pay.

(a) Financial assessment. The local authority must conduct and document a financial assessment for each person within the first 30 days of services. The local authority must update each person's financial assessment at least annually and whenever significant financial changes occur as long as the person continues to receive services. The financial assessment is accomplished using the financial documentation listed in §412.105(d) of this title (relating to Accountability), which represents the finances of the:

(1) person who is age 18 years or older and the person's spouse; or

(2) parents of the person who is under age 18 years.

(b) Maximum monthly fee. A person's maximum monthly fee is based on the financial assessment and calculated using the Monthly Ability-To-Pay Fee Schedule, referenced as Exhibit A in §412.113 of this title (relating to Exhibit). The calculation is based on the number of family members and annual gross income, reduced by extraordinary expenses paid during the past 12 months or projected for the next 12 months. No other sliding scale is used.

(1) A maximum monthly fee that is greater than zero is established for persons who are determined as having an ability to pay. If two or more members of the same family are receiving services, then the maximum monthly fee is for the family.

(2) A maximum monthly fee of zero is established for persons who are determined as having an inability to pay.

(c) Third-party coverage.

(1) Third-party coverage that will pay. A person with third-party coverage that will pay for needed services is determined as having an ability to pay for those services.

(2) Third-party coverage that will not pay.

(A) If the person's third-party coverage will not pay for needed services because the local authority does not have an approved provider on its network, then the local authority will propose to refer the person to his/her third-party coverage to identify a provider for which the third-party coverage will pay unless:

(i) the local authority is identified as being responsible for providing court-ordered outpatient services to the person;

(ii) the local authority is able to negotiate adequate payment for services with the person's third-party coverage; or

(iii) the person (or parent) voluntarily agrees to pay the standard charge(s) for the needed service(s).

(B) If the local authority proposes to refer the person to his/her third-party coverage as described in paragraph (2)(A) of this subsection, then the local authority will provide written notification to the person (or parent) in accordance with §412.109(e)(1) of this title (relating to Payments, Collections, and Non-payment), which provides an opportunity to appeal. The local authority must also comply with §412.109(e)(2)-(3) as initiated by the person (or parent).

(C) If the local authority refers the person to his/her third-party coverage, then the local authority will assist the person (or parent) in identifying a provider for which the third-party coverage will pay.

(D) If a person who has been referred to his/her third-party coverage is unable to identify or access needed services from an approved provider or if access will be unduly delayed, then the local authority will:

(i) assist the person (or parent) in resolving the matter with the third-party coverage (e.g., contacting customer service at the third-party coverage, filing a complaint with the third-party coverage or the Texas Department of Insurance); and

(ii) if clinically indicated, ensure the provision of the needed services to the person pending resolution.

(E) The local authority will maintain documentation of:

(i) all referrals as described in paragraph (2)(C) of this subsection;

(ii) all assistance as described in paragraph (2)(D)(i) of this subsection; and

(iii) whether the person received services pending resolution as described in paragraph (2)(D)(ii) of this subsection.

(d) Social Security work incentive provisions. A person who identified payment for specific needed services in his/her approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*) is determined as having an ability to pay for the specific services. Persons are not required to identify payment for any service for which they may be eligible as part of their approved plan for utilizing the Social Security work incentive provisions.

(e) Notification. After a financial assessment is conducted, the local authority must provide written notification to the person (or parents) that includes:

(1) the determination of whether the person (or parent) has an ability or an inability to pay;

(2) a copy of the financial assessment form that is signed by the person (or parent) and a copy of the Monthly Ability-to-Pay Fee Schedule, with the applicable areas indicated (i.e., annual gross income, number of family members);

(3) the amount of the maximum monthly fee;

(4) the name and phone number of at least one local authority staff who the person (or parent) may contact during office hours to discuss the information contained in the written notification; and

(5) a statement that the person (or parent) may voluntarily pay more than the maximum monthly fee.

§412.107. Standard Charges.

Each local authority must establish, at least annually, a reasonable standard charge for each community service as indicated in the performance contract. The standard charge must cover, at a minimum, the local authority's cost of ensuring the provision of the service.

§412.108. Billing Procedures.

(a) Monthly account.

(1) The local authority will maintain a monthly account for each person that lists all services provided to the person during the month and the standard charges for the services. Each service listed will indicate whether the service is:

(A) covered by Medicare third-party coverage;

(B) covered by non-Medicare third-party coverage;

(C) not covered by third-party coverage; or

(D) identified for payment in the person's approved plan utilizing Social Security work incentive provisions.

(2) If a person has exceeded the maximum third-party coverage benefit of a particular covered service, then that service is indicated as not covered by third-party coverage.

(b) Accessing funding sources. The local authority must access all available funding sources before using TDMHMR funds to pay for a person's services. Funding sources may include third-party coverage, state and/or local governmental agency funds (e.g., crime victims fund), indigent pharmaceutical programs, or a trust that provides for the person's healthcare and rehabilitative needs.

(c) Billing third-party coverage. The local authority will bill the person's third-party coverage the monthly account amount for covered services. If the local authority has negotiated a reimbursement amount with the third-party coverage that is different from the monthly account amount, then the local authority may bill the third-party coverage the negotiated reimbursement amount for covered services.

(d) Billing the person (or parents).

(1) No third-party coverage. If the monthly account amount for services not covered by third-party coverage:

(A) exceeds the person's maximum monthly fee (MMF), then the amount is reduced to equal the MMF and the local authority bills person (or parent) the MMF; or

(B) is less than the person's MMF, then the local authority bills the person (or parent) the monthly account amount for services not covered by third-party coverage.

(2) Medicare third-party coverage.

(A) The following amounts are added to equal the total amount applied toward the person's MMF:

(i) the amount of all applicable co-payments and co-insurance for services listed in the monthly account as covered by Medicare third-party coverage;

(ii) the amount Medicare third-party coverage was billed but did not pay because the deductible hasn't been met; and

(iii) the monthly account amount for services not covered by third-party coverage.

(B) If the total amount applied toward the person's MMF as described in paragraph (2)(A) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the local authority bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the local authority bills the person (or parent) the total amount applied toward the MMF.

(3) Non-Medicare third-party coverage.

(A) Cost-sharing exceeds MMF. If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage exceeds the person's MMF, then the local authority bills the person (or parent) all applicable co-payments, co-insurance, and deductibles.

(B) Cost-sharing does not exceed MMF.

(i) If the amount of all applicable co-payments, co-insurance, and deductibles for services listed in the monthly account as covered by non-Medicare third-party coverage does not exceed the person's MMF, then the following amounts are added to equal the total amount applied toward the person's MMF:

(I) the amount of all applicable co-payments, co-insurance, and deductibles; and

(II) the monthly account amount for services not covered by third-party coverage.

(ii) If the total amount applied toward the person's MMF as described in paragraph (3)(B) of this subsection:

(I) exceeds the person's MMF, then the amount is reduced to equal the MMF and the local authority bills person (or parent) the MMF; or

(II) is less than the person's MMF, then the local authority bills the person (or parent) the total amount applied toward the MMF.

(C) Annual cost-sharing limit. If the person (or parent) has reached his/her annual cost-sharing limit (i.e., maximum out-of-pocket expense) as verified by the non-Medicare third-party coverage, then the local authority will not bill the person (or parent) any co-payments, co-insurance, or deductibles, as applicable to the annual cost-sharing limit, for services covered by the non-Medicare third-party coverage for the remainder of the policy-year.

(4) Social Security work incentive provisions.

(A) If the person identified a payment amount for specific services in his/her approved plan utilizing Social Security work incentive provisions (i.e., *Plan to Achieve Self-Sufficiency; Impairment Related Work Expense*), then the local authority bills the person the monthly account amount for the specific services up to the identified payment amount. If the monthly account amount for the specific services is greater than the identified payment amount, then the remaining balance is applied toward the person's MMF.

(B) The following amounts are added to equal the total amount applied toward the person's MMF:

(i) any remaining balance as described in paragraph (4)(A) of this subsection; and

(ii) the monthly account amount for services not covered by third-party coverage.

(C) If the total amount applied toward the person's MMF as described in paragraph (4)(B) of this subsection:

(i) exceeds the person's MMF, then the amount is reduced to equal the MMF and the local authority bills person (or parent) the MMF; or

(ii) is less than the person's MMF, then the local authority bills the person (or parent) the total amount applied toward the MMF.

(e) Statements.

(1) The local authority will send to persons (and parents) who have been determined as having the ability to pay monthly or quarterly statements that include:

(A) an itemized list, at least by date and by type, of all services provided during the period;

(B) the standard charge for each service;

(C) the total charge for the period;

(D) the amount paid (or to be paid) by each funding source; and

(E) the amount to be paid by the person (or parent).

(2) Unless requested otherwise, the local authority does not send statements to persons (or parents) who have an ability to pay if they maintain a zero balance (i.e., the person (or parent) does not currently owe any money).

(3) Unless requested otherwise, the local authority does not send statements to persons (or parents) who have an inability to pay.

§412.109. Payments, Collections, and Non-payment.

(a) Payment and collection.

(1) Persons (and parents) are responsible for promptly paying all charges owed to the local authority.

(2) Local authorities are responsible for making reasonable efforts to collect payments from all available funding sources before accessing TDMHMR funds to pay for persons' services.

(b) Financial hardship.

(1) If a person (or parent) claims, and provides documentation, that financial hardship prevents prompt payment of all charges owed, then the local authority may arrange for the person (or parent) to pay a lesser amount each month.

(2) If a person (or parent) claims that financial hardship prevents prompt payment of all charges owed, then the local authority must arrange for the person (or parent) to pay a lesser amount each month only if the person has third-party coverage that is neither income-based public insurance nor Medicare and the person's cost-sharing exceeds his/her MMF. The lesser amount:

(A) will be no more than the person's MMF, if the person's MMF is greater than zero; or

(B) will be no more than $5.00, if the person's MMF is zero.

(3) Although the person (or parent) may pay a lesser amount each month because a portion of the charges will be deferred, the person (or parent) is still responsible for paying all charges owed.

(c) Discontinuing charges for services not covered by third-party coverage. If the local authority makes a decision, based on a clinical determination that is documented and includes input from the person's team, that being charged for services not covered by third-party coverage and receiving statements will result in a reduction in the functioning level of the person or the person's (or parent's) refusal or rejection of the needed services, then the local authority may discontinue charging the person (or parent) for services not covered by third-party coverage and stop sending statements. The clinical determination must be reassessed at least every three months. If the local authority decides to discontinue charging the person (or parent) for services not covered by third-party coverage, then the local authority must develop and implement a plan to address the issues related to the person's functioning level or the person's (or parent's) refusal or rejection of the needed services.

(d) Involuntary reduction or termination of services for non-payment by person (or parent).

(1) The local authority will address the past-due account of a person (or parent) who is not making payments to ensure reasonable efforts to secure payments are initiated with the person (or parent). For example, if the local authority determines that non-payment is related to financial hardship, then the local authority may assist the person (or parent) in making arrangements to pay a lesser amount each month in

accordance with subsection (a)(2) of this section or if the local authority makes a decision, based on a clinical determination that is documented and includes input from the person's team, that non-payment is related to the person's mental illness or mental retardation, then the person's treatment/service plan may be modified to address the non-payment.

(2) If the local authority makes a decision, based on a clinical determination that is documented and includes input from the person's team, that non-payment is not related to the person's mental illness or mental retardation and, despite reasonable efforts to secure payment, the person (or parent) does not pay, then the local authority may propose to involuntarily reduce or terminate the person's services. The local authority may not propose to involuntarily reduce or terminate the person's services if the proposed action would cause the person's mental or physical health to be at imminent risk of serious deterioration or the local authority is identified as being responsible for providing court-ordered outpatient services to the person.

(3) If the local authority proposes to involuntarily reduce or terminate the person's services, then the local authority must:

(A) maintain clinical documentation that the proposed action would not cause the person's mental or physical health to be at imminent risk of serious deterioration; and

(B) provide written notification to the person (or parent) in accordance with subsection (e)(1) of this section and comply with subsection (e)(2)-(3) as initiated by the person (or parent).

(e) Notification, Appeal, and Review.

(1) Notification. The local authority will notify the person (or parent) in writing of the proposed action (i.e., to involuntarily reduce or terminate the person's services or refer the person to his/her third-party coverage) and the right to appeal the proposed action in accordance with §401.464 of this title (relating to Notification and Appeals Process). The notification will describe the time frames and process for requesting an appeal and include a copy of this subchapter. If the person (or parent) requests an appeal within the prescribed time frame, then the local authority may not take the proposed action while the appeal is pending. The local authority may take the proposed action if the person (or parent) does not request a review within the prescribed time frame.

(2) Appeal and appeal decision. The appeal is conducted in accordance with §401.464(g) of this title (relating to Notification and Appeals Process). The local authority will notify the person (or parent) in writing of the appeal decision in accordance with §401.464(h) and the right to have the appeal decision reviewed by the Office of Consumer Services and Rights Protection - Ombudsman at TDMHMR Central Office if the person (or parent) is dissatisfied with the appeal decision. The notification must describe the time frames and process for requesting a review.

(3) Review of appeal decision. If the person (or parent) is dissatisfied with the appeal decision, then the person (or parent) may request a review by the Office of Consumer Services and Rights Protection - Ombudsman at TDMHMR Central Office. A request for review must be submitted to the Office of Consumer Services and Rights Protection - Ombudsman, TDMHMR, P.O. Box 12668, Austin, TX 78751, within 10 working days of receipt of the appeal decision. If the person (or parent) requests a review within the prescribed time frame, then the local authority may not take the proposed action while the review is pending. The local authority may take the proposed action if the person (or parent) does not request a review within the prescribed time frame and the appeal decision upholds the decision to take the proposed action.

(A) A person (or parent) who requests a review may choose to have the reviewer conduct the review:

(i) by telephone conference with the person (or parent) and a representative from the local authority and make a decision based upon verbal testimony made during the telephone conference and any documents provided by the person (or parent) and the local authority; or

(ii) by making a decision based solely upon documents provided by the person (or parent) and the local authority without the presence of any of the parties involved.

(B) The review:

(i) will be conducted no sooner than 10 working days and no later than 30 working days of receipt of the request for review unless an extension is granted by the director of the Office of Consumer Services and Rights Protection - Ombudsman;

(ii) will include an examination of the pertinent information concerning the proposed action and may include consultation with TDMHMR clinical staff and staff who are responsible for the policy contained in this subchapter;

(iii) will result in a final decision which will uphold, reverse, or modify the original decision to take the proposed action; and

(iv) is the final step of the appeal process for involuntarily reducing or terminating the person's services for non-payment and for referring the person to his/her third-party coverage.

(C) Within five working days after the review, the reviewer will send written notification of the final decision to the person (or parent) and the local authority.

(D) The local authority will take appropriate action consistent with the final decision.

(f) Prohibition of financial penalties. The local authority may not impose financial penalties on a person (or parent).

(g) Debt collection. Local authorities must make reasonable efforts to collect debts before an account is referred to a debt collection agency. Local authorities must document their efforts at debt collection.

(1) Local authorities must incorporate into a written agreement or contract for debt collection provisions that state that both parties shall:

(A) maintain the confidentiality of the information and not disclose the identity of the person or any other identifying information; and

(B) not harass, threaten, or intimidate persons and their families.

(2) Local authorities will enforce the provisions contained in paragraph (1) of this subsection.

§412.110. Monthly Ability-to-Pay Fee Schedule.

The Monthly Ability-To-Pay Fee Schedule, referenced as Exhibit A in §412.113 of this title (relating to Exhibit), is based on 150% of the Federal Poverty Guidelines. TDMHMR may revise the Monthly Ability-To-Pay Fee Schedule, based on any changes in the Federal Poverty Guidelines.

§412.111. Training.

In accordance with a prescribed training program developed by TDMHMR, all local authority staff who are involved in implementing

or explaining the content of this subchapter must demonstrate competency prior to performing tasks related to charging for community services and annually thereafter.

§412.112. Brochure for Persons (and Parents).

(a) TDMHMR will develop a brochure that contains the policies for charging for community services that are contained in this subchapter, including:

(1) a general reference to the statutory trust exemption; and

(2) information related to claiming financial hardship.

(b) The local authority must provide persons (and parents) a copy of the brochure prior to their entry into services, except in a crisis.

§412.113. Exhibit.

This subchapter references Exhibit A - The Monthly Ability-To-Pay Fee Schedule, copies of which are available by contacting TDMHMR, Policy Development, P.O. Box 12668, Austin, TX 78711-2668.

§412.114. References.

This subchapter references the following rules and statutes:

(1) Texas Health and Safety Code, §533.035 and §534.067;

(2) Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended by OBRA 90; and

(3) 25 TAC, §401.464 (relating to Notifications and Appeals Process).

§412.115. Distribution.

This subchapter is distributed to:

(1) all members of the Texas Board of Mental Health and Mental Retardation;

(2) executive, management, and program staff of TDMHMR Central Office;

(3) executive directors of all local authorities; and

(4) advocacy organizations.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107949
Andrew Hardin
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 206-5216

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PART 16. TEXAS HEALTH CARE INFORMATION COUNCIL

CHAPTER 1301. HEALTH CARE INFORMATION

SUBCHAPTER A. HOSPITAL DISCHARGE DATA RULES

25 TAC §§1301.11, 1301.16 - 1301.18, 1301.20

The Texas Health Care Information Council (Council) proposes amendments to §§1301.11, 1301.16-1301.18, and 1301.20, relating to Hospital Discharge Data Rules. The proposed amendments to §1301.11 changes the definition of "Attending Physician" to clarify which "physician" or "other health professional" is expected to be reported to Council, and the definition of "Provider Quality Data" to clarify that the public use data reports may be created from the public use data files or from other data resources. The Council proposes a new definition of "Operating or Other physician" to establish the "physician" or "other health professional" that the Council anticipates to be reported in the label field and the Council proposes to delete the definition of "Treating physician" because the definition would no longer be required with the adoption of these amendments. The Council proposes new §1301.16(c)(4) to address how previously missing claim data will be processed. The Council proposes to amend §1301.17(a) to complement the new §1301.16(c)(4). The Council proposes to amend §1301.17(a) and §1301.18(c)(5) to complement the new definition of "Operating or Other Physician" and the deletion of "Treating Physician".

Jim Loyd, Executive Director, has determined that for the first five-year period that the proposed sections are in effect, there will be an anticipated cost to the State of $30,000. This one time cost is for modifying the Council's data processing capabilities to limit the acceptance of claim data to only discharges in the current and one prior quarter and to return only those data for correction and certification. The cost is based on an estimate by Commonwealth Clinical Systems (Contract vendor for the Council).

Mr. Loyd has also determined that, for the first five-year period the proposed sections are in effect, there, will be no anticipated costs to affected local governments as a result of enforcing or administering the amended sections.

Mr. Loyd also has determined that, for each year the of the first five year period the rules are in effect, there will be no additional costs to persons or hospitals who are required to comply with the amended section.

Mr. Loyd also has determined that, for each year of the first five-year period the proposed sections are in effect, the anticipated public benefit will be clarification of the definition of provider quality data. These public information reports will allow consumers of health care to review qualitative measures of similar facilities and make decisions regarding health care services offered by those facilities. The facility and geographic (e.g., regional, metropolitan, county and community) focused reports will assist legislators in making decisions regarding their constituents' health conditions or issues of interest in their districts and the state. The users of the data will be assured that the quarterly data file is stabilized one quarter after it is initially released from the Council.

Comments on the proposed sections may be submitted to Jim Loyd, Executive Director, Texas Health Care Information Council, Two Commodore Plaza, 206 East 9th Street, Suite 19.140, Austin, Texas 78701. Comments must arrive no later than 31 calendar days from the date that these proposed sections are published in the *Texas Register*.

The Council will entertain requests for a public hearing until the 25th day after the date the rules are published in the *Texas Register*.

The amendments are proposed under the Health and Safety Code, §108.006 and §108.009. The Council interprets §108.006 as authorizing it to adopt rules necessary to carry out Chapter 108, including rules concerning data dissemination requirements. The Council interprets §108.009 as authorizing the Council to adopt rules regarding the collection of data from hospitals in uniform submission formats in order for the incoming data to be substantially valid, consistent, compatible and manageable.

The Health and Safety Code, §§108.002, 108.006, 108.009, 108.010, 108.011, 108.012 and 108.013 are affected by these amendments.

§1301.11. Definitions.

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

(1) Accurate and Consistent data--Data that has been edited by the Council and subjected to provider validation and certification.

(2) Attending Physician--The individual licensed under the Medical Practice Act (Occupations Code, Chapter 151) who would normally be expected to certify and recertify the medical necessity of the services rendered or the licensed health professional primarily responsible for the care of the patient [~~during the hospital episode as reported on the claim~~]. For Skilled Nursing Facility (SNF) services, the attending physician is the individual who certifies the SNF plan of care.

(3) Batch file--A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports --Records, Data Fields and Codes) which contains one or more discharge files and other required header and trailer records. A batch contains discharge files for only one hospital.

(4) Certification Process--The process by which a provider confirms the accuracy and completeness of the encounter data set required to produce the public use data file as specified in §1301.17 of this title.

(5) Charge--The amount billed by a provider for specific procedures or services provided to a patient before any adjustment for contractual allowances, government mandated fee schedules or write-offs for charity care, bad debt or administrative courtesy. The term does not include co-payments charged to health maintenance organization enrollees by providers paid by capitation or salary in a health maintenance organization.

(6) Comments--The notes or explanations submitted by the hospitals, physicians or other health professionals concerning the provider quality reports or the encounter data for public use as described in the Texas Health and Safety Code, §108.010(c) and (e) and §108.011(g) respectively.

(7) Council--The Texas Health Care Information Council.

(8) Data format--The sequence or location of data elements on a paper form or electronic record according to prescribed specifications.

(9) Discharge--The formal release of a patient by a hospital; that is, the termination of a period of hospitalization by death or by disposition to a residence or another health care provider.

(10) Discharge file --A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports --Records, Data Fields and Codes) relating to a specific patient.

(11) Discharge report--A computer file as defined in §1301.19 of this title (relating to Discharge Reports--Records, Data Fields and Codes) periodically submitted on or on behalf of a Hospital in compliance with the provisions of this chapter.

(12) DRG--Diagnosis Related Group

(13) EDI--Electronic Data Interchange--A method of sending data electronically from one computer to another. EDI helps providers and payers maintain a flow of vital information by enabling the transmission of claims and managed care transactions.

(14) Edit--An electronic standardized process developed and implemented by the Council to identify potential errors and mistakes in data elements by reviewing data fields for the presence or absence of data and the accuracy and appropriateness of data.

(15) Electronic filing--The submission of computer records in machine readable form by modem transfer from one computer to another (EDI) or by recording the records on a nine track magnetic tape, computer diskette or other magnetic media acceptable to the executive director.

(16) Error--Data submitted on a discharge report which are not consistent with the format and data standards contained in this section or with editing criteria established by the executive director, or the failure to submit required data.

(17) Ethnicity--The status of patients relative to Hispanic background. Hospitals shall report this data element according to the following ethnic types: Hispanic or Non-Hispanic.

(18) Executive director--The chief administrative officer of the Council, or, in the event the Council is without an executive director, the person designated by the chairperson of the Council to perform the functions and exercise the authority of the executive director.

(19) Facility Type Indicators--An indicator that provides information to the data user as to the type of facility or the primary health services delivered at that facility (e.g. Teaching, Acute Care, Rehabilitation, Psychiatric, Pediatric, Cancer, Skilled Nursing or other Long Term Care Facility). A facility may have more than one indicator. Hospitals may request updates to this field.

(20) Geographic identifiers--A set of codes indicating the public health region and county in which the patient resides.

(21) Health care facility--A hospital, an ambulatory surgery center licensed under Chapter 243 of the Health and Safety Code, a chemical dependency treatment facility licensed under Chapter 464 of the Health and Safety Code, a renal dialysis center, a birthing center, a rural health clinic or a federally qualified health center as defined by 42 United States Code, §1396(1)(2)(B).

(22) Hospital--A public, for-profit, or nonprofit institution licensed or owned by this state that is a general or special hospital, private mental hospital, chronic disease hospital or other type of hospital.

(23) ICD--International Classification of Disease.

(24) Inpatient--A patient, including a newborn infant, who is formally admitted to the inpatient service of a hospital and who is subsequently discharged, regardless of status or disposition. Inpatients include patients admitted to medical/surgical, intensive care, nursery, subacute, skilled nursing, long-term, psychiatric, substance abuse, physical rehabilitation and all other types of hospital units.

(25) Operating or Other Physician--The licensed "physician" or "other health professional" who performed the principal procedure or performed the surgical procedure most closely related to the principal diagnosis.

(26) [~~(25)~~] Other exempted provider--A hospital exempt from state franchise, sales, ad valorem, or other state and local taxes

that does not seek or receive reimbursement for providing health care services to patients from any source, including the patient or any person legally obligated to support the patient; a third party payer; or Medicaid, Medicare, or any other federal, state or local program for indigent health care.

(27) [~~(26)~~] Other health professional--A person licensed to provide health care services other than a physician. An individual other than a physician who admits patients to hospitals or who provides diagnostic or therapeutic procedures to inpatients. The term encompasses persons licensed under various Texas practice statutes, such as psychologists, chiropractors, dentists, nurse practitioners, nurse midwives, and podiatrists who are authorized by the hospital to admit or treat patients.

(28) [~~(27)~~] Patient control number--A number assigned to each patient by the hospital, which appears on each computer record in a patient discharge file. This number is not consistent for a given patient from one hospital to the next, or from one admission to the next in the same hospital. The Council deletes or encrypts this number to protect patient confidentiality prior to release of data.

(29) [~~(28)~~] Physician--An individual licensed under the laws of this state to practice medicine under the Medical Practice Act, Occupations Code, Chapter 151.

(30) [~~(29)~~] Provider--A physician or health care facility.

(31) [~~(30)~~] Provider quality data--A public information report or reports authored by the Council [~~on provider quality or outcomes of care, as defined in Chapter 108 of Health and Safety Code, created from data collected by the Council~~] reflecting the extent to which providers render care that obtains for patients medically acceptable health outcomes and prognoses prepared by the Council based on data elements in the public use data file and, upon approval of the scientific review panel, the research file or obtained from other public sources.

(32) Public Information Report--A report created for providing information related to health care quality or effectiveness or access to health care.

(33) [~~(31)~~] Public use data file--A data file composed of discharge files with risk and severity adjustment scores which have been altered by the deletion, encryption or other modification of data fields to protect patient and physician confidentiality and to satisfy other restrictions on the release of hospital discharge data imposed by statute.

(34) [~~(32)~~] Race--A division of patients according to traits that are transmissible by descent and sufficient to characterize them as distinctly human types. Hospitals shall report this data element according to the following racial types: American Indian, Eskimo, or Aleut; Asian or Pacific Islander; Black; White; or Other.

(35) [~~(33)~~] Required minimum data set--The list of data elements which hospitals are required to submit in a discharge file for each inpatient stay in the hospital. The required minimum data set is specified in §1301.19(d) of this title (relating to Discharge Reports --Records, Data Fields and Codes).

(36) [~~(34)~~] Research data file--A customized data file, which includes the data elements in the public use file and may include data elements other than the required minimum data set submitted to the Council, except those data elements that could reasonably identify a patient or physician. The data elements maybe released to a requestor when the requirements specified in §1301.18(f) of this title (relating to Hospital Discharge Data Release) are completed.

(37) [~~(35)~~] Risk adjustment--A statistical method to account for a patient's severity of illness at the time of admission and the likelihood of development of a disease or outcome, prior to any medical intervention.

(38) [~~(36)~~] Rural provider--A health care facility located in a county with a population of not more than 35,000 as of July 1 of the most recent year according to the most recent United States Bureau of the Census estimate; or located in a county with a population of more than 35,000 but with 100 or fewer licensed hospital beds and not located in an area that is delineated as an urbanized area by the United States Bureau of the Census; and is not state owned, or not managed or directly or indirectly owned by an individual, association, partnership, corporation, or other legal entity that owns or manages one or more other hospitals. A health care facility is not a rural provider if an individual or legal entity that manages or owns one or more other hospitals owns or controls more than 50% of the voting rights with respect to the governance of the facility.

(39) [~~(37)~~] Scientific Review Panel--The Council's appointees or agent who have experience and expertise in ethics, patient confidentiality, and health care data who review and approve or disapprove requests for data or information other than the public use data. Described in §1301.20 of this title (relating to Scientific Review Panel).

(40) [~~(38)~~] Service Unit Indicator--An indicator derived from submitted data (based on Bill type or Revenue Codes) and represents the type of service unit or units (e.g., Coronary Care Unit, Detoxification Unit, Intensive Care Unit, Hospice Unit, Nursery, Obstetric Unit, Oncology Unit, Pediatric Unit, Psychiatric Unit, Rehabilitation Unit, Sub acute Care Unit or Skilled Nursing Unit) where the patient received treatment.

(41) [~~(39)~~] Severity adjustment--A method to stratify patient groups by degrees of illness and mortality.

(42) [~~(40)~~] Submission--A set of computer records as specified in §1301.19 of this title (relating to Discharge Reports --Records, Data Fields and Codes) that constitutes the discharge report for one or more hospitals.

(43) [~~(41)~~] Submitter--The person or organization, which physically prepares discharge reports for one or more hospitals and submits them to the Council. A submitter may be a hospital or an agent designated by a hospital or its owner.

(44) [~~(42)~~] THCIC Identification Number--A string of six characters assigned by the Council to identify health care facilities for reporting and tracking purposes.

~~[(43) Treating Physician--For the purposes of this title, the person licensed under the Medical Practice Act or any other health professional licensed by the state who has been reported as having treated the patient or who has consulted on the patient's case. The term includes any physician or other health professional listed on the discharge file other than the attending physician.]~~

(45) [~~(44)~~] Uniform facility identifier--A unique number assigned by the Council to each health care facility licensed in the state. For hospitals, this will include the hospital's state license number. For hospitals operating multiple facilities under one license number and duplicating services, the Council will assign a distinguishable uniform facility identifier for each separate facility. The relationship between facility identifier and the name and license number of the facility is public information.

(46) [~~(45)~~] Uniform patient identifier--A unique identifier assigned by the Council to an individual patient and composed of numeric, alpha, or alphanumeric characters, which remains constant across hospitals and inpatient admissions. The relationship of the

identifier to the patient-specific data elements used to assign it is confidential.

(47) [~~(46)~~] Uniform physician identifier--A unique identifier assigned by the Council to a physician or other health professional who is reported as attending or treating a hospital inpatient and which remains constant across hospitals. The relationship of the identifier to the physician-specific data elements used to assign it is confidential. The uniform physician identifier shall consist of alphanumeric characters.

(48) [~~(47)~~] Validation--The process by which a provider verifies the accuracy and completeness of data and corrects any errors identified before certification.

§1301.16. Acceptance of Discharge Reports and Correction of Errors.

(a) To verify the accuracy of all discharge files prior to public release, the executive director shall establish procedures for the review of all discharge reports to determine whether the report is acceptable, as required by Health and Safety Code, §108.011.

(b) Upon receipt of a discharge report, the executive director shall determine if it satisfies minimum criteria for processing. If it does not, the executive director shall return the discharge report in the same submission format and media that is approved for that provider and state the deficiencies in writing within ten calendar days of receipt. The hospital shall resubmit the report within ten calendar days of notification by the executive director. A discharge report does not meet minimum standards for processing under the following circumstances as shown in paragraphs (1)-(3) of this subsection.

(1) The physical media and labeling do not conform to the specifications in §1301.14 of this title (relating to Instructions for Filing Discharge Reports).

(2) The physical media are unreadable due to physical damage.

(3) The file structure does not conform to the specifications in §1301.19 of this title (relating to Discharge Reports - Records, Data Fields and Codes), unless the hospital has received a letter from the Council authorizing filing in another format.

(c) Correction of Errors.

(1) The executive director shall review all discharge reports accepted for processing and will process all discharge files against the editing criteria established by this section and by the executive director. Within 10 calendar days of receipt of an accepted discharge report the executive director shall notify the hospital in detail of all errors detected in the discharge report.

(2) Within 30 calendar days of receiving initial notice of errors in a discharge report, the hospital shall correct all discharge files containing errors, add any discharge files determined to be missing from the initial discharge report and resubmit the corrected and/or previously missing discharge files. If the hospital disagrees with any identified error, the hospital may indicate that the discharge file is as accurate as it can be or cannot be corrected. Each hospital shall submit such modified and/or additional discharge files as may be required to allow the chief executive officer or the chief executive officer's designated agent to certify the quarterly discharge report as required by § 1301.17 of this title (relating to Certification of Discharge Reports). Corrections to a discharge report shall be submitted on approved media and formats as specified in §1301.14 of this title (relating to Instructions for Filing Discharge Reports) and §1301.19 of this title (relating to Discharge Reports-Records, Data Fields and Codes) unless the executive director approves another medium or format.

(3) Within ten calendar days of receiving corrections to a discharge report from a hospital, the executive director shall notify the hospital of any remaining errors. The hospital shall have ten calendar days from receipt of this notice to correct the errors noted or indicate why the data should be deemed acceptable and complete. This process may be repeated until the data is substantially accurate and the hospital is able to certify the discharge report as required by §1301.17 of this title (relating to Certification of Discharge Reports) or the deadline for submitting corrections prior to certification is reached. Corrected data is required to be submitted on or before the following dates for the respective quarter's discharges; Quarter 1 - August 1, Quarter 2 - November 1, Quarter 3 - February 1, Quarter 4 - May 1. No individual hospitals will be granted extensions to the dates. The executive director may grant an extension to all hospitals when deemed necessary.

(4) Discharge files that have not been previously submitted shall be submitted prior to the deadline for the following quarter's data. Correction and certification of these previously missing or additional discharge files for the prior calendar quarter shall be made according to the deadlines established for following quarter in which the data that is scheduled to be processed as specified in §1301.13(a)(1) of this title (relating to the Schedule for Filing Discharge Reports), paragraph (3) of this subsection (relating to the Acceptance of Discharge Reports and Correction of Errors) and §1301.17 (b) and (d) of this title (relating to the Certification of Discharge Encounter Data). Corrections to discharge files previously submitted or that have a discharge date prior to calendar quarter immediately before the calendar quarter being processed scheduled will not be processed.

(d) The executive director will document and the Council will approve all acceptance and editing criteria utilized in reviewing discharge reports. If acceptance and editing criteria are incorporated into computer software, and if the software is the property of the Council, the executive director will make copies of the portions of the software containing the criteria available on paper or magnetic media. The executive director shall make this information available to submitters without charge and to others for the cost of reproduction.

(e) Failure to correct or comment on a discharge report which has been filed but contains errors or omissions, known to the hospital, within the due dates in §1301.13 of this title (relating to Schedule for Filing Discharge Reports) is punishable by a civil penalty pursuant to Health and Safety Code, §108.014.

§1301.17. Certification of Discharge Reports.

(a) Within five months after the end of each reporting quarter the executive director shall compile one or more electronic data files for each reporting hospital using all discharge files received from each hospital. The file shall have one record for each patient discharged during the reporting quarter and one record for any patient discharged during one [~~a~~] prior [~~previous~~] reporting quarter for whom additional discharge files have been received. This file will include all data submitted by the hospital which the executive director intends to use in the creation of the public use data file. The data files, including reports and any additional information returned to the hospital, allows the hospital to provide physicians and other health professionals the opportunity to review, request correction of, and comment on records of discharged patients for whom they are shown as "attending" or "operating or other" [~~treating~~]. The executive director shall determine the format and medium in which the quarterly file will be delivered to hospitals.

(b) The chief executive officer or chief executive officer's designated agent of each hospital shall indicate whether the hospital is certifying or not certifying the discharge encounter data specified in subsection (a) of this section, sign and return the form corresponding to the discharge report for each quarter using forms supplied by the Council.

The certification form may be signed by a person designated by the chief executive officer and acting as the officer's agent. Designation of an agent does not relieve the chief executive officer of personal responsibility for the certification. If the chief executive officer or chief executive officer's designated agent does not believe the quarterly file is accurate, the officer shall provide the executive director with detailed comments regarding the errors or submit a written request (on a form supplied by the Council) and provide the data necessary to correct any inaccuracy and certify the file subject to those corrections being made prior to the deadlines specified in this subsection. Corrections to certification discharge data shall be submitted on or prior to the following schedule: Quarter 1 - October 15; Quarter 2 - January 15; Quarter 3 - April 15; Quarter 4 - July 15. Chief Executive Officers or designees that elect not to certify shall submit a reasoned justification explaining their decision to not certify their discharge encounter data and attach the justification to the certification form. Election to not certify data does not prevent data from appearing in the public use data file. Data that is not corrected and submitted by the deadline may appear in the public use data file.

(c) The signed certification form shall represent that:

(1) policies and procedures are in place within the hospital's processes to validate and assure the accuracy of the discharge encounter data and any corrections submitted; and

(2) all errors and omissions known to the hospital have been corrected or the hospital has submitted comments describing the errors and the reasons why they could not be corrected; and

(3) to the best of their knowledge and belief, the data submitted accurately represents the hospital's administrative status of discharged inpatients for the reporting quarter; and

(4) the hospital has provided physicians and other health professionals a reasonable opportunity to review and comment on the discharge data of patients for which they were reported in one of the available physician number and name fields provided on the acceptable formats specified in §1301.19 of this title (relating to Discharge Reports --Records, Data Fields and Codes) (for example, "attending physician" or "operating or other physician" as applicable. The physicians or other health professionals may write comments and have errors brought to the attention of the chief executive officer or the chief executive officer's designated agent and the chief executive officer or the chief executive officer's designated agent, shall address any comments by the physicians or other health professionals.

(5) if the chief executive officer or the officer's designee elects not to certify the discharge encounter data for a specific quarter, a written justification of any unresolved data issues concerning the accuracy and completeness of the data at the time of the certification shall be included on the certification form. Discharge data that has been edited, returned to hospital and is not certified may be released and published in the public use data file.

(d) Each hospital shall submit its certification form for each quarter's data to the Council by the first day of the ninth month (Quarter 1 - December 1; Quarter 2 - March 1; Quarter 3 - June 1; Quarter 4 - September 1) following the last day of the reporting quarter as specified in §1301.13 (a) (1)-(4) of this title (relating to Schedule for Filing Discharge Reports). Individual hospital requests for an extension to these deadlines will not be granted. The executive director may extend the deadline for all hospitals when deemed necessary.

(e) Hospitals, physicians or other health professionals may submit concise written comments regarding any data submitted by them or relating to services, they have delivered which may be released as public use data. Comments shall be submitted to the Council on or before the dates specified in subsection (d) of this section, regarding the submission of the certification form. Commenters are responsible for assuring that the comments contain no patient or physician identifying information. Comments shall be submitted electronically using the method described in §1301.14(a) and (b) of this title (relating to Instructions for Filing Discharge Reports).

(f) Failure to submit a signed certification form that is supplied by the Council on or before the dates specified in subsection (d) of this section corresponding to discharge data previously submitted is punishable by a civil penalty pursuant to Health and Safety Code, §108.014.

(g) Failure to either correct a discharge report which has been submitted and contains errors or omissions known to the hospital on or prior to the dates specified in subsection (b) of this section or to address in the comments the errors known to the hospital contained in the data and return the comments on or prior to the dates specified in subsection (d) of this section is punishable by a civil penalty pursuant to Health and Safety Code, §108.014(b).

§1301.18. Hospital Discharge Data Release.

(a) - (b) (No change)

(c) Creation of public use data file. The executive director will create a public use data file by creating a single record for each inpatient discharge and adding, modifying or deleting data elements in the following manner as listed in paragraphs (1)-(11) of this subsection:

(1) - (4) (No change.)

(5) delete physician and other health professional names and numbers and assign a alphanumeric uniform physician identifier for the physicians and other health professionals who were reported as "attending" or "operating or other" on [~~treating~~] discharged patients;

(6) - (11) (No change.)

(d) - (l) (No change.)

§1301.20. Scientific Review Panel.

(a) The Council establishes the Scientific Review Panel (Panel) for the purposes of:

(1) evaluating applications for various measures or variables that are found in the Council's hospital discharge data "research" file; and

(2) deciding whether the data requests should be granted.

(b) The Scientific Review Panel is abolished at such time as the Council ceases to maintain a hospital discharge data "research" file.

(c) The Council may establish the scientific review function through a contract with an existing institutional review board that meets federal guidelines or by appointing a separate review panel.

(d) Membership if scientific review panel is appointed.

(1) A person interested in membership on the Scientific Review Panel must submit an application, on a form specified by the Council, to the Executive Director of the Council.

(2) The Scientific Review Panel will consist of at least five members.

(3) The Council's Appointments Committee shall review all applications for membership and make recommendations to the Council. When making its recommendations, the Appointments Committee shall consider the qualification criteria in the Health and Safety Code, §108.0135 for each member and the restrictions on composition of committees in Government Code §2110.002.

(4) The Council, at its, discretion, shall appoint persons to the Scientific Review Panel. Members shall have experience and expertise in ethics, patient confidentiality, and health care data.

(5) Members shall be appointed for three-year terms, except that for the initial appointees, the terms of one-third of the members shall be for three years, another one-third for two years, and the remaining members for one year. The Appointments Committee shall assign the initial term of each member or position so as to provide for a staggered system of terms.

(6) The Council may remove a member from the Scientific Review Panel if he or she is absent from three consecutive meetings. The Chair of the Scientific Review Panel may recommend the removal of a member for non-attendance to the Council's appointments committee, which shall review the matter and make a recommendation to the Council.

(7) If a vacancy on the Scientific Review Panel occurs, the Council shall appoint an individual to serve the unexpired portion of that term.

(8) The Chair of the Scientific Review Panel is designated by the Chair of the Council from current members of the Panel. This person shall serve in that capacity at the pleasure of the Council Chair.

(e) Meetings.

(1) The Scientific Review Panel shall meet as necessary to conduct business, but in any case, at least once every three months if applications for all or part of the research file are pending.

(2) A simple majority of the members of the Scientific Review Panel shall constitute a quorum for the purpose of transacting business. All action of the Panel must be approved by majority vote. Each member shall have one vote and may not vote by proxy or in absentia.

(3) Meetings of the Panel or Subcommittees of the Panel shall be posted and conducted in accordance with the Texas Open Meets Act, Government Code, Chapter 551. All meetings of the Panel or any Subcommittee will be recorded.

(4) Minutes of all Panel and Subcommittee meetings shall be maintained by Council staff and shall include the names of members in attendance and a record of all formal actions and votes taken.

(5) Council staff shall provide administrative support for the Panel and any Subcommittees, including making of meeting arrangements. Each Panel or Subcommittee member shall be informed of a meeting at least ten calendar days prior to a meeting.

(6) The Panel and Subcommittees shall make decisions in the discharge of its duties without discrimination based on any person's race, creed, gender, religion, national origin, age, physical condition, or economic status.

(f) Decision-Making Guidelines.

(1) Requests should reasonably identify and justify the requested data elements. Requesters who have detailed information that would assist in justifying the records request are urged to provide such information in order to expedite the handling of the request. Envelopes in which written requests are submitted should be clearly identified as Open Records requests. Requests should include the fee or request determination of the fee.

(2) Fee structures for the public use data file and the research file shall be set by the executive director, in consultation with the Council.

(3) Waiver or reduction of the fees charged for the public use data file or the research file may be made upon a determination by the Executive Director when such waiver or reduction is in the Council's interest.

(4) All requests for data must be submitted in writing, either on the form provided by the Council or on a similar form containing all of the same information. Denials of written requests will be in writing and will contain the reasons for the denial including, as appropriate, a statement that a document or data element requested is nonexistent or is not reasonably described, or is subject to one or more clearly described exemption(s). Denials will also provide the requester with appropriate information on how to exercise the right of appeal to the Council.

(5) In cases where there is an alleged conflict between the Texas Open Records Act and the Council's procedures, the Executive Director will refer the issue to the Office of the Attorney General.

(6) Only data elements requested by the requestor and approved for release by the Scientific Review Panel, shall be included in the research file for release to the requestor in accordance with this chapter. [~~Records will not be created by compiling selected items from the files, and records will not be created to provide the requester with such data as ratios, proportions, percentages, per capitas, frequency distributions, trends, correlations, and comparisons. If such data have been compiled and are available in the form of a record, the record may be made available as provided herein.~~]

(g) Reports to the Council. The Chair of the Scientific Review Panel shall file with the Executive Director of the Council a written report of all action taken at any meeting of the Panel or of a Subcommittee within 3 working days of such meeting, including a detailed list of how each participating member voted.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200107955
Jim Loyd
Executive Director
Texas Health Care Information Council
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 482-3320

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SUBCHAPTER C. RULES RELATING TO PUBLIC INFORMATION REPORTS CREATED BY THE COUNCIL

25 TAC §§1301.41 - 1301.47

The Texas Health Care Information Council (Council) proposes new §§1301.41 - 1301.47 relating to the creation, validation and release of Council generated public information reports. A short version of these rules was proposed as amendments to §1301.11 and §1301.18 in the August 10, 2001 edition of the *Texas Register* (26 TexReg 5987) and addressed only the provider quality data reports regarding hospitals. The Council received comments from one commenter and the Council considered the comments and created new rules regarding all public information reports generated by the Council. Elsewhere

in this issue of the *Texas Register*, the proposed amendments to §1301.11 and 1301.18 have been withdrawn.

Jim Loyd, Executive Director, has determined that for the first five-year period that the proposed sections are in effect, there will be the following anticipated costs of $9,505 to $265,787 to the State which may require an exceptional item request to the Legislative Budget Board or request for additional personnel in regards to the implementation of the amended sections: This estimate includes the following: 1) a one-time programming cost of $1,000 to create the secure website pages and the forms to be used by hospitals to submit their comments, 2) recurring costs of $500 for website maintenance, 3) $5,453 to $261,734 This is based on an estimate of one to four provider quality reports each year. Each report will cost in the range of $893 to $10,718. Thus, costs for the first year are $2,393 to $44,371 {This is based on a range of 40 to 480 hours per report, times the average hourly salary ($ 22.33) of the Director, Health Information, the Systems Analyst and the Epidemiologist of the Council's staff develop, draft, analyze, and write the report, receive, attach and publish the comments from the hospitals named in the provider quality reports as required by §108.010(e), Health and Safety Code.} A ten percent increase above the first and each subsequent year's costs is estimated for years two through five (Second year -$1,532 to $47,709, Third year - $1,686 to $52,479, Fourth year - $1,854 to $57,727, Fifth year - $2,040 to $63,500).

Mr. Loyd has also determined that, for the first five-year period the proposed sections are in effect, there, will be the following anticipated costs to affected local governments as a result of enforcing or administering the amended sections: The Council estimates costs for reviewing and submitting comments regarding the provider quality reports to be $2,420 to $9,678 ($396 to $1,585 for the first year based on estimated 16 hours per report with a minimum of one report and a maximum of 4 per year. Per hour staff costs are estimated at $ 24.77 (using the cost of Medical and Health Services Managers (SOC 11-9111, *Average Mean Hourly Salary - Texas Workforce Commission- 2000 Occupational Employment Statistics*). This assumes a ten percent increase per year: (Second Year - $436 to $1,744, Third Year - $480 to $1,918, Fourth year - $528 to $2,110, Fifth year - $580 to $2,321))

Mr. Loyd also has determined that, for each year the of the first five year period the rules are in effect, the costs to persons or hospitals who are required to comply with the amended and new sections will be $2,420 to $9,678. ($396 to $1,585 for the first year based on estimated 16 hours per report with a minimum of one report and a maximum of 4 per year. Per hour staff costs are estimated at $24.77 (using the cost of Medical and Health Services Managers (SOC 11-9111, Average Mean Hourly Salary - Texas Workforce Commission- 2000 Occupational Employment Statistics). This assumes a ten percent increase per year: (Second Year - $436 to $1,744, Third Year - $480 to $1,918, Fourth year - $528 to $2,110, Fifth year - $580 to $2,321)). The new rules provide the persons or hospitals opportunities to review the technical documentation for the report prior to the report being generated; thereby potentially reducing the health care facilities need to have

Mr. Loyd also has determined that for each year of the first five-year period the proposed sections are in effect, the anticipated public benefit will be the release of unbiased reports developed by the Council for comparative analysis of the health care provided by hospitals in Texas and other health care facilities as allowed in Chapter 108 of the Texas Health and Safety Code. These reports will allow consumers of health care to review qualitative measures of similar facilities and make decisions regarding health care services offered by those facilities. The facility and geographic (e.g., regional, metropolitan, county and community) focused reports will assist legislators in making decisions regarding their constituents' health conditions or issues of interest in their districts and the state.

Comments on the proposed sections may be submitted to Bruce Burns, D.C., R.S., Program Specialist, Texas Health Care Information Council, Two Commodore Plaza, 206 East 9th Street, Suite 19.140, Austin, Texas 78701. Comments must arrive no later than 31 calendar days from the date that these proposed sections are published in the *Texas Register*.

The Council will entertain requests for a public hearing until the 25th day after the date the rules are published in the *Texas Register*.

The new sections are proposed under the Health and Safety Code, §108.006 and §108.009. The Council interprets §108.006 as authorizing it to adopt rules necessary to carry out Chapter 108, including rules concerning data dissemination requirements. The Council interprets §108.009 as authorizing the Council to adopt rules regarding the collection of data from hospitals in uniform submission formats in order for the incoming data to be substantially valid, consistent, compatible and manageable.

The Health and Safety Code, §§108.002, 108.003 108.006, 108.009, 108.010 and 108.011, are affected by these new sections.

§1301.41. Definitions.

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

(1) Committee--means a body of persons delegated to consider, investigate, take action on, or report on some matter.

(2) Council--means the Texas Health Care Information Council.

(3) Council Board--means the Council's Board members

(4) Chairman--The person appointed by the Governor to chair the Council as specified in §108.003 (d) of the Health and Safety Code.

(5) Chairperson--The presiding officer of a meeting or committee.

(6) Executive Committee--means the Council Board Members who serve as officers of the Council Board or Chair one of the Council committees.

(7) Executive Director--means the chief executive officer of the Council

(8) Health care facility--means:

(A) a hospital;

(B) an ambulatory surgical center licensed under Chapter 243;

(C) a chemical dependency treatment facility licensed under Chapter 464;

(D) a renal dialysis facility;

(E) a birthing center;

(F) a rural health clinic; or

(G) a federally qualified health center as defined by 42 U.S.C. Section 396d(l)(2)(B).

(9) Initiating Committee--means the committee of the Council authoring the charge.

(10) Provider--means a physician or health care facility.

(11) Provider Level--means data or information that identifies specific providers by name or uniform identifier.

(12) PIR--Public Information Report--A report created for providing information related to health care quality or effectiveness or access to health care that will be shared with the public.

(13) Qualitative Comparative Measures--means data elements or the combination of data elements or summarization of manipulated data that reflects on the quality of any specific provider.

(14) Request for information--means a request made by individual or organization for summarized or analyzed responses from publicly available data. The Council does not consider a request for information and responses as a public information report.

(15) TAC--Technical Advisory Committee--as specified in 108.003(g) of the Health and Safety Code.

§1301.42. Procedures for Collaborative Public Information Reports.

(a) The Executive Director shall notify the Council Chairman when an agency or organization expresses an interest in producing a collaborative report with the Council. The Executive Director and Council staff shall discuss and deliberate on whether this report effort will have an overall benefit to the citizens of Texas and the Council. The Executive Director and staff may consult with other individuals or groups regarding this collaborative report effort.

(b) The Council Chairman and Executive Director shall present this request to the next scheduled Board or Executive Committee meeting for a majority vote of approval or withdrawal.

§1301.43. Procedures for Council Generated Public Information Reports.

(a) One or more committees of the Council shall issue a charge to the Council's staff or to one or more of the technical advisory committees specified in Chapter 108 of the Health and Safety code to produce a report.

(b) Council staff shall provide a written description of the charge to the initiating committee chair assigning the charge. Clarification of the charge shall be made at this time, if required.

(c) Council staff shall submit the written description of the charge to the affected staff member or TAC chair.

(d) The person or TAC shall research, investigate, deliberate or reconcile the charge and generate the outcome or draft of the product requested in the charge.

(e) Upon completion of subsection (d) the Council staff or TAC chair shall submit this to any additional TAC for recommendations as required by the charge or Chapter 108, Health and Safety Code.

(f) If additional TAC or Council staff input is required the TAC or Council staff person shall follow the steps in subsections (d) and (e) of this section.

(g) The TAC chair or Council staff shall submit a report or arrange for a presentation to the committee or Council Board, after the TACs and Council staff have made their recommendations or produced the report.

(h) The initiating committee may review, discuss, deliberate or take action on the report or presentation. If the initiating committee approves the report or presentation a recommendation to the Council Board for approval shall be made. If further modifications are required for the report or presentation, the initiating committee shall issue a new charge and subsections (a) through (h) shall be followed until a recommendation for approval or is disapproved.

§1301.44. Technical Documentation regarding Public Information Reports.

(a) In conjunction with subsections §1301.43(d) and (e) a draft document containing detailed instructions on the methodology to be used in the reports shall be presented at one of the Quality Methods TAC meetings.

(b) Prior to a final report or presentation being submitted to the initiating committee in §1301.43(h) the document with the methodology shall be finalized and published on the Council's website and presented at one of the TAC meetings.

(c) The public information report shall provide contact and website information to obtain the technical documentation regarding the public information report.

§1301.45. Timeline Requirements for Release of Technical Documentation and Public Information Reports.

(a) The Council will make available the Technical Documentation regarding the Public Information Report no less than 7 days prior to the masked Public Information Report being made available to providers for review and comment.

(b) The Council intends to release the Public Information Report with the comments within 21 days after the date specified by the Council in §1301.46(b)(1) of this subchapter.

§1301.46. Provider Level Public Information Reports.

(a) The Council shall provide access to a paper copy or an electronic copy of the public information report to each hospital named in the report. In providing a copy of the report to each named provider, the Council shall mask the identities of the other providers in the report.

(b) Providers may submit comments regarding the provider report to the Council.

(1) Any comments shall be submitted to and received by the Council, on or prior to the date specified by the Council, which shall not be less than 60 calendar days after notification is sent from the Council.

(2) Comments shall be submitted on a form created by the Council.

(3) Comments shall be returned to the Council in an electronic format specified by the Council.

(4) Comments received by the Council shall be posted on the Council's Internet website with each release of the provider level public information reports.

(c) Public Information Reports that contain qualitative comparative measures of the providers in the report, shall have a minimum of one of the following the factors applied, as appropriate:

(1) case mix qualifiers,

(2) severity adjustment factors,

(3) adjustments for medical education,

(4) adjustments for research,

(5) other factors necessary to accurately reflect provider quality.

§1301.47. Regional/Geographical Public Information Reports.

The Council will not provide prior access to providers for regional/geographical public information reports which do not provide provider level information.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Jim Loyd
Executive Director
Texas Health Care Information Council
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For further information, please call: (512) 482-3320

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 9. TITLE INSURANCE

The Texas Department of Insurance proposes amendments to §9.1 and §9.401 which concern the adoption by reference of certain amendments to the Basic Manual of Rules, Rates and Forms for the Writing of Title Insurance in the State of Texas (Basic Manual) and to the Texas Title Insurance Statistical Plan (Statistical Plan). The amendments reflect changes to the Basic Manual and the Statistical Plan which the proposed sections will adopt by reference and which were considered at the rulemaking phase of the 2000 Texas Title Insurance Biennial Hearing. Adopting new rules and forms and modifying or replacing currently existing rules and forms in the Basic Manual and Statistical Plan facilitate the administration and regulation of title insurance in this state. The proposed amendments to the Basic Manual and Statistical Plan will clarify and standardize the rules and forms regulating title insurance. The proposed amendments to the Basic Manual and Statistical Plan are identified by item number and are a republication of items published for consideration at the 2000 Texas Title Insurance Biennial Hearing, Rulemaking Phase, Docket Number 2470, (rulemaking hearing), held on November 27, 2001, together with proposed amendments and typographical and formatting changes to the items. Republication is necessary to incorporate these items into the Basic Manual and Statistical Plan as applicable, to give notice of the withdrawal, by their respective submitters, of Items 2000-20, 2000-21, 2000-22, 2000-23, 2000-24, 2000-25, 2000-31, 2000-E, 2000-G, 2000-H, and 2000-K at the rulemaking hearing, to give notice of the changes to the various proposed items, and to give notice of the decision not to adopt Items 2000-17, 2000-F, and 2000-J, which decision is set forth in a separate Commissioner's Order. The items which are the subject of this proposal are as follows:

Eleven proposals relate to mortgagee policy endorsements. The purpose of these endorsements is to streamline the mortgage lending process by allowing lenders to efficiently and economically close and package real estate loans for resale in the secondary lending market. This reflects a nationwide trend regarding uniformity of these types of endorsements so lenders can readily identify the types of coverages available on each particular loan. The department has made corrective and clarifying changes to these items and has assigned form numbers to each item. A brief description of each item follows its listing:

Item 2000-1 - Submission to adopt a new First Loss Endorsement (Form T-14). This proposed endorsement would be available for mortgagee policies and would typically be used in large commercial transactions. It would allow a lender to make a claim on its policy, without having to first foreclose on its lien, if appraisals show there has been a diminution in value of at least 10%.

Item 2000-2 - Submission to adopt a new Last Dollar Endorsement (Form T-15). This proposed endorsement would be available for mortgagee policies. Normally, policy limits are reduced as the principle is paid down. With this endorsement, loan payments would be applied first against the value of any personal property or non-Texas realty securing the loan and would not reduce the policy limits unless and until the loan amount secured by those other properties has been paid down completely.

Item 2000-3 - Submission to adopt a new Mortgagee Policy Aggregation Endorsement (Form T-16). When a loan is secured by land in multiple states, this proposed endorsement for mortgagee's policies would allow any claim on any piece of property to be paid out of the aggregate coverage from all the title policies involved. Coverage would be reduced 'pro tanto', meaning dollar for dollar.

Item 2000-4 - Submission to adopt a new Planned Unit Development Endorsement (Form T-17). This proposed endorsement for mortgagee's policies would give expanded coverage for restrictions, assessments, rights of first refusal, and forcible removal of structures. Planned Unit Developments are organized in such a way that facilitates the sort of search/due diligence that would be required in underwriting such risks.

Item 2000-5 - Submission to amend Procedural Rule P-9, Endorsement of Owner or Mortgagee Policies. This proposed procedural rule will authorize the use of the endorsements described in Items 2000-1 through 2000-4.

Item 2000-6 - Submission to adopt a new Restrictions, Encroachments, Minerals Endorsement (Form T-19). This proposed endorsement provides coverage for losses arising out of building setback line violations and other restrictions which have established easements, provided for an option to purchase, a right of first refusal or the prior approval of a future purchaser or occupant, or provided a right of reentry, possibility of reverter or right of forfeiture because of violations of enforceable covenants, conditions or restrictions. Also covered is damage to existing buildings located or encroaching upon any portion of the land subject to any easement excepted in Schedule B that results from the future exercise of any right existing on the date of the policy to use the surface of the land for the extraction or development of minerals excepted from the description of the land or excepted in Schedule B and from a final court order or judgment requiring removal from the land adjoining the insured land of any encroachment, other than fences, landscaping or driveways, excepted in Schedule B.

Item 2000-7 - Submission to adopt a new procedural rule (P-50) for the proposed new Restrictions, Encroachments, Minerals Endorsement. This procedural rule would authorize the use of the endorsement described in Item 2000-6.

Item 2000-8 - Submission to adopt a Texas Short Form Residential Mortgagee Policy of Title Insurance (T-2R) and Addendum (T-2R Addendum). This proposed short form will aid in logistics and speed the delivery of policies by giving the insured a checklist by which to elect various endorsements and make the language more consistent with American Land Title Association forms.

Three proposals would implement the short form checklist proposal and provide clean up language in certain rules and forms as detailed herein:

Item 2000-9 - Submission to amend Procedural Rule P-1 to make reference to direct operations and the proposed new Texas Short Form Residential Mortgagee Policy.

Item 2000-10 - Submission to adopt a new procedural rule (P-51) to implement the proposed new Texas Short Form Residential Mortgagee Policy.

Item 2000-11 - Submission to amend Schedules A and B of the Commitment for Title Insurance (Form T-7) to reference application of the proposed new Texas Short Form Residential Mortgagee Policy.

Item 2000-12 - Submission to amend Procedural Rule P-17, Electronically Produced Endorsement Forms. As proposed by the department, it would allow title companies to electronically produce forms and endorsements and make allowance for electronic signatures while preserving safeguards for document retention and audit.

Item 2000-13 - Submission to amend paragraph 1 of the Conditions and Stipulations of the Texas Owner Policy of Title Insurance (Form T-1). This item would amend the definition of insureds to add limited liability companies and limited liability partnerships. Such companies were not authorized in Texas when the form was last revised.

Three proposals would amend existing leasehold endorsements to incorporate the language of recent revisions to the American Land Title Association forms, including changes in the definition of valuation of an estate:

Item 2000-14 - Submission to amend the Leasehold Owner Policy Endorsement (Form T-4).

Item 2000-15 - Submission to amend the Residential Leasehold Endorsement (Form T-4R).

Item 2000-16 - Submission to amend the Leasehold Mortgagee Policy Endorsement (Form T-5) should allow more flexibility in calculating damages in an eviction.

Two proposals concern amendments regarding the use of surveys in title insurance. Existing Procedural Rule P-2 provides that a current survey must be purchased as a prerequisite for the survey deletion, except in residential refinances in which a seven year old survey can be used. The 77th Legislature enacted Senate Bill 1707, which added Insurance Code Article 9.07C to provide that a survey of any age can be used if it is acceptable to the underwriter and an affidavit verifying the existing survey is provided. The submissions would implement the legislation and make conforming amendments to the title commitment form. Further, the department has noted on the promulgated residential real property affidavit that it may also be modified as appropriate for commercial transactions.

Item 2000-18 - Submission to amend Procedural Rule P-2, Amendment to Exception to Area and Boundaries.

Item 2000-19 - Submission to amend the Commitment for Title Insurance (Form T-7).

The following six proposals correct typographical errors, update minimum escrow requirements, clarify the good funds rule, revise the Statistical Plan, and establish document retention rules:

Item 2000-26 - Submission to amend Minimum Standards, Specific Instructions and Report Forms for Audit of Trust Funds Required of Texas Title Insurance Agents, Direct Operations, Title Attorneys and Attorneys Licensed as Escrow Officers. This proposed amendment to the Minimum Escrow Procedures clarifies issues related to escrow accounts and copies of checks and clarifies reporting deadlines.

Item 2000-27 - Submission to amend Procedural Rule P-22 to be more consistent with Procedural Rules P-1 and P-24. This proposed amendment clarifies issues related to the payment of fees for examination and closing and also accommodates multi-county transactions.

Item 2000-28 - Submission to amend Procedural Rule P-27, Disbursement from Trust Fund Accounts. This proposed amendment clarifies "good funds" requirements to aid in preserving the integrity of escrow accounts.

Item 2000-29 - Submission to amend Procedural Rule P-28 to correct an address of the department.

Item 2000-30 - Submission to adopt new Procedural Rule P-32 regarding document retention. This proposed amendment clarifies document retention requirements in light of emerging electronic data storage technologies, while maintaining the department's ability to audit and verify information. Title policies must be kept indefinitely; hard copies of evidence of insurability must be kept for 3 years and thereafter can be electronically scanned and kept for the remainder of the 15 year retention period as required by Article 9.34, and escrow documentation is subject to a 3 year retention schedule. Read in conjunction with the proposed amendments to P-17 (Agenda Item 2000-12), documents which are initially computer generated or electronically produced may be retained in that medium.

Item 2000-32 - Submission to amend the Texas Title Insurance Statistical Plan is necessary to update and revise reporting codes.

Item 2000-A - Submission to adopt a new Procedural Rule P-52 regarding delivery of pro forma policies and promulgated forms. This proposed procedural rule would allow companies to issue pro forma policies in commercial transactions in excess of $500,000.

The following three proposals are designed to allow consumers to obtain title insurance on manufactured housing characterized as real property pursuant to recent legislative changes:

Item 2000-B - Submission to adopt a Supplemental Coverage Manufactured Housing Unit Endorsement (Form T-31.1).

Item 2000-C - Submission to amend Procedural Rule 9.b.(7) to implement the adoption of the proposed Supplemental Coverage Manufactured Housing Unit Endorsement (Form T-31.1).

Item 2000-D - Submission to amend Procedural Rule 9.a. to implement the adoption of the proposed Supplemental Coverage Manufactured Housing Unit Endorsement (Form T-31.1).

Item 2000-I - Submission to amend Procedural Rule P-24 concerning the division of premiums between entities performing title services. Current Procedural Rule P-24 specifies the percentages of an agent's premium to be shared among agents for performing various services. This proposed amendment would eliminate a provision whereby agents can agree in writing to different percentages not prescribed by the Commissioner and would clarify the application of the payment of the percentages.

The department has filed a copy of each of the proposed items with the Secretary of State's Texas Register section. Persons desiring copies of the proposed items can obtain them from the Office of the Chief Clerk, Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas, 78714-9104. To request copies, please contact Sylvia Gutierrez at 512/463-6327.

Robert R. Carter, Jr., deputy commissioner for the title division, has determined that, for each year of the first five years the amendments are in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the amendments. Mr. Carter has also determined that there will be no effect on local employment or the local economy that is separate from any impact of legislation.

Mr. Carter has also determined that for each year of the first five years the amendments are in effect there are a number of public benefits anticipated as a result of the amendments to the Statistical Plan and Basic Manual. Providing more uniform endorsements for mortgagee policies will allow for more efficient closing of transactions. The updating and revising of the minimum escrow requirements, good funds rule, and Statistical Plan, allow for consistent administration, facilitate the efficiency of the department and the closing of transactions. The proposals adapt the Basic Manual to changing business practices. Clarifying the division of payments between agents should make dealings between agents more efficient and should result in a larger percentage of the premium remaining in the county in which expenses related to maintaining and furnishing title evidence are incurred. The new and updated promulgated forms will impose no additional regulatory costs on companies that decide to participate in the title insurance market, and the costs of reproducing such forms, estimated to be no more than $.15 per form for the cost of a photocopy, should be fully compensated by the existing premium schedule. The public benefit anticipated as a result of administering and enforcing the survey proposals will be to clarify the circumstances under which area and boundary or survey coverage is provided as required by the 77th Legislature in SB 1707. There are anticipated costs to those title insurance companies and title agents required to comply with these survey proposals in the form of affidavits which title agents and title companies must provide for consumers to execute in lieu of new surveys. To the extent that title companies and title agents already provide such affidavits pursuant to the residential refinance requirements in Procedural Rule P-2, the department expects the current premium schedule to fully compensate for such costs. Further, the proposals impose no uncompensated regulatory costs on companies that decide to participate in the title insurance market. Any additional costs associated with those proposals implementing legislation are due to the legislation and are not a result of the administration of the rule. As to all the proposals, the department anticipates no differential impact between small, large, and micro-businesses. The cost per hour of labor should not vary between small, large, and micro-businesses. Further, it is neither legal nor feasible to exempt small or micro-businesses or to waive compliance considering the purpose of the efficient regulation of title insurance for which the amendments are to be adopted.

To be considered, written comments on the proposal must be submitted no later than 5 p.m. on January 28, 2002, to Lynda H. Nesenholtz, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be submitted simultaneously to Robert R. Carter, Jr., Deputy Commissioner, Title Division, Mail Code 106-2T, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Request for a public hearing should be submitted separately to the Chief Clerk's office. It is noted that any comments received during the previous rulemaking hearing will be considered part of the record regarding the proposed amendments.

SUBCHAPTER A. BASIC MANUAL OF RULES, RATES, AND FORMS FOR THE WRITING OF TITLE INSURANCE IN THE STATE OF TEXAS

28 TAC §9.1

These amended sections are proposed pursuant to Insurance Code Articles 9.07, 9.07C, 9.21, and §36.001, and House Bill (HB) 1869 concerning changes to the Texas Manufactured Housing Standards Act and the Texas Property Code. Article 9.07 authorizes and requires the commissioner to promulgate or approve rules and policy forms of title insurance and otherwise to provide for the regulation of the business of title insurance. Article 9.07C provides that a survey of any age can be used if it is acceptable to the underwriter. Article 9.21 authorizes the commissioner to promulgate and enforce rules prescribing underwriting standards and practices, and to promulgate and enforce all other rules necessary to accomplish the purposes of chapter 9, concerning regulation of title insurance. HB 1869 establishes new requirements for "permanently affixed" manufactured homes that allow a loan on a manufactured home and a loan on real property to be combined. Section 36.001 authorizes the Commissioner of Insurance to adopt rules for the conduct and execution of the duties and functions of the Texas Department of Insurance only as authorized by statute.

The following statutes are affected by this proposal: Insurance Code, Articles 9.07, 9.07C, and 9.21 Subchapter A. Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas

§9.1. Basic Manual Of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas.

The Texas Department of Insurance adopts by reference the Basic Manual of Rules, Rates, and Forms for the Writing of Title Insurance in the State of Texas as amended effective February 28, 2002 [~~June 5, 2000~~]. The document is available from and on file at the Texas Department of Insurance, Title Division, Mail Code 106-2T, 333 Guadalupe Street, Austin, Texas 78701-1998.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200107978
Gene Jarmon
Assistant General Counsel
Texas Department of Insurance
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-6327

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SUBCHAPTER C. TEXAS TITLE INSURANCE STATISTICAL PLAN

28 TAC §9.401

These amended sections are proposed pursuant to Insurance Code Articles 9.07, 9.07C, 9.21, and §36.001, and House Bill (HB) 1869 concerning changes to the Texas Manufactured Housing Standards Act and the Texas Property Code. Article 9.07 authorizes and requires the commissioner to promulgate or approve rules and policy forms of title insurance and otherwise to provide for the regulation of the business of title insurance. Article 9.07C provides that a survey of any age can be used if it is acceptable to the underwriter. Article 9.21 authorizes the commissioner to promulgate and enforce rules prescribing underwriting standards and practices, and to promulgate and enforce all other rules necessary to accomplish the purposes of chapter 9, concerning regulation of title insurance. HB 1869 establishes new requirements for "permanently affixed" manufactured homes that allow a loan on a manufactured home and a loan on real property to be combined. Section 36.001 authorizes the Commissioner of Insurance to adopt rules for the conduct and execution of the duties and functions of the Texas Department of Insurance only as authorized by statute.

The following statutes are affected by this proposal: Insurance Code, Articles 9.07, 9.07C, and 9.21 Subchapter C. Texas Title Insurance Statistical Plan

§9.401. Texas Title Insurance Statistical Plan

The Texas Department [~~State Board~~] of Insurance adopts by reference the rules contained in the Texas Title Insurance Statistical Plan as amended effective February 28, 2002 [~~October 1, 1991~~]. This document is published by the Texas Department of Insurance and is available from the Property and Casualty Data Services [~~Statistical and Rate Development~~] Division, Mail Code 105-5D [~~109-1A~~], Texas Department of Insurance, William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, P.O. Box 149104, Austin, Texas 78714-9104.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

TRD-200107979
Gene Jarmon
Assistant General Counsel
Texas Department of Insurance
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-6327

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CHAPTER 21. TRADE PRACTICES
SUBCHAPTER M. MANDATORY BENEFIT NOTICE REQUIREMENTS

28 TAC §§21.2101 - 21.2103, 21.2105, 21.2106

The Texas Department of Insurance proposes amendments to §§21.2101 - 21.2103, 21.2105 and 21.2106 concerning mandatory notice of coverage of certain tests for the detection of colorectal cancer. The 77th Texas Legislature enacted Senate Bill 1467 which added new Article 21.53S to the Texas Insurance Code mandating certain benefits related to the detection of colorectal cancer. Article 21.53S also contains mandatory notice requirements. The department proposes the amendments to the notice provisions in subchapter M to implement the notice requirements in Article 21.53S.

Kim Stokes, Senior Associate Commissioner, Life, Health and Licensing Division, has determined that for each year of the first five years the proposed sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the rule. There will be no measurable effect on local employment or the local economy as a result of the proposal.

Ms. Stokes has determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of the proposed sections will be that affected enrollees are notified on a timely basis of available benefits related to tests for the detection of colorectal cancer. The costs to comply with the proposed amendments are the result of the legislative enactment of SB 1467, which created Article 21.53S. In an effort to minimize costs, carriers may, in a fashion similar to other notices required under this subchapter, deliver the required notice along with other plan documents rather than in a separate mailing. It is the department's position that the proposed amendments will not have an adverse economic effect on small businesses or micro-businesses and it is neither legal nor feasible to waive these requirements for small or micro businesses because to do so would have an adverse health impact on those entities' enrollees.

To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on January 28, 2002 to Lynda H. Nesenholtz, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Diane Moellenberg, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. A request for a public hearing should be submitted separately to the Office of the Chief Clerk.

The amendments are proposed under the Insurance Code Article 21.53S and Section 36.001. Article 21.53S provides rulemaking authority to the Commissioner of Insurance for the purpose of administering the statute and directs the Commissioner to adopt rules for the provision of a notice under the statute. Section 36.001 provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance only as authorized by statute.

The following articles are affected by this proposal: Insurance Code Article 21.53S

§21.2101. Scope.
The purpose of this subchapter is:

(1) to require notice to enrollees in a health benefit plan of coverage and/or benefits for prostate cancer examinations; minimum

inpatient stays for maternity and childbirth; minimum inpatient stays for mastectomy or lymph node dissection; [~~and~~] reconstructive surgery after mastectomy; and certain tests for the detection of colorectal cancer. With the exception of notice for reconstructive surgery after mastectomy and notice for colorectal cancer detection, §§21.2102 through 21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of January 1, 1998. For state notice requirements pertaining to reconstructive surgery after mastectomy, §§21.2102 - 21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of June 18, 1999. For notice requirements pertaining to tests for colorectal cancer detection, §§21.2102-21.2106 of this subchapter apply to all carriers issuing, delivering, or renewing health benefit plans as defined in this subchapter as of January 1, 2002.

(2) (No change.)

§21.2102. Definitions.

The following words and terms, when used in this subchapter shall have the following meanings, unless the context clearly indicates otherwise.

(1) Carrier--An insurance company, a group hospital service corporation, a fraternal benefit society, a stipulated premium insurance company, a health maintenance organization, a multiple employer welfare arrangement that holds a certificate of authority under Insurance Code Article 3.95-2, or an approved nonprofit health corporation that holds a certificate of authority issued by the commissioner under Insurance Code Article 21.52F. In addition, for the purposes of paragraph (3)(B) of this section, the term also includes a reciprocal exchange operating under Insurance Code Chapter 19 and for purposes of paragraph (3)(E) of this section, the term also includes a Lloyd's plan operating under Insurance Code, Chapter 18 and a risk pool created under Chapter 172, Local Government Code.

(2) Enrollee--A person enrolled in and entitled to coverage under a health benefit plan, including covered dependents.

(3) Health benefit plan--Subject to subparagraphs (A), (B), (C), [~~and~~] (D) and (E) of this paragraph, a plan that is offered by a carrier and provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness including an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract, an individual or group evidence of coverage, or any similar coverage document. The term does not include a plan that provides coverage only for accidental death or dismemberment, disability income, supplement to liability insurance, Medicare supplement, workers' compensation, medical payment insurance issued as a part of a motor vehicle insurance policy or a long-term care policy.

(A) For the inpatient mastectomy coverage notice required by subsection (a)(1) of §21.2103 of this title (relating to Mandatory Benefit Notices), the definition of health benefit plan includes a plan that provides coverage only for a specific disease or condition for the treatment of breast cancer or for hospitalization. The term does not include a small employer health benefit plan issued under the Insurance Code Chapter 26, Subchapters A-G.

(B) For the reconstructive surgery after mastectomy notices required by subsection (a)(2) of §21.2103 of this title, the definition of health benefit plan does not include a plan that provides coverage for a specified disease or other limited benefit except for cancer, a plan that provides only credit insurance, a plan that provides coverage only for dental or vision care, or only for indemnity for hospital confinement.

(C) For the prostate cancer examination notice required by subsection (a)(3) of §21.2103 of this title, the definition of health benefit plan does not include a small employer health benefit plan written under the Insurance Code Chapter 26, Subchapters A-G, a plan that provides coverage only for a specified disease or other limited benefit, or only for indemnity for hospital confinement.

(D) For the inpatient maternity and childbirth coverage notice required by subsections (a)(4) and (5) of §21.2103 of this title, the definition of health benefit plan does not include a plan that provides only credit insurance, a plan that provides coverage only for a specified disease or other limited benefit, only for dental or vision care, or only for indemnity for hospital confinement.

(E) For the detection of colorectal cancer screening coverage notice required by subsection (a)(6) of §21.2103 of this title, the definition of health benefit plan does not include a small employer health benefit plan written under the Insurance Code Chapter 26, Subchapters A-G, or a plan that provides coverage only for a specified disease or other limited benefit or only for indemnity for hospital confinement.

(4) Other limited benefit--A plan that provides coverage singularly or in combination, for benefits for a specifically named disease, accident or combination of diseases or accidents, including but not limited to heart attack, stroke, AIDS, and travel, farm or occupational accident.

(5) Primary Enrollee--For group coverage, the covered member or employee of the group. For individual coverage, the person first named on the application and/or enrollment form.

§21.2103. Mandatory Benefit Notices.

(a) Prescribed mandatory benefit notices consist of the following:

(1) - (5) (No change.)

(6) For a health benefit plan that provides coverage and/or benefits for screening medical procedures, a carrier shall issue a notice which includes the language provided in Figure 6 of subsection (b) of §21.2106 of this title (relating to Forms, Form Number 1467 Colorectal Cancer Screening).

(b) - (d) (No change.)

(e) If, before the effective date of the amendments to this subchapter relating to tests for the detection of colorectal cancer, a carrier has provided to its enrollees a notice that contains the information concerning colorectal cancer screening tests as required by §21.2103 (a)(6) or (b) of this subchapter, such notice shall be deemed to comply with the requirements of this subchapter as to those enrollees.

§21.2105. Delivery of Mandatory Benefit Notices.

(a) - (b) (No change.)

(c) The notice required by §21.2103(a)(6) of this title shall be issued to enrollees of a health benefit plan and Subsections (a)(2)-(6) of this section shall also apply to the notice, except for the timeline requirements of subsection (a)(1) of this section.

§21.2106. Forms.

(a) The forms identified in §21.2103 of this title (relating to Mandatory Benefit Notices) for notices of mandatory benefits are included in subsection (b) of this section in their entirety and have been filed with the Office of the Secretary of State. The forms can be obtained from the Texas Department of Insurance, Life/Health Division, MC 106-1A, P.O. Box 149104, Austin, Texas 78714-9104, or from the department's Web site, www.tdi.state.tx.us.

(b) The forms referenced in this chapter are as follow:

(1) - (5) (No change.)

(6) Figure Number 6: Form Number 1467 Colorectal Cancer Screening:
Figure: 28 TAC §21.2106(b)(6)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107935
Lynda Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-6327

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PART 2. TEXAS WORKERS' COMPENSATION COMMISSION

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER A. MEDICAL POLICIES

28 TAC §134.1

The Texas Workers' Compensation Commission (the commission) proposes amendments to §134.1, concerning use of the medical fee guidelines. The amendment is proposed to make §134.1 consistent with other commission rules.

The *Texas Register* published text shows words proposed to be added to or deleted from the current text, and should be read to determine all proposed changes.

Since adoption of current §134.1 a number of changes to the commission's fee guidelines have been adopted. As a result, the references in §134.1 to the Medical Fee Guidelines, the Pharmaceutical Fee Guidelines, and the Hospital and Ambulatory Surgical Center Fee Guidelines have become outdated. Subsections (c), (d), and (e) are proposed to be deleted to remove the outdated references. Because information regarding the applicability of the various fee guidelines is contained in the fee guidelines themselves, it is not necessary to include this information in §134.1.

In addition, it is proposed that the language "using the codes from" in subsection (b) be replaced with "in accordance with" because the fee guidelines will not necessarily contain coding information within the text of the guidelines. In subsection (f), the citation to the Workers' Compensation Act has been updated to reflect the appropriate Texas Labor Code citation.

Bill DeCabooter, Acting Director of Medical Review, has determined that for the first five-year period the proposed rule is in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the rule.

Local government and state government as covered regulated entities will be impacted in the same manner as described later in this preamble for persons required to comply with the rule as proposed.

Mr. DeCabooter has also determined that for each year of the first five years the rule as proposed is in effect the public benefits anticipated as a result of enforcing the rule will be consistency in the rules under which all Texas worker's compensation system participants function.

There will be no anticipated economic costs to persons who are required to comply with the rule as proposed.

There will be no costs of compliance for small businesses or micro businesses. There will be no adverse economic impact on small businesses or micro-businesses. There will be no difference in the cost of compliance for small businesses or micro businesses as compared to large businesses.

Comments on the proposal must be received by 5:00 p.m., January 28, 2002. You may comment via the Internet by accessing the commission's website at *www.twcc.state.tx.us* and then clicking on "Proposed Rules." This medium for commenting will help you organize your comments by rule chapter. You may also comment by emailing your comments to *RuleComments@twcc.state.tx.us* or by mailing or delivering your comments to Nell Cheslock at the Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

Commenters are requested to clearly identify this specific rule, §134.1, and not address their comments regarding proposed new rule, §134.202, in this proposed amended rule. The commission may not be able to respond to comments that cannot be linked to this particular proposed rule amendment. Along with your comment, it is suggested that you include the reasoning for the comment in order for commission staff to fully evaluate your recommendations.

Based upon various considerations, including comments received and the staff's or commissioners' review of those comments, or based upon the commissioners' action at the public meeting, the rule as adopted may be revised from the rule as proposed in whole or in part.

Persons in support or opposition of the rule as proposed, in whole or in part, are encouraged to comment to that effect. The failure to comment accordingly is not indicative of support or opposition. A public hearing on this proposal will be held on January 24, 2002 at the Austin central office of the commission (Southfield Building, 4000 South IH-35, Austin, Texas). Those persons interested in attending the public hearing should contact the Commission's Office of Executive Communication at (512) 804-4430 to confirm the date, time, and location of the public hearing for this proposal. The public hearing schedule will also be available on the commission's website at *www.twcc.state.tx.us*.

The amendment is proposed under the following statutes which are associated with the Medical Fee Guidelines: the Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §413.002, which requires that the commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with commission rules; the Texas Labor Code, §413.007, which sets out information to be maintained by the commission's Medical Review Division; the

Texas Labor Code, §413.011, which mandates that the commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires review and revision of the medical policies and fee guidelines at least every two years; the Texas Labor Code, §413.013, which requires the commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments refunds or overpayments; the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution and ; the Texas Labor Code, §413.044, which provides for sanctions against designated doctors who are found to be out of compliance with the medical policies and fee guidelines.

The amendment is proposed under the following statutes that are associated with the Medical Fee Guidelines: the Texas Labor Code §402.061, §413.002, §413.007, §413.011, §413.012, §413.013, §413.015, § 413.016, §413.017, §413.019, §413.031, §413.044.

No other code, statute, or article is affected by this rule action.

§134.1. Use of the Fee Guidelines.

(a) The ground rules and the medical service standards and limitations as established by the fee guidelines shall be used to properly calculate the payments due to the health care providers.

(b) Health care providers shall bill the insurance carrier for all compensable injuries in accordance with [~~using the codes from~~] the fee guidelines established by the commission. The health care provider shall bill the insurance carrier for the health care treatments and services performed, and medically necessary to relieve the effects of the compensable injury and promote recovery.

(c) [~~Doctors of medicine, osteopathy, dentistry, chiropractic, podiatry, optometry, psychology, and registered nurses, physical therapists, occupational therapists, imaging or radiology centers, minor emergency centers, free-standing pathology centers, durable medical equipment suppliers, and orthotic and prosthetic suppliers shall bill the insurance carrier using the medical fee guideline described in §134.200 of this title (relating to Medical Fee Guideline).~~]

[~~(d) Pharmacists, in settings other than a hospital, shall bill according to the Pharmaceutical Fee Guideline described in §134.501 of this title (relating to Pharmaceutical Fee Guideline).~~]

[~~(e) Hospitals, licensed by Texas Department of Health or Texas Department of Mental Health and Mental Retardation, and ambulatory surgical centers, licensed by Texas Department of Health, shall bill according to the Hospital and Ambulatory Surgical Center Fee Guideline described in §134.400 of this title (relating to Hospital and Ambulatory Surgical Center Fee Guideline).~~]

[(f)] Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 [~~§8.21(b)~~]until such period that specific fee guidelines are established by the commission.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107942
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 804-4287

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SUBCHAPTER C. MEDICAL FEE GUIDELINES

28 TAC §134.202

The Texas Workers' Compensation Commission (the commission) proposes new §134.202 concerning the Medical Fee Guideline.

This new rule is proposed to comply with statutory mandates in the Texas Labor Code. Section 413.011 of the Texas Labor Code requires the commission to adopt rules to establish medical policies and guidelines relating to fees charged or paid for medical services, including guidelines relating to payment of fees for specific medical treatments or services. The statute requires that guidelines for medical services fees be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission must consider the increased security of payment afforded by the Texas Workers' Compensation Act (the Act) in establishing the fee guidelines.

House Bill 2600 (HB-2600), adopted during the 2001 Texas Legislative Session, amended §413.011. In addition to the previous requirements, the revised statute also requires that the commission:

* use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements;

* adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration (HCFA) to achieve standardization, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of §413.053 of the Act (relating to Standards of Reporting and Billing);

* develop conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care;

* provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commission rules;

* comply with the statute by not adopting the Medicare fee schedule, and by not adopting conversion factors or other payment adjustment factors based solely on those factors as developed by the HCFA; and

* comply with the statute by not interpreting the legislation in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 3(d), Article 21.52, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle.

Currently, reimbursements for medical treatments and services are established by §134.201 of this title (regarding Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act) and §134.302 of this title (regarding Dental Fee Guideline). The Medical Fee Guideline (MFG) provides maximum allowable reimbursement (MAR) amounts for health care providers (HCPs) treating injured workers in Texas. This proposed new rule uses the required Medicare methodologies for determining reimbursement in the Texas workers' compensation system to comply with the new provisions in Texas Labor Code §413.011.

In February 2001, the commission signed a professional services agreement with Milliman & Robertson, Inc., now Milliman USA (Milliman), a professional firm specializing in actuarial and health care services, to assist the commission in developing and implementing a new MFG. Milliman provided the commission with written reports of their findings and recommendations.

Milliman conducted a market analysis of reimbursements from the 1996 MFG, commercial payers in Texas, workers' compensation systems from other states, and 2001 Medicare allowed fees in Texas, comparing the reimbursement level for corresponding services, and drew the following conclusions as a result of the market analysis:

* commercial reimbursement rates in Texas show variations that are wider than can be explained by geographic differences, and current MFG reimbursement levels fall within this broad range;

* current MFG reimbursement levels tend to be high relative to other state workers' compensation systems, with the exception of Evaluation and Management (E&M) services; and,

* current MFG MARs average approximately 130% of calendar year 2001 Medicare allowed fees.

A revision of the MFG that meets the rigorous statutory criteria and uses the most current reimbursement methodologies, models, and values or weights used by HCFA, (now the Centers for Medicare and Medicaid Services (CMS)), including applicable payment policies relating to coding, billing, and reporting (sometimes referred to as ground rules) is the goal of this proposed new rule.

In developing this proposal, commission staff met and discussed issues with the primary HB-2600 Legislative Stakeholders. This Legislative Stakeholder group included: a delegation of employers, insurance carriers, utilization review organizations, and other interested parties working together under the umbrella name, Texas Association of Business & Chambers of Commerce (TABCC) Technical Work Group; the Texas Chiropractic Association; and the Texas Medical Association. Input from this group was a major factor in developing this proposed rule.

Proposed new §134.202 establishes reimbursement for professional medical services provided on or after the effective date of the new rule. The new rule provides standardization of reimbursement methods and billing procedures by aligning the workers' compensation reimbursement structure with the structure used by the CMS.

Proposed subsection (a) establishes the applicability of the guidelines for reimbursements for professional medical services, which includes all health care as defined in §401.011(19) of the Act other than prescription drugs or medicines, and other than the facility services of a hospital or other health care facility. Current §134.201 and §134.302 would remain in effect for treatments and services provided prior to the effective date of the proposed new rule. Reimbursement is determined in accordance with the rules in effect on the date that the professional medical service was provided. In accordance with Texas Labor Code §413.011(c), subsection (a) provides that chiropractors are an exception to the CMS payment policies, and may be reimbursed for services provided within the scope of their practice act. Specific provisions contained in the workers' compensation Act, or commission rules, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Additionally, subsection (a) requires use of the most recent payment policies adopted by the Medicare program, including updated relative value units, for compliance with commission rules, decisions and orders. The policies and reimbursement methodologies in effect for Medicare on the date a service is provided are the policies and reimbursement methodologies to be used in the workers' compensation system. This will prevent the workers' compensation system from falling out of synchronization with Medicare and will achieve the standardization goals established in HB-2600.

Proposed new subsection (b) requires system participants to utilize the Medicare reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies for coding, billing, reporting, and reimbursement of professional medical services provided in the Texas workers' compensation system. This allows for the basic Medicare program provisions to be applied with any additions or exceptions necessary for adaptation to the Texas workers' compensation system. The Medicare program is not a static system. Medicare policies change frequently. To achieve standardization it is necessary to use the Medicare billing and reimbursement policies as they are modified by CMS. Adoption of policies in effect on a particular date would require participants in the Texas workers' compensation system to bill and reimburse in a manner different from the current Medicare system. Therefore, the proposed rule, in compliance with the statute, requires the use of the Medicare policies in effect on the day that a service is provided.

The Resource Based Relative Value Scale (RBRVS) system used by Medicare values services according to the relative costs required to provide them, recognizing skill, practice cost, and risk. These relative value units represent national standards assigned to medical treatments and services. The relative value units reflect the relationship between the resources necessary to provide a professional medical service relative to resources necessary to provide other professional medical services.

The RBRVS uses three components to establish the total relative value units for a particular code: work, practice expense, and malpractice insurance. RBRVS relative value units are also adjusted by Geographical Practice Cost Indices (GPCIs) to reflect geographical differences. The proposed rule also requires system participants to use these components and adjustments of

relative values. Use of CMS RBRVS aligns the basis for workers' compensation reimbursement with nationally recognized standards of relative values used in other health care delivery systems, and takes into account economic indicators in health care.

New proposed subsection (c) establishes the method to be used for determining the MAR for professional services in the Texas workers' compensation system. The MARs established in the current MFG do not correlate with RBRVS unit values, and the change to the RBRVS in this rule proposal will result in some significant increases and decreases for certain procedures. The use of a different relative value unit system, the RBRVS, results in a significant re-alignment of reimbursements among the CPT groupings. Assuming no net change in total system reimbursement, the estimated re-alignment impact of applying the RBRVS system alone, is approximately:

Evaluation & Management: +48%

Medicine: -27%

Physical Medicine and Rehabilitation: -2%

Surgery: -27%

Radiology: -20%

Pathology: -53%

Anesthesiology: 0%

Mandated by statute, this re-alignment substantially changes reimbursement for some codes.

Proposed new subsection (c) establishes a conversion factor by setting a multiplier to apply to the Medicare conversion factor. In establishing this multiplier the commission considered the statutory requirements and objectives and utilized Medicare data, current commission reimbursement levels, and available commercial payor information. The data reviewed consistently reflected current commission reimbursement equal to approximately 140% of the 2002 Medicare reimbursement and in the mid-range of commercial payor reimbursement.

Proposed new subsection (c) additionally establishes MARs for durable medical equipment, prosthetics, orthotics, supplies, laboratory services, dental treatments and services, and commission specific codes, services, and programs. The subsection provides directions for a system of payment that allows a carrier to assign a relative value for a product or service that does not contain a relative value unit and/or a recommended payment amount in either the CMS system or as established by the commission. Carriers are to assign a relative value which is based on nationally recognized published relative value studies, published medical dispute decisions, and values assigned for services involving similar work and resource commitments.

Subsection (d) provides that the reimbursement for professional medical services is the least of: the MAR as established by rule; the HCP's usual and customary charge; or, the HCP's applicable workers' compensation negotiated or contracted amount that applies to the billed service.

Proposed new subsection (e) addresses payment policies relating to coding, billing, and reporting, of commission-specific codes, services, and programs. There are some services which are specific to and necessary in the Texas workers' compensation system that are not commonly used or not used at all in the Medicare system. Some examples of these services are: case management, tests and measurements, impairment rating evaluation, designated doctor examination, and return to work rehabilitation programs. Subsection (e) sets out the payment policies relating to coding, billing, and reporting for those services. In addition, subsection (e) provides a list of modifiers to be used when billing commission-specific codes, services, and programs. The use of these modifiers will allow the commission to monitor patterns of usual, customary and reasonable medical charges, payments and treatment protocols for commission-specific services. The additions set out in subsection (e) are designed to reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements.

Proposed new subsection (f) provides that the invalidation of a section of this subchapter or its application or applications to any person or circumstance by a court of competent jurisdiction does not affect other provisions or applications of the subchapter that can be given effect without the invalidated provision or application.

Bill DeCabooter, Acting Director of the Medical Review Division, has determined the following with respect to fiscal impact for the first five-year period the proposed rules are in effect.

With regard to enforcement and administration of the rule by state government, the commission will experience increased costs in some areas and decreased costs in others. Increased costs may include expenses associated with the preparation of training materials and presentation of training classes for commission staff and other system participants, and costs associated with monitoring the Medicare payment policies.

Initially costs may increase due to increased disputes for the next twelve to twenty-four months, resulting from the initiation of a new payment methodology and the utilization of Medicare billing and payment policies. However, after system participants become familiar with the policies and the commission's administration of these policies, the use of standardized coding, billing, and methodology is expected to result in fewer disputes regarding medical reporting, billing and reimbursement because use of:

* a standardized reimbursement structure found in other health care delivery systems should reduce the number of disputes, in part because of familiarity with other reimbursement systems, and in part because of the predictability of reimbursement amounts;

* the most current Medicare program reimbursement methodologies, models and weights or values is expected to eliminate some disputes because changes in Medicare reimbursement system will be reflected in the workers' compensation system as they become effective keeping the system current and therefore reducing disputes relating to the amount of reimbursement;

* current coding, billing and reporting policies clarifies the proper coding for some professional medical services about which there were uncertainties and disputes under the current MFG; and

* standardized components of the Medicare system should decrease the cost and time required for the commission to review or revise the fee schedules.

There may be some increase in revenue to the commission as a result of enforcing or administering the rule due to an initial increase in disputes heard by the commission. Although the fees from the increase in this activity will increase revenue, these fees

generally cover expenses only and are expected to be offset by a subsequent decrease in this activity.

In recent correspondence with the commission, the TCA, stated, "the TCA believes that adoption of Medicare reimbursement methodologies and payment systems could provide a reduction to the commission for enforcing and administering these rules. This is because the commission would no longer be required to develop, maintain, and administer its own unique fee structure and payment policies. Medicare would be the basis of a fair structure, with modifications as needed, as required by HB 2600. This would benefit all parties, by allowing greater access to care, fewer disputes, and reduces administrative costs."

There will be no fiscal impact on local government as a result of enforcing or administering the rule, as local governments do not have regulatory authority with respect to these rules. Local governments and state governmental entities as regulated entities will be impacted in the same manner as persons required to comply with the rules as proposed. Aggregate medical costs should decrease for all participants in the system. The commission cannot predict if local governments will experience a decrease in their premium costs if the local government's workers' compensation coverage is provided by an insurance company. Any local government that is self-insured will likely experience a cost decrease if utilization and injury experience remain unchanged.

Mr. DeCabooter has also determined that for each year of the first five years the proposed rule is in effect, the public benefits anticipated as a result of a reimbursement system with a well-known, standardized structure for delivery of quality medical care with effective cost control, that will provide positive benefits to all participants in the system: injured employees, employers, insurance carriers, and health care providers. As suggested by the Legislative Stakeholder group, the Texas workers' compensation system as a whole will benefit by bringing its payment policies and unit costs in line with mainstream medicine. Adoption of Medicare policies should lead to reduced administrative costs, a reduced number of medical disputes, and a reduction in unproductive costs for medical services.

The commission estimates that the proposed rules will result in an aggregate reduction of approximately (16%) in total payments, if applied to historical workers' compensation system claim costs. The commission projects a similar impact on future aggregate claim costs, assuming that there is not a significant shift in the distribution of claims. A number of other factors could affect the impact including frequency of injury, severity of injury, and changes in the practice of medicine for injured workers in Texas, distribution of services provided, current billing practices, and random fluctuations. The differential between the current MFG MAR and the proposed MAR varies from service to service even within a category of services because of the adjustments made to the current MFG relative value units. Use of standardized coding, reporting, billing, and reimbursement methodologies in the rules as proposed is expected to decrease fee disputes within the workers' compensation system after a period of time for system participants to become familiar with the system.

Because the values assigned to medical services in the RBRVS are based on the relative costs required to provide a service, reimbursements under the proposed rules are more closely related to the resources required to provide the services. The re-alignment of relative values makes the Texas workers' compensation system more comparable to other health care systems and may discourage overutilization of services that have been assigned a relative value higher than that in other systems. This benefits injured employees by preventing unnecessary treatment and delayed return to work. The same impact may occur if the new rule limits or disallows payment for medical care that is not proven medically efficacious. A decrease in medical costs may increase the number of employers who elect workers' compensation coverage, and injured workers will benefit from that coverage. Again, as suggested by the Legislative Stakeholders group, the adoption of standard payment policies will result in a net reduction in the administrative costs of compliance for Texas physicians. As a consequence, it will also result in an increase in access for injured workers, or at least mitigate the current erosion in access to physician services.

The commission estimates the difference in reimbursement under the current MFG when compared to reimbursement under the proposed MFG by category as follows:

Evaluation & Management: +26%

Medicine: -38%

Physical Medicine and Rehabilitation: -17%

Surgery: -38%

Radiology: -32%

Pathology: -60%

Anesthesiology: +9%

The increase or decrease in the reimbursement for any procedure within a category can vary significantly, since the current MFG MARs do not correlate with RBRVS unit values. Some health care practitioners will receive more reimbursement than under the current MFG, while others will receive less, depending on the mix of professional medical services they typically provide to patients.

Health care practitioners will benefit from the use of standardized and current methodologies, models, and value units, and use of standardized reporting, billing, and coding requirements. Additionally, most health care practitioners are familiar with the CMS system, as there are proportionately more Medicare providers than there are Texas workers' compensation system providers. As stated in a correspondence to the commission regarding previously proposed rules, the Texas Medical Association (TMA) asserts, "Compared to other payers, the Medicare rules are straightforward, widely understood and unambiguous." Clarity in the rules and reduction in the number of disputes should also benefit health care practitioners. This general sentiment was also stated by the TABCC Technical Work Group in correspondence to the commission. Insurance carriers will likewise benefit from use of standardized and current methodologies, models, and value units, and use of standardized reporting, billing, and coding requirements. The TABCC Technical Work Group provided the following public benefits to insurance carriers in recent correspondence to the commission: "The cost to insurance carriers of shifting to Medicare payment policies in Texas will vary significantly by carrier. All carriers will incur some training costs for staff responsible for payment of medical bills. Beyond training costs, the cost to the carrier will depend on the following factors:

* Carriers that outsource medical bill review should encounter no additional costs. Any transition costs will be borne by the medical bill review consultant. Competition among medical bill

review consultants is sufficient to prevent these costs from being passed through to carriers.

* Carriers that do not outsource medical bill review, but who write insurance in one of the states that has previously adopted Medicare payment policies should incur small costs because they already have knowledgeable staff and information systems in place. Further, some carriers have adopted the Correct Coding Initiative and other Medicare payment policies on their own initiative where they do not conflict with policies of the states where they write insurance.

* Finally, most carriers that do not outsource medical bill review purchase software from large national software vendors. These vendors are responsible for updating their software as state rules change. The software market for workers' compensation bill review is sufficiently competitive that software vendors cannot pass through the costs of updating the software in Texas to their customers."

To the extent that adoption of the new MFG lowers the unit cost of medical services and reduces overutilization of medical services, carriers should benefit from lower medical benefit costs. In the short run the change may improve their medical loss ratio. In the long run these savings should be passed through to employers through price competition in the insurance market."

Employers will benefit from the reduction in costs and disputes, which may be favorably reflected in the cost to employers to provide workers' compensation coverage. In addition, if the new rule reduces overutilization of unnecessary medical services it may also enhance an injured employee's ability to return to work.

There will be some anticipated economic costs to persons required to comply with the rules as proposed. There will be no economic cost to injured workers, as these proposed rules do not impose any requirements on injured workers.

As suggested by the TABCC Technical Work Group, "the new MFG should reduce the unit cost of medical services and should reduce overutilization of medical services. Today medical services are the majority of benefit costs employers pay through workers' compensation insurance premiums or directly through self-insurance programs. Reducing the cost of medical treatment under the workers' compensation system should reduce the rate of cost increases."

Health care practitioners will experience some increased costs in some areas and decreased costs in others. Health care practitioners who do not currently participate in the Medicare system will have increased costs associated with training staff and adapting their billing systems to utilize the Medicare policies. However, these costs should not be great and, once trained, the costs to bill for workers' compensation health care should decrease. Providers are instructed to bill their usual and customary fees, therefore it is not necessary for providers to be able to calculate the Medicare reimbursement. Health care practitioners who are already participating in the Medicare system will not experience these same increased costs. Decreased costs will result from the fact that the number of disputes should decrease, after an initial increase, for the reasons described previously.

Insurance carriers should experience the same increased costs in some areas and decreased costs in others. For those carriers who do not currently participate in the Medicare system, increased costs include costs associated with training staff and adapting their billing systems to utilize the Medicare policies. Again, those who are already participating in the Medicare system or using Medicare billing and reimbursement policies will not experience these same increased costs. Decreased costs will result from the fact that the number of disputes should decrease, after an initial increase, for the reasons described previously.

There will be no adverse economic impact on small businesses or on micro-businesses as a result of the proposed new rules. Health care practitioners and insurance carriers who perform only a small amount of work in the workers' compensation system can comply with these rules without incurring costs. Many health care practitioners and insurance carriers already use the standardized items adopted in these proposed rules, and cost savings explained previously should offset any increased costs. As stated by the TABCC Technical Work Group, "The new MFG will reduce the payment per unit of service for most health care services. It will also reduce total revenue to some health care providers by restraining overutilization and ending unreasonable billing practices permitted by the current rule. These are adverse economic impacts on these health care providers."

There will be only a proportionate difference in the cost of compliance for small businesses and micro-businesses as compared to the largest businesses, including state and local government entities. The same basic processes and procedures apply, regardless of the size or volume of the business. The business size cost difference will be in direct proportion to the volume of business that falls under the purview of these proposed rules. Any increase in costs is expected to be offset by cost savings and time savings through the use of a standardized and streamlined process, resulting in no adverse economic impact.

Comments on the proposal must be received by 5:00 p.m., January 28, 2002. You may comment via the Internet by accessing the commission's *website at www.twcc.state.tx.us* and then clicking on "Proposed Rules." This medium for commenting will help you organize your comments. You may also comment by emailing your comments to *RuleComments@twcc.state.tx.us* or by mailing or delivering your comments to Nell Cheslock at the Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

Commenters are requested to clearly identify by number the specific rule and paragraph commented upon. The commission may not be able to respond to comments that cannot be linked to a particular proposed rule. Along with your comment, it is suggested that you include the reasoning for the comment in order for commission staff to fully evaluate your recommendations.

Based upon various considerations, including comments received and the staff's or commissioners' review of those comments, or based upon the commissioners' action at the public meeting, the rule as adopted may be revised from the rule as proposed in whole or in part. The conversion factors and reimbursements proposed may be revised to be higher than proposed or lower than proposed.

Persons in support or opposition of the rule as proposed, in whole or in part, are encouraged to comment to that effect. The failure to comment accordingly is not indicative of support or opposition.

A public hearing on this proposal will be held on January 24, 2002 at the Austin central office of the commission (Southfield Building, 4000 South IH-35, Austin, Texas). Those persons interested in attending the public hearing should contact the Commission's Office of Executive Communication at (512) 804-4430

to confirm the date, time, and location of the public hearing for this proposal. The public hearing schedule will also be available on the commission's website at *www.twcc.state.tx.us*.

The new rules are proposed under the Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §413.002, which requires the commission's Medical Review Division monitor health care providers, insurance carriers and claimants to ensure compliance with commission rules; the Texas Labor Code, §413.007, which sets out information to be maintained by the commission's Medical Review Division; the Texas Labor Code §413.011, which mandates that the commission by rule establish medical policies and guidelines; the Texas Labor Code, §413.012, which requires review and revision of the medical policies and fee guidelines at least every two years; the Texas Labor Code, §413.013, which requires the commission by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review; the Texas Labor Code, §413.015, which requires insurance carriers to pay charges for medical services as provided in the statute and requires that the commission ensure compliance with the medical policies and fee guidelines through audit and review; the Texas Labor Code, §413.016, which provides for refund of payments made in violation of the medical policies and fee guidelines; the Texas Labor Code, §413.017, which provides a presumption of reasonableness for medical services fees which are consistent with the medical policies and fee guidelines; the Texas Labor Code, §413.019, which provides for payment of interest on delayed payments refunds or overpayments; and the Texas Labor Code, §413.031, which provides a procedure for medical dispute resolution; the Texas Labor Code, §413.044, which provides for sanctions against designated doctors who are found to be out of compliance with the medical policies and fee guidelines.

The new rules are proposed under the Texas Labor Code §402.061, § 413.002, §413.007, §§413.011-413.013, §§413.015-413.017, §413.019, §413.031, §413.044,.

No other statutes, articles or codes are affected by the proposed rules.

§134.202. Medical Fee Guideline.

(a) Applicability of this rule is as follows:

(1) This section applies to professional medical services (health care other than prescription drugs or medicine, and the facility services of a hospital or other health care facility) provided in the Texas Workers' Compensation system.

(2) This section shall be applicable for professional medical services provided on or after June 1, 2002. For professional medical services provided prior to June 1, 2002, §134.201 and §134.302 of this title (relating to Medical Fee Guidelines) shall be applicable.

(3) Notwithstanding Centers for Medicare and Medicaid Services (CMS) payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(4) Specific provisions contained in the Texas Workers' Compensation Act (Act), or commission rules, including this rule, shall take precedence over any conflicting provision adopted by or utilized by CMS in administering the Medicare program. Exceptions to Medicare payment policies for medical necessity may be provided by commission rule or through medical dispute resolution in accordance with the Act and commission rules.

(5) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with commission rules, decisions and orders for services rendered on or after the effective date of the revised component.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section.

(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications:

(1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 120%. For Anesthesiology services, the same conversion factor shall be used.

(2) for HCPCS Level II codes A, E, J. K, and L:

(A) 120% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule;

(B) if the code has no published Medicare rate, 120% of the published Texas Medicaid Fee Schedule Durable medical Equipment/Medical Supplies Report J, for HCPCS; or

(C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection.

(3) for laboratory services 120% of the fee listed for the code in the Medicare Clinical Fee Schedule.

(4) for dental treatments and services 120% of the fee listed for the code in the Texas Medicaid Dental Fee Schedule in effect on the date the service is provided.

(5) for commission specific codes, services and programs (e.g. Functional Capacity Evaluation, Impairment Rating Evaluations, Return to Work Programs, etc.) as calculated in accordance with subsection (e) of this section.

(6) for products and services for which CMS or the Commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published medical dispute decisions, and values assigned for services involving similar work and resource commitments.

(d) In all cases, reimbursement shall be the least of the:

(1) MAR amount as established by this rule;

(2) health care provider's usual and customary charge; or,

(3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s).

(e) Payment Policies Relating to Coding, Billing, and Reporting for commission-specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges. HCPs shall submit medical bills in accordance with subsection (b), the Act, and commission rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate CPT code. Additionally, commission specific modifiers are identified in paragraph (10) of this subsection. When two modifiers are applicable to a single code, indicate each modifier on the bill.

(3) Case Management. Case Management is the responsibility of the treating doctor. Team conferences and phone calls shall include coordination with an interdisciplinary team (members shall not be employees of the coordinating HCP and the coordination must be outside of an interdisciplinary program). Documentation shall include the name and specialty of each individual attending the team conference or engaged in a phone call. Team conferences and phone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee. Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) The development or revision of a treatment plan;

(B) To alter or clarify previous instructions;

(C) To coordinate the care of employees with catastrophic or multiple injuries requiring multiple specialties; or,

(D) To coordinate with the employer, employee, and/or an assigned medical or vocational case manager to determine return to work options.

(4) Tests and Measurements. The following provisions apply to Tests and Measurements services:

(A) Tests and Measurements Current Procedural Terminology (CPT) codes require a report of the results, to include the start and end times. No additional reimbursement shall be allowed for this report.

(B) Job site visit/assessment shall be billed using the "Community/work reintegration training..." CPT code with modifier "JA". Job site visit/assessments shall be reimbursed at $25.00 per 15 minutes.

(C) A maximum of three Functional Capacity Evaluations (FCEs) for each compensable injury shall be billed and reimbursed. FCEs ordered by the Commission shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using the "Physical performance test or measurement..." CPT code with modifier "FC." FCEs shall be reimbursed at $25 per 15-minute increment up to a maximum of five hours ($500) for the first test and for a Commission ordered test; and, a maximum of two hours ($200) for a second and/or third test. FCEs shall include the following elements:

(i) A physical examination and neurological evaluation, which include the following:

(I) appearance (observational and palpation);

(II) flexibility of the extremity joint or spinal region (usually observational);

(III) posture and deformities;

(IV) vascular integrity;

(V) neurological tests to detect sensory deficit;

(VI) myotomal strength to detect gross motor deficit; and

(VII) reflexes to detect neurological reflex symmetry.

(ii) A physical capacity evaluation of the injured area, which includes the following:

(I) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(II) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative data base. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(iii) Functional abilities tests, which include the following:

(I) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(II) hand function tests which measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(III) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(IV) static positional tolerance (observational determination of tolerance for sitting or standing).

(5) Return To Work Rehabilitation Programs. The following shall be applied for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs.

(A) Accreditation by the Commission for Accreditation of Rehabilitation Facilities (CARF) is recommended, but not required. To qualify as a Return to Work Rehabilitation Program, a program should meet the clinical standards for the program as listed in the most recent CARF Medical Rehabilitation Standards Manual.

(i) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100% of the MAR.

(ii) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80% of the MAR.

(B) Work Conditioning/General Occupational Rehabilitation Programs (for TWCC purposes, CARF accredited General Occupational Rehabilitation Programs are considered Work Conditioning.)

(i) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WC." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $36.00 per hour. Units of less than 31 minutes shall not be billed or reimbursed.

(C) Work Hardening/Comprehensive Occupational Rehabilitation Programs (for TWCC purposes, CARF accredited Comprehensive Occupational Rehabilitation Programs are considered Work Hardening.)

(i) The first two hours of each session shall be billed and reimbursed as one unit, using the "Work hardening/conditioning; initial 2 hours" CPT code with modifier "WH." Each additional hour shall be billed using the "Work hardening/conditioning; each additional hour" CPT code with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $64.00 per hour. Units of less than 31 minutes shall not be billed or reimbursed.

(D) Outpatient Medical Rehabilitation Programs

(i) Program shall be billed and reimbursed using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $90.00 per hour. Units of less than 31 minutes shall not be billed or reimbursed.

(E) Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(i) Program shall be billed and reimbursed using the "Unlisted physical medicine/rehabilitation service or procedure" CPT code with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(ii) Reimbursement shall be $125.00 per hour. Units of less than 31 minutes shall not be billed or reimbursed.

(6) Maximum Medical Improvement and/or Impairment Rating (MMI/IR). MMI/IR shall be billed and reimbursed as follows.

(A) The total MAR for an MMI/IR examination shall be equal to the MMI examination reimbursement plus the reimbursement for the body area(s) rated for the assignment of an IR. The total MAR for determination of MMI/IR shall include:

(i) the examination;

(ii) consultation with the injured employee;

(iii) review of the records and films;

(iv) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets;

(v) range of motion, strength and sensory testing, and measurements; and,

(vi) other tests used to validate the IR, as outlined in the American Medical Association (AMA) *Guides to the Evaluation of Permanent Impairment (the Guides).*

(B) For IR testing, the HCP shall indicate the number of body areas rated in the units column of the billing form. Body areas shall be billed and reimbursed as follows:

(i) The examining doctor may bill for a maximum of three musculoskeletal body areas.

(I) Musculoskeletal body areas are defined as follows:

(-a-) spine and pelvis;
(-b-) upper extremities and hands; and,
(-c-) lower extremities (including feet).

(II) The MAR for musculoskeletal body areas shall be:

(-a-) one musculoskeletal body area: $300.00; and,

(-b-) each additional musculoskeletal body area: $150.00.

(III) When the examining doctor conducts the MMI examination and the IR testing, the examining doctor shall bill using the appropriate MMI/IR code with modifier "WP." Reimbursement shall be 100% of the total MAR.

(IV) If the examining doctor conducts the MMI examination and determines the assignment of IR, excluding the testing, then the examining doctor shall bill using the appropriate MMI/IR code with CPT modifier "26." Reimbursement shall be 80% of the total MAR.

(V) If testing is performed by a HCP other than the examining doctor, then the HCP shall bill using the appropriate MMI/IR code with modifier "TC." Reimbursement shall be 20% of the total MAR.

(ii) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the tests required for the assignment of IR.

(I) Non-musculoskeletal body areas are as follows:

(-a-) body systems;
(-b-) body structures (including skin); and,
(-c-) mental and behavioral disorders.

(II) For a complete list of non-musculoskeletal body areas refer to the Guides, as stated in the commission Act and Rules Chapter 130 relating to Impairment and Supplemental Income Benefits.

(C) When testing is required for the assignment of IR and the examining doctor refers the testing to a specialist, then the following shall apply:

(i) The examining doctor (e.g., the referring doctor) shall bill specialist referred testing as one unit on the billing form using the appropriate MMI/IR CPT code with modifier "SP." Reimbursement shall be $50.00 for incorporating one or more specialists' report information into the final IR. This reimbursement shall be allowed only once per examination.

(ii) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(D) Testing that falls outside of what is outlined in the *Guides*, but is required for the determination of MMI and/or the assignment of an IR, shall be billed using the appropriate CPT codes and reimbursed in addition to fees outlined in this section.

(E) When the result of the evaluation is that MMI has not been reached, the total reimbursement shall be equal to the reimbursement for the determination of MMI. This reimbursement shall include all services required for an MMI/IR examination excluding those services unique to assigning an IR. The examining doctor shall bill using the appropriate MMI/IR CPT code with modifier "NM."

(F) The treating doctor shall bill for an MMI/IR examination using the "Work related or medical disability examination by the treating physician..." CPT code with the appropriate modifier.

(i) Reimbursement for the determination of MMI shall be the applicable established patient office visit level associated with the examination. Modifiers "V1", "V2", "V3", "V4", or "V5"

shall be added to the MMI/IR examination CPT code to correspond with the last digit of the applicable office visit.

(ii) Reimbursement for the determination of an IR shall be according to the areas rated.

(iii) If the treating doctor refers the injured employee to another doctor for the certification of MMI and assignment of IR and the referral doctor has:

(I) not previously treated the injured employee, then the referral doctor shall bill using the "Unlisted evaluation and management service" CPT code and the reimbursement shall be as outlined in subsection (H) for Required Medical Examinations (RME); or,

(II) previously been treating the injured employee, then the billing and reimbursement shall be as outlined for the treating doctor.

(iv) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor (other than the designated doctor) as required by Chapter 130 of this title. The treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00.

(G) A designated doctor shall bill for an MMI/IR examination using the "Work related or medical disability examination by other than the treating physician..." CPT code with the appropriate modifier.

(i) Reimbursement for the determination of MMI shall be based on the amount of time that has elapsed since the date of injury (DOI). One of the following modifiers shall be added to the MMI/IR examination CPT code:

(I) D1 (less than one year since the DOI) - $200.00

(II) D2 (greater than or equal to one year and less than two years since the DOI) - $300.00

(III) D3 (greater than or equal to two years since the DOI) - $400.00

(ii) Reimbursement for the determination of an IR shall be according to the areas rated. If the testing is performed by a HCP other than the designated doctor, then to qualify for reimbursement, the testing HCP shall:

(I) not have previously examined or treated the injured employee within the past 12 months, or with regard to the medical condition being evaluated by the designated doctor; and,

(II) have successfully completed commission-approved training in the proper use of the *Guides*.

(iii) Appointments canceled or not attended by the injured employee, with less than 24 hours notice to the designated doctor, shall be billed using the MMI/IR examination CPT code with modifier "BA" and the reimbursement shall be $100.00.

(H) A doctor performing a Required Medical Examination (RME) for the purpose of certifying MMI and assigning an IR shall bill using the "Unlisted evaluation and management service" CPT code with the appropriate modifier.

(i) Reimbursement for the determination of MMI shall be based on the amount of time that has elapsed since the date of injury (DOI). One of the following modifiers shall be added to the MMI/IR CPT code:

(I) R1 (first RME if less than one year from DOI or any subsequent RMEs) - $100.00

(II) R2 (first RME if greater than or equal to one year and less than two years since the DOI) - $200.00

(III) R3 (first RME if greater than or equal to two years since the DOI) - $300.00

(ii) Reimbursement for the determination of an IR shall be according to the areas rated.

(iii) Appointments scheduled by the commission and canceled or not attended by the injured employee, with less than 24 hours notice to the doctor, shall be billed using the MMI/IR CPT code with modifier "BA" and the reimbursement shall be $100.00.

(iv) An injured employee's treating doctor attending an RME shall bill using the "Unlisted evaluation and management service" CPT code with modifier "AR." Reimbursement shall be $25.00 per 15-minute increment (any amount over ten minutes shall be considered an additional 15 minute increment). Reimbursement includes the duration of the examination and the time required to travel to and from the treating doctor's usual place of business to the place of examination. A maximum of four hours shall be allowed, unless the insurance carrier previously approved extended time.

(7) Return to Work Exam. When a designated doctor is appointed by the commission to perform an examination to resolve a return to work dispute, the designated doctor shall bill using the "Work related or medical disability examination by other than the treating physician..." CPT code with modifier "RW." The reimbursement shall be $350.00 and shall include commission-required reports. Testing that is required for the return to work determination shall be billed using the appropriate CPT codes and reimbursed in addition to the return to work examination fee. Appointments scheduled by the commission and canceled or not attended by the injured employee, with less than 24 hours notice to the designated doctor, shall be billed using the "Work related or medical disability examination by other than the treating physician..." CPT code with modifier "BA" and the reimbursement shall be $100.00.

(8) Evaluation of Medical Care Exam. When conducting a commission or insurance carrier requested RME that is not for the purpose of certifying MMI and/or assigning an IR (e.g. evaluation of medical care), the examining doctor shall bill and be reimbursed using the appropriate consultation CPT code with modifier "RM." Appointments scheduled by the commission and canceled or not attended by the injured employee with less than 24 hours notice to the HCP shall be billed using the "Unlisted special service, procedure or report" CPT code with modifier "BA," and reimbursement shall be $50.00.

(9) Work Status Report. When billing for a Work Status Report refer to the commission Act and Rules Chapter 129 relating to Income Benefits - Temporary Income Benefits.

(10) Commission Modifiers. HCPs billing professional medical services shall utilize the following modifiers, in addition to the modifiers prescribed by the Medicare policies required to be used in subsection (b) of this section, for correct coding, reporting, billing, and reimbursement of the procedure codes.

(A) AR, Treating Doctor Attendance at RME - This modifier shall be added to the "Unlisted evaluation and management service" CPT code to indicate an injured employee's treating doctor attended an RME.

(B) BA, Broken Appointment - This modifier shall be added to the appropriate CPT code when appointments scheduled by

the commission are canceled or not attended by the injured employee, with less than 24 hours notice to the HCP.

(C) CA, Commission of Accreditation of Rehabilitation Facilities (CARF) Accredited programs - This modifier shall be used when an HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(D) CP, Chronic Pain Management Program - This modifier shall be added to the "Unlisted physical medicine/rehabilitation service or procedure" CPT code to indicate Chronic Pain Management Program services were performed.

(E) D1, Time of MMI/IR for Designated Doctor - This modifier shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when the amount of time that has elapsed since the date of injury is less than one year.

(F) D2, Time of MMI/IR for Designated Doctor - This modifier shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when the amount of time that has elapsed since the date of injury is greater than or equal to one year and less than two years.

(G) D3, Time of MMI/IR for Designated Doctor - This modifier shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when the amount of time that has elapsed since the date of injury is greater than or equal to two years.

(H) FC, Functional Capacity - This modifier shall be added to the "Physical performance test or measurement..." CPT code when a functional capacity evaluation is performed.

(I) JA, Job Site Analysis/Assessment - This modifier shall be added to the "Community/work reintegration training..." CPT code when a job site visit/assessment is performed.

(J) MR, Outpatient Medical Rehabilitation Program - This modifier shall be added to the "Unlisted physical medicine/rehabilitation service or procedure" CPT code to indicate Outpatient Medical Rehabilitation Program services were performed.

(K) NM, Not at Maximum Medical Improvement (MMI) - This modifier shall be added to the appropriate MMI/IR CPT code to indicate that the injured employee has not reached MMI when the purpose of the exam was to determine MMI.

(L) RM, Required Medical Examination to Evaluate Medical Care - This modifier shall be added to the appropriate consultation CPT code to indicate an RME not for the purpose of certifying MMI or assessing an IR has been performed.

(M) RW, Required Return-to-Work Exam - This modifier shall be added to the "Work related or medical disability examination by other than the treating physician..." CPT code when a designated doctor is appointed by the commission to perform an examination to resolve return to work disputes.

(N) R1, Time of MMI/IR for RME Doctor - This modifier shall be added to the "Unlisted evaluation and management service" CPT code when the amount of time that has elapsed since the date of injury is less than one year; or, for any subsequent RMEs.

(O) R2, Time of MMI/IR for RME Doctor - This modifier shall be added to the "Unlisted evaluation and management service" CPT code when the amount of time that has elapsed since the date of injury is greater than or equal to one year and less than two years.

(P) R3, Time of MMI/IR for RME Doctor - This modifier shall be added to the "Unlisted evaluation and management service" CPT code when the amount of time that has elapsed since the date of injury is greater than or equal to two years.

(Q) SP, Specialty Area - This modifier shall be added to the appropriate MMI/IR CPT code when a specialty area is incorporated into the MMI/IR report.

(R) TC, Technical Component - This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(S) VR, Review report - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code to indicate that the service was the treating doctor's review of report(s) only.

(T) V1, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to a "minimal" level.

(U) V2, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "self limited or minor" level.

(V) V3, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "low to moderate" level.

(W) V4, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.

(X) V5, Level of MMI for Treating Doctor - This modifier shall be added to the "Work related or medical disability examination by the treating physician..." CPT code when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

(Y) WC, Work Conditioning - This modifier shall be added to the "Work hardening/conditioning" CPT code to indicate work conditioning was performed.

(Z) WH, Work Hardening - This modifier shall be added to the "Work hardening/conditioning" CPT code to indicate work hardening was performed. (AA) WP, Whole Procedure - This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(f) Where any terms or parts of this section or its application to any person or circumstance are determined by a court of competent jurisdiction to be invalid, the invalidity does not affect other provisions or applications of this section that can be given effect without the invalidated provision or application.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107941

Susan Cory
General Counsel
Texas Workers' Compensation Commission
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 804-4287

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 365. INVESTMENT RULES

The Texas Water Development Board (the board) proposes amendments to 31 TAC §§365.2, 365.11, and 365.12, concerning Investment Rules. The amendments are proposed for clarification of the rules, to include provisions resulting from legislative action affecting the rules, and compliance with the Public Funds Investment Act (PFIA), Government Code, Chapter 2256.

Section 365.2 is proposed for amendment to reflect the Legislature's change in the name of the state agency from the General Services Commission to the Building and Procurement Commission. Section 365.11 is proposed for amendment to combine registration requirements items in paragraphs (4) and (6) for a more concise and applicable requirement of the selection process.

Section 365.12 is proposed for amendment to delete duplication and the requirement of one year's registration in Texas. Registration with the National Association of Security Dealers is required in §365.11(4). The requirement of one year's registration in Texas is not required by law and serves no useful purpose in selecting dealers. Section 365.12 requires one year's experience in government securities and proposed changes to §365.11(4) require registration in Texas.

Ms. Melanie Callahan, Director of Fiscal Services, has determined that for the first five-year period these sections are in effect there will not be fiscal implications on state and local government as a result of enforcement and administration of the sections.

Ms. Callahan has also determined that for the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be clarity and simplification in the administration of the board's investment activities. Ms. Callahan has determined there will not be economic costs to small businesses or individuals required to comply with the sections as proposed.

Comments on the proposed amendments will be accepted for 30 days following publication and may be submitted to Robert Moreland, Staff Attorney, Administration and Northern Legal Services, Texas Water Development Board, P.O. Box 13231, Austin, Texas, 78711-3231, by e-mail to robert.moreland@twdb.state.tx.us or by fax at (512) 463-5580.

SUBCHAPTER A. GENERAL PROVISIONS

31 TAC §365.2

The amendments are proposed under the authority of the Texas Water Code §6.101 which provide the Texas Water Development with the authority to adopt rules necessary to carry out the powers and duties in the Water Code and other laws of the State, and the Texas Government Code, Chapters 2256 and 2257 which requires each State agency to adopt rules regarding the investment of its funds.

There are no statutory provisions affected by the proposed amendments.

§365.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) - (6) (No change.)

(7) HUB--Historically Underutilized Business (HUB) that is currently certified by the Texas Building and Procurement [~~General Services~~] Commission as a HUB.

(8) - (14) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 12, 2001.

TRD-200107808
Suzanne Schwartz
General Counsel
Texas Water Development Board
Proposed date of adoption: February 20, 2002
For further information, please call: (512) 463-7981

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SUBCHAPTER B. SELECTION OF AUTHORIZED DEALERS

31 TAC §365.11, §365.12

The amendments are proposed under the authority of the Texas Water Code §6.101 which provide the Texas Water Development with the authority to adopt rules necessary to carry out the powers and duties in the Water Code and other laws of the State, and the Texas Government Code, Chapters 2256 and 2257 which requires each State agency to adopt rules regarding the investment of its funds.

There are no statutory provisions affected by the proposed amendments.

§365.11. Authorized Dealers.

The investment officer will invest funds through the use of banks and broker/dealers which are approved as authorized dealers. A list of authorized dealers will be maintained by the investment officer. The finance committee will review, revise and adopt, at least annually, a list of qualified brokers that are authorized to engage in investment transactions with the board. All primary dealers and secondary dealers requesting qualification as an authorized dealer must submit all of the following information, if applicable, to the investment officer:

(1)- (3) (No change.)

(4) proof that the dealer is registered in Texas through National Association of Securities Dealers, Texas State Securities Board, or the Comptroller of the Currency;

(5) references from investment activity in Texas and one reference from the state in which the dealer has its principal place of business; and

[(6) proof that the dealer is registered to do business in Texas or is registered with the State Securities board; and]

(6) [(7)] proof that the dealer qualifies as a HUB.

§365.12. Selection of Authorized Dealers.

(a) (No change.)

(b) Only those secondary dealers that meet the following criteria may be considered and selected as authorized dealers to do business with the board or authority.

(1) (No change.)

(2) the dealer must have at least $300,000 in net or liquid capital if it settles securities through its own clearinghouse; and

(3) if the dealer settles securities through an outside clearinghouse, then the dealer acting as the clearinghouse must have at least $2 million in capital.[; and]

[(4) the dealer must be registered with the National Association of Securities Dealers and registered to do business in Texas for at least one year.]

(c) - (g) (No change.)

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Suzanne Schwartz
General Counsel
Texas Water Development Board
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For further information, please call: (512) 463-7981

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CHAPTER 367. AGRICULTURAL WATER CONSERVATION PROGRAM

SUBCHAPTER A. GRANTS FOR EQUIPMENT PURCHASES

31 TAC §§367.1, 367.2, 367.21, 367.22, 367.27

The Texas Water Development Board (the board) proposes amendments to 31 TAC §§367.1, 367.2, 367.21, 367.22 and 367.27 concerning Grants for Equipment Purchases of the Agricultural Water Conservation Program. The amendments provide cleanup and reflect expanded purposes of grants approved by the 77th Texas Legislature.

Proposed amendments to §367.1 expand the policy statement to reflect recent changes by the Legislature in the purposes for which grants may be made and to correct the Water Code cite. Section 367.2 is proposed for amendment to remove definitions that are no longer used and to incorporate new purposes of measuring and collecting data on groundwater conservation for which grants may be used as added to Texas Water Code §15.471 by the 77th Texas Legislature. The definition of political subdivision is added to define entities eligible for grants under the Agricultural Water Conservation Grants for Equipment Purchases Program. The change reflects changes made by the 77th Texas Legislature. The definition is identical to the Texas Water Code Chapter 15 definition. The proposed amendment to §367.21 incorporates this expanded use of grants.

Section 367.22 expands the entities eligible to receive grants to include all political subdivisions (as defined by Chapter 15 of the Texas Water Code). This reflects changes made by the 77th Texas Legislature. Because the definition for political subdivision includes both underground water conservation districts and other districts, amendment of §367.22 is proposed to remove specific reference to those entities as eligible. The proposed amendments to §367.27 remove reference to the executive administrator's award of grants because the Board may not delegate this responsibility to the executive administrator.

Ms. Melanie Callahan, Director of Fiscal Services, has determined that for the first five-year period these sections are in effect there will not be fiscal implications on state and local government as a result of enforcement and administration of the sections.

Ms. Callahan has also determined that for the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be a broader use of the Grants for Equipment Purchases Program, thereby advancing water conservation. Ms. Callahan has determined there will not be economic costs to small businesses or individuals required to comply with the sections as proposed.

Comments on the proposed amendments will be accepted for 30 days following publication and may be submitted to Ron Pigott, Attorney, Texas Water Development Board, P.O. Box 13231, Austin, Texas, 78711-3231, by e-mail to ron.pigott@twdb.state.tx.us or by fax @ 512/463-5580.

The amendments are proposed under the authority of the Texas Water Code §6.101 and Texas Water Code §§15.435, 15.472, and 15.541 which provide the Texas Water Development Board with the authority to adopt rules necessary to carry out the powers and duties in the Water Code and other laws of the State.

The statutory provisions affected by the proposed amendments are Texas Water Code Chapter 15, Subchapter H.

§367.1. Policy Statement.

It is the policy of the board to provide grants for equipment purchases [to provide for agricultural water conservation] to conserve and protect the state's water resources and provide resulting benefits to all of the state's citizens. This subchapter implements the Texas Water Code, Chapter 15, Subchapter H.

§367.2. Definitions.

The following words and terms, when used in this subchapter [chapter], shall have the following meanings, unless the context clearly indicates otherwise.

(1) Board--The six-member Texas Water Development Board.

[(2) Borrower--A person who receives funds from a lender in order to purchase agricultural water conservation equipment under the pilot loan program.]

[(3) Conservation loan--A loan made to a borrower, except when the borrower is an irrigation district that will be making improvements to its irrigation water delivery system.]

(2) [~~(4)~~] Equipment--Storage units, instruments, tools, and supplies necessary to perform a field evaluation or demonstration of the efficiency of an irrigation system and agricultural water conservation practices on irrigated land, dryland, and rangeland, to measure, sample, test, and evaluate water quality, [~~or~~] to evaluate and demonstrate agricultural chemical systems which will prevent contamination of groundwater and surface water from agricultural chemicals , or to measure and collect data related to conservation of groundwater.

(3) [~~(5)~~] Executive administrator--The executive administrator of the Texas Water Development Board.

(4) Political subdivision--A city, county, district or authority created under the Texas Constitution Article III, Section 52, or Article XVI, Section 59, any other political subdivision of the state, any interstate compact commission to which the state is a party, and any nonprofit water supply corporation created and operating under Texas Water Code Chapter 67.

[~~(6) Lender--A district which participates as the lending institution in the pilot loan program.~~]

§367.21. Purpose.

In accordance with the Texas Water Code, §15.471, grants may be made to political subdivisions [~~districts~~] for purchasing equipment required to:

(1) measure and evaluate irrigation systems and agricultural water conservation practices on irrigated land, dryland, and rangeland;

(2) demonstrate efficient irrigation systems and agricultural water conservation practices on irrigated land, dryland, and rangeland;

(3) measure, sample, test, and evaluate water quality and the suitability of water from groundwater or surface water resources for irrigation, rural domestic, livestock, or agricultural industry use; [~~or~~]

(4) demonstrate efficient or sound chemical application and evaluate or demonstrate systems which will prevent contamination of groundwater and surface water from chemicals and other substances used in agriculture; or

(5) measure and collect data related to conservation of groundwater resources.

§367.22. Entities [~~Districts~~] Eligible for Grants.

In accordance with the Texas Water Code, §15.471, grants may be made to political subdivisions. [~~underground water conservation districts and to other districts created under the Texas Constitution, Article III, §52(b)(1) and (2), or Article XVI, §59.~~]

§367.27. Approval of Grants.

(a) In passing on an application for a grant, [~~the executive administrator or~~]the board shall consider:

(1) the degree to which the applicant [~~district~~] submitting the application has utilized other available resources to finance the use for which application is being made;

(2) the willingness and ability of the applicant [~~district~~] to raise revenue;

(3) the applicant's [~~district's~~] commitment to water conservation;

(4) the benefits that will be gained by making the grant;

(5) the priority stated in §367.26 of this title (relating to Priority in Expenditure of Funds); and

(6) if applicable, the adequacy of the quality assurance plan and water quality data accessibility to the state.

(b) The board [~~or executive administrator~~] shall make a grant only upon a finding that the grant funds to be made available will supplement rather than replace money to be made available by the applicant [~~district~~] receiving the grant.

[~~(c) The executive administrator may consider approval of grant applications of less than $25,000 and the board will consider approval of grant applications of $25,000 or greater.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 12, 2001.

TRD-200107807
Suzanne Schwartz
General Counsel
Texas Water Development Board
Proposed date of adoption: February 20, 2002
For further information, please call: (512) 463-7981

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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION
SUBCHAPTER O. STATE SALES AND USE TAX

34 TAC §3.320

The Comptroller of Public Accounts proposes a new §3.320, concerning Texas emissions reduction plan surcharge; off-road, heavy-duty diesel construction equipment. This section implements Senate Bill 5, 77th Legislature, 2001. Senate Bill 5 added Tax Code, §151.0515, which imposes a 1.0% surcharge on taxable diesel construction equipment sold, leased, or rented on or after September 1, 2001. The comptroller administers the collection and remittance of the surcharge under Tax Code, Chapter 151, and deposits the surcharges to the credit of the Texas Emissions Reduction Plan Fund. The Texas Emissions Reduction Plan Fund is administered by the Texas Natural Resource Conservation Commission and is used to provide grants and other incentives to improve air quality in Texas.

James LeBas, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant fiscal impact on the state or units of local government.

Mr. LeBas also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be in providing taxpayers with a more efficient means of obtaining tax information. This rule is adopted under the Tax Code, Title 2, and does not require a statement of fiscal implications for small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Bryant K. Lomax, Manager, Tax Policy Division, P.O. Box 13528, Austin, Texas 78711.

This new rule is proposed under Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of the Tax Code, Title 2.

The new rule implements Tax Code, §151.0515.

§3.320. Texas Emissions Reduction Plan Surcharge; Off-Road, Heavy-Duty Diesel Construction Equipment.

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

(1) Off-road, heavy-duty diesel construction equipment--Diesel powered equipment of 50 horsepower or greater, other than motor vehicles, that is used in the construction of improvements to realty such as roads, buildings, and other permanent structures, or in the repair, restoration, or remodeling of real property. Off-road, heavy-duty diesel construction equipment includes accessories and attachments sold with the equipment. Off-road, heavy-duty diesel construction equipment includes:

(A) backhoes;

(B) bore equipment and drilling rigs;

(C) bulldozers;

(D) compactors (plate compactors, etc.);

(E) cranes;

(F) crushing and processing equipment (rock and gravel crushers, etc., used by contractors to process the construction materials they incorporate into realty);

(G) dumpsters and tenders;

(H) excavators;

(I) forklifts (rough terrain forklifts, etc.);

(J) graders;

(K) light plants (generators) and signal boards;

(L) loaders;

(M) mixers (cement mixers, mortar mixers, etc.);

(N) off-highway vehicles and other moveable specialized equipment (equipment, such as a motorized crane, that does not meet the definition of a motor vehicle because it is designed to perform a specialized function rather than designed to transport property or persons other than the driver);

(O) paving equipment (asphalt pavers, concrete pavers, etc.);

(P) rammers and tampers;

(Q) rollers;

(R) saws (concrete saws, industrial saws, etc.);

(S) scrapers;

(T) surfacing equipment;

(U) tractors;

(V) trenchers.

(2) Surcharge--A 1.0% fee is imposed on the sale, lease, or rental in Texas of new or used off- road, heavy-duty diesel construction equipment. This surcharge is in addition to state and local sales taxes that are due on the equipment and is for the benefit of the Texas Emissions Reduction Fund, which is administered by the Texas Natural Resources Conservation Commission.

(3) Total price--The entire amount a purchaser pays a seller for the purchase, lease, or rental of off-road, heavy-duty diesel construction equipment. The total price includes charges for accessories, transportation, installation, services, and other expenses that are connected to the sale.

(b) Collection of surcharge. A seller must collect the surcharge from the purchaser on the total price of each sale, lease, or rental in Texas of off-road, heavy-duty diesel construction equipment that is not exempt from sales tax. The surcharge is collected at the same time and in the same manner as sales tax. See §3.286 of this title (relating to Seller's and Purchaser's Responsibilities) for information on the collection and remittance of sales tax. The surcharge is collected in addition to state and local sales taxes but is not collected on the amount of the sales tax.

(c) Exemptions and exclusions.

(1) No surcharge is due on the sale, lease, or rental of off-road, heavy-duty diesel construction equipment that is exempt from sales tax. A seller who accepts a valid and properly completed resale or exemption certificate, direct payment exemption certificate, or other acceptable proof of exemption from sales tax is not required to collect the surcharge. For example, a seller may accept an exemption certificate in lieu of collecting sales tax and the surcharge from a farmer who purchases a bulldozer to be used exclusively in the construction or maintenance of roads and water facilities on a farm that produces agricultural products that are sold in the regular course of business.

(2) No surcharge is due on the sale, lease, or rental of off-road, heavy-duty diesel equipment that is not used in construction. A seller may accept an exemption certificate in lieu of collecting the surcharge even if the sale, lease, or rental of the equipment is not exempt from sales tax. For example, a purchaser who buys equipment listed in subsection (a)(6) of this section for a purpose other than use in construction may issue an exemption certificate that states that the equipment will not be used to construct improvements to realty. The seller may accept the exemption certificate in lieu of collecting the surcharge, but is required to collect sales tax if there is no exemption from sales tax. Examples of non-construction activities include mining at quarries, and oil and gas exploration and production at oil and gas well sites.

(3) No surcharge is due on the sale, lease, or rental of off-road, heavy-duty diesel construction equipment that is subject to use tax under Tax Code, Chapter 151, Subchapter D. A purchaser who brings off-road, heavy-duty diesel construction equipment into Texas for storage, use, or consumption in this state, or in other situations in which use tax rather than sales tax is due, is not required to pay or accrue the surcharge.

(d) Reports and payments.

(1) A seller must report and pay the surcharge in the same manner as sales tax, but separate reports and payments for the surcharge are required. A seller's reporting period (i.e., monthly, quarterly, or yearly) and due date for the surcharge is determined by the amount of surcharge that the seller collects. See §3.286 of this title (relating to Seller's and Purchaser's Responsibilities).

(2) A seller must report and pay the surcharge to the comptroller on forms prescribed by the comptroller for the surcharge. A seller is not relieved of the responsibility for filing a surcharge report

and paying the surcharge by the due date because the seller fails to receive the correct form from the comptroller.

(3) The penalties and interest imposed for failure to timely file and pay the surcharge are the same as those imposed for failure to timely file and pay sales tax. Likewise, the 0.5% discount for timely filing and payment is applicable to surcharge reports and payments. No prepayment discount will be paid a seller for prepayment of the surcharges.

(e) Effective date.

(1) The surcharge is due on the total price of off-road, heavy-duty diesel construction equipment sold in Texas if the purchaser takes possession of or title to the construction equipment after August 31, 2001 and before October 1, 2008.

(2) The surcharge is due on the total price, excluding separately stated interest charges, of off- road, heavy-duty diesel construction equipment leased under a financing lease, as defined in §3.294 of this title (relating to Rental and Lease of Tangible Personal Property), if the lessee takes possession of the construction equipment after August 31, 2001 and before October 1, 2008.

(3) The surcharge is due on the lease payments for off-road, heavy-duty diesel construction equipment that is leased under an operating lease, as defined in §3.294, if the lessee takes possession of the construction equipment after August 31, 2001 and before October 1, 2008.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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TRD-200107726
Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
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For further information, please call: (512) 463-3699

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CHAPTER 9. PROPERTY TAX ADMINISTRATION

SUBCHAPTER C. APPRAISAL DISTRICT ADMINISTRATION

34 TAC §9.417

The Comptroller of Public Accounts proposes a new §9.417, concerning property tax exemption for organizations engaged primarily in charitable activities. The new rule is proposed to implement House Bill 1689, 77th Legislature, 2001, effective September 1, 2001.

James LeBas, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant fiscal impact on the state or units of local government.

Mr. LeBas also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be in providing taxpayers with a more efficient means of obtaining tax information. There are no fiscal implications for small businesses. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Buddy Breivogel, Manager, Property Tax Division, P.O. Box 13528, Austin, Texas 78711-3528.

This new section is proposed under Tax Code, §5.03, which requires the comptroller to adopt rules establishing the minimum standards for the administration and operation of an appraisal district, Tax Code, §5.07, which requires the comptroller to prescribe the contents and form for the administration of the property tax system, and Tax Code, §11.43(f), which requires the comptroller to prescribe the contents and form for each kind of property tax exemption.

The new section implements Tax Code, Chapter 11, Subchapter B, §11.184.

§9.417. Property Tax Exemption for Organizations Engaged Primarily in Charitable Activities.

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

(1) Local charitable organization--An organization that is a chapter, subsidiary, or branch of a statewide charitable organization and that is engaged primarily in performing functions that are listed in Tax Code, §11.18(d).

(2) Statewide charitable organization--An organization that is statewide and that is engaged primarily in performing functions that are listed in Tax Code, §11.18(d).

(b) A taxing unit may adopt a tax exemption for property that a statewide or local charitable organization owns if the property is used exclusively by the charitable organization or by other organizations that are eligible for tax exemption under Tax Code, §11.18 or §11.184, except as provided in subsection (c) of this section. The exemption may be adopted either by the governing body of the taxing unit or by the voters at an election that is called by the governing body of a taxing unit.

(c) Use of exempt property by persons who are not charitable organizations eligible for exemption does not result in the loss of an exemption authorized by this section if the use is incidental to use by those charitable organizations and limited to activities that benefit the charitable organization that owns or uses the property.

(d) An organization that seeks a tax exemption under this section must obtain from the comptroller and submit with its application a determination letter that verifies that the organization is exempt from sales tax and, if applicable, franchise tax, as a charitable organization. For information or procedures on obtaining a determination letter from the comptroller, see §3.322 of this title (relating to Exempt Organizations) and other publications that the comptroller issues.

(e) A determination by the comptroller that a statewide charitable organization is exempt from sales tax and, if applicable, franchise tax, will also constitute a determination of exempt status for any local charitable organizations that have been identified in the statewide charitable organization's application for determination. The comptroller will send a determination letter to that statewide organization and to any subchapters that are included in the statewide organization's application.

(f) An organization must submit a copy of the comptroller's determination letter to the chief appraiser at the same time that the organization submits its application for property tax exemption. The

chief appraiser shall determine if the charitable organization is using its property exclusively for charitable activities.

(g) An organization must comply with the filing requirements for application for property tax exemption that are stated in Tax Code, §11.43(d). A request to the comptroller for a determination letter for purposes of compliance with subsection (d) of this section does not automatically extend the filing due date of April 30. If an organization has not received a determination letter from the comptroller, an organization may use the following procedure to request that the chief appraiser extend the filing due date for an application for exemption.

(1) The organization must submit to the chief appraiser a written request by no later than April 1;

(2) The request for extension should state that the organization has submitted a request for a determination letter to the comptroller and should have as an attachment a copy of the request for determination letter that the organization submitted to the comptroller;

(3) The chief appraiser shall grant the organization's request for extension for a period of not longer than 60 days if the organization has complied with paragraphs (1) and (2) of this subsection;

(4) The chief appraiser may verify with the comptroller that a request for a determination letter has been submitted.

(h) If the chief appraiser, upon receipt of the application for tax exemption, disagrees with the comptroller's determination, then the chief appraiser may request a review of the determination by submitting a written request to the comptroller.

(1) The written request for reconsideration must be directed to the manager of the Property Tax Division, must contain specific grounds on which the chief appraiser disagrees with the comptroller's determination, and must be accompanied by specific evidence that supports each ground that the chief appraiser asserts.

(2) The comptroller will respond to the written request for reconsideration within 30 calendar days from the date on which the request for reconsideration was received.

(3) The comptroller's decision to uphold the determination is conclusive evidence that an organization is engaged primarily in performing charitable function. The decision is not subject to further appeal.

(i) An exemption under this section expires at the end of the fifth tax year after the year in which the exemption is granted. The organization may obtain a new determination letter and reapply for the exemption.

(j) An application for exemption must be substantially in the form of the Application for Primarily Charitable Organization Property Tax Exemption (Form 50-299). The comptroller proposes this form by reference. Copies of the form are available for inspection at the office of the *Texas Register* or may be obtained from the Comptroller of Public Accounts, P.O. Box 13528, Austin, Texas 78711. Copies may also be requested by calling our toll-free number, 1-800-252-9121. In Austin, call (512) 305-9999. From a Telecommunications Device for the Deaf (TDD), call 1-800-248-4099, toll free. In Austin, the local TDD number is (512) 463-4621.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-3699

34 TAC §9.419

The Comptroller of Public Accounts proposes a new §9.419, concerning property tax exemption for motor vehicles leased for personal use. The new rule is proposed to implement Senate Bill 248, 77th Legislature, 2001, effective January 1, 2002.

James LeBas, Chief Revenue Estimator, has determined that for the first five-year period the rule will be in effect, there will be no significant fiscal impact on the state or units of local government.

Mr. LeBas also has determined that for each year of the first five years the rule is in effect, the public benefit anticipated as a result of enforcing the rule will be in providing taxpayers with additional information regarding their tax responsibilities. The new rule will have no fiscal impact on small business. There is no significant anticipated economic cost to individuals who are required to comply with the proposed rule.

Comments on the proposal may be submitted to Buddy Breivogel, Manager, Property Tax Division, P.O. Box 13528, Austin, Texas 78711-3528.

This new section is proposed under Tax Code, §5.03, which requires the comptroller to adopt rules establishing the minimum standards for the administration and operation of an appraisal district, Tax Code, §5.07, which requires the comptroller to prescribe the contents and form for the administration of the property tax system, and Tax Code, §11.43(f), which requires the comptroller to prescribe the contents and form for each kind of property tax exemption.

The new section implements Tax Code, Chapter 11, Subchapter B, §11.252.

§9.419. Procedures for Determining Property Tax Exemption for Motor Vehicles Leased for Personal Use.

(a) Effective Date. This section is effective for motor vehicles that are leased on or after January 2, 2001.

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

(1) Lease--An agreement whereby an owner of a motor vehicle for consideration gives exclusive use of a motor vehicle to another for a period that is longer than 180 days.

(2) Lessee--A person who enters into a lease for a specific motor vehicle primarily for the personal use of the lessee or the lessee's family.

(3) Lessor--A person who owns a motor vehicle that is leased to another person.

(4) Lessee's Affidavit--A sworn statement that a lessee executes to attest that the lessee does not hold the leased motor vehicle for the production of income and does not primarily use the leased motor vehicle for the production of income.

(5) Motor vehicle--A passenger car or truck with a shipping weight of 9,000 pounds or less.

(6) Reasonable date and/or time--A work weekday, Monday through Friday, and a time that is after 8:00 a.m. and before 5:00 p.m., unless the appraisal district and the lessor agree otherwise.

(c) The Comptroller will make available model forms that are adopted by reference in paragraph (1)of this subsection. Copies of the form are available for inspection at the office of the *Texas Register* or may be obtained from the Comptroller of Public Accounts, P.O. Box 13528, Austin, Texas 78711. Copies may also be requested by calling our toll-free number, 1- 800-252-9121. In Austin, call (512) 305-9999. From a Telecommunications Device for the Deaf (TDD), call 1-800-248-4099, toll free. In Austin, the local TDD number is (512) 463-4621.

(1) The comptroller adopts by reference the following model forms:

(A) Lessee's Affidavit of Primarily Non Income Producing Vehicle Use (Form 50-285);

(B) Lessor's Application for Personal Use Lease Automobile Exemptions (Form 50-286); and

(C) Lessor's Rendition or Property Report for Leased Automobiles (Form 50-288).

(2) A chief appraiser or lessor must use the comptroller model forms that are adopted by reference in paragraph (1) of this subsection, unless the non-model form:

(A) for Lessor's Application for Personal Use Lease Automobile Exemptions, and Lessor's Rendition or Property Report for Leased Automobiles substantially complies with Form 50-286 and Form 50-288 by using the same language in the same sequence as the model form;

(B) is an electronic version of a comptroller model form and preserves the same language in the same sequence as the comptroller model form; or

(C) has been approved by the comptroller in writing before the form is used.

(3) Notwithstanding paragraph (2)(A) of this subsection, the comptroller Lessee's Affidavit of Primarily Non Income Producing Vehicle Use (Form 50-285) must be used, and no other form may be used regardless of whether it substantially complies with Form 50-285.

(4) Subject to the limitations that are provided in paragraph (2) of this subsection, if a chief appraiser uses a form other than the one that the comptroller has adopted, then the chief appraiser must make the form available to the lessor. A chief appraiser may not mandate the use of his form in lieu of the comptroller model form and may not deny a lessor's claim for exemption based solely on the lessor's failure to use the chief appraiser's form.

(5) A Lessee's Affidavit of Personal Use of Leased Vehicle, which the comptroller prescribed on September 10, 2001, is the acceptable exemption form until the effective date of the comptroller model forms that are adopted by reference in paragraph (1) of this subsection.

(d) A lessor satisfies the requirements of Tax Code, §11.252, for exemption of leased motor vehicles if the lessor:

(1) properly completes and timely files with the chief appraiser the Lessor's Rendition or Property Report for Leased Automobiles (Form 50-288);

(2) properly completes and timely files with the chief appraiser the Lessor's Application for Personal Use Lease Automobile Exemptions (Form 50-286);

(3) receives Lessee's Affidavit of Primarily Non Income Producing Vehicle Use (Form 50-285) that the lessee executed on or before the date on which the required forms that are enumerated in paragraphs (1) and (2) have been filed; and

(4) maintains each Lessee's Affidavit of Primarily Non Income Producing Vehicle Use (Form 50-285) that pertains to each leased motor vehicle for which the lessor seeks an exemption;

(e) A chief appraiser may inspect and/or obtain copies of lessees' affidavits that the lessor maintains.

(1) A lessor and a chief appraiser shall use the following procedures when the chief appraiser proposes to inspect lessees' affidavits on leased motor vehicles for which the lessor seeks an exemption.

(A) No less than 10 days prior to the inspection, the chief appraiser shall provide the lessor with notice of the chief appraiser's intention to inspect the lessees' affidavits in the lessor's possession or control. The notice must state a reasonable date and time when the chief appraiser proposes to inspect the lessees' affidavits and shall identify the affidavits that will be subject to inspection.

(B) If the proposed date or time is not convenient, then the lessor may propose an alternate reasonable date or time by notifying the chief appraiser in writing.

(C) The lessor shall provide the chief appraiser with reasonable accommodations to inspect and copy any of the lessees' affidavits, or shall permit the chief appraiser to take the affidavits off premises for a period of no less than 48 hours to inspect and copy.

(D) The lessor may provide electronic images of the lessees' affidavits, unless the chief appraiser does not have equipment to receive or read electronic images. If the image is not sufficiently clear to distinguish the characteristics of a lessee's handwriting and to see the notarized signature and any other relevant details, the chief appraiser may request to inspect an original lessee's affidavit.

(E) If the lessor is located more than 150 miles from the appraisal district's office, then the chief appraiser may submit a written request that the lessor either copy and mail the identified lessees' affidavits or send the original affidavits to the chief appraiser for at least 14 days for inspection and copying. The chief appraiser and the lessor may determine who should bear the costs of copying and mailing.

(2) A chief appraiser should first attempt to obtain information from the lessor. If the lessor does not provide the requested information within the specified time period, then the chief appraiser may contact the lessee directly.

(f) A properly executed Lessee's Affidavit of Primarily Non Income Producing Vehicle Use (Form 50-285) is prima facie evidence that the motor vehicle is not held for the production of income and is used primarily for non-income producing activities.

(1) A chief appraiser shall also consider the following evidence of primarily non-income producing use:

(A) an affidavit by the lessee's spouse or other credible person who has information about the use of the leased motor vehicle and mileage records; and

(B) a statement by the lessee's employer that the motor vehicle was not used or required to be used in the lessee's employment.

(2) Since the rulemaking authority that is given the comptroller does not extend to the Appraisal Review Board, this subsection does not apply to proceedings or decisions of the Appraisal Review Board.

(g) If a chief appraiser has reason to question, in whole or in part, the validity of the lessor's application for exemption, then the chief appraiser may investigate and shall notify the lessor of the chief appraiser's intent to investigate. The notice that is required by this rule shall:

(1) identify the motor vehicle that the chief appraiser questions as qualifying for the exemption;

(2) state separately the reason for questioning the claimed exemption or lessee's affidavit;

(3) specify the additional information that the chief appraiser seeks; and

(4) state the due date upon which the requested information must be delivered.

(h) If a chief appraiser determines that some of the motor vehicles that the lessor claims in the application for exemption do not qualify for exemption, then the chief appraiser may modify the exemption by disallowing the amount of value that the non-exempt leased motor vehicles represent, but shall grant the exemption on the remaining value of the leased motor vehicles. Any notice of modification or denial of the claimed exemption shall be made in accordance with the notice requirements of Tax Code, §11.43 and §11.45.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 13. TEXAS COMMISSION ON FIRE PROTECTION

CHAPTER 421. STANDARDS FOR CERTIFICATION

37 TAC §§421.5, 421.15, 421.17

The Texas Commission on Fire Protection (TCFP) proposes amendments and new sections to Chapter 421, Standards for Certification. Amendments to §421.5, Definitions, add definitions for immediately dangerous to life or health (IDLH), incipient stage fire, interior structure fire fighting, personal alert safety system (PASS), and structural fire protection personnel. New §421.15, Requirement to Be Certified Within One Year, provides for fire departments to request an extension to the one-year time period. New §421.17, Requirement to Maintain Certification, provides additional clarification for certification issues discussed in Chapter 437, Fees, and Chapter 441, Continuing Education.

Jake Soteriou, Fire Service Standards and Certification Division Director, has determined that for each year of the first five-year period that the proposed amendments and new sections are in effect, there will be no significant fiscal impact on state or local governments.

Mr. Soteriou has determined that for the first five-year period that the amendments and proposed new sections are in effect, the public benefit anticipated as a result of enforcing the amended and new sections will be that applicants for certification will have clearer guidelines for certification requirements. There are no additional costs of compliance anticipated for individuals and small businesses.

Comments on the proposed amendments may be submitted to Jake Soteriou, Fire Service Standards and Certification Division Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, TX 78768-2286 or submitted by e-mail to info@tcfp.state.tx.us.

The amendments and new sections are proposed under Texas Government Code, §419.008, which provides the TCFP with authority to propose rules for the administration of its powers and duties, Texas Government Code, §419.022 which provides the TCFP with the authority to establish minimum requirements for fire protection personnel, and for the purpose of implementing Senate Bill 382 enacted by the 77th Legislature.

Texas Government Code, §419.022 and §419.0341 are affected by the proposed amendments and new sections.

§421.5. Definitions.

The following words and terms, when used in this part, shall have the following meanings, unless the context clearly indicates otherwise.

(1)- (22) (No change.)

(23) Immediately dangerous to life or health (IDLH)--An atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

(24) Incipient stage fire--a fire which is in the initial or beginning stage and which can be controlled or extinguished by portable fire extinguishers, Class II standpipe or small hose systems without the need for protective clothing or breathing apparatus.

(25) Interior structural fire fighting--the physical activity of fire suppression, rescue or both, inside of buildings or enclosed structures which are involved in a fire situation beyond the incipient stage. (See 29 CFR §1910.155)

(26) [~~(23)~~] Lead instructor--An individual charged with the responsibility of conducting a training school under the provision of the Code.

(27) [~~(24)~~] Municipality--Any incorporated city, village, or town of this state and any county or political subdivision or district in this state. Municipal pertains to a municipality as herein defined.

(28) [~~(25)~~] National Fire Academy credit hours-For the purpose of determining the number of hours to credit for National Fire Academy courses both resident and hand off. The number of hours credited for attendance of National Fire Academy courses is determined as recommended in the most recent edition of the "National Guide to Educational Credit for Training Programs," American Council on Education (ACE). For courses that have not been evaluated by ACE, commission staff will review and determine credit.

(29) [~~(26)~~] Participating volunteer fire fighter--An individual who voluntarily seeks certification and regulation by the Commission under the Government Code, Chapter 419, Subchapter D.

(30) [~~(27)~~] Participating volunteer fire department--A fire department that voluntarily seeks regulation by the Commission under the Government Code, Chapter 419, Subchapter D.

(31) [~~(28)~~] Part-time fire protection employee--An individual who is designated as a part-time fire protection employee and who receives compensation, including benefits and reimbursement for expenses. A part-time fire protection employee is not full-time as defined in this section.

(32) Personal alert safety system (PASS)--Devices that are certified as being compliant with NFPA 1982, and that automatically activates an alarm signal (which can also be manually activated) to alert and assist others in locating a fire fighter or emergency services person who is in danger.

(33) [~~(29)~~] Recognition of training--A document issued by the Commission stating that an individual has completed the training requirements of a specific phase level of the Basic Fire Suppression Curriculum.

(34) [~~(30)~~] School--Any school, college, university, academy, or local training program which offers fire service training and included within its meaning the combination of course curriculum, instructors, and facilities.

(35) Structural fire protection personnel--Any person who is a permanent full-time employee of a government entity who engages in fire fighting activities involving structures and may perform other emergency activities typically associated with fire fighting activities such as rescue, emergency medical response, confined space rescue, hazardous materials response, and wildland fire fighting.

(36) [~~(31)~~] Trainee--An individual who is participating in a commission approved training program.

(37) [~~(32)~~] Training officer--The officer or supervisor, by whatever title he or she may be called, that is in charge of a commission certified training facility.

(38) [~~(33)~~] Volunteer fire protection personnel--Any person who has met the requirements for membership in a volunteer fire service organization, who is assigned duties in one of the following categories: fire suppression, fire inspection, fire and arson investigation, marine fire fighting, aircraft rescue fire fighting, fire training, fire education, fire administration and others in related positions necessarily or customarily appertaining thereto.

(39) [~~(34)~~] Years of experience--For purposes of higher levels of certification or fire service instructor certification as provided for in Chapter 425, Subchapter A of this title (relating to Fire Service Instructor Certification):

(A) Except as provided in subparagraph (B) of this paragraph, years of experience is defined as full years of full-time, part- time or volunteer fire service while holding:

(i) a Texas Commission on Fire Protection certification as a full- time, or part-time employee of a government entity, a member in a volunteer fire service organization, and/or an employee of a regulated non-governmental fire department; or

(ii) a State Firemen's and Fire Marshals' Association advanced fire fighter certification and have completed as a minimum requirements for a Texas Department of Health Emergency Care Attendant (ECA) certification, or its equivalent; or

(iii) an equivalent certification as a full-time fire protection personnel of a governmental entity from another jurisdiction, including the military, and have completed as a minimum requirements for a Texas Department of Health Emergency Care Attendant (ECA) certification, or its equivalent; or

(iv) for fire service instructor certification only, a State Firemen's and Fire Marshals' Association Level II Instructor Certification.

(B) For fire service personnel certified as required in subparagraph (A) of this paragraph on or before October 31, 1998, years of experience includes the time from the date of employment or membership to date of certification not to exceed one year.

§421.15. Requirement To Be Trained Within One Year.

(a) An individual that receives an appointment, either temporary or probationary, as fire protection personnel must satisfactorily complete a basic course in fire protection, as prescribed by the commission, within one year from the date of the original appointment. An individual that fails to complete the prescribed training shall forfeit, and be removed from the appointed position.

(b) A temporary or probationary appointment may not be extended beyond the initial one year time period, except as provided for in §421.15(d).

(c) The fire department may petition the commission, one year after the date of forfeiture and removal, and the commission may reinstate the person's temporary or probationary employment.

(d) A fire department may apply for a one-time request or an ongoing request to the commission to extend the one year period, identified in §421.15(a), to a time period not exceeding two years from the date of original appointment as follows:

(1) the request for extension shall be placed on the fire fighter advisory committee's agenda to be heard at its next regular or special called meeting after submission of the request;

(2) if recommended by the fire fighter advisory committee, the application will be sent to the commission at its next regular meeting. If the request for extension is approved by the commission the request for extension shall be effective immediately; and

(3) the one year extension of training time, if granted, shall run from the date of forfeiture and removal or at the latest from one year after the original date of appointment, whichever occurs first.

§421.17. Requirement to Maintain Certification.

(a) All full-time or part-time employees of a fire department or local government who are assigned duties identified as fire protection personnel duties must maintain certification by the commission in the discipline(s) to which they are assigned for the duration of their assignment.

(b) In order to maintain the certification required by this section, the certificate(s) of the employees must be renewed annually by complying with §437.5, Fees--Renewal, and Chapter 441, Continuing Education, of the Commission's Standards Manual.

(c) The commission will provide proof of current certification to individuals whose certification has been renewed.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
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For further information, please call: (512) 239-4921

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CHAPTER 423. FIRE SUPPRESSION SUBCHAPTER A. MINIMUM STANDARDS FOR STRUCTURE FIRE PROTECTION PERSONNEL CERTIFICATION

37 TAC §423.13

The Texas Commission on Fire Protection (TCFP) proposes amendments to Chapter 423, Fire Suppression, Subchapter A, Minimum Standards for Structure Fire Protection Personnel Certification. Amendments to §423.13, International Fire Service Accreditation Congress (IFSAC) Certification, add IFSAC certifications for First Responder Awareness and First Responder Operations.

Jake Soteriou, Fire Service Standards and Certification Division Director, has determined that for each year of the first five-year period that the proposed amendments are in effect, there will be no significant fiscal impact on state or local governments.

Mr. Soteriou has determined that for the first five-year period that the proposed amendments are in effect, the public benefit anticipated will be the increased opportunities for individuals who are employed outside of the fire service to earn IFSAC certifications through studies which can enhance their job performance. There are no additional costs of compliance anticipated for individuals and small businesses.

Comments on the proposed amendments may be submitted to Jake Soteriou, Fire Service Standards and Certification Division Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, TX 78768-2286 or submitted by e-mail to info@tcfp.state.tx.us.

The amendments are proposed under Texas Government Code, §419.008, which provides the TCFP with authority to propose rules for the administration of its powers and duties, and Texas Government Code, §419.022, which provides the TCFP with the authority to establish minimum requirements for fire protection personnel.

Texas Government Code, §419.022 is affected by the proposed amendments.

§423.13. International Fire Service Accreditation Congress (IFSAC) Certification.

(a) - (d) (No change.)

(e) Individuals completing commission approved Hazardous Materials Awareness and Hazardous Materials Operations training (this training may be part of a commission approved basic structure fire suppression program) and passing the applicable state examination may be granted IFSAC Certifications as First Responder Awareness and First Responder Operations.

(f) [~~(e)~~] Certification from the American Red Cross of successful completion of the American Red Cross Emergency Response course of at least 53 hours, including optional lessons and enrichment sections, may also be used to satisfy the requirement of this section for certification as an Emergency Care Attendant.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 11, 2001.

TRD-200107786
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 239-4921

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CHAPTER 435. FIRE FIGHTER SAFETY

37 TAC §§435.1, 435.3, 435.9, 435.11, 435.13, 435.15, 435.17, 435.19

The Texas Commission on Fire Protection (TCFP) proposes changes and new sections to Chapter 435, Fire Fighter Safety, to incorporate amendments to Chapter 419 of the Texas Government Code effected by Senate Bill 382 on September 1, 2001. Changes to §435.1, Protective Clothing, establish deadlines by which protective clothing must comply with NFPA 1851. Changes to §435.3, Self-contained Breathing Apparatus, establish time frames for inspecting and testing SCBA. New §435.9, Personal Alert Safety System (PASS), outlines an employing entity's duty in regard to providing PASS devices to fire protection personnel. New §435.11, Incident Management System (IMS), new §435.13, Personnel Accountability System, new §435.15, Operating at Emergency Incidents, and new §435.17, Procedures for Interior Structural Fire Fighting (2-In/2-Out Rule), provide guidelines for fire departments to use in developing written departmental standard procedures. New §435.19, Commission Enforcement of Chapter 435, lists timeframes related to Commission investigations.

Jake Soteriou, Fire Service Standards and Certification Division Director, has determined that for each year of the first five-year period that the proposed changes and new sections are in effect, there will be no significant fiscal impact on state or local governments.

Mr. Soteriou has determined that for the first five-year period that the changes and proposed new sections are in effect, the public benefit anticipated as a result of enforcing the amended and new sections will be a reduction in injuries and deaths to fire fighters. The development and use of the required procedures should ensure the safety of fire fighters operating at emergency scenes. There are no additional costs of compliance anticipated for individuals and small businesses.

Comments on the proposed amendments may be submitted to Jake Soteriou, Fire Service Standards and Certification Division Director, Texas Commission on Fire Protection, P.O. Box 2286, Austin, TX 78768-2286 or submitted by e-mail to info@tcfp.state.tx.us.

The amendments and new sections are proposed under Texas Government Code, §419.008, which provides the TCFP with authority to propose rules for the administration of its powers and duties; Texas Government Code, §419.022, which provides the TCFP with the authority to assist fire departments and fire protection personnel with problems relating to fire-fighting

techniques, clothing, and equipment; Texas Government Code, §419.040, which relates to protective clothing; Texas Government Code, §419.041, which relates to self-contained breathing apparatus, Texas Government Code, §419.042 which relates to personal alert safety systems, Texas Government Code, §419.043 which relates to NFPA standards; Texas Government Code, §419.044, which relates to incident management systems; Texas Government Code, §419.045, which relates to personnel accountability systems; Texas Government Code, §419.046, which relates to fire protection personnel operating at emergency incidents; and Texas Government Code, §419.047, relating to TCFP enforcement.

Texas Government Code, §§419.022, 419.040, 419.041, 419.042, 419.043, 419.044, 419.045, 419.046, and 419.047 are affected by the proposed amendments and new sections.

§435.1. Protective Clothing.

A regulated fire department shall:

(1) purchase, provide, and maintain a complete set of protective clothing for all fire protection personnel who would be exposed to hazardous conditions from fire or other emergencies or where the potential for such exposure exists [~~or provide an adequate clothing allowance and require the fire protection personnel to purchase and maintain a complete set of protective clothing~~]. A complete set of protective clothing shall consist of garments including bunker coats, bunker pants, boots, gloves, helmets, and protective hoods, worn by fire protection personnel in the course of performing fire-fighting operations.

(2) ensure that all protective clothing which are used by fire protection personnel assigned to fire suppression duties comply with the minimum standards of the National Fire Protection Association suitable for the tasks the individual is expected to perform:

(A) the National Fire Protection Association standard applicable to protective clothing is the standard in effect at the time the entity contracts for new, rebuilt, or used protective clothing;

(B) an entity may continue to use protective clothing in use or contracted for before a change in the National Fire Protection Association standard, unless the commission determines that the protective clothing constitutes an undue risk to the wearer, in which case the commission shall order that the use be discontinued and shall set an appropriate date for compliance with the revised standard;

(C) it has been demonstrated that the product identified as BREATHE-TEX®[~~BREATHE-TEXr~~], manufactured by Aldan Engineered Coated Fabrics, used as a moisture barrier in some protective clothing, may fail unpredictably and allow moisture to pass through the barrier. This product is the subject of recalls by some manufacturers. Pursuant to the Government Code, §419.040(b), the commission has determined that continued use of protective clothing having the moisture barrier identified above constitutes an undue risk to the wearer. Therefore, all regulated fire departments shall:

(i) immediately inspect all protective clothing and identify any protective clothing containing a BREATHE-TEX®[~~BREATHE-TEXr~~] moisture barrier;

(ii) immediately and each thirty days thereafter, test all BREATHE-TEX®[~~BREATHE-TEXr~~] moisture barriers found and remove from service any protective clothing with a moisture barrier that allows moisture to pass through the barrier. The protective clothing shall only be returned to service when the moisture barrier has been replaced with a moisture barrier which complies with the current applicable NFPA standard;

(iii) no later than January 1, 2002, remove from service all protective clothing containing BREATHE- TEX®[~~BREATHE-TEXr~~] moisture barriers without regard to whether or not the moisture barrier has failed.

(iv) maintain records for at least five years, which document compliance with this section.

(3) maintain and provide upon request by the commission, a departmental standard operating procedure regarding the use, selection, care, and maintenance of protective clothing which complies with NFPA 1851, Standard on Selection, Care, and Maintenance of Structural Fire Fighting Protective Ensembles.

(4) Protective clothing in use or contracted for prior to January 1, 2002, shall be exempted from the record keeping requirements contained in Section 2.3, Records, of NFPA 1851.

§435.3. Self-contained Breathing Apparatus.

The employing entity shall:

(1) purchase, provide, and maintain a complete self-contained breathing apparatus for each on duty fire protection personnel who engage in operations where IDLH atmospheres may be encountered, where the atmosphere is unknown or would be exposed to hazardous atmospheres from fire or other emergencies or where the potential for such exposure exists;

(2) ensure that all self-contained breathing apparatus used by fire protection personnel complies with the minimum standards of the National Fire Protection Association identified in NFPA 1981, Standard on Open-Circuit Self-contained Breathing Apparatus for Fire Fighters:

(A) the National Fire Protection Association standard applicable to a self-contained breathing apparatus is the standard in effect at the time the entity contracts for new, rebuilt, or used self- contained breathing apparatus;

(B) an entity may continue to use a self-contained breathing apparatus that meets the requirements of an earlier edition of NFPA 1981, unless the commission determines that the continued use of the self-contained breathing apparatus constitutes an undue risk to the wearer, in which case the commission shall order that the use be discontinued and shall set an appropriate date for compliance with the revised standard;

(3) ensure that an SCBA that is assigned to an individual user or in-service apparatus be inspected at the beginning of each duty period and where an SCBA is not assigned to an individual user or in-service apparatus for a duty period, the inspection shall be performed at least monthly[~~, inspections of respiratory protection equipment are conducted~~] and shall include a check of the entire unit for deteriorated components, air tightness of cylinders and valves, gauge comparison, reducing valve and bypass valve operation, and check of the regulator, exhalation valve, and low-air alarm. The inspection shall comply with the minimum requirements of the National Fire Protection Association. The SCBA shall be clean[~~cleaned~~] and ready[~~returned to~~] for service;

(4) ensure that compressed breathing air from any source, including but not limited to transferred air from vendor cylinders to other cylinders, fire department air compressors, cascade systems and private sources, that is used to fill the cylinders of a self-contained breathing apparatus complies with the minimum standards of the National Fire Protection Association for air quality testing of compressed breathing air and identified in NFPA 1500,[~~1992 edition,~~] Standard on Fire Department Occupational Safety and Health Program:

(5) ensure that at least every six months, samples of the air used to fill the cylinders of self-contained breathing apparatus are

tested by a testing laboratory which currently holds accreditation to test breathing air from a nationally recognized accrediting organization. Air samples shall be taken directly from the point where self-contained breathing apparatus cylinders are connected for filling. If a fill station has more than one port where a self-contained breathing apparatus cylinder can be attached and if only one sample is taken from the fill station, then the sample shall be taken from the port that ensures that all components of the fill station are tested. It is "recommended" that the air used to fill cylinders of self-contained breathing apparatus be tested at least every three months.

(6) develop procedures to ensure that all bottles used on self- contained breathing apparatus are tested as required by the manufacturer and the Department of Transportation;

(7) maintain and supply upon request by the commission, records and reports documenting compliance with commission requirements concerning self-contained breathing apparatus and a record of all tests shall be made and the record shall be retained for a period of no less than three years;

(8) maintain and provide upon request by the commission, a departmental standard operating procedure regarding the use, selection, care, and maintenance of self-contained breathing apparatus; and

(9) ensure that at least annually, the facepiece, regulator, end of service indicator(s), hoses, and cylinder valve are tested for proper function on test equipment approved by the manufacturer. The test of the regulator shall include a flow test. This test shall be performed in a manner prescribed by the manufacturer and by personnel authorized by the manufacturer to perform such test and shall meet the minimum requirements for testing as required by the National Fire Protection Association.

§435.9. Personal Alert Safety System (PASS).

The employing entity shall:

(1) purchase, provide, and maintain a PASS device for each of its fire protection personnel who engage in operations where IDLH atmospheres may be encountered, or where the atmosphere is unknown, or where hazardous conditions from fire or other emergencies exist, or where the potential for such exposure exists;

(2) ensure that all PASS devices used by fire protection personnel comply with the minimum standards of the National Fire Protection Association identified in NFPA 1982, Standard on Personal Alert Safety Systems (PASS) for Fire Fighters:

(A) the National Fire Protection Association standard applicable to a PASS device is the standard in effect at the time the entity contracts for new, rebuilt, or used PASS devices;

(B) an entity may continue to use a PASS device that meets the requirements of an earlier edition of NFPA 1982, unless the commission determines that the continued use of the PASS device constitutes an undue risk to the wearer, in which case the commission shall order that the use be discontinued and shall set an appropriate date for compliance with the revised standard;

(3) ensure that the PASS device assigned to an individual user be inspected at the beginning of each duty period and before each use.

(4) maintain and provide upon request by the commission, a departmental standard operating procedure regarding the proper use, selection, care and maintenance of PASS devices.

§435.11. Incident Management System (IMS).

(a) The fire department shall develop, maintain and use an incident management system.

(b) The incident management system shall:

(1) include a written operating procedure for the management of emergency incidents;

(2) require that the IMS be used at all emergency incidents;

(3) require operations to be conducted in a manner that recognizes hazards and assists in the prevention of accidents and injuries;

(4) require that all fire protection personnel be trained in the use of the IMS; and

(5) require that the IMS be applied to all drills, exercises and all other situations that involve hazards similar to those encountered at an actual emergency.

(c) The IMS shall meet the requirements of the applicable sections of the National Fire Protection Association 1561, Standard on Fire Department Incident Management System.

§435.13. Personnel Accountability System.

(a) The fire department shall develop, maintain and use a personnel accountability system that provides for a rapid accounting of all personnel at an emergency incident.

(b) The accountability system shall:

(1) require all fire protection personnel be trained in the use of the accountability system;

(2) require that the fire protection personnel accountability system be used at all incidents;

(3) require that all fire protection personnel operating at an emergency incident to actively participate in the personnel accountability system; and

(4) require that the incident commander be responsible for the overall personnel accountability system for the incident;

(c) The fire department shall be responsible for developing the system components required to make the personnel accountability system effective.

(d) The personnel accountability system shall meet the minimum standards required by the National Fire Protection Association 1561, Standard on Fire Department Incident Management System. If the standard is revised, the fire department shall have one (1) year from the effective date of the new standard to comply.

§435.15. Operating At Emergency Incidents.

(a) The fire department shall develop, maintain and use a standard operating procedure for fire protection personnel operating at emergency incidents.

(b) The standard operating procedure shall:

(1) specify an adequate number of personnel to safely conduct emergency scene operations;

(2) limit operations to those that can be safely performed by personnel at the scene;

(3) require all personnel to be trained in and use the standard operating procedures; and

(4) comply with §435.17 (Procedures for Interior Structural Fire Fighting).

(c) The fire department may use standards established by the National Fire Protection Association for fire protection personnel operating at an emergency incident.

§435.17. Procedures for Interior Structural Fire Fighting (2-In/2-Out Rule).

(a) The fire department shall develop written procedures that comply with the Occupational Safety and Health Administration's Final Rule, 29 CFR Section 1910.134(g)(4) by requiring:

(1) a team of four fire fighters must be assembled before an interior fire attack can be made when the fire has progressed beyond the incipient stage;

(2) at least two fire fighters to enter the IDLH atmosphere and remain in visual or voice (not radio) contact with each other;

(A) Visual means that the fire fighters must be close enough to see each other.

(B) Voice means that the fire fighters of the entry team must be close enough to speak to one another without the use of radios.

(3) at least two fire fighters remain located outside the IDLH atmosphere to perform rescue of the fire fighters inside the IDLH atmosphere;

(4) all fire fighters engaged in interior structural fire fighting use self-contained breathing apparatus and be clothed in a complete set of protective clothing as identified in Chapter 435;

(5) all fire fighters located outside the IDLH atmosphere be equipped with appropriate retrieval equipment where retrieval equipment would contribute to the rescue of the fire fighters that have entered the IDLH atmosphere;

(6) one of the outside fire fighters must actively monitor the status of the inside fire fighters and not be assigned other duties. The second outside fire fighter may be assigned to an additional role(s), including, but not limited to, incident commander, safety officer, driver-operator, command technician or aide, or fire fighter/EMS personnel, so long as this individual is able to perform assistance or rescue activities without jeopardizing the safety or health of any fire protection personnel working at the scene;

(7) the fire fighters outside the IDLH atmosphere must remain in communication (including, but not limited to, radio) with the fire fighters in the IDLH atmosphere. Use of a signal line (rope) as a communications instrument for interior fire fighting is not permitted by the commission. This does not preclude the use of rescue guide ropes (guide line or lifeline or by what ever name they may be called) used during structural searches; and

(8) each standby fire protection personnel must have a complete set of protective clothing and self-contained breathing apparatus, as identified in Chapter 435, immediately accessible for use if the need for rescue activities inside the IDLH atmosphere is necessary.

(b) The fire department shall comply with the 2-in/2-out rule as described in this section except in an imminent life-threatening situation when immediate action could prevent the loss of life or serious injury before the team of four fire fighters are assembled.

§435.19. Commission Enforcement Of Chapter 435.

(a) The commission shall enforce Chapter 435 at anytime, including, but not limited to, commission investigations, biennial fire department inspections, or upon receiving a written complaint of an alleged infraction of Chapter 435.

(b) Upon receipt of a written complaint alleging a violation of Chapter 435, the commission shall have 30 days to initiate an investigation and report back to the complainant its progress.

(c) Upon substantiating the validity of a written complaint, the commission shall follow the procedures outlined in Government Code, Chapter 419, §§419.011(b) and (c).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

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Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 239-4921

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CHAPTER 437. FEES

37 TAC §437.3

The Texas Commission on Fire Protection (TCFP) proposes an amendment to §437.3, concerning certification fees. The amendment adds language to provide for a non-refundable application fee for each certification issued by the TCFP. The application fee will apply towards certification if the application is approved. This amendment was originally adopted by the TCFP on October 11, 2000 (25 TexReg 10189). However, the old rule inadvertently was published by the *Texas Register* on October 27, 2000. Hence, the TCFP is re-proposing the same amendment to effectuate what was originally intended in the prior rulemaking process.

Jake Soteriou, Fire Service Standards and Certification Division Director, has determined that for each year of the first five-year period that the amended section is in effect there will be fiscal implications for state and local governments. The TCFP may experience an increase in revenue of approximately $10,000 per year based on the number of refunds (500) processed each year previously. In addition, approximately 250 hours of staff time required to processing refunds may be devoted to more productive activity. Local fire departments that are required to pay the non-refundable fees will experience an increase in costs of $20 per application. Those departments that submit properly completed and qualified applications will not experience additional costs.

Mr. Soteriou has also determined that for the first five-year period that the proposed amendment is in effect the public benefit anticipated as a result of enforcing the amended section will be that there will be a more efficient use of state resources due to a higher percentage of properly completed applications.

There are no additional costs of compliance anticipated for small or large businesses. Individuals who submit unqualified or incomplete applications will incur an additional cost of compliance of $20 per application.

Comments on the proposal may be submitted to Jake Soteriou, Fire Service Standards and Certification Division Director, Texas Commission on Fire Protection, P. O. Box 2286, and Austin, TX 78768-2286 or submitted by e-mail to info@tcfp.state.tx.us.

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with authority to propose

rules for the administration of its powers and duties; Texas Government Code, §419.026, which provides the TCFP with the authority to establish fees for certifications and examinations; and Texas Government Code, §419.034, which provides the TCFP with the authority to establish standards for certificate renewal.

Texas Government Code, §419.026 and §419.034 are affected by the proposed amendment.

§437.3. Fees--Certification.

(a) A $20 non-refundable application[~~certification~~] fee is required for each certificate issued by the commission. If a certificate is issued within the time provided in §401.125 of this title (relating to Processing Periods), the fee will be applied to certification. If the certificate is denied the applicant must pay a new certification application fee to file a new application.

(b) - (g) No change.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
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For further information, please call: (512) 239-4921

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CHAPTER 463. APPLICATION CRITERIA

37 TAC §463.4

The Texas Commission on Fire Protection (TCFP) proposes an amendment to §463.4, concerning application criteria for the Fire Department Emergency Program (FEDP). The amendment to §463.4 concerning competitive needs criteria, changes the requirement for participation in TEXFIRS from during the three months prior to the application to participation at the time of application or an agreement to participate at the time of funding.

Ms. Barbara Jenkins, Program Administrator for the FDEP, has determined that for the first five year period the amended section is in effect there will be no fiscal implications for state or local governments.

Ms. Jenkins has also determined that for each of the first five years the proposed amendment is in effect the public benefit anticipated as a result of enforcing the amended section will be an increase in the number of eligible applicants.

There are no additional costs of compliance for small or large businesses or individuals required to comply with the amendments.

Comments on the proposal may be submitted to: Gary L. Warren, Sr., Executive Director, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

The amendment is proposed under Texas Government Code, §419.008, which provides the TCFP with authority to propose rules for the administration of its powers and duties and Texas Government Code, §§419.051-419.064, which provide the TCFP with authority to administer the FDEP.

Texas Government Code, §419.059 and §419.060 are affected by the proposed amendment.

§463.4. Competitive Needs Criteria.

(a) All applications must meet the following minimum standards.

(1) Applicants must train its members on a regular basis (at least monthly).

(2) Training provided must be approved under §465.3 of this title (relating to Education and Training Standards).

(3) Applicants must have at least 10 volunteer and/or paid personnel active in the organization.

(4) Applicants must provide fire protection services and/or fire fighting education and training.

(5) Applicants must report through the TEXFIRS system,[~~for the three months preceding the date of the application~~] or agree to report if awarded funding assistance.

(6) Except for applicants for scholarships, all applicants must participate in a training certification program approved by the Texas Commission on Fire Protection at the time of application. Participation in a training certification program means:

(A) participation by a majority of a department's members in an approved training program as identified in §465.3 of this title (relating to Education and Training Standards);

(B) current certification of the department as a commission approved training facility that conducts at least 48 hours of drills each calendar year attended by a majority of members; or

(C) current certification by the commission of at least 10 members with current continuing education.

(b) No change.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. TEXAS DEPARTMENT OF HUMAN SERVICES

CHAPTER 19. NURSING FACILITY REQUIREMENTS FOR LICENSURE AND MEDICAID CERTIFICATION

SUBCHAPTER P. PHARMACY SERVICES

40 TAC §19.1510

The Texas Department of Human Services (DHS) proposes to amend §19.1510, concerning emergency drugs, in its Nursing Facility Requirements for Licensure and Medicaid Certification chapter. The purpose of the amendment is to implement Senate Bill 768, 77th Legislature, which addresses emergency medication kits in nursing facilities.

Nursing facilities are allowed to keep emergency medication kits that contain small doses of commonly prescribed drugs, such as antibiotics, narcotics, anti-anxiolitics, and anti-convulsants, for residents who may need them with little notice to obtain them from a pharmacy. Senate Bill 768 transfers responsibility for emergency medication kit rules from DHS to the Texas State Board of Pharmacy (TSBP). DHS proposes to amend its current rules to reflect TSBP's new rules.

James R. Hine, Commissioner, has determined that for the first five-year period the section is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Mr. Hine also has determined that for each year of the first five years the section is in effect, the public benefit anticipated as a result of adoption of the proposed rule will be improved access to appropriate medication for nursing facilities when residents need pharmaceuticals. There will be no adverse economic effect on small or micro businesses, because the rule assigns ownership of the emergency medication kit to pharmacies. Emergency medication kits previously had been considered the property of a physician. The section will facilitate reimbursement to pharmacies for drugs contained in the kits. There is no anticipated economic cost to persons who are required to comply with the proposed section. There is no anticipated effect on local employment in geographic areas affected by this section.

Questions about the content of this proposal may be directed to Susan Syler at (512) 438-3111 in DHS's Long Term Care-Policy Section. Written comments on the proposal may be submitted to Supervisor, Rules and Handbooks Unit-070, Texas Department of Human Services E-205, P.O. Box 149030, Austin, Texas 78714-9030, within 30 days of publication in the *Texas Register.*

Under §2007.003(b) of the Texas Government Code, the department has determined that Chapter 2007 of the Government Code does not apply to these rules. Accordingly, the department is not required to complete a takings impact assessment regarding these rules.

The amendment is proposed under the Health and Safety Code, Chapter 242, which authorizes DHS to license and regulate convalescent and nursing homes and related institutions.

The section implements the Health and Safety Code §§242.001-242.268.

§19.1510. Emergency Medication Kits [~~Drugs~~].

Stocks of inventoried emergency medications [~~dangerous drugs~~] may be kept in facilities.

(1) Emergency medication kits must be maintained in compliance with 22 TAC §291.20(b), relating to remote pharmacy services using emergency medication kits [~~The contents of the emergency dangerous drug kit will be determined by the consultant pharmacist, medical director, and the director of nurses~~].

(2) Facilities must have contracts with the pharmacy that provides the emergency medication kit. The contract must outline the services to be provided by the pharmacy and the responsibilities and accountabilities of each party in fulfilling the terms of the contract in compliance with federal and state laws and regulations [~~Ownership of the emergency drugs is limited to a physician with the exception of controlled substances which are the property of a pharmacy~~].

[~~(3) The facility must develop policies and procedures for the emergency dangerous drug kit that include the following:~~]

[~~(A) a requirement that the facility is responsible for proper control and accountability for emergency kits within the facility. A prescription number and balance verifiable by inventory of controlled substances at every shift change, as required by §19.1509 of this title (relating to Controlled Substances), is not applicable;~~]

[~~(B) a signed agreement for obtaining controlled drugs from a pharmacy; and~~]

[~~(C) a limitation on the type and quantity of controlled substances, as follows:~~]

[~~(i)~~] ~~the controlled drugs must be limited to units of use in dosage strengths generally recommended for single dose therapy for each route of administration;~~]

[~~(ii)~~] ~~controlled drugs must be limited to no more than three different drugs per therapeutic drug class with a maximum total of doses necessary to treat for a 72-hour period; and~~]

[~~(iii)~~] ~~the facility's professional staff must:~~]

[~~(I)~~] ~~determine, select, and record a prudent number of controlled drugs for potential emergency incidents based on clinical criteria applicable to each facility's demographics; and~~]

[~~(II)~~] ~~document treatment protocols for controlled substance use in the emergencies that might be reflective of the facility's census and environment.~~]

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 17, 2001.

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Paul Leche
General Counsel, Legal Services
Texas Department of Human Services
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For further information, please call: (512) 438-3734

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 4. EMPLOYMENT PRACTICES
SUBCHAPTER F. EMPLOYEE TRAINING AND EDUCATION

The Texas Department of Transportation proposes the repeal of §§4.60-4.64 and simultaneously proposes new §§4.60-4.63, concerning employee training and education.

EXPLANATION OF PROPOSED REPEALS AND AMENDMENTS

Government Code, §656.048, requires a state agency to adopt rules relating to the eligibility of the state agency's administrators and employees for training and education supported by the state agency and the obligations assumed by the administrators and employees on receiving the training and education.

The repeals and new sections are proposed for several reasons. First, the rules are thoroughly revised to simplify the structure, clarify the meaning, and shorten the length by eliminating unnecessary duplication. The result is a set of rules that are both shorter and easier to use. Second, the revision strengthens the training and education program to ensure that the department's expenditures yield an appropriate return. Third, the degree program is divided into two programs, a job-related degree program and a non-job-related degree program, to facilitate administration.

Section 4.60 is based on former §4.60. There are no substantive changes.

Section 4.61 is based on former §4.61. Some definitions have been added, and others have been deleted. The definitions of district, district engineer, division director, employee, office director, part-time position, professional development requirement, prospective duty assignment, regular employee, and training have been eliminated. In each case, either the meaning is clear from the context in which the term is used, or the term has been eliminated from the rules.

Several new definitions have been added. Director is defined as the director of the Human Resources Division. Employee's executive officer is defined as an employee's district engineer, division director, or office director (or that person's designee). Executive director has been defined to include a designee. In each case, the reason for the new definition is for ease of reference. In addition, institution has been defined to establish the kinds of schools that an employee may attend. This establishes that employees may receive assistance for attending only accredited colleges and universities and ensures that employees will participate in programs of high quality. For the same reason, trade schools will no longer be eligible.

Former §4.62 is eliminated because it provided no substantive guidance.

Section 4.62(a) is added to provide context and to clarify that in the event of conflict, the program-specific rules in §4.63 will govern.

Section 4.62(b)(1) is based on former §4.63(b)(1)(A), (2)(A) and (3)(A). Section 4.62(b)(2) is based on former §4.63(b)(1)(B), (2)(B) and (3)(B). Section 4.63(b)(3) is based on former §4.63(b)(1)(D), (2)(F) and (3)(D). There are no substantive changes.

Section 4.62(c)(1) is based on former §4.63(d). Employees are given greater latitude in taking correspondence and internet courses if they are offered by, in order of preference, Texas public institutions, Texas private institutions, and other institutions. This will increase the availability of eligible courses while providing opportunities for cost reductions.

Section 4.62(c)(2) is based on former §4.63(e). There are no substantive changes.

Section 4.62(c)(3) is based on former §4.63(f)(2). Current policy is clarified by adding that employees may use department equipment only during non-duty hours and when use would not interfere with ordinary department business.

Section 4.62(c)(4) is based on former §4.62(d)(5)(B). There are no substantive changes.

Section 4.62(d)(1) is based on former §4.64(a)(5). Section 4.62(d)(2) is based on former §4.64(b). Section 4.62(d)(3) is based on former §4.63(c)(1)(C) and (2)(B), and §4.64(c)(2). The new language clarifies that an employee's executive officer is the person responsible for deciding to suspend an employee's participation in an assistance program.

Section 4.62(e) is based on former §4.64(a)(2), (3) and (4). Section 4.62(f) is based on former §4.64(a)(2), (3) and (4); (c)(1)(D); and (d). There are no substantive changes.

Section 4.62(g) is based on §4.64(c)(1) and (d)(9). The waiting period required to reenter an assistance program after cancellation, in the absence of hardship, is reduced from three years to two. This change is made because the repayment provisions adequately protect the department from abuse of a program by an employee.

Section 4.63(a) is based on former §4.63(a). It contains particular standards applicable to degree programs and splits the degree programs into two categories, the job-related degree program and the non-job-related degree program. This division will facilitate administration of the degree programs.

Section 4.63(a)(1) contains standards that are applicable to both degree programs. Section 4.63(a)(1)(a) is based on former §4.63(b)(1)(C), (E) and (G). There are no substantive changes.

Section 4.63(a)(1)(B) is based on former §4.63(g). It now provides that an employee's chosen elective may not be rejected if rejection would extend the employee's time in the program.

Section 4.63(a)(1)(C) is based on former §4.63(c)(1). Section 4.63(a)(1)(D) is based on former §4.63(c)(1)(B) and (f)(1). Section 4.63(a)(1)(E) is based on former §4.64(d)(7) and (8). There are no substantive changes.

Section 4.63(a)(2) contains standards that are applicable only to the job-related degree program. Section 4.63(a)(2)(A) is based on former §4.63(b)(1)(F)(i) and (ii). Section 4.63(a)(2)(B) is based on former §4.64(a)(3). There are no substantive changes.

Section 4.63(a)(3) contains standards that are applicable only to the non-job-related degree program. Section 4.63(a)(3)(A) is based on former §4.63(b)(1)(F)(iii). Section 4.63(a)(3)(B) is based on former §4.64(a)(3). There are no substantive changes.

Section 4.63(b) is based on former §4.63(a). It contains particular standards applicable to the full-time master's program.

Section 4.63(b)(1) is based on former §4.63(b)(2)(C), (D), (E), (G), (H) and (I). Section 4.63(b)(2) is based on former §4.63(g). Section 4.63(b)(3) is based on former §4.63(c)(2). Section 4.63(b)(4) is based on former §4.63(b)(2), (e)(5) and (f). Section 4.63(b)(5) is based on former §4.64(1)(2). There are no substantive changes.

Section 4.63(b)(6) is based on former §4.64(d)(2), (7) and (8). Reduction or elimination of repayment obligations will no longer

be authorized for an employee who leaves the department to work for another state agency. This change is necessary to ensure that the department is not, in effect, using its resources to train employees for the benefit of other agencies and not the department.

Section 4.63(b)(7) is based on former §4.64(a)(1)(B). There are no substantive changes.

Section 4.63(c) is based on former §4.63(a). It contains particular standards applicable to the full-time degree completion program.

Section 4.63(c)(1) is based on former §4.63(b)(3)(C), (E), (F) and (G). There are no substantive changes.

Section 4.63(c)(2) is based on former §4.63(g). It now provides that an employee's chosen elective may not be rejected if rejection would extend the employee's time in the program.

Section 4.63(c)(3) is based on former §4.63(c)(3). Previously, an employee might be granted the ability to skip the summer semester if the employee returned to work for the summer. This provision is generalized to apply to any semester and to permit a combination of part-time work and part-time school, as long as the combination is approved by the director of the Human Resources Division.

Section 4.63(c)(4) is based on former §4.63(c)(3) and (f)(1). Section 4.63(c)(5) is based on former §4.64(a)(4). Section 4.63(c)(6) is based on former §4.64(d)(2), (7) and (8). Section 4.63(c)(7) is based on former §4.64(c)(1)(C)(iii). There are no substantive changes.

Section 4.63(d) is based on former §4.63(a). It contains particular standards applicable to the non-degree program.

Section 4.63(d)(1) is based on former §4.63(b)(4). There are no substantive changes. Section 4.63(d)(2) is added to state explicitly that there is no service requirement under the non-degree program; this conforms to current practice and was implicit in the former rules. Section 4.63(d)(3) is based on former §4.64(d)(7) and (8). It now permits the executive director to defer or extend repayment in the best interest of the department.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five-years the repeals and new sections are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeals and new sections. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Diana L. Isabel, Director, Human Resources Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeals and new sections.

PUBLIC BENEFIT

Ms. Isabel has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the repeals and new sections will be will be better educated and trained state employees. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeals and new sections may be submitted to Diana L. Isabel, Director, Human Resources Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

43 TAC §§4.60 - 4.64

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeals are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Government Code, §656.048 which requires state agencies to adopt rules relating to the eligibility of the department's administrators and employees for training and education supported by the state agencies and the obligations assumed by the administrators and employees on receiving the training and education.

No statutes, articles, or codes are affected by the proposed repeals.

§4.60. Purpose and Scope

§4.61. Definitions

§4.62. Employee Training

§4.63. Education Programs

§4.64. Employee Obligations

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107884
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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43 TAC §§4.60 - 4.63

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Government Code, §656.048 which requires state agencies to adopt rules relating to the eligibility of the department's administrators and employees for training and education supported by the state agencies and the obligations assumed by the administrators and employees on receiving the training and education.

No statutes, articles, or codes are affected by the proposed new sections.

§4.60. Purpose.

It is the policy of the Texas Department of Transportation to encourage the professional development of employees through education and

training under the State Employees Training Act, Government Code, Chapter 656, Subchapter C. These programs are designed to increase the job potential of employees, provide financial assistance for continuing education, and introduce new technology and educational methods into the workplace. This subchapter governs the eligibility and obligations of employees under training and education programs.

§4.61. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Assistance - Financial aid provided by the department to its employees for education expenses.

(2) Department - The Texas Department of Transportation.

(3) Director - The director of the Human Resources Division or the director's designee not below the level of section director.

(4) Employee's executive officer - An employee's district engineer, division director, or office director, or that person's designee.

(5) Executive director - The executive director of the department or the executive director's designee not below the level of assistant executive director.

(6) Good standing - Meeting of all performance standards in an employee's most recent performance evaluation and not being on probation.

(7) Hardship - A serious illness, family emergency, or extenuating circumstance that is beyond the control of the employee and that reasonably precludes the employee from complying with an assistance agreement.

(8) Institution - A college or university accredited by a major regional academic accrediting agency for institutions of higher learning, such as the Southern Association of Colleges and Schools.

(9) Program Selection Committee - A committee that is appointed by the executive director and that selects employees who will participate in the full-time master's program.

§4.62. General Standards.

(a) Applicability. This section establishes standards applicable to all assistance unless different standards are established for a particular program as described in §4.63 of this subchapter.

(b) Eligibility. An employee must meet the following requirements to be eligible for an assistance program.

(1) The employee must be a full-time employee. Summer employees and temporary recruitment program employees are ineligible, except for the non-degree program.

(2) The employee must be in good standing with the department.

(3) The employee must complete an assistance agreement setting forth the conditions of assistance, including the amount of the assistance, the requirements of continued eligibility, and the employee's repayment responsibilities.

(c) Scope of assistance.

(1) Type of institution.

(A) Assistance will be authorized only for courses and degrees earned through an institution.

(B) All courses, whether offered in person, through correspondence, or over the internet, must be taken if possible from a public institution in Texas.

(C) If an employee is enrolled in a degree program in a private institution in Texas, the employee must earn as many credits as possible at a Texas public institution if that will reduce the amount of required assistance. Courses, whether offered in person, through correspondence, or over the internet, may be taken from a Texas private institution only if:

(i) no public institution offers a comparable course that can reasonably be attended by the employee during non-duty hours;

(ii) no public institution offers the approved courses or degree;

(iii) the employee cannot meet the admission requirements of a public institution;

(iv) the completion of the degree or course at a private institution would cost less than at a public institution; or

(v) the employee agrees the department will only provide the amount of assistance that would have been required if the employee had attended a public institution.

(D) An employee may take a correspondence course or an internet course offered by an out-of-state institution only if the course is not available from any private or public institution in Texas, whether in person, as a correspondence course, or over the internet.

(2) Eligible expenses. The following expenses are eligible for financial assistance:

(A) tuition;

(B) College Level Equivalency Program exams or similar exams if they relate to a course that is part of the employee's approved degree plan and if the employee scores high enough to receive college credit or a waiver of course requirements;

(C) life experience assessments for which the employee obtains a credit if the credit is part of the employee's approved degree plan; and

(D) required fees and books.

(3) Use of state property. An employee participating in a program may use the department's self-service copy machines, typewriters, calculators, copy paper, and microcomputers to complete course assignments during non-duty hours and when use does not interfere with the department's business.

(4) Retaken courses. The department will not pay expenses incurred to retake a course or to take a substitute for a failed course unless the department has been reimbursed for the cost of the failed course.

(d) Conditions of participation.

(1) Grade verification. Each semester an employee shall provide grade reports to the employee's executive officer to verify that the employee received full credit for all courses.

(2) Outside aid. An employee shall provide receipts for all fees and shall promptly report any outside funds received. The department will deduct any amounts received by the employee through grants, scholarships, or other financial aid from the assistance provided to the employee.

(3) Suspension.

(A) The employee's executive officer may suspend an employee for any of the following reasons.

(i) Participation may be suspended indefinitely if an employee is placed on disciplinary probation.

(ii) Participation may be suspended indefinitely if the employee does not meet any obligation or does not maintain eligibility or if the employee's executive officer determines that the employee's participation in an assistance program adversely affects the employee's job performance.

(iii) An employee's participation may be suspended based on extraordinary work requirements as determined by the employee's executive officer.

(B) Suspension will not be considered a failure to remain active in the program.

(e) Service requirement. An employee shall agree to work for the department in return for assistance. This service requirement shall begin 30 days after the date the employee receives the degree if the employee meets all conditions of employment and eligibility at that time.

(f) Repayment.

(1) Circumstances requiring repayment.

(A) An employee who voluntarily withdraws from an assistance program or who separates from department employment shall repay all assistance provided by the department for courses taken under the assistance agreement.

(B) An employee who does not meet all conditions of employment and eligibility during a service requirement or who does not complete a service requirement in its entirety shall repay all assistance provided by the department. Repayment shall not be prorated or reduced because a portion of a service requirement has been fulfilled.

(2) Failure to pass course. An employee who does not pass a course must repay funds provided by the department for that course. If the employee repays the department for the course, the employee may continue in the program. If the employee does not repay the department for the course, no additional assistance will be provided. An employee in a continuing program must repay the debt before the next semester to continue participation in the assistance program.

(3) Repayment schedule. The executive officer will establish a repayment schedule and send a copy to the director and to the Finance Division. Employees shall follow the repayment schedule set by the department. The repayment schedule will consist of:

(A) up to 60 equal monthly installments beginning 90 days after employment or participation ceases; and

(B) minimum installments of no less than $20 based on the employee's ability to repay and the amount owed.

(4) Costs of collection. An employee is liable to the department for any reasonable expense incurred in obtaining payment, including reasonable attorney's fees.

(5) Credit agencies. The department may notify credit agencies if an employee does not repay the department.

(g) Cancellation.

(1) Grounds. The department will cancel an employee's participation if the employee:

(A) withdraws from the approved institution;

(B) is removed or prohibited from attending the approved institution;

(C) does not comply with any term of the assistance agreement; or

(D) is terminated from the department while participating in a program or before completion of a service requirement.

(2) Resumption of eligibility. If the department cancels an employee's participation, the employee will no longer be eligible for assistance unless the employee has fully repaid the department and:

(A) the employee demonstrates that the cancellation resulted from hardship; or

(B) two years have elapsed since the employee's participation was canceled.

§4.63. Particular Programs.

(a) Degree programs. The department offers two degree programs, the job-related degree program and the non-job-related degree program. These programs provide assistance to employees who continue to work while earning their degrees.

(1) In general.

(A) Eligibility. An employee must meet the following additional requirements to be eligible for a degree program.

(i) The employee must have at least 12 months of service time with the department for an undergraduate degree and at least 24 months for a graduate degree.

(ii) The employee must have written acceptance from an institution and a degree plan signed by the institution's representative.

(iii) The employee's executive officer must approve the employee's participation. If the employee is seeking a doctoral degree, the executive director must also approve the employee's participation.

(B) Elective courses. An employee's executive officer may reject an elective course if it is not related to the employee's duties unless rejection of the elective will extend the employee's time in the program. Substitutions will not be made for any courses required for a degree.

(C) Conditions of participation. An employee's executive officer will reconsider the employee's participation in the program each semester. An employee must meet the following additional standards to maintain eligibility.

(i) The employee must be enrolled at an approved institution and in a course of instruction leading toward an approved degree.

(ii) The employee must be enrolled at least two semesters per school year. The employee's executive officer may waive this requirement in writing if a copy of the written waiver is sent to the director.

(D) Use of state time. Department duty hours may not be used for attending classes, studying, or other activities associated with a degree program. An employee may use annual leave, flextime, or compensatory time with prior written approval from the employee's supervisor. With the approval of the employee's executive officer, an employee may change the employee's work status from full-time to part-time to accommodate class scheduling.

(E) Repayment. The executive director may approve a deferral or an extension of the repayment period or the reduction or cancellation of debt or service requirements in the best interest of the

department or if an employee demonstrates hardship. Deferral or extension of repayment does not relieve the employee of the responsibility to repay the funds owed.

(2) Job-related degree program.

(A) Eligibility. To participate in the job-related degree program, an employee must seek enrollment and participation in a field of study that:

(i) relates to the employee's current assigned work and position;

(ii) enables the employee to meet increased demands of the employee's job assignment; or

(iii) is required for the employee to progress in the employee's career ladder.

(B) Service requirement. An employee shall work for the department for one year after completing the program.

(3) Non-job-related degree program.

(A) Eligibility. To participate in the non-job-related degree program, an employee must seek enrollment and participation in a field of study that meets minimum requirements for an occupation in which the department anticipates staffing needs. The employee must have demonstrated an aptitude through job performance and receive the approval of the employee's executive officer and the concurrence of the director.

(B) Service requirement. An employee shall work for the department for two years after receiving an undergraduate degree and for three years after receiving a graduate degree.

(b) Full-time master's program. The department offers a full-time master's program, under which an employee may attend school full-time while receiving full salary.

(1) Eligibility. An employee must meet the following additional requirements to be eligible for the program.

(A) The employee must have at least 5 years of service time with the department, or for engineering disciplines, at least 4 years and a Texas professional engineering license.

(B) The employee must submit a statement of career goals and research interests.

(C) The employee must have written acceptance from an institution and a degree plan signed by the institution's representative.

(D) The employee's executive officer must nominate the employee and the Program Selection Committee must select the employee based on academic qualifications and work experience.

(E) The employee must have an undergraduate degree that is approved as an appropriate base for the desired graduate field of study by the Program Selection Committee.

(2) Elective courses. The director may reject an elective course if it is not related to the employee's duties. Substitutions will not be made for any courses required for a degree.

(3) Conditions of participation. The employee must be enrolled continuously for no more than four semesters, including the summer semester if one is offered, in an institution in a course of instruction leading to a master's degree in the approved major field of study. The director may approve an extension if the employee's approved course of study requires additional time to complete.

(4) Scope of assistance.

(A) Eligible expenses.

(i) The employee will continue to receive a full salary.

(ii) The executive director may approve reimbursement for relocation costs.

(B) Use of state time. Department duty hours may be used for attending classes, studying, or other activities associated with the program.

(5) Service requirement. An employee shall work for the department for three years after completing the program.

(6) Repayment.

(A) For employees not performing their duties for three or more months while participating in the program, the repayment obligation shall include salary not attributable to paid vacation or compensatory leave.

(B) By minute order the Texas Transportation Commission may approve the reduction or cancellation of debt or service requirements if an employee demonstrates hardship.

(C) The executive director may approve a deferral or an extension of the repayment period if an employee demonstrates hardship. Deferral or extension of repayment does not relieve the employee of the responsibility to repay the funds owed.

(7) Cancellation. The department will cancel an employee's participation if the employee does not complete the program in the required time, including any extensions.

(c) Full-time degree completion program. The department offers a full-time degree completion program, under which an employee who has already earned substantial credits toward a bachelor's degree may attend school full-time to complete those requirements.

(1) Eligibility. An employee must meet the following additional requirements to be eligible for the program.

(A) The employee must have at least 12 months of service time with the department.

(B) The employee must have written acceptance from an institution and a degree plan signed by the institution's representative for the number of credit hours required for the approved degree.

(C) The employee's executive officer must approve the employee's participation.

(D) The employee must be able to complete the degree in 42 credit hours or less.

(E) The executive director must designate the field of study as a critical field due to a shortage of employees in jobs related to that field of study.

(2) Elective courses. An employee's executive officer may reject an elective course if it is not related to the employee's duties unless rejection of the elective will extend the employee's time in the program. Substitutions will not be made for any courses required for a degree.

(3) Conditions of participation.

(A) An employee's executive officer will reconsider the employee's participation in the program each semester. As part of this reconsideration, the employee's executive officer will review the employee's degree plan and course schedule to ensure that appropriate electives are selected.

(B) The employee must be enrolled continuously for no more than three semesters in an institution in a course of instruction leading to a bachelor's degree in the approved major field of study. The director may approve an extension if the employee's approved course of study requires additional time to complete.

(C) During each semester in which an employee is receiving a full salary, the employee shall work full-time, attend school full-time, or work and attend school in a combination approved by the director.

(4) Scope of assistance.

(A) Eligible expenses. The employee will continue to receive a full salary.

(B) Use of state time. Department duty hours may be used for attending classes, studying, or other activities associated with the program.

(5) Service requirement. An employee shall work for the department for three years after completing the program.

(6) Repayment.

(A) For employees not performing their duties for three or more months while participating in the program, the repayment obligation shall include salary not attributable to paid vacation or compensatory leave.

(B) By minute order the Texas Transportation Commission may approve the reduction or cancellation of debt or service requirements if an employee demonstrates hardship.

(C) The executive director may approve a deferral or an extension of the repayment period if an employee demonstrates hardship. Deferral or extension of repayment does not relieve the employee of the responsibility to repay the funds owed.

(7) Cancellation. The department will cancel an employee's participation if the employee does not complete the program in the required time, including any extensions.

(d) Non-degree program. The department offers a non-degree program, under which an employee may, as part of the employee's developmental plan, take courses to improve the employee's knowledge and skills to meet current job requirements while continuing to work.

(1) Eligibility. Any full-time department employee, including a summer employee or a temporary recruitment program employee, is eligible for the non-degree program with the approval of the employee's executive officer.

(2) Service requirement. There is no service requirement for a course taken under the non-degree program.

(3) Repayment. The executive director may approve a deferral or an extension of the repayment period or the reduction or cancellation of debt or service requirements in the best interest of the department or if an employee demonstrates hardship. Deferral or extension of repayment does not relieve the employee of the responsibility to repay the funds owed.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107885

Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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CHAPTER 15. TRANSPORTATION PLANNING AND PROGRAMMING

SUBCHAPTER E. FEDERAL, STATE, AND LOCAL PARTICIPATION

43 TAC §15.54

The Texas Department of Transportation proposes amendments to §15.54, Construction, concerning federal, state, and local participation in highway improvement projects.

Transportation Code, Chapter 203, provides that the Texas Transportation Commission (commission) may layout, construct, maintain, and operate a modern state highway system, with emphasis on the construction of controlled access highways. To promote public safety, facilitate the movement of traffic, preserve the public's financial investment in highways, and promote national defense, the commission may convert where necessary an existing street, road, or highway into a controlled access highway in accordance with modern standards of speed and safety.

This chapter also authorizes the commission to designate a state highway as a controlled access highway, deny access to or from a controlled access highway, designate the location, type and extent of access to be permitted to a controlled access highway, and to close a public or private way at or near its intersection with a controlled access highway.

Due to the significant cost associated with the construction and maintenance of controlled access highways, it is imperative that they provide maximum traffic handling capacity for as long as practical. Adjacent development and access points along controlled access highways contribute to congestion and early deterioration of the operation of the main travel lanes, thereby reducing the ability of the state highway system to safely and efficiently move higher volumes of traffic. By limiting construction of new frontage roads, it is anticipated that the capacity of the main travel lanes will be preserved by promoting future development along parallel or perpendicular facilities. In addition, limiting the construction of new frontage roads will allow scarce state highway funding to be used to address other needed highway improvement projects across the state.

The amendments remove the consideration of funding for a frontage road in §15.54(d)(3) through (5) from the decision of whether to build a frontage road. Elimination of these paragraphs will ensure administrative authorization of all new frontage road construction in the state and provide more concise requirements for inclusion of frontage road construction and provisions for added access to new and existing controlled access facilities.

The amendments state that it is the intent of the department to not construct frontage roads on new or existing controlled access facilities unless approved by the executive director or designee. Frontage road construction may be approved when needed to improve the safety and efficient operations of the state highway

corridor, there is a need to resolve a landlock condition on the remainder of a parcel of land that has a value that exceeds the cost of the frontage road, or if the cost to purchase the right of access control would exceed the cost of the frontage road. Frontage roads may also be constructed when needed to restore local circulation due to roads or streets being severed. The commission may approve additional frontage roads when construction is determined to be in the best interest of the state.

Where the department owns the right of access control, public or private access will not be allowed to controlled access highways, including frontage roads, from abutting property except in certain circumstances. Access to a specific property will be allowed when a frontage road is constructed to resolve a landlock condition for that property or because the cost to purchase the access rights to that property was too great. Otherwise, the commission may approve a site specific exception to allow access after considering the safety and operation of the state highway corridor, prior commitments or development based on the previous frontage road policy, and whether such access is determined to be in the best interest of the state. Such site specific exceptions must be approved by the commission prior to the department accepting any funds or consideration for engineering, development, or construction of frontage roads where it is anticipated that additional access will be requested. All cost associated with preparing the request shall be at the sole expense of the requestor.

James Bass, Director, Finance Division, has determined that for the first five-year period the amendments are in effect, there will be no direct fiscal implications for state or local governments as a result of enforcing or administering the amendments. There are no anticipated economic costs for persons required to comply with the amendments as proposed.

Kenneth Bohuslav, Director, Design Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments as future development may occur along parallel or perpendicular facilities. By not encouraging development fronting the state highway corridor, freeway capacity will be maintained for longer periods of time and system expansion can be accomplished with fewer impacts to developed property.

Mr. Bohuslav has also determined that for each year of the first five years the amendments are in effect, the public benefits anticipated as a result of enforcing or administering the amendments will be to provide savings to the state by not constructing frontage roads along controlled access facilities and that mainlane capacity will be further preserved by this effort. There will be no adverse effect on small businesses.

Pursuant to the Administrative Procedure Act, Government Code, Chapter 2001, the Texas Department of Transportation will conduct six public hearings to receive comments concerning the proposed amendments. Each public hearing will begin at 4:00 p.m. local time and last at least until 6:00 p.m. on the following dates and at the following locations:

January 8, 2002: City of San Antonio Council Chambers; Municipal Plaza Building, 103 Main Plaza; San Antonio, Texas 78205.

January 15, 2002: Irving Arts Center; 3333 North MacArthur Boulevard; Irving, Texas 75062.

January 18, 2002: Houston-Galveston Area Council (HGAC); 3555 Timmons Lane; Houston, Texas 77027.

January 22, 2002: Lubbock Chamber of Commerce; 1301 Broadway; Lubbock, Texas 79401.

January 23, 2002: McAllen Tourist Center; 1300 South 10th Street; McAllen, Texas 78501.

January 24, 2002: Ysleta Independent School District (YISD); Administrative Office; 9600 Sims Drive; El Paso, Texas 79925.

These public hearings will be conducted in accordance with the procedures specified in 43 TAC §1.5. Prior to each hearing, department employees will be available beginning at 2:00 p.m. to conduct an open house where informal discussion can occur to further clarify the proposed amendments. Comments made to department staff during the open house will not be considered part of the public comment made regarding these proposed amendments. Those desiring to make official comments or presentations may register starting at 2:00 p.m. Any interested persons may appear and offer comments, either orally or in writing; however, questioning of those making presentations will be reserved exclusively to the presiding officer as may be necessary to ensure a complete record. While any person with pertinent comments will be granted an opportunity to present them during the course of the hearing, the presiding officer reserves the right to restrict testimony in terms of time and repetitive content. Organizations, associations, or groups are encouraged to present their commonly held views and identical or similar comments through a representative member when possible. Comments on the proposed text should include appropriate citations to sections, subsections, paragraphs, etc. for proper reference. Any suggestions or requests for alternative language or other revisions to the proposed text should be submitted in written form. Presentations must remain pertinent to the issues being discussed. A person may not assign a portion of his or her time to another speaker. Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services such as interpreters for persons who are deaf or hearing impaired, readers, large print or Braille, are requested to contact Randall Dillard, Director, Public Information Office, 125 East 11th Street, Austin, Texas 78701-2483, 512/463-8588 at least two working days prior to the hearing so that appropriate services can be provided.

Written comments on the proposed amendments may be submitted to Kenneth Bohuslav, Director, Design Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on February 4, 2002.

The amendments are proposed for adoption under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation.

No statutes, articles, or codes are affected by the proposed amendments.

§15.54. Construction.

(a) Purpose. This section describes the conditions under which state, federal and local financing of construction costs are to be shared.

(b) Funding. Construction costs may be funded by the commission at the entire expense of the department, with local participation, and/or with federal participation, as described in §15.55 of this title (relating to Construction Cost Participation), and in accordance with criteria set forth by federal and state law and regulations. The local government shall also be responsible for the total cost of any work included which is ineligible for federal or state participation as specified in §15.52 of this title (relating to Agreements).

(c) Sidewalks. The department will also provide for sidewalk construction, accomplished in accordance with the requirements of the Americans with Disabilities Act and other applicable state and federal laws, on designated state highway system routes:

(1) when replacing an existing sidewalk;

(2) where highway construction severs an existing sidewalk system (the state will make connections within highway right of way to restore sidewalk system continuity); or

(3) where pedestrian traffic is causing or is expected to cause a safety conflict.

(d) Control of Access [~~on Freeway Mainlanes~~].

(1) Designation. All facilities to be developed as freeways or relief routes shall be designated by the commission as controlled access highways pursuant to Transportation Code, Chapter 203. The department may also designate discrete areas of control of access on non-controlled access state highway facilities as necessary to facilitate the flow of traffic and promote the public safety and welfare.

(2) Access to controlled access highways.

(A) Existing access. It is the intent of the department when developing expanded controlled access facilities that if a property owner has access to the system prior to the expansion, that property owner would have access to a frontage road on the system after development. Exceptions under this provision would be for unusual safety or circuity situations.

(B) New access. Public or private access will not be allowed to controlled access highways or frontage roads, except where a frontage road is provided under paragraph (3)(A)(i)(III) or (3)(B)(i)(III) of this subsection or the commission approves a site specific exception.

(i) Request for exception. Approval for a site specific exception to allow access rights to a facility must be approved by the commission prior to accepting any funds or consideration for engineering, development, or construction of frontage roads for which there is an anticipation of allowing access rights. Any cost of traffic studies of access appraisals required under this section shall be at the sole expense and risk of those making the request.

(ii) Approval. The commission may approve an exception after considering:

(I) impacts on the safety and operation of the state highway corridor as justified by an engineering study approved by the department;

(II) significant prior commitments or development work based on the previous frontage road policy; and

(III) whether access is judged to be in the best interest of the state.

(C) Disposal of access rights. When the commission approves a release of access control to property adjoining the facility, the sale or disposal of access rights shall be accomplished in accordance with §§21.101-21.104 of this title (relating to Disposal of Real Estate Interests).

(3) Frontage road provision.

(A) New location freeways and relief routes. For new location freeways and relief routes, it is the intent of the department not to construct frontage roads.

(i) The department may approve frontage road construction when the executive director or designee determines that:

(I) short sections of frontage road are needed to improve the safety and operations of the main travel lanes;

(II) the geometric design of an interchange requires the provision of a short section of frontage road for operational purposes;

(III) there is no other feasible means to resolve a landlock condition on the remainder of a parcel of land that has a value that exceeds the cost of the frontage road;

(IV) there is no other feasible means to restore circulation of local traffic due to state or local roads or streets being severed; or

(V) frontage roads would be beneficial to the safety and operation of the state highway corridor or the local road system as justified by an engineering study approved by the department.

(ii) The commission may approve frontage road construction when they determine that such construction is in the best interest of the state.

(B) Existing facilities designated as controlled access. For existing freeways and other facilities designated as controlled access, it is the intent of the department not to construct new or additional frontage roads.

(i) The department may approve frontage road construction when the executive director or designee determines that:

(I) short sections of frontage road are needed to improve the safety and operations of the main travel lanes;

(II) the geometric design of an interchange requires the provision of a short section of frontage road for operational purposes;

(III) the anticipated cost to purchase the right of access control would exceed the cost of the frontage road;

(IV) there is no other feasible means to restore circulation of local traffic due to state or local roads or streets being severed; or

(V) frontage roads would be beneficial to the safety and operation of the state highway corridor or the local road system as justified by an engineering study approved by the department.

(ii) The commission may approve frontage road construction when they determine that such construction is in the best interest of the state.

(4) Backage roads.

(A) For purposes of this paragraph, "backage road" means a local street or road that is generally parallel to an arterial highway but that does not abut the highway right of way. Direct access for businesses or properties located between the highway and the backage road is provided to the backage road rather than the highway. Backage roads also provide access to properties located on the opposite side of the backage road from the highway.

(B) In those instances where backage roads are necessary to restore circulation or can be utilized as a means to resolve a landlock condition on a remaining parcel of land, backage roads may be included in the freeway construction project on a standard participation basis as established in Appendix A of §15.55(c) of this subchapter. Commission approval shall be obtained prior to the department entering into any agreements to provide backage roads in conjunction with a department project. Backage roads will not be considered service projects as defined in §15.56 of this subchapter.

[(1) For facilities with full control of access, such as interstate highways or freeways developed by commission designation pursuant to Transportation Code, Chapter 203, access to the main travel lanes is fully controlled through designation, purchase of access rights, or provision of frontage roads.]

[(2) The department will include frontage roads in the planning stage of highways with full access control when:]

[(A) it is necessary to unlandlock the remainder of a parcel of land which has a value equal to or nearly equal to the cost of the frontage road;]

[(B) the appraised damages, resulting from the absence of frontage roads at the time of planning, would exceed the cost of the frontage roads; or]

[(C) it is necessary to restore circulation of local traffic due to local roads or streets being severed or seriously impaired by the construction of the controlled access highway, and an economic analysis shows the benefits derived more than offset the costs of constructing and maintaining the frontage roads.]

[(3) In those instances where requests for additional frontage roads are received during or subsequent to the planning stage or after the freeway has been constructed, they may be considered and placed in order of the priority of highway needs.]

[(A) When right of way and utility adjustment costs are shared with a local government on a standard participation basis applicable to the highway designation, the department may assume 100% responsibility for additional frontage road construction as follows:]

[(i) on relatively short sections of frontage roads where through lane traffic is experiencing high accident rates due to local access and where such construction can be expected to substantially improve safety; or]

[(ii) in heavily traveled urban corridors where gaps occur in the existing frontage road systems, and closing these frontage road gaps will restore system continuity and provide a cost-effective method of enhancing traffic operations in the corridor.]

[(B) The department may assist a requesting local government in the construction of additional frontage roads as follows:]

[(i) where a usable section of frontage road that will be of benefit to the traveling public is to be developed (usable section being defined as an addition or extension from a cross road separation to cross road separation or connecting to a public roadway or major traffic generator);]

[(ii) where such frontage road construction is judged to not adversely impact existing traffic operations or safety;]

[(iii) where the department is responsible for design and construction of the added frontage roads; and]

[(iv) except as provided in subparagraph (E) of this paragraph, and as adjusted under §15.55 of this title (relating to Construction Cost Participation), when the requesting local government furnishes 100% of needed right of way and utility adjustment costs and 50% of the cost of construction, including preliminary and construction engineering.]

[(C) The department may approve additional frontage road construction, which is 100% funded by the requesting local government as follows:]

[(i) if the frontage road construction primarily provides new or improved access to abutting property and does not necessarily provide a usable section as defined in subparagraph (B)(i) of this paragraph (a type of addition that would provide limited benefits to the general traveling public); and]

[(ii) except as provided in subparagraph (E) of this paragraph, where the department is responsible for designing and constructing the frontage road and the requesting local government is responsible for 100% of the construction, right of way, and utility adjustment costs including preliminary and construction engineering.]

[(D) Where right of way costs are 100% the responsibility of the requesting local government, relocation assistance benefits will also be 100% the responsibility of the local government and must be accomplished in compliance with department policies and procedures.]

[(E) The department may waive any one or more of the cost conditions stated in subparagraphs (B)(iv) and (C)(ii) of this paragraph, provided that the waiver is first approved by written order of the commission. In approving a waiver, the commission will base its decision on consideration of the population level, bonded indebtedness, tax base, and tax rate of the local government involved, or other conditions the commission deems pertinent.]

[(4) For additional frontage roads requested subsequent to the planning stage or after the freeway has been constructed, control of access as originally conceived for the facility may be modified to allow access to the proposed frontage road only to the extent as may be permitted by safety considerations and in keeping with department policies and procedures. The sale or disposal of access rights shall be accomplished in accordance with §§21.101-21.104 of this title (relating to Disposal of Real Estate Interests).]

[(5) Access driveway facilities shall be for securing access to abutting property. Costs and provision thereof shall be in accordance with the criteria and responsibilities established in §§11.50-11.53 of this title (relating to Access Driveways to State Highways).]

(e) Drainage Construction Costs.

(1) In general, it shall be the duty and responsibility of the department to construct, at its expense, a drainage system within state highway right of way, including outfalls, to accommodate the storm water which originates within and reaches state highway right of way from naturally contributing drainage areas.

(2) Where a drainage channel, man-made, natural, or a combination of both, is in existence prior to the acquisition of highway right of way, including right of way for widening the highway, it shall be the duty and responsibility of the state to provide for the construction of the necessary structures and/or channels to adjust or relocate the existing drainage channel in such a manner that the operation of the drainage channel will not be injured. The construction expense required shall be considered a construction item. The acquisition of any land required to accomplish this work shall be considered a right of way item, with cost participation to be in accordance with §15.55 of this title (relating to Construction Cost Participation).

(3) Where an existing highway crosses an existing drainage channel, and a political unit or subdivision with statutory responsibility for drainage develops a drainage channel to improve its operation, both upstream and downstream from the highway, and after the state establishes that the drainage plan is logical and beneficial to the state highway system, and there is no storm water being diverted to the highway location from an area which, prior to the drainage plan, did not contribute to the channel upstream of the highway, and after construction on the drainage channel has begun or there is sufficient evidence to insure that the drainage plan will be implemented, the department,

at its expense, shall adjust the structure and/or channels within the existing highway right of way as necessary to accommodate the approved drainage plan.

(4) Where a state highway is in existence, and there is a desire of others to cross the existing highway at a place where there is not an existing crossing for drainage, then those desiring to cross the highway must provide for the entire cost of the construction and maintenance of the facility which will serve their purpose while at the same time adequately serving the highway traffic. The design, construction, operation, and maintenance procedures for the facility within state highway right of way must be acceptable to the department.

(5) In the event the local government involved expresses a desire to join the department in the drainage system in order to divert drainage into the system, the local government shall pay for the entire cost of collecting and carrying the diverted water to the state's system and shall contribute its proportional share of the cost of the system and outfall based on the cubic feet per second of additional water diverted to it when compared to the total cubic feet per second of water to be carried by the system. The local government requesting the drainage diversion shall indemnify the state against or otherwise acknowledge its responsibility for damages or claims for damages resulting from such diversion.

(f) Highway adjustments for reservoir construction.

(1) Where existing highways and roads provide a satisfactory traffic facility in the opinion of the department and no immediate rehabilitation or reconstruction is contemplated, it shall be the responsibility of the reservoir agency, at its expense, to replace the existing road facility disturbed by reservoir construction in accordance with the current design standards of the department, based upon the road classification and traffic needs.

(2) Where no highway or road facility is in existence but where a route has been designated for construction across a proposed reservoir area, the department will bear the cost of constructing a satisfactory facility across the proposed reservoir, on a line and grade for normal conditions of topography and stream flow, and any additional expense as may be necessary to construct the highway or road facility to line and grade to comply with the requirements of the proposed reservoir shall be borne by the reservoir agency.

(3) In soil conservation and flood control projects involving the construction of flood retarding structures where a highway or road operated by the department will be inundated at less than calculated 50-year frequencies by the construction of a floodwater retarding structure, it will be expected that the soil conservation service or one of its cooperating agencies will provide funds as necessary to raise or relocate the road above the water surface elevation which might be expected at 50-year intervals. In those cases where a highway or road operated by the department will not be inundated by floods of less than 50-year calculated frequency, it will be the purpose of the department to underwrite this hazard for the general welfare of the state and continue to operate the road at its existing elevation until such time as interruption and inconvenience to highway travel may necessitate raising the grade.

(g) Irrigation crossings.

(1) Where an irrigation facility is in existence prior to the acquisition of highway right of way, including right of way for widening, and the highway project will interfere with such a facility, the following provisions shall govern.

(A) If, at the place of interference, the irrigation facility consists primarily of an irrigation canal which crosses the entire width of the proposed right of way, this shall be considered a crossing and it shall be the duty and responsibility of the department to construct and maintain an adequate structure and to make the necessary adjustments or relocations of minor laterals and pumps, etc., associated with the crossing, in such a manner that the operation of the irrigation facility will not be injured. The construction work at a crossing will be considered a construction item with the expense to be borne by the department. The acquisition of any land required to accomplish the adjustments and/or relocation shall be a right of way consideration.

(B) Any irrigation facility encountered which does not cross the right of way and consists primarily of a longitudinal canal and/or associated irrigation appurtenances such as pumps, gates, etc., which must be removed and relocated shall be considered a right of way item.

(C) In those cases where both crossing and longitudinal adjustments or relocation of irrigation facilities are encountered, each segment shall be classified in accordance with subparagraph (A) and (B) of this paragraph.

(2) Where a highway is in existence, and there is a desire of others to cross the existing highway with an irrigation facility at a highway point where there is not an existing crossing facility, then those desiring to cross the highway must provide for the entire cost of the construction and maintenance of the irrigation facility which will serve their purpose while at the same time adequately serve the highway traffic. The design, construction, operation, and maintenance procedures for the facility within highway right of way must be acceptable to the department.

(h) Continuous and safety lighting systems and traffic signals. For the installation, maintenance, and operation of continuous and safety lighting systems and traffic signals, the local government shall be responsible for providing matching funds as shown in Appendix A of §15.55 of this title (relating to Construction Cost Participation), except as adjusted under that section. Such installation, maintenance, and operation shall be accomplished in accordance with §25.5 of this title (relating to Installation, Operation, and Maintenance of Traffic Signals) and §25.11 of this title (relating to Continuous and Safety Lighting Systems).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107886
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

CHAPTER 17. VEHICLE TITLES AND REGISTRATION

The Texas Department of Transportation proposes amendments to §§17.1-17.3, concerning motor vehicle certificates of title, and §§17.21, 17.22, and 17.52, concerning motor vehicle registration.

EXPLANATION OF PROPOSED AMENDMENTS

House Bill 642, 77th Legislature, 2001, amended Transportation Code, Chapter 501, to eliminate the requirement that a "Duplicate Original" certificate of title be issued and mailed to the recorded owner of a motor vehicle when a lien is recorded on a certificate of title. Transportation Code, Chapter 501, was also amended by eliminating the term "Original" when referring to the negotiable certificate of title; to allow use of a registration receipt or title receipt to evidence title; and to allow the department to provide, by rule, for issuance of a receipt for registration purposes only.

House Bill 2134, 77th Legislature, 2001, added Transportation Code §501.0276, amended Transportation Code §502.009, and added Transportation Code §502.1535, relating to vehicle emissions tests on resale in affected counties.

House Bill 2217, 77th Legislature, 2001, added Transportation Code, §501.036, to allow the issuance of a certificate of title for farm semitrailers with a gross weight of more than 4,000 pounds that are registered in accordance with Transportation Code, §502.276. Previously, farm semitrailers were exempt from the Certificate of Title Act.

House Bill 2204, 77th Legislature, 2001, exempts electric bicycles from the need to be registered.

House Bill 1378, 77th Legislature, 2001, exempts motorized mobility devices from the need to be registered.

House Bill 2409, 76th Legislature, 1999, amended Transportation Code, §548.256, to eliminate the requirement of an identification certificate before a vehicle is titled and to create exceptions to the need for an identification certificate before a vehicle is registered.

Senate Bill 432, 76th Legislature, 1999, permitted owners to specify registration periods under some circumstances.

Throughout the affected sections, terms and cross-references have been updated, grammar has been improved, and language has been simplified and clarified.

Section 17.1 is amended to update the citation to the Certificate of Title Act and to remove unnecessary verbiage.

Existing §17.2(5) is amended to clarify that the bond release letter requirements apply only to motor vehicles that are imported into the United States.

Existing §17.2(22) is amended to delete the definition of importer. This definition is not currently used in the rules.

Existing §17.2(32) is amended to clarify that motor vehicle importation forms refer only to vehicles that are imported into the United States.

Existing §17.2(33) and (37) is amended to delete the definitions of negotiable and non-negotiable titles. This distinction was eliminated by HB 642.

Section §17.3(a)(2)(D) is added and §17.3(a)(3)(B) and §17.3(a)(4) are amended to conform the rules to HB 2217, which allowed certificates of title to be issued to farm semitrailers with a gross weight of more than 4,000 pounds if they are registered in accordance with Transportation Code, §502.276.

Section 17.3(b)(4)(C) is amended by clarifying that applicants for a certificate of title must provide proof of financial responsibility.

Existing §17.3(b)(4)(D) is amended to conform the rules to HB 2409, 76th Legislature, 1999.

Section 17.3(c)(3) is amended to clarify that it refers only to vehicles imported into the United States.

Section 17.3(d) is amended throughout to conform the rules to HB 642, which abolished non-negotiable or duplicate certificates of title.

Section 17.3(d)(1) is amended to eliminate the reference to an original certificate of title.

Section 17.3(d)(2) is amended to permit a title application receipt to be used as evidence of title, except for purposes of transferring an ownership interest or establishing a lien. Because title and registration receipts are always issued on receipt of an application, the explanations in §17.3(d)(2)(A) and (B) are no longer necessary.

Existing §17.3(e)(4) is deleted because the information is clearly set forth in Transportation Code, §501.134.

Existing §17.21(8) and (9) is deleted and is replaced by new §17.21(31) and (47) to place the definitions in alphabetical order without inverting the normal word order. The definitions are altered to conform more closely to those contained in Transportation Code, §502.001.

New §17.21(17) is added to conform the rules to HB 2204 and to define electric bicycle.

Existing §17.21(24) is revised to include former military vehicles in the definition of exhibition vehicles, as specified in Transportation Code, §502.275.

New §17.21(32) is added to conform the rules to HB 1378 and to define motorized mobility device.

Existing §17.21(34) is amended to delete the definition of official. This definition is not currently used in the rules.

Section 17.21(35) is amended to conform the definition of owner more closely to the definition contained in Transportation Code, §502.001.

Section 17.21(38) is amended to conform the rules to SB 432, 76th Legislature, 1999, by allowing registration periods of variable length.

Existing §17.21(49) is amended to conform the definition of tow truck more closely to the definition contained in Transportation Code, §502.281.

Existing §17.21(52) is amended to conform the definition of vehicle more closely to the definition contained in Transportation Code, §502.001.

New §17.22(b)(4) is added to conform the rules to HB 642 and to provide criteria for initial registration when the applicant is not simultaneously applying for a certificate of title. The necessary information is consistent with the information ordinarily submitted in connection with a combined application for title and registration. The new paragraph makes clear that a registration receipt cannot be used to transfer ownership or create a lien.

Section 17.22(f)(2) is amended to conform the rules to HB 2409, 76th Legislature, 1999.

Existing §17.52(b)(3) and (4) is deleted and is replaced by new §17.52(1) and (7) to conform more closely to the terminology used in HB 2134 and elsewhere in the section.

Section 17.52(d) is added to conform the rules to HB 2134. It provides that a vehicle is not eligible for a title receipt, a certificate of title, or registration in an affected county unless proof is

presented to the county assessor-collector that the vehicle has passed the emissions test. An exemption is provided for vehicles used fewer than 60 days in an affected county.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five-years the amendments are in effect, there will be fiscal implications for state or local governments as a result of enforcing or administering the amendments. The effect on state government for Fiscal Years 2002-2006 will be an estimated annual reduction in cost to the state of $882,000. There will be no fiscal implications for local governments. There are no anticipated economic costs for persons required to comply with the sections as proposed.

Jerry L. Dike, Director, Vehicle Titles and Registration Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the amendments.

PUBLIC BENEFIT

Mr. Dike has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the amendments will be to provide the public with current and accurate information regarding vehicle emission tests on resale, issuance of certificates of title, and for filing of applications for registration purposes only. The amendments will also provide a permissive issuance of a certificate of title for those farm semitrailers with a gross weight of more than 4,000 pounds that are registered in compliance with Transportation Code, §501.036. Another benefit will be to provide for the use of electric bicycles and motorized mobility devices without registration. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed amendments may be submitted to Jerry L. Dike, Director, Vehicle Titles and Registration Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

SUBCHAPTER A. MOTOR VEHICLE CERTIFICATES OF TITLE

43 TAC §§17.1 - 17.3

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Transportation Code, Chapter 501, which authorizes the department to carry out the provisions of those laws governing issuance of motor vehicle certificates of title, and Transportation Code, Chapter 502 which authorizes the department to carry out the provisions of those laws governing issuance of motor vehicle registration.

No statutes, articles, or codes are affected by the proposed amendments.

§17.1. Purpose and Scope.

The Certificate of Title Act, Transportation Code, Chapter 501 [~~Texas Civil Statutes, Article 6687-1~~], charges the department with the responsibility of issuing certificates of title for motor vehicles, unless they [~~such motor vehicles~~] are otherwise exempted by law. For [~~In order for~~] the department to efficiently and effectively issue motor vehicle certificates of titles, maintain records, and collect the applicable fees [~~consistent with the Certificate of Title Act~~], and to ensure proper application by motor vehicle owners [~~in accordance with statutory provisions~~], the sections under this subchapter prescribe the policies and procedures for the application for and issuance of motor vehicle certificates of titles.

§17.2. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Actual cash value - The market value of a motor vehicle as determined:

(A) from publications commonly used by the automotive and insurance industries to establish the value of motor vehicles; or

(B) if the entity determining the value is an insurance company, by any other procedure recognized by the insurance industry, including market surveys, that is applied by the company in a uniform manner.

(2) Automobile recycler - A person in the business of dealing in salvage motor vehicles for the purpose of dismantling the vehicles to sell used parts, or a person otherwise engaged in the business of acquiring, selling, or dealing in salvage parts for reuse or resale as parts. The term includes a dealer in used motor vehicle parts.

(3) Alias - The name of a vehicle owner reflected on a [~~the~~] certificate of title, when the name on the certificate of title is different from [~~than~~] the name of the legal owner of the vehicle.

(4) Alias certificate of title - A title document issued by the department for a vehicle that is used by an exempt law enforcement agency in covert criminal investigations.

(5) Bond release letter - Written notification from the United States Department of Transportation authorizing United States Customs to release the bond posted for a [~~an imported~~] motor vehicle imported into the United States to ensure compliance with federal motor vehicle safety standards.

(6) Casual sale - The sale at auction of not more than one nonrepairable motor vehicle or new or late model salvage motor vehicle to the same person during a calendar year.

(7) Certificate of title - A written instrument that may be issued solely by and under the authority of the department and that reflects the transferor, transferee, vehicle description, license plate and lien information, and rights of survivorship agreement as specified in this subchapter or as required by the department.

(8) Certificate of title application - A form prescribed by the division director that reflects the information required by the department to create a motor vehicle title record.

(9) Date of sale - The date of the transfer of possession of a specific vehicle from a seller to a purchaser.

(10) Department - The Texas Department of Transportation.

(11) Distributor - A person engaged in the business of selling to a dealer motor vehicles bought from a manufacturer.

(12) Division director - The director of the department's Vehicle Titles and Registration Division.

(13) Executive administrator - The director of a federal agency, the director of a Texas state agency, the sheriff of a Texas county, or the chief of police of a Texas city who by law possesses the authority to conduct covert criminal investigations.

(14) Exempt agency - A governmental body exempt by law from paying registration fees for motor vehicles.

(15) Federal motor vehicle safety standards - Motor vehicle safety requirements promulgated by the United States Department of Transportation, National Highway Traffic Safety Administration, set forth in Title 49, Code of Federal Regulations.

(16) First sale - A bargain, sale, transfer, or delivery with intent to pass an interest, other than a lien, and accompanied by registration, of a motor vehicle that has not been previously registered in this state or elsewhere.

(17) Flood damage - A remark that is initially indicated on a salvage or nonrepairable motor vehicle certificate of title to denote that the damage to the vehicle was caused exclusively by flood and that is carried forward on [~~upon~~] subsequent title issuance.

(18) House moving dolly - An apparatus consisting of metal beams and axles used to move houses. House moving dollies, by nature of their construction and use, actually form [~~a~~] large semitrailers [~~semi-trailer~~].

(19) House trailer - A vehicle without automotive power designed for human habitation, [~~and~~] for carrying persons and property on [~~upon~~] its own structure, and for being drawn by a motor vehicle, not including [~~to include~~] manufactured housing.

(20) Identification certificate - A form issued by an inspector of an authorized safety inspection station [~~on a vehicle previously registered or titled in another state or country~~] in accordance with Transportation Code, §548.256.

(21) Implements of husbandry - Farm implements, machinery, and tools used in tilling the soil, including self-propelled machinery specifically designed or especially adapted for applying plant food materials or agricultural chemicals. This term does not include an implement unless it is designed or adapted for the sole purpose of transporting farm materials or chemicals. This term does not include[~~, or~~] any passenger car or truck.

[~~(22) Importer - A person, except a manufacturer, who brings any used motor vehicle into this state for the purpose of sale within this state.~~]

(22) [~~(23)~~] Insurance company - A person authorized to write automobile insurance in Texas or an out-of-state insurance company that pays a loss claim for a motor vehicle in Texas.

(23) [~~(24)~~] Late model motor vehicle - A motor vehicle with a model year equal to the then current calendar year or one of the five preceding calendar years.

(24) [~~(25)~~] Late model salvage motor vehicle - A late model motor vehicle, other than a late model vehicle that is a nonrepairable motor vehicle, that is damaged to the extent that the total estimated cost of repairs, other than repairs related to hail damage but including parts and labor, is equal to or greater than an amount equal to 75% of the actual cash value of the vehicle in its predamaged condition.

(25) [~~(26)~~] Lien - A security interest, as defined in Business and Commerce Code, §1.201(37), of whatsoever kind or character whereby an interest, other than an absolute title, is sought to be held or given in a motor vehicle. This term includes [~~, and~~] a lien created or given by constitution or statute in a motor vehicle.

(26) [~~(27)~~] Major component part - One of the following parts of a motor vehicle:

(A) the engine;

(B) the transmission;

(C) the frame;

(D) the right or left front fender;

(E) the hood;

(F) a door allowing entrance to or egress from the passenger compartment of the vehicle;

(G) the front or rear bumper;

(H) the right or left quarter panel;

(I) the deck lid, tailgate, or hatchback;

(J) the cargo box of a pickup truck;

(K) the cab of a truck; or

(L) the body of a passenger vehicle.

(27) [~~(28)~~] Manufacturer - A person regularly engaged in the business of manufacturing or assembling new motor vehicles, either within this state or elsewhere.

(28) [~~(29)~~] Manufacturer's certificate of origin - A form prescribed by the department showing the original transfer of a new motor vehicle from the manufacturer to the original purchaser, whether importer, distributor, dealer, or owner, and when presented with an application for certificate of title, showing, on appropriate forms prescribed by the department, each subsequent transfer between distributor and dealer, dealer and dealer, and dealer and owner.

(29) [~~(30)~~] Moped - A motor driven cycle whose attainable speed is not more than 30 miles per hour and that is equipped with a motor that produces not more than two-brake horsepower. If an internal combustion engine is used, the piston displacement may not exceed 50 cubic centimeters and the power drive system may not require the operator to shift gears.

(30) [~~(31)~~] Motor vehicle - Any motor driven or propelled vehicle required to be registered under the laws of this state; a trailer or semitrailer, other than manufactured housing, that has a gross vehicle weight that exceeds 4,000 pounds; a house trailer; a four-wheel all-terrain vehicle designed by the manufacturer for off-highway use that is not required to be registered under the laws of this state; or a motorcycle, motor-driven cycle, or moped that is not required to be registered under the laws of this state, other than a motorcycle, motor-driven cycle, or moped designed for and used exclusively on a golf course.

(31) [~~(32)~~] Motor vehicle importation form - A [~~An importer's~~] declaration form prescribed by the United States Department of Transportation and certified by United States Customs that relates to any motor vehicle being brought into the United States and the [~~an imported~~] motor vehicle's compliance with federal motor vehicle safety standards.

[~~(33) Negotiable title - A title that may be used to transfer an interest or ownership in a motor vehicle, or to establish a new lien.~~]

(32) [~~(34)~~] New model motor vehicle - A motor vehicle with a model year that is newer than the current calendar year.

(33) [~~(35)~~] New model salvage motor vehicle - A new model motor vehicle, other than a new model vehicle that is a nonrepairable motor vehicle, that is damaged to the extent that the total estimated cost of repairs, other than repairs related to hail damage

but including parts and labor, is equal to or greater than an amount equal to 75% of the actual cash value of the vehicle in its predamaged condition.

(34) [~~(36)~~] New motor vehicle - A motor vehicle that has never been the subject of a first sale either within this state or elsewhere.

~~[(37) Non-negotiable title - A title that may be used only as evidence of title and may not be used to transfer any interest or ownership in a motor vehicle, or to establish a new lien.]~~

(35) [~~(38)~~] Nonrepairable motor vehicle - A new or late model motor vehicle that is damaged or missing a major component part to the extent that the total estimated cost of repairs to rebuild or reconstruct the vehicle, including parts and labor other than the costs of materials and labor for repainting the vehicle and excluding sales taxes on the total cost of the repairs, and excluding the cost of repairs to repair hail damage, is equal to or greater than an amount equal to 95% of the actual cash value of the vehicle in its predamaged condition.

(36) [~~(39)~~] Nonrepairable motor vehicle certificate of title - A document issued by the department that evidences ownership of a nonrepairable motor vehicle.

(37) [~~(40)~~] Non United States standard motor vehicle - A motor vehicle not manufactured in compliance with federal motor vehicle safety standards.

(38) [~~(41)~~] Obligor - An individual who is required to make payments under the terms of a support order for a child.

(39) [~~(42)~~] Older model motor vehicle - A motor vehicle that was manufactured in a model year before the sixth preceding model year, including the current model year.

(40) [~~(43)~~] Other negotiable evidence of ownership - A document, other than a Texas certificate of title or a salvage certificate of title, that relates to a motor vehicle and that the department considers sufficient to support issuance of a Texas certificate of title for the vehicle.

(41) [~~(44)~~] Out-of-state buyer - A person licensed by another state or jurisdiction in an automotive business if the department has listed the holders of the license as permitted purchasers of salvage motor vehicles or nonrepairable motor vehicles based on substantially similar licensing requirements and on whether salvage vehicle dealers licensed in Texas are permitted to purchase salvage motor vehicles or nonrepairable motor vehicles in the other state or jurisdiction.

(42) [~~(45)~~] Owner - A person, firm, association, or corporation, other than a manufacturer, importer, distributor, or dealer, claiming title to a motor vehicle, or having a right to operate a motor vehicle pursuant to a lien after the motor vehicle has been the subject of a first sale, except the Federal Government and its agencies, and except the State of Texas and a governmental subdivision or agency not required by law to register motor vehicles owned or used in this State.

(43) [~~(46)~~] Person - An individual, firm, corporation, company, partnership, or other entity.

(44) [~~(47)~~] Rebuilder - A person that acquires and repairs, for operation on public highways, five or more new or late model salvage motor vehicles in any 12-month period.

(45) [~~(48)~~] Rebuilt salvage - A remark indicated on the face of a certificate of title issued by the department that evidences ownership of a rebuilt salvage motor vehicle.

(46) [~~(49)~~] Safety certification label - A label placed on a motor vehicle by a manufacturer certifying that the motor vehicle complies with all federal motor vehicle safety standards.

(47) [~~(50)~~] Salvage motor vehicle - A new or late model motor vehicle, other than a new or late model vehicle that is a nonrepairable motor vehicle, that is damaged to the extent that the total estimated cost of repairs, other than repairs related to hail damage but including parts and labor, is equal to or greater than an amount equal to 75% of the actual cash value of the vehicle in its predamaged condition.

(48) [~~(51)~~] Salvage motor vehicle certificate of title - A document issued by the department that evidences ownership of a salvage motor vehicle.

(49) [~~(52)~~] Salvage vehicle - A term that refers to both salvage and nonrepairable vehicles.

(50) [~~(53)~~] Salvage vehicle dealer - A person who is engaged in this state in the business of acquiring, selling, or otherwise dealing in salvage vehicles or vehicle parts of a type required to be covered by a salvage vehicle certificate of title or nonrepairable vehicle certificate of title under a license issued by the department that allows the holder of the license to acquire, sell, dismantle, repair, or otherwise deal in salvage vehicles.

(51) Semitrailer [~~(54) Semi-Trailer~~] - A vehicle of the trailer type having a gross weight in excess of four thousand (4,000) pounds so designed or used in conjunction with a motor vehicle that some part of its own weight and that of its load rests on [~~upon~~] or is carried by another vehicle.

(52) [~~(55)~~] Statement of fact - A written declaration that supports an application for a certificate of title, that is executed by the seller of a motor vehicle or another involved party to a transaction involving [~~of~~] a motor vehicle, and that clarifies an error made on a certificate of title or other negotiable evidence of ownership. When a written declaration is necessary to correct an odometer disclosure error, the signatures of both the seller and buyer are required.

(53) [~~(56)~~] Subsequent sale - The bargain, sale, transfer, or delivery of a motor vehicle that has been previously registered or licensed in this state or elsewhere, with intent to pass an interest in the vehicle, other than a lien, regardless of where the bargain, sale, transfer, or delivery occurs, and the registration of the vehicle if registration is required under the laws of this state.

(54) [~~(57)~~] Token trailer fee - A registration fee paid for certain semitrailers, meeting the qualifications delineated in Transportation Code, §502.167, and used in combination with truck tractors or commercial motor vehicles whose registration is based on [~~upon~~] a combined gross weight.

(55) [~~(58)~~] Trailer - Every vehicle having a gross unloaded weight in excess of four thousand (4,000) pounds and designed or used to carry its load wholly on its own structure and to be drawn by a motor vehicle.

(56) [~~(59)~~] Used motor vehicle - A motor vehicle that has been the subject of a first sale, whether within this state or elsewhere.

(57) [~~(60)~~] Vehicle identification number - A number, assigned by the manufacturer of a motor vehicle or the department, that describes the motor vehicle for purposes of identification.

(58) [~~(61)~~] Verifiable proof - Additional documentation required of a vehicle owner, lienholder, or agent executing an application for a certified copy of a certificate of title.

(A) Individual applicant. If the applicant is an individual, verifiable proof consists of a copy of a current photo identification issued by this state or by the United States.

(B) Business applicant. If the applicant is a business, verifiable proof consists of a letter of signature authority on original

letterhead, a business card, or a copy of employee identification and a copy of current photo identification issued by this state or by the United States.

(C) Power of attorney. If the applicant is a person in whose favor a power of attorney has been executed by the owner or lienholder, verifiable proof consists of the documentation required under subparagraphs (A) or (B) of this subsection both for the owner or lienholder and for the person in whose favor the power of attorney is executed.

§17.3. Motor Vehicle Certificates of Title.

(a) Certificates of title. Unless otherwise exempted by law or this chapter, the owner of any vehicle that is required to be registered in accordance with Transportation Code, Chapter 502, shall apply for a Texas certificate of title in accordance with Transportation Code, Chapter 501.

(1) Motorcycles, motor-driven cycles, and mopeds.

(A) The title requirements of a motorcycle are the same requirements prescribed for any motor vehicle.

(B) A motorcycle, motor-driven cycle, or moped designed for or used exclusively on golf courses is not classified as a motor vehicle and, therefore, title cannot be issued until the unit is registered.

(C) A vehicle that meets the criteria for a moped and has been certified as a moped by the Department of Public Safety will be registered and titled as a moped. If the vehicle does not appear on the list of certified mopeds published by that agency, the vehicle will be treated as a motorcycle for title and registration purposes.

(D) A motor installed on a bicycle must be certified by the Department of Public Safety before the vehicle may be classified as a moped.

(2) Farm vehicles.

(A) The term motor vehicle does not apply to implements of husbandry, which may not be titled.

(B) Farm tractors owned by agencies exempt from registration fees in accordance with Transportation Code, §502.202, are required to be titled and registered with "Exempt" license plates issued in accordance with Transportation Code, §502.201.

(C) Farm tractors used as road tractors to mow rights of way or used to move commodities over the highway for hire are required to be registered and titled.

(D) Farm semitrailers with a gross weight of more than 4,000 pounds that are registered in accordance with Transportation Code, §502.276, may be issued Texas certificates of title.

(3) Exemptions from title. Vehicles registered with the following distinguishing license plates may not be titled under Transportation Code, Chapter 501:

(A) vehicles eligible for machinery license plates and permit license plates in accordance with Transportation Code, §502.276[~~, and §502.278~~]; and

(B) vehicles eligible for farm trailer license plates in accordance with Transportation Code, §502.163, with the exception of farm semitrailers with a gross weight of more than 4,000 pounds as referenced in subsection (a)(2)(D) of this section. [~~; and~~]

[~~(C) vehicles eligible for permit license plates in accordance with Transportation Code, §§502.351-502.353.~~]

(4) Trailers, semitrailers, and house trailers. Owners of trailers and semitrailers shall apply for and receive a Texas certificate of title for any stand alone (full) trailer, including homemade full trailers, having an empty weight in excess of 4,000 pounds or any semitrailer having a gross weight in excess of 4,000 pounds. Farm semitrailers with a gross weight of more than 4,000 pounds that are registered in accordance with Transportation Code, §502.276, may be issued Texas certificates of title. House trailer-type vehicles must meet the criteria outlined in subparagraph (C) of this paragraph [~~in order~~] to be titled.

(A) In the absence of a manufacturer's rated carrying capacity for a trailer or semitrailer, the rated carrying capacity will not be less than one-third of its empty weight.

(B) Mobile office trailers, mobile oil field laboratories, and mobile oil field bunkhouses are not designed as dwellings, but are classified as commercial semitrailers and must be registered and titled as commercial semitrailers if operated on [~~upon~~] the public streets and highways.

(C) House trailer-type vehicles and camper trailers must meet the following criteria in order to be titled.

(i) A house trailer-type vehicle designed for living quarters and that is eight body feet or more in width or forty body feet or more in length (not including the hitch), is classified as a mobile home and is titled under the Texas Manufactured Housing Standards Act, Texas Civil Statutes, Article 5221f, administered by the Department of Housing and Community Affairs.

(ii) A house trailer-type vehicle that is less than eight feet in width and less than forty feet in length is classified as a travel trailer and shall be registered and titled.

(iii) A camper trailer shall be titled as a house trailer and shall be registered with travel trailer license plates.

(b) Initial application for certificate of title.

(1) Place of application. When motor vehicle ownership is transferred, except as provided by Transportation Code, Chapters 501 and 502 and by §17.8(a)(1) of this subchapter, a certificate of title application must be filed with the county tax assessor-collector in the county in which the applicant resides or in the county in which the motor vehicle was purchased or encumbered, within 20 working days of the date of sale.

(2) Information to be included on application. An applicant for an initial certificate of title must file an application on a form prescribed by the department. The form will at a minimum require the:

(A) motor vehicle description including, but not limited to, the motor vehicle's:

(i) year;

(ii) make;

(iii) model;

(iv) identification number;

(v) body style;

(vi) manufacturer's rated carrying capacity in tons for commercial motor vehicles; and

(vii) empty weight;

(B) license plate number, if the motor vehicle is subject to registration under Transportation Code, Chapter 502;

(C) [~~the~~] odometer reading and brand, or the word "exempt" if the motor vehicle is exempt from federal and state odometer disclosure requirements;

(D) previous owner's name and city and state of residence;

(E) name and complete address of the applicant;

(F) name and mailing address of any lienholder and the date of lien, if applicable;

(G) signature of the seller of the motor vehicle or the seller's authorized agent and the date the certificate of title application was signed;

(H) signature of the applicant or the applicant's authorized agent and the date the certificate of title application was signed; and

(I) applicant's social security number, if the application is filed in a county in which the department's automated registration and title system has been implemented, with the following exceptions:

(i) an application filed in the name of an entity that does not have a social security number, or

(ii) an individual applicant who does not have a social security number, in which case the applicant must execute a statement to that effect on a form prescribed by the department.

(3) Serial number. If no serial number is die-stamped by the manufacturer on a motor vehicle, house trailer, trailer, semitrailer [~~semi-trailer~~], or item of equipment required to be titled, or if the serial number assigned and die-stamped by the manufacturer has been lost, removed, or obliterated, the department will on [~~upon~~] proper application, presentation of evidence of ownership, and presentation of evidence of a law enforcement physical inspection, assign a serial number to the motor vehicle, trailer, or equipment. The manufacturer's serial number or the assigned serial number will be used by the department as the major identification of the motor vehicle or trailer in the issuance of a certificate of title.

(4) Accompanying documentation. The certificate of title application must be supported by, at a minimum, the following documents:

(A) evidence of vehicle ownership, as described in subsection (c) of this section;

(B) an odometer disclosure statement properly executed by the seller of the motor vehicle and acknowledged by the purchaser, if applicable;

(C) proof of financial responsibility in the applicant's name, as required by Transportation Code, §502.153, unless otherwise exempted by law; and

(D) an [~~(C) the~~] identification certificate if required by Transportation Code, §548.256, and Transportation Code, §501.030, and if the vehicle [~~was last registered in another state or country~~] is being titled and registered, or registered only; and

(E) [~~(D)~~] a release of any liens, provided that if any liens are not released, they will be carried forward on the new certificate of title application with the following limitations.

(i) A [~~An out-of-state~~] lien recorded on out-of-state evidence as described in subsection (c) of this section cannot be carried forward to a Texas title when there is a transfer of ownership, unless a release of lien or authorization from the lienholder is attached.

(ii) A lien recorded on out-of-state evidence as described in subsection (c) of this section is not required to be released when there is no transfer of ownership from an out-of-state title and the same lienholder is being recorded on the Texas application as is recorded on the out-of-state title.

(c) Evidence of motor vehicle ownership. Evidence of motor vehicle ownership properly assigned to the applicant must accompany the certificate of title application. Evidence must include, but is not limited to, the following documents.

(1) New motor vehicles. A manufacturer's certificate of origin assigned by the manufacturer or the manufacturer's representative or distributor to the original purchaser is required for a new motor vehicle that is sold or offered for sale.

(A) The manufacturer's certificate of origin must be in the form prescribed by the division director and must contain, at a minimum, the following information:

(i) motor vehicle description including, but not limited to, the motor vehicle's year, make, model, identification number, body style and empty weight;

(ii) the manufacturer's rated carrying capacity in tons when the manufacturer's certificate of origin is invoiced to a licensed Texas motor vehicle dealer and is issued for commercial motor vehicles as that term is defined in Transportation Code, Chapter 502; and

(iii) a statement identifying a motor vehicle designed by the manufacturer for off-highway use only.

(B) When a motor vehicle manufactured in another country is sold directly to a person other than a manufacturer's representative or distributor, the manufacturer's certificate of origin must be assigned to the purchaser by the seller [~~importer~~].

(2) Used motor vehicles. A certificate of title issued by the department, a certificate of title issued by another state if the motor vehicle was last registered and titled in another state, or other evidence of ownership must be relinquished in support of the certificate of title application for any used motor vehicle. A letter of Title and Registration verification is required from a vehicle owner coming from a state that no longer titles vehicles after a certain period of time.

(3) Motor [~~Imported motor~~] vehicles brought into the United States. An application for certificate of title for a motor vehicle last registered or titled in a foreign country must be supported by documents including, but not limited to, the following:

(A) the motor vehicle registration certificate or other verification issued by a foreign country reflecting the name of the applicant as the motor vehicle owner, or reflecting that legal evidence of ownership has been legally assigned to the applicant; and

(B) for motor vehicles that are less than 25 years old, proof of compliance with United States Department of Transportation (USDOT) regulations, including, but not limited to, the following documents:

(i) the original bond release letter with all attachments advising that the motor vehicle meets federal motor vehicle safety requirements or a letter issued by the USDOT, National Highway Traffic Safety Administration, verifying the issuance of the original bond release letter;

(ii) a legible copy of the motor vehicle importation form validated with an original United States Customs stamp, date, and signature as filed with the USDOT confirming the exemption from the

bond release letter required in clause (i) of this subparagraph, or a copy thereof certified by United States Customs;

(iii) a verification of motor vehicle inspection by United States Customs certified on its letterhead and signed by its agent verifying that the motor vehicle complies with USDOT regulations;

(iv) a written confirmation that a physical inspection of the safety certification label has been made by the department and that the motor vehicle meets United States motor vehicle safety standards;

(v) the original bond release letter, verification thereof, or written confirmation from the previous state verifying that a bond release letter issued by the USDOT was relinquished to that jurisdiction, if the non United States standard motor vehicle was last titled or registered in another state for one year or less; or

(vi) verification from the vehicle manufacturer on its letterhead stationary.

(4) Alterations to documentation. An alteration to a registration receipt, certificate of title, manufacturer's certificate, or other evidence of ownership constitutes valid reason for the rejection of any transaction to which altered evidence is attached.

(A) Altered lien information on any surrendered evidence of ownership requires a release from the original lienholder or a statement from the proper authority of the state in which the lien originated. The statement must verify the correct lien information.

(B) A strikeover that leaves any doubt about the legibility of any digit in any document will not be accepted.

(C) A corrected manufacturer's certificate of origin will be required if the manufacturer's certificate of origin contains an:

(i) incomplete or altered vehicle identification number;

(ii) alteration or strikeover of the vehicle's [~~year~~] model year;

(iii) alteration or strikeover to the body style, or omitted body style on the manufacturer's certificate of origin; or

(iv) alteration or strikeover to the manufacturer's rated carrying capacity.

(D) A Statement of Fact may be requested to explain errors, corrections, or conditions from which doubt does or could arise concerning the legality of any instrument. A Statement of Fact will be required in all cases:

(i) in which [~~where~~] the date of sale on an assignment has been erased or altered in any manner; or

(ii) of alteration or erasure on a Dealer's Reassignment of Title.

(5) Rights of survivorship. A signed "rights of survivorship" agreement may be executed by a natural person acting in an individual capacity in accordance with Transportation Code, §501.031.

(d) Certificate of title issuance. On [~~upon~~] receiving a completed application for certificate of title, along with the statutory [~~title application~~] fee for a title application [~~of $13~~] and any other applicable fees, the department or its designated agent will issue a receipt and process the application for [~~and issue a~~] certificate of title.

(1) Titles [~~Negotiable titles~~]. The department will issue and mail or deliver a certificate of title [~~negotiable title, marked "Original,"~~] to the applicant or, in the event that there is a lien disclosed in the application, to the first lienholder.

(2) Receipt. The receipt issued at the time of application for title [~~Non-negotiable titles. The department will issue non-negotiable titles, which~~] may be used only as evidence of title and may not be used to transfer any interest or ownership in a motor vehicle or to establish a new lien [~~, in the following circumstances~~].

[~~(A) In the event that there is a lien disclosed in the application, a duplicate certificate of title marked "Duplicate Original" will be mailed or delivered to the address of the applicant as disclosed upon the application.~~]

[~~(B) In the event that the owner of a vehicle last registered or titled in another state (and subject to registration in this state) cannot or does not wish to relinquish the negotiable out-of-state evidence of ownership to obtain a negotiable Texas title, a duplicate certificate of title marked "Registration Purposes Only" will be mailed or delivered to the address of the applicant as disclosed upon the application. In instances in which the title or registration receipt is assigned to the applicant, an application for "Registration Purposes Only" will not be processed.~~]

(e) Replacement of certificate of title. If a certificate of title is lost or destroyed, the department will issue a certified copy of the title to the owner, the lienholder, or a verified agent of the owner or lienholder in accordance with Transportation Code, Chapter 501, on [~~upon~~] proper application and payment of the appropriate fee to the department.

(1) Certified copy.

(A) Issuance. An application for a certified copy must be properly executed and supported by appropriate verifiable proof for the vehicle owner, lienholder, or agent regardless of whether the application is submitted in person or by mail.

(i) If the applicant requests that a certified copy be issued before the fourth business day following application, the application must be made in person.

(ii) An applicant other than the vehicle owner, lienholder, or verified agent must apply for a certified copy of a certificate of title by mail.

(B) Denial. If issuance of a certified copy is denied, the applicant may resubmit the request with the required verifiable proof or may pursue the privileges available in subsection (g)(2)(A) and (B) of this section.

(2) Certified copy designation. A certified copy of an existing certificate of title will be marked "Certified Copy" until ownership of the vehicle is transferred, when the words "Certified Copy" will be eliminated from the new certificate of title.

(3) Fees. The fee for obtaining a certified copy of a certificate of title is $2.00 if the application is processed at the department's headquarters office and $5.45 if the application is processed at one of the department's regional offices.

[~~(4) Recovery of lost title. In the event that the "Duplicate Original" or "Original" certificate of title is recovered, the owner shall relinquish the "Duplicate Original" or "Original" certificate of title to the department for cancellation. Thereafter, if a subsequent application for certificate of title is filed in the current owner's name, the department will issue an "Original" certificate of title.~~]

(f) Department notification of second hand vehicle transfers. A transferor of a motor vehicle may voluntarily make written notification to the department of the sale of the vehicle, in accordance with Transportation Code, Chapter 520, Subchapter C, and this subsection.

(1) Notification form. The department will provide a form for written notice of transfer. The form will include the:

(A) vehicle identification number of the vehicle;

(B) license plate number issued to the vehicle, if any;

(C) full name and address of the transferor;

(D) full name and address of the transferee;

(E) date the transferor delivered possession of the vehicle to the transferee;

(F) signature of the transferor; and

(G) date the transferor signed the form.

(2) Records. On [~~upon~~] receipt of written notice of transfer and a $5.00 fee from the transferor of a motor vehicle, the department will mark its records to indicate the date of transfer and the full name and address of the transferee.

(3) Ownership of transferred vehicle. After the date of the transfer of the vehicle as shown in the department records, the transferee of the vehicle is rebuttably presumed to be:

(A) the owner of the vehicle; and

(B) subject to civil and criminal liability arising out of the use, operation, or abandonment of the vehicle, to the extent that ownership of the vehicle subjects the owner of the vehicle to criminal or civil liability under another provision of the law.

(4) Certificate of title issuance. A certificate of title will not be issued in the name of a transferee until the transferee files an application for the certificate of title as described in this section.

(g) Suspension, revocation, or refusal to issue Certificates of Title.

(1) Grounds for title suspension, revocation, or refusal to issue. The department will refuse issuance of a certificate of title, or having issued a certificate of title, will suspend or revoke the certificate of title if the:

(A) application contains any false or fraudulent statement;

(B) applicant has failed to furnish required information requested by the department;

(C) applicant is not entitled to the issuance of a certificate of title under Transportation Code, Chapter 501;

(D) department has reasonable grounds to believe that the vehicle is a stolen or converted vehicle or that the issuance of a certificate of title would constitute a fraud against the rightful owner or a lienholder [~~mortgagee~~];

(E) registration of the vehicle stands suspended or revoked; or

(F) required fee has not been paid.

(2) Contested case procedure. Any person who has an interest in a motor vehicle to which the department has refused to issue a certificate of title or has suspended or revoked the certificate of title may contest the department's decision in accordance with Transportation Code, §501.052 and §501.053, in the following manner.

(A) Hearing. Any person who has an interest in a motor vehicle to which the department has refused to issue a certificate of title or has suspended or revoked the certificate of title may apply for a hearing to the designated agent of the county in which the applicant resides. At the hearing the applicant and the department may submit evidence, and a ruling of the designated agent will bind both parties. An applicant wishing to appeal the ruling of the designated agent may do so to the County Court of the county in which the applicant resides.

(B) Alternative to hearing. In lieu of a hearing, any person who has an interest in a motor vehicle to which the department has refused to issue a certificate of title or has suspended or revoked a certificate of title may file a bond with the department, in an amount equal to one and one-half times the value of the vehicle as determined by the department, and in a form prescribed by the department. On [~~upon~~] the filing of the bond, the department may issue a certificate of title. The bond shall expire three years after the date it becomes effective and will be returned to the person posting bond, on [~~upon~~] expiration, unless the department has been notified of the pendency of an action to recover on the bond.

(h) Discharge of lien. A lienholder shall provide the owner, or the owner's designee, a discharge of the lien after receipt of the final payment within the time limits specified in Transportation Code, Chapter 501. The lienholder shall submit one of the following documents:

(1) the certificate of title including an authorized signature in the space reserved for release of lien;

(2) a release of lien form prescribed by the department, with the form filled out to include the:

(A) certificate of title or document number, or a description of the motor vehicle including, but not limited to, the motor vehicle's:

(i) year;

(ii) make;

(iii) vehicle identification number; and

(iv) license plate number, if the motor vehicle is subject to registration under Transportation Code, Chapter 502;

(B) printed name of lienholder;

(C) signature of lienholder or an authorized agent;

(D) printed name of the authorized agent if the agent's signature is shown;

(E) telephone number of lienholder; and

(F) date signed by the lienholder;

(3) signed and dated correspondence submitted on company letterhead that includes:

(A) a statement that the lien has been paid;

(B) a description of the vehicle as indicated in paragraph (2)(A) of this subsection;

(C) a certificate of title or document number; or

(D) lien information;

(4) any out-of-state prescribed release of lien form, including an executed release on a lien entry form;

(5) out-of-state evidence with the word "Paid" or "Lien Satisfied" stamped or written in longhand on the face, followed by the name of the lienholder, countersigned or initialed by an agent, and dated; or

(6) original security agreements or copies of the original security agreements if the originals or copies are stamped "Paid" or "Lien Satisfied" with a company paid stamp or if they contain a statement in longhand that the lien has been paid followed by the company's name.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Richard D. Monroe
General Counsel
Texas Department of Transportation
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♦ ♦ ♦

SUBCHAPTER B. MOTOR VEHICLE REGISTRATION

43 TAC §§17.21, 17.22, 17.52

STATUTORY AUTHORITY

The amendments are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Transportation Code, Chapter 501, which authorizes the department to carry out the provisions of those laws governing issuance of motor vehicle certificates of title, and Transportation Code, Chapter 502 which authorizes the department to carry out the provisions of those laws governing issuance of motor vehicle registration.

No statutes, articles, or codes are affected by the proposed amendments.

§17.21. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Affidavit for alias exempt registration - A form prescribed by the director that must be executed by an exempt law enforcement agency to request the issuance of exempt registration in the name of an alias.

(2) Agent - A duly authorized representative possessing legal capacity to act for an individual or legal entity.

(3) Alias - The name of a vehicle registrant reflected on the registration, different than the name of the legal owner of the vehicle.

(4) Alias exempt registration - Registration issued under an alias to a specific vehicle to be used in covert criminal investigations by a law enforcement agency.

(5) Apportioned license plate - A license plate issued in lieu of a truck license plate or combination license plate to a motor carrier in this state who proportionally registers a vehicle owned by the carrier in one or more other states.

(6) Axle load - The total load transmitted to the road by all wheels whose centers may be included between two parallel transverse vertical planes 40 inches apart, extending across the full width of the vehicle.

(7) Border commercial zone - A commercial zone established under Title 49, C.F.R., Part 372 that [~~which~~] is contiguous to the border with Mexico.

[~~(8) Bus (motor) - A motor propelled vehicle used in transporting persons upon the public highways of this State for compensation or hire exclusively within the limits of incorporated cities and/or towns or suburban additions to such cities and/or towns.~~]

[~~(9) Bus (street or suburban) - A vehicle, except a motor bus or passenger car, used in transporting persons for compensation (or hire) exclusively within the limits of cities and towns or suburban additions to such cities or towns.~~]

(8) [~~(10)~~] Carrying capacity - The maximum safe load that a commercial vehicle may carry, in tons, as determined by the manufacturer.

(9) [~~(11)~~] Character - A numeric or alpha symbol displayed on a license plate.

(10) [~~(12)~~] Combination license plate - A license plate issued for a truck or truck tractor that has a manufacturer's rated carrying capacity of more than one ton and is used or intended to be used in combination with a semitrailer that has a gross weight of more than 6,000 pounds.

(11) [~~(13)~~] Commercial vehicle - Any vehicle (other than a motorcycle or passenger car) designed or used primarily for the transportation of property, including any passenger car that [~~which~~] has been reconstructed so as to be used, and that [~~which~~] is being used, primarily for delivery purposes, with the exception of passenger cars used in the delivery of the United States mail.

(12) [~~(14)~~] Conventional vehicle - A regular truck or regular trailer that is eligible only for regular registration[~~,~~] and that is [~~which are~~] primarily designed to transport divisible loads, regardless of the vehicle's present use. Vehicles that [~~(vehicles which~~] have been altered or reconstructed, or on [~~upon~~] which machinery has been mounted or attached, permanently or otherwise, retain their conventional status[~~)~~].

(13) [~~(15)~~] County or city civil defense agency - An agency authorized by a commissioner's court order or by a city ordinance to provide protective measures and emergency relief activities in the event of hostile attack, sabotage, or natural disaster.

(14) [~~(16)~~] Department - The Texas Department of Transportation.

(15) [~~(17)~~] Director - The director of the Vehicle Titles and Registration Division, Texas Department of Transportation.

(16) [~~(18)~~] Disabled person - A person who has mobility problems that substantially impair the person's ability to ambulate or who is legally blind.

(17) Electric bicycle - A device that has two tandem wheels and is designed to be propelled by an electric motor. An electric bicycle cannot attain a speed of more than 20 miles per hour without the application of human power and weighs 100 pounds or less.

(18) [~~(19)~~] Escrow account - A deposit of a specific amount of money held by the department for security.

(19) [~~(20)~~] Evidence of financial responsibility - The original document or photocopy of any one of the following items:

(A) a liability insurance policy or liability self-insurance or pool coverage document issued in at least the minimum amount required by law;

(B) a personal automobile insurance policy used as evidence of financial responsibility, written for at least the term required by the Insurance Code, Article 5.06;

(C) a standard proof of liability form issued by a liability insurer;

(D) an insurance binder that confirms that the owner is in compliance with the law;

(E) a certificate issued by the Texas Department of Public Safety that shows the vehicle is covered by self-insurance;

(F) a certificate issued by the state treasurer that shows that the owner has money or securities in an amount not less than $55,000 on deposit with the state treasurer;

(G) a certificate issued by the Texas Department of Public Safety that shows that the vehicle has a bond on file with that department, that the bond is in the form and amount required by law, and that the [~~on file with that department, such~~] bond is guaranteed by [~~shall include~~] at least two individual sureties each owning real estate within this state;

(H) a certificate issued by the county judge in the county where the owner resides showing that the owner has cash or a cashier's check in an amount not less than $55,000 on deposit with the county judge.

(20) [~~(21)~~] Executive administrator - The director of a federal agency, the director of a Texas state agency, the sheriff of a Texas county, or the chief of police of a Texas city that by law possesses the authority to conduct covert criminal investigations.

(21) [~~(22)~~] Exempt agency - A governmental body exempted by statute from paying registration fees when registering motor vehicles.

(22) [~~(23)~~] Exempt license plates - Specially designated license plates issued to certain vehicles owned or controlled by exempt agencies.

(23) [~~(24)~~] Exhibition vehicle -

(A) An assembled complete passenger car, truck, or motorcycle that [~~which~~]:

[~~(A) is at least 25 years old;~~]

(1) [~~(B)~~] is a collector's item;

(2) [~~(C)~~] is used exclusively for exhibitions, club activities, parades, and other functions of public interest;

(3) [~~(D)~~] does not carry advertising; and

(4) [~~(E)~~] has a frame, body, and motor that is at least 25 years old; or

(B) A Former Military Vehicle as defined in Transportation Code, §502.275.

(24) [~~(25)~~] Fire fighting equipment - Equipment mounted on fire fighting vehicles used in the process of fighting fires, including, but not limited to, ladders and hoses.

(25) [~~(26)~~] Gross weight - The sum of the empty weight of a commercial vehicle (or vehicles, if operated in combination), combined with its maximum carrying capacity, rounded up to the next 100 pounds.

(26) [~~(27)~~] Highway construction project - That section of the highway between the warning signs giving notice of a construction area.

(27) [~~(28)~~] International symbol of access - The symbol adopted by Rehabilitation International in 1969 at its Eleventh World Congress of Rehabilitation of the Disabled.

(28) [~~(29)~~] Legally blind - Having not more than 20/200 [~~of~~] visual acuity in the better eye with correcting lenses, or visual acuity greater than 20/200 but with a limitation in the field of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees.

(29) [~~(30)~~] Light truck - As defined in Transportation Code, §541.201, any truck with a manufacturer's rated carrying capacity not to exceed two thousand pounds, including those trucks commonly known as pickup trucks, panel delivery trucks, and carryall trucks.

(30) [~~(31)~~] Make - The trade name of the vehicle manufacturer.

(31) Motor bus - A motor-propelled vehicle used to transport persons on public highways for compensation, other than a street or suburban bus.

(32) Motorized mobility device - A device designed for transportation of persons with physical disabilities that:

(A) has three or more wheels;

(B) is propelled by a battery-powered motor;

(C) has not more than one forward gear; and

(D) is not capable of speeds exceeding eight miles per hour.

(33) [~~(32)~~] Net carrying capacity - 150 pounds multiplied by the seating capacity as determined by the manufacturer's rated seating capacity, exclusive of the driver's or operator's seat, or in the case of a vehicle that is not rated by the manufacturer, as determined by an allowance of one passenger for each sixteen inches, exclusive of the driver's or operator's seat.

(34) [~~(33)~~] Nonprofit organization - An unincorporated association or society or a corporation that is incorporated or holds a certificate of authority under the Texas Non-Profit Corporation Act, as amended (Texas Civil Statutes, Article 1396-1.01 et seq.).

[~~(34) Official - A representative of a taxing entity who is authorized to secure vehicle registration information for the purposes of taxation.~~]

(35) Owner - A person who holds the legal title to a vehicle, has the legal right to possess a vehicle, or has the legal right to control a vehicle. [~~In accordance with Transportation Code, §502.001, any person who holds the legal title of a vehicle or who has the legal right of possession thereof, or the legal right of control of said vehicle.~~]

(36) Passenger car - In accordance with Transportation Code, §502.001, any motor vehicle other than a motorcycle, golf cart, or a bus, designed or used primarily for the transportation of persons.

(37) Political subdivision - A county, municipality, local board, or other body of this state having authority to provide a public service.

(38) Registration period - A designated period during which registration is valid. A registration period always begins on the first day of a calendar month and ends on the last day of a calendar month. [~~A 12-month period beginning on the first day of a calendar~~

~~month and expiring on the last day of the last calendar month in that 12-month period.~~]

(39) Rental fleet - A fleet of five or more vehicles that are owned by the same owner, offered for rent or rented without drivers, and designated by the owner in the manner prescribed by the department as a rental fleet.

(40) Rental trailer - A utility trailer that has a gross weight of 4,000 pounds or less and is part of a rental fleet.

(41) Road tractor - A vehicle designed for the purpose of mowing the right of way of a public highway or a motor vehicle designed or used for drawing another vehicle or a load and not constructed to carry:

(A) an independent load; or

(B) a part of the weight of the vehicle and load to be drawn.

(42) Service agreement - A contractual agreement that [~~which~~] allows individuals or businesses to access the department's vehicle registration records.

(43) Special category license plate - A special design license plate issued by the department under statutory authority.

(44) Special category license plate fee - Statutorily or department required fee payable on [~~upon~~] submission of an application for a special category license plate, symbol, [~~or~~] tab, or other device, and collected in addition to statutory motor vehicle registration fees.

(45) Special district - A political subdivision of the state established to provide a single public service within a specific geographical area.

(46) Sponsoring entity - An institution, college, university, sports team, or any other individual or group that desires to support a particular special category license plate by coordinating the collection and submission of the prescribed applications and associated license plate fees or deposits for that particular license plate.

(47) Street or suburban bus - A vehicle, other than a passenger car, used to transport persons for compensation exclusively within the limits of a municipality or a suburban addition to a municipality.

(48) [~~(47)~~] Tandem axle group - Two or more axles spaced 40 inches or more apart from center to center having at least one common point of weight suspension.

(49) [~~(48)~~] Token trailer -[~~A~~]:

(A) A semitrailer that has a gross weight of more than 6,000 pounds and is operated in combination with a truck; or

(B) a truck tractor that has been issued an apportioned license plate, a combination license plate, or a forestry vehicle license plate.

(50) [~~(49)~~] Tow truck - A motor vehicle equipped with a [~~or~~] mechanical device adapted or used to tow, winch, or otherwise move another motor vehicle [~~disabled motor vehicles~~].

(51) [~~(50)~~] Travel trailer - A house trailer-type vehicle or a camper trailer that is less than eight feet in width or 40 feet in length, exclusive of any hitch installed on the vehicle, and is designed primarily for use as temporary living quarters in connection with recreational, camping, travel, or seasonal use and not as a permanent dwelling.

(52) [~~(51)~~] Unconventional vehicle - A vehicle built entirely as machinery from the ground up, that is permanently designed to perform a specific function, and is not designed to transport property.

(53) [~~(52)~~] Vehicle - A [~~Every~~] device in[~~,~~] or by which a [~~, any~~] person or property is or may be transported or drawn on [~~upon~~] a public highway, other than a device [~~except devices~~] used exclusively on [~~upon~~] stationary rails or tracks.

(54) [~~(53)~~] Vehicle classification - The grouping of vehicles in categories for the purpose of registration, based on [~~upon~~] design, carrying capacity, or use.

(55) [~~(54)~~] Vehicle description - Information regarding a specific vehicle, including, but not limited to, the vehicle make, [~~year~~] model year, body style, and vehicle identification number.

(56) [~~(55)~~] Vehicle identification number - A number assigned by the manufacturer of a motor vehicle or the department that describes the motor vehicle for purposes of identification.

(57) [~~(56)~~] Vehicle inspection sticker - A sticker issued by the Texas Department of Public Safety signifying that a vehicle has passed all applicable safety and emissions tests.

(58) [~~(57)~~] Vehicle registration insignia - A license plate, symbol, tab, or other device issued by the department evidencing that all applicable fees have been paid for the current registration period and allowing [~~which allows~~] the vehicle to be operated on [~~upon~~] the public highways.

(59) [~~(58)~~] Vehicle registration record - Information contained in the department's files that [~~which~~] reflects, but is not limited to, the make, vehicle identification number, [~~year~~] model year, body style, license number, and the name of the registered owner.

(60) [~~(59)~~] Volunteer fire department - An association that is organized for the purpose of answering fire alarms, extinguishing fires, and providing emergency medical services.

§17.22. Motor Vehicle Registration.

(a) Registration. Unless otherwise exempted by law or this chapter, a vehicle to be used on [~~upon~~] the public highways of this state must be registered in accordance with Transportation Code, Chapter 502 and the provisions of this section. Transportation Code, Chapter 501, Subchapter E and §17.8 of this title (relating to Certificates of Title for Salvage Vehicles) prohibit registration of a vehicle whose owner has been issued a salvage or nonrepairable motor vehicle certificate of title. These vehicles may not be operated on [~~upon~~] a public roadway.

(b) Initial application for vehicle registration.

(1) An applicant for initial vehicle registration must file an application on a form prescribed by the department. The form will at a minimum require:

(A) the signature of the owner;

(B) the motor vehicle description, including, but not limited to, the motor vehicle's year, make, model, vehicle identification number, body style, manufacturer's rated carrying capacity in tons for commercial motor vehicles, and empty weight;

(C) the license plate number;

(D) the odometer reading, or the word "exempt" if the motor vehicle is exempt from federal and state odometer disclosure requirements;

(E) the name and complete address of the applicant; and

(F) the name, mailing address, and date of any liens.

(2) The application must be accompanied by the following documents:

(A) evidence of vehicle ownership as specified in Transportation Code, §501.030, unless the vehicle has been issued a salvage or nonrepairable motor vehicle certificate of title in accordance with Transportation Code, Chapter 501, Subchapter E;

(B) registration fees prescribed by law;

(C) any local fees or other fees prescribed by law and collected in conjunction with registering a vehicle;

(D) evidence of financial responsibility required by Transportation Code, §502.153, unless otherwise exempted by law; and

(E) any other documents or fees required by law.

(3) An initial application for registration must be filed with the tax assessor-collector of the county in which the owner resides, except that an application for registration as a prerequisite to filing an application for certificate of title may also be filed with the county tax assessor-collector in the county in which the motor vehicle is purchased or encumbered.

(4) The recorded owner of a vehicle that was last registered or titled in another jurisdiction and is subject to registration in this state may apply for registration if the owner cannot or does not wish to relinquish the negotiable out-of-state evidence of ownership to obtain a Texas certificate of title. On receipt of a form prescribed by the department and payment of the statutory fee for a title application and any other applicable fees, the department will issue a registration receipt to the applicant.

(A) Registration receipt. The receipt issued at the time of application may serve as proof of registration and evidences title to a motor vehicle for registration purposes only, but may not be used to transfer any interest or ownership in a motor vehicle or to establish a lien.

(B) Information to be included on the form. The form will include the:

(i) out-of-state title number, if applicable;

(ii) out-of-state license plate number, if applicable;

(iii) state or country that issued the out-of-state title or license plate;

(iv) lienholder name and address as shown on the out-of-state evidence, if applicable;

(v) statement that negotiable evidence of ownership is not being surrendered; and

(vi) signature of the applicant or authorized agent of the applicant.

(C) Accompanying Documentation. An application for registration under this paragraph must be supported, at a minimum, by:

(i) a completed application for registration, as specified in paragraph (1) of this subsection;

(ii) presentation, but not surrender of, evidence from another jurisdiction demonstrating that legal evidence of ownership has been issued to the applicant as the motor vehicle's owner, such as a validated title or registration verification from the other jurisdiction, a registration receipt, a non-negotiable title, or written verification from the other jurisdiction; and

(iii) any other documents or fees required by law.

(D) Assignment. In instances in which the title or registration receipt is assigned to the applicant, an application for registration purposes only will not be processed. The applicant must apply for a certificate of title under Transportation Code, Chapter 501.

(c) Vehicle registration insignia.

(1) On [~~upon~~] receipt of a complete initial application for registration with the accompanying documents and fees, the department will issue vehicle registration insignia to be displayed on the vehicle for which the registration was issued for the current registration period.

(A) If the vehicle has a windshield, the symbol, tab, or other device prescribed by and issued by the department shall [~~must~~] be attached to the inside lower left corner of the vehicle's front windshield within six inches of the vehicle inspection sticker in a manner that will not obstruct the vision of the driver.

(B) If the vehicle has no windshield, the symbol, tab, or other device prescribed by and issued by the department shall be attached to the rear license plate.

(C) If the vehicle is registered as a Former Military Vehicle as prescribed by Transportation Code, §502.275, the vehicle's registration number shall be displayed instead [~~in lieu~~] of displaying a symbol, tab, or license plate.

(i) Former Military Vehicle registration numbers shall be displayed on a prominent location on the vehicle in numbers and letters of at least two inches in height.

(ii) To the extent possible, the location and design of the Former Military Vehicle registration number must conform to the vehicle's original military registration number.

(2) Unless otherwise prescribed by law, each vehicle registered under this subchapter must display two license plates, one at the front and one at the rear of the vehicle.

(3) In accordance with Transportation Code, §502.052 and §502.180(e), the department will cancel or not issue any license plate with a number that:

(A) conflicts with the department's current or proposed regular license plate numbering system;

(B) is determined to be obscene or objectionable by the director; or

(C) is currently issued to another owner.

(4) The provisions of paragraph (1) of this subsection do not apply to vehicles registered with annual license plates issued by the department.

(d) Vehicle registration renewal.

(1) To renew vehicle registration, a vehicle owner must apply, prior to the expiration of the vehicle's registration, to the tax assessor-collector of the county in which the owner resides.

(2) The department will mail a license plate renewal notice, indicating the proper registration fee and the month and year the registration expires, to each vehicle owner approximately six to eight weeks prior to the expiration of the vehicle's registration.

(3) The license plate renewal notice must be returned by the vehicle owner to the appropriate county tax assessor- collector or to the tax assessor-collector's deputy, either in person or by mail, and must be accompanied by the following documents and fees:

(A) registration renewal fees prescribed by law;

(B) any local fees or other fees prescribed by law and collected in conjunction with registration renewal; and

(C) evidence of financial responsibility required by Transportation Code, §502.153, unless otherwise exempted by law.

(4) If a renewal notice is lost, destroyed, or not received by the vehicle owner, the vehicle may be registered if the owner presents personal identification acceptable to the tax assessor-collector. Failure to receive the notice does not relieve the owner of the responsibility to renew the vehicle's registration.

(5) Renewal of expired vehicle registrations.

(A) In accordance with Transportation Code, §502.407, a vehicle with an expired registration may not be operated on [~~upon~~] the highways of the state after the fifth working day after the date a vehicle registration expires.

(B) A 20% delinquency penalty is due when registration is renewed if the owner has been arrested or cited for operating the vehicle without valid registration.

(C) If the county tax assessor-collector determines that a registrant has a valid reason for being delinquent in registration, the vehicle owner will be required to pay for twelve months' registration. Renewal will establish a new registration expiration month that will end on the last day of the eleventh month following the month of registration renewal.

(D) If the county tax assessor-collector determines that a registrant does not have a valid reason for being delinquent in registration, the full annual fee will be collected and the vehicle registration expiration month will remain the same.

(E) If a vehicle is registered in accordance with Transportation Code, §502.164, §502.167, §502.203, §502.255, §502.267, §502.277, §502.278, §502.295, or §502.2951, and if the vehicle's registration is renewed more than one month after expiration of the previous registration, the registration fee will be prorated.

(F) Any delinquent registration submitted directly to the department for processing will be evaluated to verify the reason for delinquency. If the department determines that a registrant has a valid reason for being delinquent in registration, the vehicle owner will be required to pay for 12 months' registration. Renewal will establish a new registration expiration month that will end on the last day of the 11th month following the month of registration. If the department determines that a registrant does not have a valid reason for being delinquent in registration, the full annual fee will be collected and the vehicle registration expiration month will remain the same. Valid reasons for delinquency include those reasons set forth in Transportation Code, §502.176(e).

(6) License plate reissuance and recall program.

(A) The county tax assessor-collectors are authorized to issue new multi-year license plates at no additional charge on [~~upon~~] request by the owner at the time of registration renewal, provided the current plates are over five years old.

(B) The county tax assessor-collectors shall issue new multi-year license plates at no additional charge at the time of registration renewal provided the current plates are over eight years old.

(e) Replacement of license plates, symbols, tabs, and other devices.

(1) When a license plate, symbol, tab, or other registration device is lost, stolen, or mutilated, a replacement may be obtained from any county tax assessor-collector as prescribed by law.

(2) To obtain a replacement, the owner must properly execute an affidavit containing the vehicle description, the original license plate number, and a sworn statement that the license plate, symbol, tab, or other registration device furnished for the described vehicle has been lost, stolen, or mutilated, and will not be used on any other vehicle.

(3) If the owner remains in possession of any part of the lost, stolen, or mutilated license plate, symbol, tab, or other registration device, that remaining part must be removed and surrendered to the department on [~~upon~~] issuance of the replacement and on [~~upon~~] request by the county tax assessor-collector.

(f) Out-of-state vehicles. A vehicle brought to Texas from out-of-state must be registered within 30 days of the date on which the owner establishes residence or secures gainful employment, except as provided by Transportation Code, §502.0025. Accompanying a completed application, an applicant must provide:

(1) an application for certificate of title as required by Transportation Code, Chapter 501, if the vehicle to be registered has not been previously titled in this state; and

(2) any other documents or fees required by law [~~an identification certificate required by Transportation Code, §548.256 and §501.030~~].

(g) Enforcement of traffic warrant. The department or a county tax assessor-collector may, pursuant to the provisions of a contract entered into under Transportation Code, §702.003, refuse to register a vehicle owned by a person for whom a warrant of arrest is outstanding for failure to appear or pay a fine on a complaint involving a violation of a traffic law.

(h) Refusal to register vehicle in certain counties. The department or a county tax assessor-collector may, pursuant to the provisions of a contract entered into in accordance with Government Code, Chapter 791, and Transportation Code, §502.185, refuse to register a vehicle owned by a person who owes the county money for a fine, fee, or tax that is past due.

(1) To place or remove a registration denial flag on a vehicle record, the county must submit a magnetic tape or other acceptable submission medium as determined by the department in a format prescribed by the department.

(2) The information submitted by the county will include, at a minimum, the vehicle identification number [~~(VIN)~~] and the license [~~registration~~] plate number of the affected vehicle.

(3) If a county data submission contains bad or corrupted data, the submission medium will be returned to the county with no further action by the department.

(4) The magnetic tape or other submission medium must be submitted to the department from a single source within the county, as approved by the county commissioner's court.

(5) County submission of a magnetic tape or other submission medium to the department constitutes a certification that the county has notified owners of vehicles whose records appear on the tapes that past due fines, fees, or taxes are owed to the county.

§17.52. Vehicle Emissions Enforcement System.

(a) Purpose. Transportation Code, §502.009, requires the department to implement a system requiring verification that a vehicle complies with vehicle emissions inspection and maintenance [~~(I/M)~~] programs as required by the Health and Safety Code, §382.037 and §382.0372, and Transportation Code, Chapter 548, Subchapter F. Transportation Code, §501.0276 and §502.1535, requires a vehicle to pass an emissions test on resale in an affected county before it is

titled or registered. This section prescribes the department's policies and procedures [for a denial of registration enforcement system] if a vehicle does not comply with the emissions standards set by federal and state laws and the provisions of the Texas air quality State Implementation Plan.

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

(1) Affected County - Any portion of an air quality control region where any pollutant exceeds the national ambient air quality standards for the pollutant as designated under the Federal Clean Air Act.

(2) [(1)] Department - The Texas Department of Transportation.

(3) [(2)] DPS - The Texas Department of Public Safety.

[(3) Nonattainment area - Any portion of an air quality control region where any pollutant exceeds the national ambient air quality standards for the pollutant as designated pursuant to the Federal Clean Air Act.]

[(4) State Implementation Plan (SIP) - A document required by the United States Environmental Protection Agency that commits to the adoption and implementation of a vehicle emissions I/M program which meets all the requirements of the Environmental Protection Agency.]

(4) [(5)] TNRCC - The Texas Natural Resource Conservation Commission.

(5) [(6)] Vehicle - A self-propelled [motor-driven or propelled] vehicle required to be registered in the state, except those vehicles exempted by [the] TNRCC.

(6) [(7)] Vehicle inspection report - A vehicle inspection form prescribed by [the] DPS that is printed by the vehicle exhaust gas analyzer immediately following an emissions test.

(7) Vehicle emissions I/M program - A vehicle emissions inspection and maintenance program meeting all the requirements of the Environmental Protection Agency.

(8) Waiver - A form and certificate that allows a vehicle to be considered in compliance with the vehicle emissions I/M program for a specified period of time after a vehicle fails an emissions test.

(c) Notice from DPS or TNRCC. [Conditions to vehicle registration denial.]

(1) [The] DPS, after notice to the vehicle owner, will notify the department if a motor vehicle owner fails to comply with the requirements of Transportation Code, Chapter 548, Subchapter F.

(2) [The] TNRCC, after notice to the vehicle owner, will notify the department if a motor vehicle fails to comply with the requirements of Health and Safety Code, §382.037 and §382.0372, and Transportation Code, Chapter 548, Subchapter F.

(3) The notice will include the vehicle identification number [(VIN)] and the license [registration] plate number of the affected vehicle.

(4) If the department receives a notice of emissions noncompliance from [the] DPS or TNRCC, the department will place a notation on the motor vehicle record that the motor vehicle has failed to comply with the vehicle emissions I/M program.

(5) If the department receives a notice emissions compliance from [the] DPS or TNRCC, the department will remove the noncompliance notation from the motor vehicle record.

(6) If a vehicle record contains a notation of failure to comply with the vehicle emissions I/M program, the tax assessor-collector will deny registration unless provided with:

(A) proof of compliance with the vehicle emissions I/M program with a "passing" vehicle inspection report; or

(B) proof of a waiver issued by [the] DPS that includes the vehicle identification number [(VIN)] and the license [registration] plate number.

(7) [The] DPS and TNRCC will provide the department with the notifications in a format approved by the department.

(8) [The] DPS and TNRCC will enter into an agreement with TxDOT regarding the remittance to the department for costs associated with implementation of the emissions program.

(d) Vehicles moved into affected counties. If a vehicle was last titled in an unaffected county and is to be titled or registered in an affected county, it is not eligible for a title receipt, a certificate of title, or registration after a retail sale unless proof is presented to the county tax assessor-collector that the vehicle has passed the emissions test. This subsection does not apply to a vehicle that will be used in the affected county for fewer than 60 days during the registration period for which registration is sought.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107888
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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CHAPTER 21. RIGHT OF WAY
SUBCHAPTER G. RELOCATION ASSISTANCE AND BENEFITS

The Texas Department of Transportation proposes the repeal of §§21.111-21.117 and simultaneously proposes new §§21.111-21.118, concerning relocation assistance and benefits.

EXPLANATION OF PROPOSED REPEALS AND NEW SECTIONS

The Texas Department of Transportation's relocation rules set forth the eligibility requirements and procedures for providing relocation assistance to individuals and businesses displaced by highway improvement projects.

The repeals and new sections are required due to changes in state and federal law and regulations and recommendations for revised appeal procedures following a joint process review conducted by the department and the Federal Highway Administration (FHWA). Additional nonsubstantive changes are made to enhance clarity and to improve grammar. The repeals and new

sections will bring the relocation assistance and benefits regulations up to date and into compliance with current law and federal regulations, including the position designation change of the former "state engineer-director" to that of "executive director".

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five-years the repeals and new sections are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeals and new sections. There are no anticipated economic costs for persons required to comply with the sections as proposed.

John Campbell, Director, Right of Way Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeals and new sections.

PUBLIC BENEFIT

Mr. Campbell has also determined that for each year of the first five years the sections are in effect, the public benefit anticipated as a result of enforcing or administering the repeals and new sections will be to further the department's mission to provide an efficient and fair process of administering the relocation assistance and benefit program in accordance with state and federal law and regulations. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeals and new sections may be submitted to John Campbell, Director, Right of Way Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

43 TAC §§21.111 - 21.117

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeals are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation.

No statutes, articles, or codes are affected by the proposed repeals.

§21.111. Relocation Assistance Advisory Service.

§21.112. Public Information.

§21.113. Written Notices to Displacees.

§21.114. Applicability of Relocation Payments and Services.

§21.115. Moving and Related Expense Payments.

§21.116. Replacement Housing Payment.

§21.117. Relocation Review Committee.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107889
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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43 TAC §§21.111 - 21.118

STATUTORY AUTHORITY

The new sections are proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation.

No statutes, articles, or codes are affected by the proposed new sections.

§21.111. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Commission - The Texas Transportation Commission.

(2) Department - The Texas Department of Transportation.

(3) Displacee - A person lawfully present in the United States who, as a result of the acquisition of property for highway right of way purposes, is required to move from a dwelling, business, or farm.

(4) District engineer - The chief administrative officer in charge of a district of the department, or the designee.

(5) Executive director - The chief executive officer of the Texas Department of Transportation.

(6) Relocation Review Committee - An administrative committee whose members are appointed by the executive director and include the deputy executive director (chair) and at least two other department employees who are not directly involved with the relocation assistance program.

§21.112. Relocation Assistance Advisory Service.

The department will establish a relocation advisory service office that is reasonably convenient to individuals affected by right-of-way acquisitions. Relocation services will be made available at hours convenient to:

(1) occupants of property to be acquired;

(2) occupants of property immediately adjacent to the property acquired who will suffer substantial economic injury because of the acquisition; and

(3) those who move from real property used for a dwelling or who move their personal property because of the acquisition of real property used for a business or farm.

§21.113. Public Information.

In order to assure that the public has adequate knowledge of the relocation assistance program, the department will discuss services and benefits at public hearings, present them in a brochure, and give them in writing to each displacee either by hand delivery or certified mail, return receipt requested.

§21.114. Written Notices to Displacees.

The following written notices shall be furnished to ensure that each displacee is fully informed of the benefits and services available.

(1) Notice of displacement.

(A) Owner-occupants. At the initiation of negotiations for the property, the department will furnish the owner with a written explanation of the eligibility requirements to receive relocation payments for the acquired business or dwelling unit. The notice to an owner-occupant of a dwelling for more than 180 days will include entitlement to payments for replacement housing, incidental expenses, any increased interest costs required for financing a replacement dwelling, and the option to rent if the owner-occupant so desires. In addition, each owner-occupant will receive a copy of the department's relocation brochure and an explanation of the relocation services available and where they may be obtained.

(B) Tenants. As soon as feasible after the initiation of negotiations for the purchase of the property, each tenant shall be furnished a written statement that includes the date of initiation of negotiations for the property and an explanation of the eligibility requirements to receive applicable relocation benefits. In addition, each tenant will be provided with a copy of the department's relocation brochure and an explanation of the relocation services available and where they may be obtained.

(2) Notice of replacement payments. The amount of the replacement housing payment to which a displacee is entitled will be furnished near the time the displacee will be actively looking for replacement housing. The amount of the payment shall be based on the cost of a replacement dwelling comparable to the one from which the person is being displaced and will be sufficient to preserve, as nearly as possible, the displacee's original ownership or tenancy status. If the displacee desires alternate ownership/tenancy status, an alternate payment will be computed and offered when feasible.

(3) Notices to vacate. To the greatest extent practicable, no person lawfully occupying real property shall be required to move from a dwelling, or to move a business or farm operation, without at least 90 days written notice of the intended vacation date. Normally, the department will provide the displacee with two notices described as follows.

(A) Ninety-day notice. This notice may be given on or after the initiation of negotiations for the property. It shall include a statement that the displacee will not be required to move from the dwelling, business, or farm before 90 days from the date of the notice. The notice shall also inform the displacee that a 30-day written notice will follow, specifying the date by which the property must be vacated.

(B) Thirty-day notice. This notice shall specify the date by which the property must be vacated, and will not be given until the department has control of the property. A notice is not required if an occupant moves prior to the time the notice is given.

(4) Notice of right to review. Eligible relocatees who are dissatisfied with relocation payment amounts have a right to a review by the district engineer and the department's Relocation Review Committee. All eligible relocatees shall receive a written notice informing them of this right and the procedures to follow in requesting a review.

§21.115. Applicability of Relocation Payments and Services.

Relocation payments and services are applicable to all individuals, families, businesses, farm operations, or nonprofit organizations who have held lawful physical occupancy and who are displaced as a result of the acquisition of their real property, in whole or in part, for highway right of way purposes, except that aliens who are not lawfully present in the United States are not eligible for relocation assistance or payments. Individuals or families who occupy living quarters on the same premises as a displaced business, farm, or nonprofit organization are separate displacees for purposes of determining entitlement to relocation payments. A displacee who relocates without using the department's relocation services may be eligible for payments if the relocation meets all eligibility requirements.

§21.116. Moving and Related Expense Payments.

When a person is required to relocate as a result of the acquisition of right-of-way for a highway project, the department will pay the reasonable expenses of relocating the displacee and his or her business and personal property, so long as the eligibility requirements are met. Payment will be made for one move of not more than 50 miles to a single location, unless the department determines it to be in the public interest to waive one or more of these limitations.

§21.117. Replacement Housing Payment.

(a) General. Individuals and families displaced from their dwellings on parcels required for a designated highway project are entitled to replacement housing payments if they relocate into decent, safe, and sanitary replacement housing and meet other eligibility requirements necessary, as determined by the department, to meet applicable legal requirements. If a displacee requests alternate ownership/tenancy status, the department will make a reasonable effort to accommodate the request. The displacee may relocate to any dwelling, but the amount actually paid will be the lesser of the actual cost or actual rent of the replacement dwelling or the housing supplement previously approved by the department. In the case of condemned property and in certain hardship cases, a preliminary replacement housing payment may be made to a qualified displacee prior to the department's acquisition of the property if the displacee signs a contract agreeing to return any overpayment when the department makes final payment for the property acquired.

(b) Payments to owner-occupants for 180 days or more. A displaced owner-occupant of a dwelling may receive supplemental payments, as determined by the department, for the additional cost necessary to purchase replacement housing, to compensate for the loss of favorable financing on an existing mortgage in the financing of replacement housing, or to reimburse the displacee for certain expenses incident to the purchase of replacement housing. The displacee may receive a payment to cover the cost of renting a replacement dwelling. A displacee who is otherwise qualified for a replacement housing payment but who has previously received a rental payment may receive a revised supplement if the displacee purchases and occupies a replacement dwelling within the required one year period and files the claim within 18 months of that date. The amount of the rental payment will be deducted from the housing payment.

(c) Payment to owner-occupants for less than 180 days but not less than 90 days. As determined by the department, a displaced owner of dwelling may receive a payment sufficient to make a down payment on the purchase of a replacement dwelling and to reimburse actual incidental expenses. The displacee may choose to receive a payment to rent a replacement dwelling. A displacee who is otherwise qualified for a down payment supplement but who has previously received a rental payment may receive a revised supplement if the displacee purchases and occupies a replacement dwelling within the required one year period and files the claim within 18 months of that date. The amount of the rental payment will be deducted from the down payment amount.

(d) Tenant-occupants for not less than 90 days. As determined by the department, a displaced tenant may receive a payment sufficient to make a down payment on the purchase of a decent, safe, and sanitary replacement dwelling, as well as the expenses incidental to such purchase. The displacee may choose to receive a payment to rent a replacement dwelling. If the displacee elects to purchase a mobile home as replacement housing, all transportation and set up expense necessary to place the mobile home on a lot, in decent, safe, and sanitary

condition, will be included as a part of the total acquisition price of the replacement housing. A change from a rental payment to a down payment will be allowed on the same basis as for an owner-occupant of less than 180 days.

(e) Residential displacees not meeting length of occupancy requirements. A displacee who does not meet the length of occupancy requirement for a replacement housing payment may receive rental assistance when comparable replacement rental housing is not available for less than 30% of the displacee's gross monthly household income. Such assistance shall cover a period of 42 months.

§21.118. Relocation Review Committee.

A displacee who is dissatisfied with the department's determination of eligibility or relocation payments and services may request a review by the Relocation Review Committee. The review procedures are as follows.

(1) Applications must be filed with the appropriate district office within 90 days after the displacee receives notice of relocation entitlements.

(2) The district engineer will promptly and carefully review the facts and attempt to resolve the matter at the district level. The displacee will be promptly notified in writing of the results of the district engineer's review.

(3) A displacee who is still dissatisfied after the first review may request that the district engineer's decision be reviewed by the department's Relocation Review Committee.

(4) The district shall promptly forward the application together with all the information the district has relating to the displacee's application and the district engineer's personal recommendation to the department's Right of Way Division. The division will review the materials, make a determination on the application, and prepare a written statement as to the issues involved for the relocation assistance appeal file. If the division does not find in favor of the displacee's claim, the division will promptly forward the file to the Relocation Review Committee.

(5) The Relocation Review Committee shall give each displacee a full opportunity to be heard, carefully review all facts presented, and render a prompt decision. The decision will be supported by the necessary rationale and will be documented in the parcel file.

(6) The committee may discuss an application with the executive director. The executive director shall make the final ruling or may counsel with the commission if necessary.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

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Richard D. Monroe
General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-8630

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CHAPTER 23. TRAVEL INFORMATION

SUBCHAPTER C. TEXAS HIGHWAYS MAGAZINE

43 TAC §23.29

The Texas Department of Transportation proposes new §23.29, concerning magazine advertising.

EXPLANATION OF NEW SECTION

Texas Civil Statutes, Article 6144e authorizes the department to publish *Texas Highways*, the state's official travel magazine, and other travel literature for the purpose of assisting and encouraging travel in Texas. In furtherance of that purpose, the department may include certain paid advertising in travel literature, provided that the quality and quantity of the primary information content is not impaired. New §23.29 prescribes department policies and procedures relating to the advertising content of *Texas Highways*.

Subsection (a) describes the purpose of new §23.29.

Subsection (b) prescribes subjects acceptable for advertising in *Texas Highways*. *Texas Highways* is the official travel magazine of the State of Texas, encouraging recreational travel within the state and telling the Texas story to readers around the world. Accordingly, the content of the magazine is focused on Texas vacation, recreational, travel, or tourism related subjects, shopping opportunities in Texas and for Texas related products, various outdoor events, sites, facilities, and services in the state, transportation modes and facilities in the state, and other sites, products, facilities, and services that are travel related or Texas based, and that are determined by the department to be of cultural, educational, historical, or recreational interest to *Texas Highways* readers. Acceptable advertising subjects in the magazine must be related to the scope of the magazine's content.

Subsection (c) specifies those subjects that are not acceptable for advertising in *Texas Highways*. The purpose of the magazine is to encourage travel in Texas. Unacceptable advertising subjects include out-of-state travel or tourism locations, destinations, facilities, and services that do not augment Texas travel or tourism or that are not located on border locations with ties to Texas. The magazine tells the Texas story and encourages travel to Texas by promoting the positive attributes of the state. Accordingly, subjects that may be perceived as negative by readers, such as alcoholic beverages, tobacco products, and sexually oriented products and services are not acceptable advertising subjects.

Subsection (d) prescribes policies and procedures for soliciting advertising sales and accepting orders for advertising in *Texas Highways*. The department will annually publish in the *Texas Register* an invitation to be included in a mailing list containing those entities and individuals interested in advertising in *Texas Highways* and receiving advertising rate information. Subsection (d) requires the department to calculate advertising rates and develop a rate card for the magazine. The department will publish the advertising rate information in various publications, including the *Texas Register*. The rate card will include information about advertising space and positions, advertising rates, publication issue and closing dates, circulation data, publisher's editorial profile, and other related information.

The department and/or its designated agent will mail an announcement of advertising opportunities and the rate card to those on the mailing list 30 days after the publication of that information in the *Texas Register*. Subsequent to that date, a

rate card will also be sent upon request to an entity or individual not on the mailing list. In order to fairly allocate advertising space and positions, the department or its designated agent will accept all insertion orders (orders for paid advertising) received prior to the closing date on a first-come, first-served basis until all advertising space for a particular publication is filled. However, in order to make the most efficient use of advertising space, insertion orders for an inside front cover spread and inside back cover spread will take precedence over an inside front cover and inside back cover insertion order, notwithstanding the date of receipt of the insertion order.

Subsection (e) prescribes conditions under which the department will not accept advertising or will remove an advertiser. *Texas Highways* tells the Texas story to its readers around the world and encourages travel to Texas by promoting the positive attributes of the state. Accordingly, advertising that may be perceived as negative by readers, such as that from an entity that discriminates against customers on the basis of race, color, creed, religion, sex, or national origin, will not be accepted. The department will also not accept advertising that is misleading or that misrepresents the facts. The department may remove an advertiser based on three or more valid consumer complaints concerning service or merchandise, and will no longer accept orders from advertisers that have been removed.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five years the new section is in effect, there will be fiscal implications for state and local governments as a result of enforcing or administering the new section. The department will receive increased revenue as a result of implementing a program to accept advertising in *Texas Highways*. The department has estimated that it will receive $16,037 in increased revenue in FY 2002, $400,022 in FY 2003, $607,136 in FY 2004, $740,724 in FY 2005, and $897,197 in FY 2006. The department anticipates that there will be fiscal implications for local governments desiring to advertise in *Texas Highways*. Those costs cannot be quantified with any specificity, as the amount will depend on the number and type of insertion orders made. There are anticipated economic costs for persons required to comply with the new section as proposed. Persons desiring to advertise in *Texas Highways* will incur those costs. Those costs cannot be quantified with any specificity, as the amount will depend on the number and type of insertion orders made.

Doris Howdeshell, Director, Travel Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the new section.

PUBLIC BENEFIT

Ms. Howdeshell has also determined that for each year of the first five years the new section is in effect, the public benefit anticipated as a result of enforcing or administering the new section will be to offset the cost of producing *Texas Highways*, adding to the information provided to readers on services and merchandise available in Texas, and maintaining the magazine's subscription price at a competitive level, thereby reaching more potential readers and facilitating the department's mission of encouraging travel in Texas. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed new section may be submitted to Doris Howdeshell, Director, Travel Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

STATUTORY AUTHORITY

The new section is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Texas Civil Statutes, Article 6144e, which authorizes the department to publish *Texas Highways* and other travel literature for the purpose of assisting and encouraging travel in Texas, and to include certain paid advertising in travel literature.

No statutes, articles, or codes are affected by the proposed new section.

§23.29. Magazine Advertising.

(a) Purpose. Texas Civil Statutes, Article 6144e authorizes the department to publish Texas Highways, the state's official travel magazine, and other travel literature for the purpose of assisting and encouraging travel in Texas. In furtherance of that purpose, the department may include certain paid advertising in travel literature, provided that the quality and quantity of the primary information content is not impaired. This section prescribes department policies and procedures relating to the advertising content of Texas Highways magazine.

(b) Acceptable subjects. Subjects acceptable for advertising in Texas Highways include:

(1) Texas vacation, recreational, travel, or tourism-related sites, facilities, destinations, accommodations, restaurants, events, equipment, and services;

(2) Texas shopping opportunities related to destinations, food products, and Texas-related products;

(3) pleasure-driving equipment, facilities, destinations, and services;

(4) camping, hiking, fishing, birding, boating, bicycling, gardening, photography, wildlife viewing, astronomy, geology, and other outdoor events, sites, equipment, facilities, and services;

(5) public transportation modes, products, facilities, and services; and

(6) other sites, products, equipment, facilities, and services that are travel related or Texas based, and that are determined by the department to be of cultural, educational, historical, or recreational interest to Texas Highways readers.

(c) Unacceptable subjects. Advertising subjects not acceptable in Texas Highways include:

(1) out-of-state travel-tourism locations, destinations, facilities, and services that do not augment Texas travel or tourism or that are not located on border locations with ties to Texas;

(2) alcoholic beverages;

(3) tobacco products; and

(4) sexually-oriented products and services.

(d) Advertising sales and solicitations.

(1) Mailing list. Any entity or individual interested in advertising in Texas Highways magazine will be included in the department's mailing list upon request. The department will annually publish

in the Texas Register an invitation to be added to the mailing list and to receive advertising rate information.

(2) Publication of advertiser information. The department will calculate advertising rates and develop a rate card for Texas Highways magazine. The department will publish the information on a continuous basis in the Standard Rate and Data Service, Consumer Magazine and Agri-Media Source. The department will also publish the advertising rate information annually in the Texas Register.

(3) Contents of the rate card. The rate card will include information about:

(A) advertising space and positions;

(B) advertising rates;

(C) publication issue and closing dates;

(D) circulation data;

(E) publisher's editorial profile; and

(F) other related information.

(4) Procedure for selling advertising.

(A) The department and/or its designated agent will mail an announcement of advertising opportunities and the rate card to those on the mailing list 30 days after publication in the Texas Register.

(B) The department or its designated agent will subsequently mail a rate card upon request to an entity or individual not on the mailing list.

(C) The department or its designated agent will accept all insertion orders (orders for paid advertising) received prior to the closing date on a first-come, first-served basis until all advertising space for a particular publication is filled. All insertion orders will be stamped with the date as they are received. Insertion orders for an inside front cover spread and inside back cover spread will take precedence over an inside front cover and inside back cover insertion order, notwithstanding the date of receipt of the insertion order.

(D) Reminders of advertising space deadlines and rates may be mailed to those on the mailing list at the discretion of the department if advertising space remains available prior to space closing deadline.

(e) Restrictions.

(1) The department will not accept advertising it considers to be misleading or a misrepresentation of facts.

(2) The department will not accept advertising from an entity that discriminates against customers on the basis of race, color, creed, religion, sex, or national origin.

(3) The director may remove an advertiser based on the department's receipt of three or more consumer complaints concerning service or merchandise. The department will send a written notice of noncompliance to the advertiser. If the director determines the complaints are valid and they remain unresolved after 180 days, the director will remove the advertiser from Texas Highways magazine, and will no longer accept insertion orders from that advertiser. An advertiser may appeal the removal to the department's executive director, whose decision will be final.

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 14, 2001.

TRD-200107891
Richard D. Monroe
General Counsel
Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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PART 2. TEXAS TURNPIKE AUTHORITY DIVISION OF THE TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 50. MANAGEMENT

The Texas Department of Transportation proposes the repeal of Chapter 50, concerning management of the Texas Turnpike Authority Division of the Texas Department of Transportation. This proposed repeal includes §50.1 and §50.2, General Provisions; §§50.3-50.30, Governance of the Authority; §50.32 and §50.33, Public Meetings and Public Access; §§50.41-50.45, Employment Practices; §§50.50-50.54, Indemnification; and §50.60-§50.62, Public Records, Complaint Procedures, and Debt Collection.

EXPLANATION OF PROPOSED REPEALS

Senate Bill 342, 77th Legislature, 2001, abolished the Board of Directors (board) of the Texas Turnpike Authority Division (TTA) of the Texas Department of Transportation (department), subject to the approval by the voters of Senate Joint Resolution 16. The voters approved SJR 16 on November 6, 2001. Senate Bill 342 further provided that rules of the board continue in effect as rules of the Texas Transportation Commission (commission)

The commission promulgates rules governing the operations of the department, codified in Title 43, Part 1 (Chapters 1-31). The board was responsible for promulgating rules governing the operations of TTA, codified in Title 43, Part 2 (Chapters 50-54). With the abolishment of the board, TTA will be more completely consolidated with the department, and the commission will be responsible for promulgating rules governing the operations of TTA.

The rules contained in Chapter 50 are no longer necessary due to the abolishment of the board and, more specifically, the following reasons.

Subchapter A, General Provisions, will not be necessary due to the repeal of the entire chapter.

The provisions of §§50.3-50.26, 50.28-50.30, and 50.32 all govern the operations of the now abolished board.

The provisions of §§50.27 and 50.28 govern the staff of the TTA. This subject will now be governed by §1.2 and other department policies and procedures.

Section 50.33 concerns public access to information and auxiliary aids. This subject will now be governed by §1.5, concerning department public hearings, and other applicable department policies.

Subchapter D concerns employment practices. TTA employees will be governed by Chapter 4, Employment Practices, and the department's Human Resources Manual.

The provisions of Subchapter E, Indemnification, are not necessary due to provisions of state law and department policy.

Subchapter F concerns public records, complaint procedures, and debt collection. These subjects will be governed by: Chapter 3, Subchapter A, Access to Official Records; Chapter 3, Subchapter B, Complaint Resolution; and §5.10, Collection of Debts.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five-years the repeals are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeals. There are no anticipated economic costs for persons required to comply with the repeals as proposed.

Phillip E. Russell, Director, Turnpike Authority Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeals.

PUBLIC BENEFIT

Mr. Russell has also determined that for each year of the first five years the repeals are in effect, the public benefit anticipated as a result of enforcing or administering the repeals will be the repeal of unnecessary and duplicative rules. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeals may be submitted to Phillip E. Russell, Director, Turnpike Authority Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

SUBCHAPTER A. GENERAL PROVISIONS

43 TAC §50.1, §50.2

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.1. The Authority
§50.2. Definitions

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

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Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
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For further information, please call: (512) 463-8630

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SUBCHAPTER B. GOVERNANCE OF THE AUTHORITY

43 TAC §§50.3 - 50.30

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.3. Principal Office.
§50.4. General Powers.
§50.5. Number.
§50.6. Appointment.
§50.7. Qualifications.
§50.8. Term.
§50.9. Vacancies.
§50.10. Resignation and Removal.
§50.11. Compensation of Directors.
§50.12. Meetings.
§50.13. Quorum.
§50.14. Meetings by Telephone.
§50.15. Procedure.
§50.16. Committees.
§50.17. Notice.
§50.18. Waiver of Notice.
§50.19. Attendance as Waiver.
§50.20. Officers.
§50.21. Election and Term of Office.
§50.22. Removal and Vacancies.
§50.23. Chair.
§50.24. Vice Chair.
§50.25. Secretary.
§50.26. Treasurer.
§50.27. Administrators.
§50.28. Director.
§50.29. Assistant Secretary.
§50.30. Assistant Treasurer

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
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For further information, please call: (512) 463-8630

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SUBCHAPTER C. PUBLIC MEETINGS AND PUBLIC ACCESS

43 TAC §50.32, §50.33

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.32. Public Access to Board Meetings

§50.33. Public Access to Information and Auxiliary Aids

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

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Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
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SUBCHAPTER D. EMPLOYMENT PRACTICES

43 TAC §§50.41 - 50.45

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.41. General Policy
§50.42. Sick Leave Pool Program
§50.43. Employee Training and Education
§50.44. Termination of Employees
§50.45. Standards of Conduct

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

TRD-200107865
Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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SUBCHAPTER E. INDEMNIFICATION

43 TAC §§50.50 - 50.54

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.50. Indemnification by the Authority.
§50.51. Expenses
§50.52. Procedure
§50.53. Additional Indemnification
§50.54. Definitions

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

TRD-200107866

Richard D. Monroe

General Counsel

Texas Turnpike Authority Division of the Texas Department of Transportation

Earliest possible date of adoption: January 27, 2002

For further information, please call: (512) 463-8630

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SUBCHAPTER F. PUBLIC RECORDS, COMPLAINT PROCEDURES AND DEBT COLLECTION

43 TAC §§50.60 - 50.62

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, §361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§50.60. Public Records

§50.61. Complaints Procedure

§50.62. Debt Collection

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

TRD-200107867

Richard D. Monroe

General Counsel

Texas Turnpike Authority Division of the Texas Department of Transportation

Earliest possible date of adoption: January 27, 2002

For further information, please call: (512) 463-8630

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CHAPTER 53. CONTRACTING AND PROCUREMENT PROCEDURES

The Texas Department of Transportation proposes the repeal of §§53.60-53.71, concerning disadvantaged business enterprise/historically underutilized business procedures, and §§53.90-53.94, concerning contract workforce.

EXPLANATION OF PROPOSED REPEALS

Senate Bill 342, 77th Legislature, 2001, abolished the Board of Directors (board) of the Texas Turnpike Authority Division (TTA) of the Texas Department of Transportation (department), subject to approval by the voters of Senate Joint Resolution 16. The voters approved SJR 16 on November 6, 2001. Senate Bill 342 further provided that rules of the board continue in effect as rules of the Texas Transportation Commission (commission).

The commission promulgates rules governing the operations of the department, codified in Title 43, Part 1 (Chapters 1-31). The TTA board of directors was responsible for promulgating rules governing the operations of TTA, codified in Title 43, Part 2 (Chapters 50-54). With the abolishment of the board, TTA will be more completely consolidated with the department, and the commission will be responsible for promulgating rules governing the operations of TTA.

Sections 53.60-53.71 establish policies and procedures to implement TTA's Disadvantaged Business Enterprise (DBE) and Historically Underutilized Business (HUB) programs. With the abolishment of the board, these rules are no longer needed since the department has comprehensive DBE and HUB program rules found in §§9.50-9.57.

Sections 53.90-53.94 describe the analyses required prior to TTA procuring and utilizing contract workforce. These rules will no longer be necessary since existing department contract workforce policies will be applicable to all department divisions using contract workforce.

FISCAL NOTE

James Bass, Director, Finance Division, has determined that for each of the first five-years the repeals are in effect, there will be no fiscal implications for state or local governments as a result of enforcing or administering the repeals. There are no anticipated economic costs for persons required to comply with the repeals as proposed.

Phillip E. Russell, Director, Turnpike Authority Division, has certified that there will be no significant impact on local economies or overall employment as a result of enforcing or administering the repeals.

PUBLIC BENEFIT

Mr. Russell has also determined that for each year of the first five years the repeals are in effect, the public benefit anticipated as a result of enforcing or administering the repeals will be the removal of duplicative and unnecessary rules. There will be no adverse economic effect on small businesses.

SUBMITTAL OF COMMENTS

Written comments on the proposed repeals may be submitted to Phillip E. Russell, Director, Turnpike Authority Division, 125 East 11th Street, Austin, Texas 78701-2483. The deadline for receipt of comments is 5:00 p.m. on January 28, 2002.

SUBCHAPTER D. DBE/HUB PROGRAM

43 TAC §§53.60 - 53.71

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the

Texas Department of Transportation, and Transportation Code, Section 361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§53.60. Purpose

§53.61. Definitions

§53.62. Policy

§53.63. Applicability

§53.64. DBE/HUB Goals

§53.65. Good Faith Effort

§53.66. DBE Certification

§53.67. HUB Certification

§53.68. Contract Compliance

§53.69. Business Complaints

§53.70. Investigation

§53.71. Appeals

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

TRD-200107868
Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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SUBCHAPTER E. CONTRACT WORKFORCE

43 TAC §§53.90 - 53.94

(Editor's note: The text of the following sections proposed for repeal will not be published. The sections may be examined in the offices of the Texas Turnpike Authority Division of the Texas Department of Transportation or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

STATUTORY AUTHORITY

The repeal is proposed under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and Transportation Code, Section 361.042, which requires the commission to adopt rules for the regulation of its affairs and the conduct of its business under Transportation Code, Chapter 361.

No statutes, articles, or codes are affected by the proposed repeals.

§53.90. Purpose

§53.91. Definitions

§53.92. Prerequisites to Utilizing Contract Workforce

§53.93. Cost-Benefit Analyses

§53.94. Guidance

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's legal authority to adopt.

Filed with the Office of the Secretary of State, on December 13, 2001.

TRD-200107869
Richard D. Monroe
General Counsel
Texas Turnpike Authority Division of the Texas Department of Transportation
Earliest possible date of adoption: January 27, 2002
For further information, please call: (512) 463-8630

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WITHDRAWN RULES

An agency may withdraw a proposed action or the remaining effectiveness of an emergency action by filing a notice of withdrawal with the ***Texas Register***. The notice is effective immediately upon filling or 20 days after filing as specified by the agency withdrawing the action. If a proposal is not adopted or withdrawn within six months of the date of publication in the ***Texas Register***, it will automatically be withdrawn by the office of the Texas Register and a notice of the withdrawal will appear in the ***Texas Register.***

TITLE 22. EXAMINING BOARDS

PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 193. STANDING DELEGATION ORDERS

22 TAC §193.6

The Texas State Board of Medical Examiners has withdrawn from consideration the proposed amendment to §193.6, which appeared in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8700).

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107989
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: December 17, 2001
For further information, please call: (512) 305-7016

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TITLE 25. HEALTH SERVICES

PART 2. TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION

CHAPTER 403. OTHER AGENCIES AND THE PUBLIC

SUBCHAPTER B. CHARGES FOR COMMUNITY-BASED SERVICES

25 TAC §§403.41 - 403.53

The Texas Department of Mental Health and Mental Retardation has withdrawn from consideration proposed repeals to §§403.41 - 403.53 which appeared in the October 19, 2001, issue of the *Texas Register* (26 TexReg 8315-8316).

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107948
Andrew Hardin
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Effective date: December 14, 2001
For further information, please call: (512) 206-5216

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CHAPTER 412. LOCAL AUTHORITY RESPONSIBILITIES

SUBCHAPTER C. CHARGES FOR COMMUNITY SERVICES

25 TAC §§412.101 - 412.115

The Texas Department of Mental Health and Mental Retardation has withdrawn from consideration proposed new §§412.101 - 412.115 which appeared in the October 19, 2001, issue of the *Texas Register* (26 TexReg 8316-8322).

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107947
Andrew Hardin
Chairman, Texas MHMR Board
Texas Department of Mental Health and Mental Retardation
Effective date: December 14, 2001
For further information, please call: (512) 206-5216

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PART 16. TEXAS HEALTH CARE INFORMATION COUNCIL

CHAPTER 1301. HEALTH CARE INFORMATION

SUBCHAPTER A. HOSPITAL DISCHARGE DATA RULES

25 TAC §1301.11, §1301.18

The Texas Health Care Information Council has withdrawn from consideration the proposed amendments to §1301.11 and §1301.18, which appeared in the August 10, 2001, edition of the *Texas Register* (26 TexReg 5987).

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107954
Jim Loyd
Executive Director
Texas Health Care Information Council
Effective date: December 17, 2001
For further information, please call: (512) 482-3320

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TITLE 28. INSURANCE

PART 2. TEXAS WORKERS' COMPENSATION COMMISSION

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER F. PHARMACEUTICAL BENEFITS

28 TAC §134.505

The Texas Workers' Compensation Commission has withdrawn from consideration proposed new §134.505 which appeared in the August 31, 2001, issue of the *Texas Register* (26 TexReg 6584).

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107939
Susan Cory
General Counsel
Texas Workers' Compensation Commission
Effective date: December 14, 2001
For further information, please call: (512) 804-4287

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ADOPTED RULES

An agency may take final action on a section 30 days after a proposal has been published in the ***Texas Register***. The section becomes effective 20 days after the agency files the correct document with the ***Texas Register***, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice.

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published. If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. MEDICAID REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

1 TAC §355.8061

The Texas Health and Human Services Commission. (HHSC) adopts amendments to §355.8061, concerning payment for hospital services, with changes to the proposed text published in the August 31, 2001, issue of the *Texas Register* (26 TexReg 6513). Subsection (a)(2) is revised to clarify that the discount factor of 80.3% of allowable cost is applicable to all hospitals for September 2001.

The amendment specifies that, effective October 1, 2001, the discount factor for outpatient hospital services will be increased from 80.3% to 84.48% for high volume providers. The amendment will function by clarifying the reimbursement oversight of HHSC, providing a date specific reference to the applicable Medicare reimbursement methodology, and describing the requirements to hold a public hearing and respond to public comments before subsequent changes are made to the discount factor.

During the 30-day public comment period, comments were received from the Texas Hospital Association. The following is a summary of the comments received and HHSC's response to each comment.

Comment: The commenter stated that HHSC should implement a tiered approach with high volume-hospitals receiving a greater increase in hospital outpatient reimbursement. This would provide a rate increase for all hospitals and allow the state to meet the intent of the legislative riders.

Response: HHSC disagrees with this comment. HHSC believes that the legislative intent was the establishment of a reimbursement methodology that recognizes and rewards high-volume providers. No changes were made to the text of the rule based on these comments.

Comment: The commenter stated that Rider 48, 77th Texas Legislature, requires HHSC to implement mechanisms to pass the fee directly to providers and that the rule does not address how HHSC will monitor and enforce the fee increase payment directly to providers from contractors.

Response: This comment is beyond the scope of the proposal. The amendment addresses changes to the reimbursement methodology. It does not address processes for monitoring and enforcing fee increases. These issues are more appropriately addressed in the state's contracts with its contractors. No changes were made to the text of the rule based on these comments.

Comment: In the preamble the estimated fiscal impact to health and human service agencies was omitted. Following is the projected increase in spending for the first five years that the rules are in effect:

Figure 1 TAC Chapter 355-Preamble

The amendments are adopted under Section 531.021(b), Government Code, which requires HHSC to adopt reasonable rules and standards to govern the determination of fees, charges, and rates for medical assistance payments under Chapter 32, Human Resources Code, in consultation with agencies that operate the Medicaid program; and Section 531.033, Government Code, which provides the commissioner of HHSC with the authority to adopt rules necessary to carry out the duties of HHSC under Chapter 531, Government Code.

§355.8061. Payment for Hospital Services.

(a) The Health and Human Services Commission (commission) or its designated agent shall reimburse hospitals approved for participation in the Texas Medical Assistance Program for covered Title XIX hospital services provided to eligible Medicaid recipients. The Texas Title XIX State Plan for Medical Assistance provides for reimbursement of covered hospital services to be determined as specified in paragraphs (1)-(3) of this subsection.

(1) The amount payable for inpatient hospital services shall be determined as specified in §29.606 of this title (relating to Reimbursement Methodology for Inpatient Hospital Services).

(2) The amount payable for outpatient hospital services shall be determined under similar methods and procedures used in the Social Security Act, Title XVIII, as amended, effective October 1, 1982 through July 31, 2000, by Public Law 97-248, except as may be otherwise specified by the Health and Human Services Commission. For the period of September 1, 1999 through and including September 30, 2001, payments to all providers were at 80.3% of allowed costs. For the period beginning October 1, 2001, Medicaid reimbursement

for outpatient hospital services for high-volume providers, as defined by the commission, shall be at 84.48% of allowable cost. For the remaining providers, reimbursement for outpatient hospital services shall be at 80.3% of allowable cost. For the purpose of establishing the proposed discount factor, a high-volume provider is defined as one, which is paid at least $200,000 during calendar year 2000. Any subsequent changes to the discount will require HHSC to hold a public hearing on proposed reimbursements before the HHSC approves any changes. The purpose of the hearing is to give interested parties an opportunity to comment on the proposed reimbursements. Notice of the hearing will be provided to the public. The notice of the public hearing will identify the name, address, and telephone number to contact for the materials pertinent to the proposed reimbursements. At least ten working days before the public hearing takes place, material pertinent to the proposed change will be made available to the public. This material will be furnished to anyone who requests it. After the public hearing, if negative comments are received, a summary of the comments made during the public hearing will be presented to the HHSC. Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to ambulatory surgical centers (ASCs) for similar services, the hospital's actual charge, the hospital's customary charge, or the allowable cost determined by the commission or its designee.

(3) Variances shall be accounted for in the Texas State Plan for Medical Assistance or as otherwise specified by the commission.

(b) Title XIX providers may not carry forward those unreimbursed costs attributed to either the lower costs or charge limitations authorized by 42 Code of Federal Regulations §405.455 et seq., effective for all accounting periods beginning on or after January 1, 1982.

(c) The direct and indirect costs of caring for charity patients shall have no relationship to eligible recipients of the Texas Medical Assistance program and are not allowable costs under the Texas Title XIX Medical Assistance program. Obligations by hospitals to provide free care, under the Hill-Burton Act or any other arrangement as a condition to secure federal grants or loans, are not recognized as a cost under the Texas Medical Assistance program.

(d) The contents of subsection (a)-(c) of this section do not describe the amount, duration, or scope of services provided to eligible recipients under the Texas Medical Assistance Program.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107952
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Effective date: January 3, 2002
Proposal publication date: August 31, 2001
For further information, please call: (512) 424-6576

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CHAPTER 371. MEDICAID FRAUD AND ABUSE PROGRAM INTEGRITY
SUBCHAPTER E. OPERATING AGENCY RESPONSIBILITIES RULE

1 TAC §371.1002

The Texas Health and Human Services Commission (HHSC) adopts an amendment to §371.1002 in chapter 371, concerning the minimum collection goal for the Texas Department of Human Services that specifies the percentage of the amount of benefits granted by the department in error under the food stamp program or the program of financial assistance under chapter 31, Human Resources Code. Section 531.050 of the Texas Government Code directs the Health and Human Services Commission to set the minimum collection goal for each year. The amended §371.1002 sets out the minimum collection goal for state fiscal year 2002.

Section 371.1002 is adopted without changes to the proposed text as published in the November 9, 2001, issue of the *Texas Register* (26 TexReg 8935).

The amended rule is proposed under the Texas Government Code, §531.033, which authorizes the Commissioner of Health and Human Services to adopt rules necessary to carry out the Health and Human Services Commission's duties under Chapter 531.

The amended rule implements Texas Government Code, §531.050.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107999
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Effective date: January 6, 2002
Proposal publication date: November 9, 2001
For further information, please call: (512) 424-6576

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TITLE 7. BANKING AND SECURITIES

PART 1. FINANCE COMMISSION OF TEXAS

CHAPTER 1. CONSUMER CREDIT REGULATION
SUBCHAPTER J. AUTHORIZED LENDER'S DUTIES AND AUTHORITY

7 TAC §1.841

The Finance Commission of Texas adopts new 7 TAC §1.841, concerning non-standard contract filing procedures. The new rule is adopted with changes to the proposal as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8625).

The purpose of the new rule is to implement the provisions of Texas Finance Code §341.502 as mandated by the 77th Legislative Session in Senate Bill 317. Section 341.502 requires contracts for consumer loans under Chapter 342, motor vehicle

installment sales contracts under Chapter 348, and home equity transactions regulated by the Office of Consumer Credit Commissioner to be written in plain language. The section requires the Finance Commission to adopt rules governing the form of contracts including model provisions for contracts in plain language. A drafting workgroup has been formed to develop plain language contracts for the various transactions. The final draft contract provisions will be proposed as rules when the draft provisions are complete. The statute requires creditors who choose not to use the model contracts to file their non-standard contracts for a plain language review. It is the view of the Finance Commission and the Office Consumer Credit Commissioner that the statute contemplates that model contract provisions would be promulgated before creditors begin submitting non-standard contracts for a plain language review. Towards that end, the rule proposes to establish a schedule for the submission of non-standard contracts that reflects deadlines that would follow the estimated dates for promulgating model contract provisions.

The agency received written comments on the rule proposal from: Mark Morris, J.P. Morgan Chase & Co.; Ann Graham, Texas Bankers Association; and Scott Sheehan, McGlinchey Stafford, PLLC.

The commenters generally expressed concern about the jurisdictional and regulatory aspects of the proposed rule. The commenters' concerns were primarily directed at §1.840, a rule that is not being offered for adoption at this time. The comments focus upon the language of the statute §341.502(a) that reads as follows:

Sec. 341.502. FORM OF LOAN CONTRACT. (a) A contract for a loan under Chapter 342, a retail installment transaction under Chapter 348, or a home equity loan regulated by the Office of Consumer Credit Commissioner, whether in English or Spanish, must be written in plain language designed to be easily understood by the average consumer. The contract must be printed in an easily readable font and type size.

Although the commenters note they support the concept of plain language contracts, the development of model contracts, and the proposed time frame established in 7 TAC §1.841, they object to submission of non-standard contracts to the Office of Consumer Credit Commissioner for review. The rule has been modified to remove the provision requiring submission to the Office of Consumer Credit Commissioner, although as a practical matter many creditors will file non-standard contracts with the Office of Consumer Credit Commissioner.

The primary purpose of §1.841 is to establish a time frame for creditors who desire to file non-standard contracts. The section also provides some guidance and minimal procedural requirements for those creditors who voluntarily desire to file non-standard contracts in advance of the deadlines provided by the rule. Because some creditors have expressed a desire to file these non-standard contracts, the agency believes that some minimal basic procedures are necessary to facilitate this process. In response to the commenters' concern of the requirement of banks to file non-standard contacts with the OCCC, the agency has removed the reference to the OCCC in subsection (a) of the rule. The agency believes that establishing detailed procedures and processes for reviewing non-standard contracts is premature at this time. The agency plans to study the review process and its applicability to entities with different primary regulators. The agency believes the rule as modified meets the objective of providing procedures for those creditors who desire early filing for their contracts, while overcoming the objection of the commenters by deferring the detailed review and filing procedures.

The new rules are adopted under the Texas Finance Code §11.304 and §341.502, which authorize the Finance Commission to adopt rules to enforce Title 4 of the Texas Finance Code. Additionally, Texas Finance Code §14.108 grants the Consumer Credit Commissioner and the Finance Commission the authority to interpret the provisions of Title 4, Subtitle B, in which Chapter 341 is located.

These rules affect Chapter 341, 342 and 348, Texas Finance Code.

§1.841. Non-standard Contract Filing Procedures.

(a) Non-standard contracts. A non-standard contract is a contract that does not use the model contract provisions. Non-standard contracts submitted in compliance with the provisions of §341.502(c) will be reviewed to determine that the contract is written in plain language. Non- standard contracts submitted for review may gain certain protections under the provisions of §341.502.

(b) Certification of readability. Contract filings subject to this subchapter must be accompanied by a certification signed by an officer of the creditor or the entity submitting the form on behalf of the creditor. The certification must state that the contract is written in plain language (i.e., that the contract can be easily understood by the average consumer). The certification must also state that the contract is printed in an easily readable font and type size.

(c) Filing requirements. Contract filings must be identified as to the transaction type. Contract filings must be submitted on paper that is suitable for permanent record storage and imaging. Handwritten forms or handwritten corrections will not be accepted.

(d) Contact Person. One person shall be designated as the contact person for each filing submitted. Each submission should provide the name, address, phone number, and fax number, if available, of the contact person for that filing. If the contracts are submitted by anyone other than the company itself, the contracts must be accompanied by a dated letter which contains a description of the anticipated users of the contracts and designates the legal counsel or other designated contact person for that filing.

(e) Filing deadlines. Submission of non-standard contracts is not required until the model contract provisions have been adopted by rule.

(1) For subchapter F loans under 342, non-standard contracts are not required to be filed before May 1, 2002.

(2) For subchapter E loans under 342, non-standard contracts are not required to be filed until September 1, 2002.

(3) For subchapter G loans under Chapter 342 or home equity loans, non-standard contracts are not required to be filed before February 1, 2003.

(4) For retail installment transactions under Chapter 348, non-standard contracts are not required to be filed before May 1, 2003.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107945

Leslie L. Pettijohn
Commissioner
Finance Commission of Texas
Effective date: January 3, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 936-7640

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CHAPTER 4. CURRENCY EXCHANGE

7 TAC §§4.3 - 4.6, 4.10

The Finance Commission of Texas (the commission) adopts amendments to §4.3, concerning reporting and recordkeeping requirements that apply to currency businesses; §4.4, concerning changes in location of a currency business; §4.5, concerning acquisition or control of a currency business licensee; §4.6, concerning exemptions to licensing as a currency business; and §4.10, concerning mobile currency businesses. These sections are adopted without changes to the proposed text as published in the November 2, 2001 issue of the *Texas Register* (26 TexReg 8626) and the text will not be republished.

The amendments are made to reflect a change in Finance Code Chapter 153, which added currency transportation as a currency business regulated under that statute.

The amendments to §4.3 make reporting and recordkeeping requirements for currency businesses applicable to persons engaged in currency transportation transactions. The amendments also add a new requirement in subsection (e)(2)(G) for currency exchange, transportation, and transmission businesses to obtain receipts for all transactions conducted with other financial institutions and to retain those receipts for five years. The amendments delete subsection (i), which allows a currency business to maintain records under 31 CFR, Part 103 in lieu of compliance with §4.3. The amendments also delete the requirements in subsections (e)(1)(A) and (e)(2)(A) that receipts required under these subsections must be sequentially numbered. The remaining amendments to §4.3 are proposed to improve clarity and are nonsubstantive.

The amendments to §§4.4, 4.5, 4.6, and 4.10 add currency transportation as a currency business to which these sections apply.

The commission received no comments regarding the proposal.

The amendments are adopted under the authority of Finance Code, §153.002, which authorizes the commission to adopt rules necessary to enforce and administer Finance Code, Chapter 153.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107904
Everette D. Jobe
Certifying Official
Finance Commission of Texas
Effective date: January 3, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 475-1300

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PART 2. TEXAS DEPARTMENT OF BANKING

CHAPTER 11. MISCELLANEOUS

SUBCHAPTER A. GENERAL

7 TAC §11.37

The Finance Commission of Texas (the commission) adopts new §11.37 concerning the filing of consumer complaints with the Texas Department of Banking (department). This section is adopted without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8630), and the text will not be republished.

New §11.37 implements the requirements of Finance Code, §11.307, pertaining to the filing of consumer complaints with the department.

Section 11.37 specifies the manner in which banks, foreign banks, bank holding companies, and trust companies provide consumers with information on how to file complaints with the department. The section also requires that the information on how to file complaints be included with each privacy notice a bank, foreign bank, bank holding company, or trust company is required by law to provide to consumers.

The commission received one comment regarding the proposed section. The commenter questioned the necessity of providing the banking public with the contact information for the department. The commission is acting to implement Finance Code, §11.307, which requires the commission to adopt rules applicable to each entity for the department "specifying the manner in which the entity provides consumers with information on how to file complaints" with the department.

The commenter also questioned the requirement in subsection (b)(3) that the required notice be included with each privacy notice sent out. The commission is acting to implement Finance Code, §11.307, which requires the commission to adopt rules requiring each entity regulated by the department to include information on how to file complaints with the department with each privacy notice the entity is required to provide under law.

The commenter also asked whether the required notice must be included in the wording of the privacy notice or must be an insert or attachment to the privacy notice. The requirement of the new section may be met in either manner. The commenter also asks whether the new rule retroactively applies to privacy notices already sent. It does not. It applies to all privacy notices sent after the effective date of the new rule. The commenter also questions the proposed cost of compliance with subsection (b)(5)(a) stating that it wishes to print and frame a high quality notice for its locations. The commission believes that compliance with the rule may be cost effectively achieved.

The commenter also inquired as to whether the required website notice must be included with the website's privacy notice. That is not required by the rule. The portion of the website that offers consumer goods and services, however, must contain access to the required notice.

Section 11.37 is adopted under the authority of Finance Code, §11.307, which requires the commission to adopt rules specifying the manner in which banks, foreign banks, bank holding

companies, and trust companies provide consumers with information on how to file complaints with the department.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
Certifying Official
Texas Department of Banking
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For further information, please call: (512) 475-1300

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CHAPTER 25. PREPAID FUNERAL CONTRACTS

SUBCHAPTER B. REGULATION OF LICENSES

7 TAC §25.41

The Finance Commission of Texas (the commission) adopts new §25.41 concerning the filing of consumer complaints with the Texas Department of Banking (department). New §25.41 is being adopted with changes to the proposal as published in the November 2, 2001, *Texas Register* (26 TexReg 8638). The text of new §25.41 will be republished.

Section 25.41 implements the requirements of Finance Code, §11.307, pertaining to the filing of consumer complaints with the department.

New §25.41 specifies the manner in which prepaid funeral benefits contract sellers provide consumers with information on how to file complaints with the department. The new section also requires that the information on how to file complaints be included with each privacy notice a prepaid funeral benefits contract seller is required by law to provide to consumers.

The commission received one comment on the proposed section from a representative of a coalition of insurers. The commenter questioned the necessity of the requirement in subsection (b)(3) that the required notice be included with each privacy notice sent out. The commenter also raised a concern about confusion between the privacy notice and the consumer complaint notice. The commission is acting to implement Finance Code, §11.307, which requires the commission to adopt rules requiring each entity regulated by the department to include information on how to file complaints with the department with each privacy notice the entity is required to provide under law. Entities regulated by the department should make every effort to avoid confusion between the two notices.

The commenter also questioned the usefulness and suitability of the posted notice in light of the fact that the section requires that the required notice be included within the preneed contract. The commission agrees with the comment and has eliminated the posting requirement in subsection (b)(5)(a). The commission believes that the consumer will be more likely to be made aware of the complaint process through inclusion in the contract.

The commission added "I" to the definition's section at subsection (a)(4). The commission eliminated the e-mail address from the required notice at subsection (b)(1) to make the notice consistent with the notice required in a preneed funeral contract by §25.3(j) of this title (relating to What Requirements Apply to a Non-Model Contract or Waiver). The e-mail address is contained on the department's website.

Section 25.41 is proposed under the authority of Finance Code, §11.307, which requires the commission to adopt rules specifying the manner in which prepaid funeral benefits contract sellers provide consumers with information on how to file complaints with the department.

§25.41. How Do I Provide Information to Consumers on How to File a Complaint?

(a) Definitions

(1) "Consumer" means an individual who obtains or has obtained a product or service from you that is to be used primarily for personal, family, or household purposes.

(2) "Privacy notice" means any notice which you give regarding a consumer's right to privacy as required by a specific state or federal law.

(3) "Required notice" means a notice in a form set forth or provided for in subsection (b)(1) of this section.

(4) "You" or "I" means a prepaid funeral benefits contract seller that is licensed or permitted by the Texas Department of Banking under the Finance Code.

(b) How do I provide notice of how to file complaints?

(1) You must use the following notice in order to let your consumers know how to file complaints: The (your name) is licensed or permitted under the laws of the State of Texas and by state law is subject to regulatory oversight by the Texas Department of Banking. Any consumer wishing to file a complaint against the (your name) should contact the Texas Department of Banking through one of the means indicated below: In Person or U.S. Mail: 2601 North Lamar Boulevard, Suite 300, Austin, Texas 78705-4294 Telephone No.: 877/276-5554 Fax No.: 512/475-1288 Website: www.banking.state.tx.us

(2) You must provide the required notice in the language in which a transaction is conducted.

(3) You must include the required notice with each privacy notice that you send out.

(4) Regardless of whether you are required by any state or federal law to give privacy notices, you must take appropriate steps to let your consumers know how to file complaints by giving them the required notice in compliance with paragraph (1) of this subsection.

(5) You must use the following measures to give the required notice:

(A) For consumers who are not given privacy notices, you must give the required notice when the consumer first obtains a product or service from you.

(B) Those portions of your website that offer consumer goods and services must contain access to the required notice.

(C) You must also include in all contract forms the notice required by §25.3(j) of this title (relating to What Requirements Apply to a Non-Model Contract or Waiver).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 26. PERPETUAL CARE CEMETERIES

7 TAC §26.11

The Finance Commission of Texas (the commission) adopts new §26.11 concerning the filing of consumer complaints with the Texas Department of Banking (department). New §26.11 is being adopted with changes to the proposal as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8639). The text of new §26.11 will be republished.

Section 26.11 implements the requirements of Finance Code, §11.307, pertaining to the filing of consumer complaints with the department.

New §26.11 specifies the manner in which perpetual care cemeteries provide consumers with information on how to file complaints with the department. The section also requires that the information on how to file complaints be included with each privacy notice a perpetual care cemetery is required by law to provide to consumers.

The commission received two comments on the proposed section. One commenter suggested that the new section require that a complaint made in person be in writing. While the department may require that an oral complaint be reduced to writing, the commission believes the suggested additional requirement may discourage legitimate consumer complaints.

Another commenter questioned the usefulness and suitability of the posted notice and suggested that the required notice be contained in a purchase agreement. The department agrees with this comment and has eliminated the posting requirement and added language that the required notice may be delivered through the inclusion in a purchase agreement. This commenter also noted that there was no definition of "I" in the definition section. The commission has added "I" to the definitions' section.

The commission eliminated the e-mail address from the required notice. The e-mail address is contained on the department's website.

Section 26.11 is adopted under the authority of Finance Code, §11.307, which requires the commission to adopt rules specifying the manner in which perpetual care cemeteries provide consumers with information on how to file complaints with the department.

§26.11. How Do I Provide Information to Consumers on How to File a Complaint?

(a) Definitions

(1) "Consumer" means an individual who obtains or has obtained a product or service from you that is to be used primarily for personal, family, or household purposes.

(2) "Privacy notice" means any notice which you give regarding a consumer's right to privacy as required by a specific state or federal law.

(3) "Required notice" means a notice in a form set forth or provided for in subsection (b)(1) of this section.

(4) "You" or "I" means a perpetual care cemetery that is certificated by the Texas Department of Banking under the Finance Code.

(b) How do I provide notice of how to file complaints?

(1) You must use the following notice in order to let your consumers know how to file complaints: The (your name) is certificated under the laws of the State of Texas and by state law is subject to regulatory oversight by the Texas Department of Banking. Any consumer wishing to file a complaint against the (your name) should contact the Texas Department of Banking through one of the means indicated below: In Person or U.S. Mail: 2601 North Lamar Boulevard, Suite 300, Austin, Texas 78705-4294 Telephone No.: 877/276-5554 Fax No.: 512/475-1288 Website: www.banking.state.tx.us

(2) You must provide the required notice in the language in which a transaction is conducted.

(3) You must include the required notice with each privacy notice that you send out.

(4) Regardless of whether you are required by any state or federal law to give privacy notices, you must take appropriate steps to let your consumers know how to file complaints by giving them the required notice in compliance with paragraph (1) of this subsection.

(5) You must use the following measures to give the required notice:

(A) For consumers who are not given privacy notices, you must give the required notice when the consumer first obtains a product or service from you. This may be accomplished by including the required notice in a purchase agreement.

(B) Those portions of your website that offer consumer goods and services must contain access to the required notice.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 31. PRIVATE CHILD SUPPORT ENFORCEMENT AGENCIES

The Finance Commission of Texas (the "commission") adopts new Chapter 31, §§31.1, 31.11-31.19, 31.31-31.39, 31.51-31.56, 31.71-31.76, 31.91-31.96, 31.111-31.115, concerning the licensing and regulation of private child support enforcement agencies ("agencies") by the Texas Department of Banking (the "department"). Chapter 31 is adopted with changes to the proposal as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8642). Sections 31.15-31.18, 31.32-31.36, 31.38, 31.39, 31.51-31.55, 31.91, 31.93-31.96, and 31.111-31.115 are adopted without changes. The text of Chapter 31 will be republished.

House Bill 1365, 77th Legislature promulgated new Chapter 396 of the Texas Finance Code ("Chapter 396"). The purpose of this chapter is to establish rules necessary for the administration of Chapter 396, pertaining to the department's licensing and regulating of agencies.

Section 31.1(10) was amended to allow a foreign agency to collect from fewer than 10 resident obligors without subjecting it to registration requirements. However, if the banking commissioner validates a complaint against such an agency, the agency may be required to submit an application for registration. This change was made in response to concerns about a foreign agency that is attempting to collect child support for a client residing in another state against an obligor residing in Texas. This change was made in recognition of the fact that requiring foreign agencies, who do not otherwise engage in business in Texas, to register to enforce against an obligor who resides or moves to Texas would unreasonably delay enforcement. Further, the expenses and delay of registering such a foreign agency could be wasted because an obligor could merely move to another state once the agency is licensed, leaving the agency with an unnecessary license and unnecessary expenses.

Section 31.1(13) and (14) were amended to limit obligees and obligors to Texas residents. This change was made in recognition of the fact that transactions between registered agencies and non-resident obligees or non-resident obligors lack nexus to the state of Texas.

Section 31.1(19) was changed to state that a registered office is an office where an agency performs certain services for clients. This change was made to clarify that the department does not regulate agency offices that do not service Texas residents. This section was further changed to state that it is not necessary to register a residence of a person working from home so long as the person is only performing collection activities.

Section 31.11(b)(2) and §31.11(b)(3)(A) were amended to clarify that information submitted with an application does not need to include information on lawsuits filed by an agency on behalf of clients. Section 31.11(b)(8) is added to require copies of findings from supervisory enforcement actions by governmental entities and the subsequent paragraphs of Section 31.11(b) were renumbered.

Section 31.11(c)(2)(C) is deleted. Agencies will not be required to give a statement of change in equity and cash flow. Section 31.11(c)(4)(B) is moved to the end of §31.11(a)(3).

Section 31.13(a) was changed to allow the commissioner to approve a cash bond not to exceed $50,000. This change was made to mirror the statute.

Section 31.14(a) was added to clarify that the department's requirements for contracts between obligees and agencies only applies to those contracts that were entered into with obligees who were Texas residents at the time of contracting. Subsequent subsections of this section were re-lettered.

Chapter 396 requires that contracts between agencies and obligees be in "clear" language. The usual terminology is "plain" language, but there is precedent for calling it "clear" language, for example a web site called Clear Language and Design ("CLAD") available at http://www.eastendliteracy.on.ca/ClearLanguageAndDesign/start.htm . The principles are the same.

In addition to the CLAD site, the department located numerous resources from which to derive the clear language requirements of §31.14, including these two web sites: http://www.plainlanguagenetwork.org/ and http://www.plainlanguage.gov. The changes made to §31.14 were made to conform the section with plain language requirements the agency has promulgated for other industries it regulates and to reorganize the sections into a logical order.

Subsection (a) was added to clarify that the contract is only required when contracting with obligees who reside in Texas at the time the contract is executed.

Former subsection (a), renamed subsection (b), was amended to replace the word "obligees" with the word "clients."

Subsection (b) was renamed subsection (c) and the word "model" removed because the department will provide sample clear language, but will not necessarily develop a model contract.

Subsection (c) was renamed subsection (d). Paragraph (1) is rewritten to more closely conform with the language with other department rules, without changing the substance. The paragraph was also changed to require an applicant to disclose its readability scores. Section 31.14(d)(1)(B) was changed from 18 words to 19 words to conform it with other department rules.

Section 31.14(d)(2) was changed to explain that clear and plain language concepts are synonymous and to require the contracts submitted to substantially comply with the paragraph. Subparagraph (A) was changed to further develop organizational requirements for the contracts. Subparagraphs (B) and (C), former subparagraph (J) and (B) respectively, have only grammatical changes. Subparagraph (D), formerly subparagraph (B), states the reason for writing in a question answer format.

Section 31.14(d)(2)(E) allows the use of tables, bullet lists, pictures, logos, charts, graphs and other design elements. Subparagraph (F), formerly subparagraph (C), has no new content. Subparagraph (G), formerly subparagraph (D), merely further defines the use of personal pronouns.

Section 31.14(d)(2)(H), formerly subparagraph (E), is rewritten, but contains no new content. Subparagraph (I), formerly subparagraph (F), further refines the requirement of use of active and passive voice. Subparagraph (J), formerly subparagraph (G), further refines the use of everyday words in drafting contracts. Subparagraph (K) is merely a rewrite. Subparagraph (L) contains merely grammatical changes to former subparagraph (H).

Section 31.14(d)(2)(M) is a new paragraph that states a preference for left justified, ragged right text. New subparagraph (N) further refines the typeface and line spacing requirements. New subparagraph (O) and (P) state a preference for serif and sans serif typeface and the relative advantages of these categories of typeface in differing circumstances. New subparagraph (Q) contains information to assist drafters in avoiding the most common

writing problems that hinder a reader's understanding, including undefined terms, superfluous words, complex presentations, repetition, and multiple negatives.

The amendment to §31.31(b) allows an agency that contracts with clients electronically to place the required link to the department's web site on a page other than its homepage. This change was necessary to avoid giving clients who do not reside in Texas the mistaken idea that they were protected in some way by Texas law.

Section 31.31(c) was changed to require an agency that contracts with clients electronically to include a link to the department's web site so that obligees are given the opportunity to visit the department's web site before contracting. To avoid giving non-residents the impression that they are protected by Texas law, the rule states that this opportunity must be set up in a manner that diminishes the number of non-residents who view it.

In response to a written comment, §31.37(c) was amended to add paragraph (4). The comment stated that a significant problem involves agencies falsely representing the amount of child support or child support arrearage. Paragraph (4) makes this a prohibited practice.

Section 31.56(a)(3) was changed to clarify that it is addressing an agency that is ceasing to engage in business and not merely closing an office.

In consideration of the fact that sometimes businesses cannot predict when events beyond their control may cause them to cease engaging in business, §31.56(c) was added to give the commissioner discretion to waive any of the requirements of §31.56(a) or (b).

Section 31.56(c) was renamed §31.56(d) and changed to clarify that it is addressing an agency that is ceasing to engage in business and not merely an agency that is closing an office.

Section 31.56(d) was renamed §31.56(e).

Section 31.71(a) and (b) were changed to allow an agency until July 1, 2002 to communicate with clients and obligors that the department now has licensing and enforcement authority.

Section 31.72(a)(1) and §31.72(a)(2)(B) were amended to clarify that claims against an agency's bond may be made only by clients.

Throughout Chapter 31, the phrase "notice and hearing" was changed to "notice and opportunity for hearing" to reconcile the hearing requirements in this chapter with the hearing requirements of other rules administered by the department.

A written comment stated that the Attorney General receives complaints regarding these agencies and may want to file a complaint with the department if a complaint affects numerous individuals. The comment further stated that the Attorney General may wish to appeal a decision of the department if it affects numerous persons. In response to these comments, § 31.73(a) was changed to allow a governmental entity to file a complaint with the department against an agency and § 31.76 was amended to allow a governmental entity to appeal a department decision on a complaint.

Section 31.92(a)(2) was changed to correct a typographical error and to remove the word "foreign."

Section 31.92(a)(3) was amended to replace the word "that" with the word "your" to make this section consistent with the remainder of Chapter 31.

Chapter 31 will have the effect of establishing the framework from which the department will administer Chapter 396.

Stephanie Newberg, Deputy Commissioner, Texas Department of Banking, has determined that for each year of the first five years that Chapter 31 is in effect, there will be no fiscal implication for local government, but a fiscal implication of $5,000 for state government as a result of enforcing or administering the proposed chapter as adopted.

Ms. Newberg also has determined that, for each of the first five years the section as adopted is in effect, the public benefit anticipated as a result of the adoption of the chapter will be a clearer understanding of the agencies products by consumers and fewer incidents of questionable or abusive collection practices by agencies. Persons required to comply with this section will incur a $500 annual cost of regulation, $500 triennial registration fee for each location, $750 to $1,500 for a surety bond, and possibly the expense of drafting and printing new contracts. There may be some additional expense to the agencies in notifying obligors and obligees of the Department's regulatory authority. There will be no deleterious effect on small businesses.

The department received a comment that §31.37 does not make an agency's false representations about support a prohibited practice. In response to this comment the department amended §31.37 to make false representations about the support a prohibited practice.

A comment was made that §31.37 did not make it a prohibited practice to inform anyone that payment is to be made to the agency when there is a court order to pay the child support to a registry. The department also received a comment that §31.37 should be amended to require an agency in receipt of child support that should have been sent to a court ordered registry to forward the child support to the registry immediately. Although the department agrees that agencies should not engage in these practices, it did not make these amendments because there is no authority for them in Chapter 396.

A comment was made that a governmental entity should have authority under §31.73 to file a complaint against an agency and under §31.76 to appeal a decision of the department on a complaint. The justification given was that the Attorney General receives complaints on these agencies and needs this authority if the complaints affect numerous persons. The department made these amendments.

A comment was made that language should be inserted to allow the department to revoke a license, suspend a license or deny the renewal of a license of an agency that engages in activity prohibited under 31.37. The department did not make this suggested change because §31.37(a)(1) and (b)(1) already give the banking commissioner this authority.

One comment letter was received from the Office of the Attorney General - State of Texas.

SUBCHAPTER A. GENERAL PROVISIONS

7 TAC §31.1

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.1. Definitions.

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

(1) Additional registered office--A registered office of an agency that is not the principal business office.

(2) Agency--A private child support enforcement agency, including a foreign private child support agency, that is or is desiring to register under Chapter 396.

(3) Certificate of registration--The form specified by the department certifying that an agency has fulfilled the registration requirements of Chapter 396 and this chapter for the registered location indicated thereon. A certificate of registration is sometimes referred to as a "certificate."

(4) Chapter 396--Finance Code Chapter 396, as amended.

(5) Child support enforcement--An action, conduct, or practice in enforcing, or in soliciting for enforcement, a child support obligation, including the collection of an amount owed under a child support obligation.

(6) Child support obligation--An obligation for the payment of financial support for a child under an order or writ issued by a court or other tribunal.

(7) Client--An obligee who has contracted with a child support enforcement agency for the enforcement of a child support obligation.

(8) Controlling interest--Ownership interest in a private child support enforcement agency of 25 percent or more.

(9) Department--The Texas Department of Banking.

(10) Foreign agency--A private child support enforcement agency that engages in business in this state solely by use of telephone, mail, the Internet, facsimile transmission, or any other means of interstate communication. For purposes of this definition, an agency engages in business in this state if in the previous consecutive 12 months it:

(A) conducted activities in collecting child support obligations from 10 or more obligors; or

(B) conducted activities in collecting child support obligations on behalf of one or more clients. The department retains the authority to investigate complaints against such an agency that conducted activities in collecting child support obligations from fewer than 10 obligors in the previous consecutive 12 months. If a complaint against such an agency is deemed valid by the banking commissioner, the banking commissioner, in the exercise of discretion, may inform the agency in writing that it is deemed to have engaged in business in this state.

(11) Hearings officer--An employee of the department designated by the banking commissioner to take certain actions on behalf of the banking commissioner.

(12) Material change--A change to information provided that could affect or be taken into consideration by the department or banking commissioner in acting or making a decision on issuing, revoking, or suspending an agency's certificate of registration.

(13) Obligee--A Texas resident identified in an order for child support issued by a court or other tribunal as the payee to whom amounts of ordered child support are due.

(14) Obligor--A Texas resident identified in an order for child support issued by a court or other tribunal as the individual required to make payments under the terms of a support order for a child.

(15) Person--An individual, partnership, joint stock or other association, trust, or corporation. The term does not include the United States, this state, or any other governmental entity.

(16) Principal business office--The registered office designated in the agency's application for registration as its principal business office. This location must be in Texas if the agency has a location in Texas.

(17) Principal owner--The person who has the largest ownership interest in the agency. If two or more persons have the largest ownership interest in the agency, this term includes each person.

(18) Private child support enforcement agency--An individual or nongovernmental entity that engages in the enforcement of child support ordered by a court or other tribunal for a fee or other consideration. The term does not include:

(A) an attorney enforcing a child support obligation on behalf of, and in the name of, a client, unless the attorney has an employee who is not an attorney and who on behalf of the attorney:

(i) regularly solicits for child support enforcement; or

(ii) regularly contacts child support obligees or obligors for the purpose of child support enforcement;

(B) a state agency designated to serve as the state's Title IV-D agency in accordance with Part D, Title IV, Social Security Act *(42 U.S.C. Section 651 et seq.)*, as amended; or

(C) a contractor awarded a contract to engage in child support enforcement on behalf of a governmental agency, including a contractor awarded a contract:

(i) under Chapter 236, Family Code; or

(ii) by a political subdivision of this or another state that is authorized by law to enforce a child support obligation.

(19) Registered office--

(A) A physical location of an agency where:

(i) its records regarding child support collections on behalf of clients are maintained;

(ii) clients' child support payments are received or processed;

(iii) it conducts activities in collecting child support obligations for clients;

(iv) appointments are conducted with obligees or clients; or

(v) contracts are executed by obligees.

(B) This does not include a location where a person residing at the location conducts only activities described in subparagraph (A)(iii) of this paragraph. If any other activity under subparagraph (A) of this paragraph is conducted at the residence, it is a registered office. If a person who does not reside at the location conducts any activity under subparagraph (A) of this paragraph, it is a registered office.

(20) Sign--

(A) to sign; or

(B) to execute or otherwise adopt a symbol, or encrypt or similarly process a record in whole or in part, with the present intent of the authenticating person to identify the person and adopt or accept a record.

(21) You or Your--A duly authorized representative of an agency.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. HOW DO I REGISTER MY AGENCY TO ENGAGE IN THE BUSINESS OF CHILD SUPPORT ENFORCEMENT?

7 TAC §§31.11 - 31.19

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.11. What must I do to legally engage in the business of child support enforcement in Texas?

(a) First, you must submit an application to the department for a certificate of registration that includes the following information:

(1) with respect to your agency and its principal owner, the name, title, physical street address, mailing address, business telephone number, fax number, web site address, and e-mail address of:

(A) the principal owner;

(B) each person with a controlling interest;

(C) each officer and director;

(D) the principal business office; and

(E) each additional registered office;

(2) the name, address, states in which operated, and current license status of any agency ever operated in any state by:

(A) your agency;

(B) your agency's principal owner;

(C) an officer or director of your agency or your agency's principal owner; or

(D) a person owning a controlling interest in your agency or principal owner;

(3) a notarized statement by your agency's principal owner or chief executive officer stating that the application and accompanying information is accurate and truthful in all respects and that the agency is able to meet its financial obligations as they become due; and

(4) such other information as the banking commissioner may require you to submit.

(b) Second, you must submit the following documents with your application:

(1) a copy of your agency's assumed name certificate if it is doing business or intends to do business in this state under a different name; financial disclosures that comply with this chapter;

(2) a list containing information on each pending lawsuit, civil or criminal (other than lawsuits filed on behalf of clients), involving your agency, including:

(A) the parties;

(B) a synopsis of the facts alleged by each party;

(C) the nature of the action;

(D) the court in which it is pending; and

(E) the amount in controversy;

(3) a list, containing the information required in paragraph (2) of this subsection, on each pending lawsuit involving an owner of a controlling interest in your agency that:

(A) is related to child support enforcement (other than lawsuits filed on behalf of clients); or

(B) may affect your agency.

(4) a list for the previous ten years of each judgment awarded against your agency or any owner of a controlling interest in the agency and a statement as to whether an appeal is pending;

(5) a surety bond in the amount of $50,000 that meets the requirements of §31.12;

(6) a certificate of account status from the Texas Comptroller of Public Accounts or a certificate of good standing from the Texas Secretary of State, if you are a Texas business corporation or a foreign business corporation;

(7) a copy of the findings from any supervisory enforcement actions taken against your agency by a governmental entity for the previous 5 years;

(8) a paper and electronic (Word or WordPerfect) copy of the form contract your agency will use for an obligee to engage its services to enforce a child support obligation and the scores you calculated under §31.14(c) and the readability statistics you generated; and

(9) such other information as the banking commissioner may require you to submit.

(c) Third, you must submit a certified financial statement with your application containing the following:

(1) information that demonstrates the financial solvency of your agency;

(2) for your agency's most recent fiscal year:

(A) a balance sheet; and

(B) an income statement.

(3) if the end of your agency's most recent fiscal year was more than 120 days prior to submission of your application, an interim version of each document required under paragraph (2) of this subsection covering the period from the end of the most recent fiscal year to a date less than 120 days prior to submission;

(4) a written certification by your agency's chief financial officer or accountant that it is a true and correct statement of the agency's financial position; and

(5) any information the banking commissioner requests you to submit to demonstrate your agency's financial solvency, including an audited financial statement.

(d) Fourth, you must submit the following fees with your application:

(1) a nonrefundable filing fee of $500 for each location you want to register; and

(2) a $500 fee to cover the annual cost of regulation.

§31.12. What are the requirements of my agency's surety bond?

(a) Your agency is required to maintain a surety bond in the amount of $50,000. The surety bond must be:

(1) approved by the department;

(2) issued by a surety company authorized to do business in this state;

(3) in favor of the department for the benefit of a person damaged by a violation of Chapter 396; and

(4) conditioned on your agency's compliance with Chapter 396 and this chapter and the faithful performance of the obligations under its agreements with its clients.

(b) Your agency's surety bond must be filed with and held by the department.

§31.13. May my agency make a deposit of money instead of a surety bond?

(a) Your agency may request in writing that instead of furnishing a surety bond the banking commissioner authorize it to deposit money with a federally insured depository in this state. You designate the depository. In the discretion of the banking commissioner a deposit of money in an amount determined by the banking commissioner, not to exceed $50,000, may be accepted. The banking commissioner must approve or deny your agency's request within 30 days of receipt.

(b) Your agency's deposit must be held in trust for the benefit of a person damaged by a violation of Chapter 396. The deposit secures the same obligations as the surety bond. Your agency is entitled to receive all interest and dividends on the deposit.

(c) If a claim is paid from your agency's money deposit, then within 15 days of the payment of the claim your agency must either:

(1) make a deposit pursuant to subsection (a) of this section in the amount of the money paid; or

(2) furnish the required surety bond.

§31.14. What are the requirements for the contract for services with my agency's clients?

(a) Is my agency required to use a contract that is in compliance with the requirements of this section with all of its clients? No, your agency is only required to use a contract that complies with this section when contracting with clients who are Texas residents at the time the contract is executed for the enforcement of child support owed to the client.

(b) What elements must be in my agency's contract with clients for engaging my agency's child support enforcement services? The contract your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, must be:

(1) dated;

(2) signed by both parties;

(3) written in clear language; and

(4) approved by the department.

(c) Will the department provide a model contract? The department will prepare and provide a clear language contract that your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, may use.

(d) How will I know if my agency's contracts with clients is in "clear language?"

(1) The department will apply automated readability tests commonly available in Microsoft Word or Corel WordPerfect software to your proposed contract. Whenever you submit a proposed contract for the department to consider, you must disclose the readability scores you generated for it. Because mechanical readability formulas do not evaluate the substantive content of the contract, the department will exercise judgment when considering the readability statistics generated by these tests. However, absent explanatory circumstances or additional justification persuasive to the banking commissioner, your contract will ordinarily not be approved if:

(A) over 20% of its sentences are passive in structure;

(B) the average sentence length exceeds 19 words;

(C) the Flesch Reading ease score is less than 49.0; and

(D) the Flesch-Kincaid grade level score is higher than 10.5.

(2) The department considers "clear language" to be synonymous with the more commonly known concept of "plain language." In evaluating your proposed contract, the department will consider the extent to which you have incorporated clear language principles into its organization, language, and design. At a minimum, your proposed contract should substantially comply with each of the clear language writing principles identified in this paragraph.

(A) You must organize the material in clear, concise sections, paragraphs and sentences, in an order that emphasizes the main ideas first, then progress down to the details and eliminates repetitious information.

(B) You should divide and caption the contract in a meaningful sequence such that each section contains an underlined, bold-faced, or otherwise conspicuous title or caption at the beginning of the section that indicates the nature or subject matter included or covered by the section of the contract.

(C) You should use informative tables, especially "if, then" tables, with respect to your fees and the length of the term of the contract.

(D) You should make complex information more understandable by using an example scenario or by writing sections in a question and answer format.

(E) You may use tabular presentations or bullet lists to simplify disclosure of complex material. You may also use pictures, logos, charts, graphs, or other design elements so long as the design is not misleading and the required information is clear.

(F) You should write in a clear and coherent manner.

(G) You should use first-person plural (we, us, our/ours) and second-person singular (you, your/yours) pronouns to write directly to the reader.

(H) You should write to one reader.

(I) Whenever possible, you should use the active voice with strong verbs in short explanatory sentences and bullet lists. Passive voice, while not banned, should be used sparingly.

(J) You should use everyday words whenever possible and avoid the use of legal and highly technical business terminology. In those instances where no clear language alternative is apparent, you should explain what the term means when the term is first used. Use of a definition may improve readability in such instances.

(K) You should attempt to use an average sentence length of less than 15 words.

(L) You should use paper that does not measure more than 8-1/2 inches by 11 inches if at all possible.

(M) You must align the text flush on the left, with a loose, or ragged, right edge. Although discouraged, you may seek approval of a document with full justification (text aligned flush on both left and right sides), but your proposed document must at a minimum use a larger type size than specified in subparagraph (N) of this paragraph. You should also add other readability enhancements, such as a more readable typeface or greater use of white space, including wider margins and additional leading between lines.

(N) You must use typeface size that is at least as large as 10-point type in the Times typeface. Line spacing must be at least 120% of the point size. For example, a 10-point typeface should be set with 12-point leading (two additional leading between the lines). At the request of your agency, the banking commissioner has the discretion to approve smaller typeface size or denser line spacing in limited circumstances, such as keeping related information grouped together. However, you must offset smaller typeface size or denser line spacing by use of other readability enhancements such as more readable typeface or greater use of white space through wider margins or divisions between sections of the document.

(O) The text of your proposed contract must be set in a serif typeface. Popular serif typefaces include Times, Scala, Caslon, Century Schoolbook, and Garamond.

(P) A sans serif typeface may be used for titles, headings, subheadings, captions, and illustrative or explanatory tables or sidebars to distinguish between different levels of information or provide emphasis. Popular sans serif typefaces include Scala Sans, Franklin Gothic, Frutiger, Helvetica, Ariel, and Univers.

(Q) In preparing your proposed contract, you should not:

(i) include a term in definitions unless the meaning of the term is unclear from the context and cannot be easily explained in context, or rely on artificially defined terms as the primary means of explaining information;

(ii) use superfluous words (words that can be replaced with fewer words that mean the same thing) that detract from understanding;

(iii) rely on legalistic or overly complex presentations;

(iv) copy complex information directly from legal documents, statutes, or rules without a clear and concise explanation of the material;

(v) unnecessarily repeat information in different sections of the contract; or

(vi) use multiple negatives.

(3) If your agency submits a contract that does not meet the requirements under paragraph (1) of this subsection, in the discretion of the banking commissioner, the contract may be approved if your contract otherwise uses the techniques of clear language and you submit a statement specifying:

(A) the reasonable efforts your agency made to draft the contract in clear language;

(B) the clear language techniques that were used in the drafting; and

(C) the reasons why the required readability level was not achieved.

(e) Are there any other contractual requirements for clients who engage the services of my agency on or after January 1, 2002? A written contract with a client for the enforcement of child support executed on or after January 1, 2002 by your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, must contain the following provision in substantially similar language in a font at least as large as the other provisions of the contract, but no smaller than 10-point with line spacing at least 120% of the point size: Direct your inquiries to the Texas Department of Banking. Complaints must be in writing. Texas Department of Banking, 2601 North Lamar, Austin, Texas 78705, 877-276-5554 (toll free), www.banking.state.tx.us.

(f) Are there any other contractual requirements for clients who engaged the services of my agency prior to January 1, 2002? If prior to January 1, 2002, a client engaged the child support enforcement services of your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, without a written contract and the agency is continuing to perform services for the client, then on or before the effective date of Chapter 396, the agency must execute a contract with the client, complying with the provisions of this section.

§31.19. When and how will my agency's certificate of registration be issued and mailed?

(a) On or before the 60th day after the date your application is accepted for filing the banking commissioner will either:

(1) approve your application by issuing a certificate of registration for each location approved; or

(2) refer your application to the administrative law judge for notice and opportunity for hearing under Chapter 9 of this title.

(b) If your application is approved, the department will issue a certificate of registration for each location in your application.

(c) The banking commissioner will mail each certificate of registration for your agency to your agency's principal business office mailing address within 15 days of approval.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
Certifying Official
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For further information, please call: (512) 475-1300

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SUBCHAPTER C. WHAT ARE MY AGENCY'S RESPONSIBILITIES AFTER REGISTRATION?

7 TAC §§31.31 - 31.39

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.31. Is my agency required to display its certificate of registration?

(a) Your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, must have a certificate of registration posted in the lobby of each registered office at a point accessible to the public.

(b) If your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, offers obligees the opportunity to contract for the agency's child support enforcement services electronically on its web site, the web site must contain either:

(1) a link, in no less than 8 point font, to the page of the department's web site which links to agency certificates of registration; or

(2) the certificate of registration graphic link provided by the department.

(c) Before an obligee contracts electronically for collection of child support with your agency, on your agency's web site or otherwise, the obligee must be given an opportunity to view the page of the department's web site which links to agencies' certificates of registration. The obligee must not be able to skip the page containing this opportunity before contracting electronically with your agency. The agency must offer this opportunity in a manner that diminishes the number of non-Texas residents that view the page.

§31.37. What practices are my agency prohibited from employing in enforcing a child support obligation?

(a) In enforcing a child support obligation, your agency may not use threats, coercion, or attempts to coerce that employ any of the following practices:

(1) using or threatening to use violence or other criminal means to cause harm to an obligor or property of the obligor;

(2) accusing falsely or threatening to accuse falsely an obligor of a violation of state or federal child support laws;

(3) taking or threatening to take an enforcement action against an obligor that is not authorized by law; or

(4) intentionally representing to a person that your agency is a governmental agency authorized to enforce a child support obligation.

(b) Your agency is not prevented from:

(1) informing an obligor that the obligor may be subject to penalties prescribed by law for failure to pay a child support obligation; or

(2) taking, or threatening to take, an action authorized by law for the enforcement of a child support obligation by your agency.

(c) In enforcing a child support obligation, your agency or an employee of your agency may not:

(1) identify your agency by any name other than one by which it is registered with the department;

(2) falsely represent the nature of the child support enforcement activities in which your agency is authorized by law to engage;

(3) falsely represent that an oral or written communication is the communication of an attorney; or

(4) falsely represent the amount of current or prospective child support or the amount of a child support arrearage ordered by a court or other tribunal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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SUBCHAPTER D. WHAT ARE THE DEPARTMENT REQUIREMENTS FOR ADDING AN OFFICE, CLOSING AN OFFICE, RELOCATING AN OFFICE, TRANSFERRING CONTROL OF MY AGENCY, CEASING TO DO BUSINESS, OR CHANGING MY EMAIL OR WEB SITE ADDRESSES?

7 TAC §§31.51 - 31.56

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.56. What are the requirements for my agency to cease engaging in the business of child support enforcement?

(a) Thirty days before your agency will cease engaging in the business of child support enforcement, you must submit to the department a notice containing:

(1) the name, physical street address, mailing address, telephone number, fax number, web site, and e-mail address:

(A) of your agency;

(B) of all registered offices of your agency;

(C) of all officers, directors, and owners of your agency;

(D) where the department can reach the following persons after your agency ceases engaging in the business of child support enforcement:

(i) your agency's chief executive officer;

(ii) your agency's principal owner;

(iii) your agency's officers and directors; and

(iv) anyone owning a controlling interest in your agency or in the principal owner of your agency.

(2) a notarized statement by the chief executive officer or principal owner of your agency that all child support payments received on behalf of its clients have been properly distributed to the clients;

(3) a copy of a written notice that your agency is ceasing to engage in the business of child support enforcement and evidence that your agency distributed it to all its clients at least 45 days prior to the date your agency proposes to cease engaging in the business of child support enforcement;

(4) the physical street address, mailing address, telephone number, fax number, and Internet or other electronic mail address of the location where your agency will hold agency records for the period of time required under Chapter 396; and

(5) such other information as the banking commissioner may require you to submit.

(b) The written notice your agency is required to send each client under subsection (a) of this section must include:

(1) the date the agency intends to cease engaging in the business of child support enforcement;

(2) a form for the client to change his or her address with the registry through which child support payments are paid;

(3) an accounting of all child support payments collected on behalf of the client, the amounts remitted to the client, the amount of fees retained by the agency, and the amount of outstanding child support the agency is currently under contract to collect;

(4) the consumer hotline telephone number, address, and web site address of the department; and

(5) such other information as the banking commissioner may require you to submit.

(c) Upon good cause shown by your agency in writing, the banking commissioner, in the exercise of discretion, may waive any requirement under subsections (a) or (b) of this section.

(d) Within 15 days after the date your agency ceases to engage in the business of child support enforcement, it must surrender all certificates and submit a statement to the department, sworn to by the chief executive officer of your agency as being truthful and correct, disclosing:

(1) that your agency has distributed all client funds; and

(2) a list of all outstanding complaints from your clients or obligors or that your agency has no such outstanding complaints.

(e) This section does not affect a contract between your agency and a client, and your agency may not rely on this section to escape any continuing contractual obligations.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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SUBCHAPTER E. HOW DOES THE DEPARTMENT EXERCISE ITS ENFORCEMENT AUTHORITY?

7 TAC §§31.71 - 31.76

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.71. How will obligors and clients be notified of the department's licensing and enforcement authority?

(a) How will clients engaging the services of my agency prior to January 1, 2002 be notified of the department's licensing and enforcement authority? If prior to January 1, 2002, a client executed a written contract with your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, to enforce child support and the agency is continuing to perform services for the client on or after January 1, 2002, then on or before July 1, 2002 the agency must send the client a letter containing, in substantially similar language, the provision contained in §31.14(d). The provision must be in font at least as large as the font used for the text of the letter, but no smaller than 10-point with line spacing at least 120% of the point size.

(b) How will obligors of clients engaging the services of my agency be notified of the department's licensing and enforcement authority? If your agency, or a foreign agency authorized to engage in business under Subchapter F of this chapter, has contracted with a client to enforce a child support obligation against an obligor, it must include with its initial written communication with the obligor or within 15 days of its initial oral communication with the obligor, whichever is earlier, a letter containing, in substantially similar language, the provision contained in §31.14(d). If your agency made its initial communication with an obligor prior to January 1, 2002, it must include, in substantially similar language, the provision in its next written communication with the obligor or by July 1, 2002, whichever is earlier. The provision must be in font at least as large as the font used for the text of the letter, but no smaller than 10-point with line spacing at least 120% of the point size.

§31.72. What claims may be made against my agency's surety bond or money deposit?

(a) A person may make a claim against your agency's surety bond or money deposit in lieu of a surety bond for actual financial losses if:

(1) a court of competent jurisdiction liquidated the financial losses and entered an award, under Finance Code, §396.351, against your agency in favor of the person making the claim against the bond or money deposit, and either:

(A) the time for appeal of the award has passed; or

(B) all appeals have been exhausted and award has been upheld in whole or in part; or

(2) after opportunity for hearing and issuance of a proposal for decision by the administrative law judge:

(A) the banking commissioner signed a final order adopting, or modifying and adopting the proposal for decision;

(B) the final order found that the client making the claim against your agency's bond or money deposit suffered actual financial losses due to your agency's violation of Chapter 396; and

(C) either:

(i) the time for appeal of the banking commissioner's order has passed; or

(ii) all appeals of the banking commissioner's have been exhausted and the banking commissioner's order has been upheld in whole or in part.

(b) If there is an appeal of an order or award described in subsection (a) of this section, the person making a claim against your agency's surety bond or money deposit may only claim the amount of actual financial losses upheld upon final appeal.

§31.73. How does the department conduct the administrative investigation of complaint filed against my agency?

(a) How is a complaint filed against my agency? A person or a governmental entity may file a complaint against your agency for violation of Chapter 396 or this chapter in writing mailed, faxed, or e-mailed to the department at 2601 North Lamar Blvd., Austin, Texas 78705, (512) 475-1313, or consumer.complaint@banking.state.tx.us.

(b) Is there a form for filing a complaint against my agency? The department will prepare and provide a form to anyone requesting it. Request the form by calling the toll free consumer hotline at 877-276-5554.

(c) How does the department investigate a complaint filed against my agency? Within 30 days of receiving a complaint under Finance Code, §396.304, the department will initiate an investigation into the merits of the complaint.

(d) Who conducts the investigation? The banking commissioner may appoint a hearings officer to conduct the investigation.

(e) Is my agency required to submit records relating to the complaint? Your agency must submit records requested by the banking commissioner, or a hearings officer appointed under this section, within ten business days of receiving a written request for the records.

(f) Can we mediate a complaint against my agency? The banking commissioner, or a hearings officer appointed under this section, may arrange for the services of a qualified mediator and attempt to:

(1) resolve the complaint and any differences between the parties; and

(2) reach a settlement without the requirement of further investigation.

(g) What if the evidence does not support a complaint filed against my agency?

(1) The banking commissioner after an initial investigation may dismiss the complaint against your agency; or

(2) The banking commissioner may delegate to a hearings officer appointed to investigate a complaint against your agency the authority to dismiss the complaint, after notice to each affected party and an opportunity for hearing.

(h) Will the banking commissioner allow my agency to take corrective action to resolve the complaint? It is within the banking commissioner's discretion to permit your agency to take appropriate action to correct a failure to comply and not revoke, suspend, or deny the registration of the agency.

(i) What if a complaint arises from a bona fide error by my agency? If your agency's failure to comply with Chapter 396 or this chapter was the result of bona fide error that occurred despite the use of reasonable procedures to avoid the error, the failure is not a violation of Chapter 396 or this chapter.

§31.74. How can the department deny my agency's application or revoke or suspend its registration?

(a) How can my agency's registration be revoked? After notice and opportunity for hearing, under Chapter 9 of this title, the banking commissioner may revoke the registration of your agency if it has:

(1) failed to comply with this chapter or Chapter 396;

(2) failed to pay a fee or other charge imposed by the department; and

(3) failed to maintain and produce at the request of the department records attesting to the financial solvency of your agency or other business records concerning client accounts.

(b) How can my agency's registration be suspended or its renewal of registration be denied? After notice and opportunity for hearing, under Chapter 9 of this title, the banking commissioner may suspend the registration or deny the renewal of registration of your agency if it has failed:

(1) to comply with this chapter or Chapter 396;

(2) to pay a fee or other charge imposed by the department; or

(3) to maintain and produce at the request of the department records attesting to its financial solvency or other business records concerning client accounts.

(c) How can an application for certificate of registration submitted by my agency be denied? After notice and opportunity for hearing, under Chapter 9 of this title, the banking commissioner may deny the registration of your agency if it has:

(1) failed to comply with this chapter or Chapter 396; or

(2) failed to pay a fee or other charge imposed by the department.

§31.75. How is the hearing process conducted?

(a) When will a hearing be held on a complaint filed against my agency, on an application filed by my agency under this chapter, or on my agency's registration? The matter must be referred to the administrative law judge for notice and opportunity for hearing under Chapter 9 of this title if at the completion of the investigation of the matter, the banking commissioner, his designee or a hearings officer appointed under this section, determines that sufficient evidentiary basis exists:

(1) supporting the complaint filed against your agency;

(2) to deny your agency's application filed under this chapter; or

(3) to revoke or suspend your agency's registration.

(b) How is a hearing on a complaint against my agency, on an application filed by my agency, or on my agency's registration conducted?

(1) If the matter is referred to the administrative law judge, appropriate order(s) must be entered and the hearing conducted within

30 days after the date the hearing was granted, or as soon thereafter as is reasonably possible, under Chapter 9 of this title and the Administrative Procedure Act *(Texas Government Code, Chapter 2001).*

(2) Issues will be limited to those on which testimony is absolutely necessary.

(3) The administrative law judge may require testimony be submitted in written form and prefiled.

(4) No evidence will be received on matters that are not in dispute.

(5) No issues or evidence will be considered that are not relevant to the standards set forth in this chapter or that are not supported by the notice, response, or reply. Chapter 9 of this title governs a proposal for decision, exceptions and replies to such proposal for decision, the final decision of the banking commissioner, and motions for rehearing.

§31.76. Is it possible to appeal a decision of the department on a complaint filed against my agency?

If you, another person, or a governmental entity who is a party to the complaint, is harmed by a decision of the department on a complaint against your agency, then you or that person may appeal the decision to a district court in Travis County.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Everette D. Jobe
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SUBCHAPTER F. FOREIGN AGENCIES REGISTERED IN OTHER STATES

7 TAC §§31.91 - 31.96

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

§31.92. How can my foreign agency obtain a registration exemption and an authorization to engage in business in this state?

(a) If your foreign agency meets the requirements of §31.91, you may submit an application with:

(1) the following information:

(A) with respect to your agency and its principal owner, the name, title, physical street address, mailing address, telephone number, fax number, and Internet or other electronic mail address of:

(i) the principal owner;

(ii) each person with a controlling interest;

(iii) each officer and director;

(iv) the principal business office; and

(v) each additional registered office;

(B) the name, address, states in which operated, and current license status of any agency ever operated in any state by:

(i) your agency;

(ii) your agency's principal owner;

(iii) an officer or director of your agency or your agency's principal owner; or

(iv) a person owning a controlling interest in your agency or principal owner;

(C) a copy of the form contract your foreign agency will use for an obligee to engage its services to enforce a child support obligation; and

(D) a notarized statement by your chief executive officer stating that the application and all accompanying documents are accurate and truthful in all respects; and

(2) a surety bond or deposit of money that meets the requirements of this chapter unless you provide proof to the satisfaction of the department that your agency maintains in the state in which it has its principal office an adequate bond or similar instrument for purposes similar to the purposes required for the filing of a surety bond in this state;

(3) a copy of the license or other authorization issued by the state in which your agency is authorized to operate;

(4) a paper and electronic (Word or WordPerfect) copy of the form contract your agency will use for an obligee to engage its services to enforce a child support obligation and the scores you calculated under §31.14(c);

(5) a single administrative fee of $500 to cover the cost of the department in processing and acting on the application; and

(6) such other information as the banking commissioner may request that you submit.

(b) Your application is subject to abandonment as provided under §31.18.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER G. CIVIL REMEDIES

7 TAC §§31.111 - 31.115

The new sections are proposed under the authority of Finance Code, §396.051(b), which requires the commission to adopt rules as necessary for the administration of the chapter.

Finance Code, Chapter 396, is affected by the proposed new sections.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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PART 4. TEXAS SAVINGS AND LOAN DEPARTMENT

CHAPTER 64. BOOKS, RECORDS, ACCOUNTING PRACTICES, FINANCIAL STATEMENTS, RESERVES, NET WORTH, EXAMINATIONS, CONSUMER COMPLAINTS

7 TAC §64.10

The Finance Commission of Texas (the "Finance Commission") adopts a new 7 TAC §64.10 concerning the filing of consumer complaints with the Texas Savings and Loan Department (the "department") without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8652). The new §64.10 will implement the requirements of *Finance Code*, §11.307, pertaining to the filing of consumer complaints with the department, as enacted by the 77th Legislative through House Bill 1763.

Background and Summary of Factual Basis for the Rules

Section 64.10 will specify the manner in which a savings and loan association provides consumers with information on how to file complaints with the department. The new section will also require that the information on how to file complaints be included with each privacy notice a savings and loan association is required by law to provide to consumers.

The new rule was approved by the Finance Commission on October 19, 2001, for publication for public comments, and published for public comment in the November 2, 2001, issue of the *Texas Register*. No written comments were received.

The section is adopted under the authority of *Finance Code*, §11.307, which requires the Finance Commission to adopt rules specifying the manner in which savings and loan associations provide consumers with information on how to file complaints with the department.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107962
Timothy K. Irvine
General Counsel
Texas Savings and Loan Department
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 475-1350

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CHAPTER 79. MISCELLANEOUS SUBCHAPTER H. CONSUMER COMPLAINT PROCEDURES

7 TAC §79.122

The Finance Commission of Texas (the "Finance Commission") adopts a new 7 TAC §79.122 concerning the filing of consumer complaints with the Texas Savings and Loan Department (the "department") without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8653). The new §79.122 will implement the requirements of *Finance Code*, §11.307, pertaining to the filing of consumer complaints with the department, as enacted by the 77th Legislative through House Bill 1763.

Background and Summary of Factual Basis for the Rules

Section 79.122 will specify the manner in which state savings banks provide consumers with information on how to file complaints with the department. The new section will also require that the information on how to file complaints be included with each privacy notice a state savings bank is required by law to provide to consumers.

The new rule was approved by the Finance Commission on October 19, 2001, for publication for public comments, and was published for public comment in the November 2, 2001, issue of the *Texas Register*. No written comments were received.

The section is adopted under the authority of *Finance Code*, §11.307, which requires the Finance Commission to adopt rules specifying the manner in which savings and loan associations provide consumers with information on how to file complaints with the department.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Timothy K. Irvine
General Counsel
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Proposal publication date: November 2, 2001
For further information, please call: (512) 475-1350

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CHAPTER 80. MORTGAGE BROKER AND LOAN OFFICER LICENSING
SUBCHAPTER K. ANNUAL REPORTS

7 TAC §80.23

The Finance Commission adopts an amendment to §80.23 of the regulations (the "Regulations") that implement the Mortgage Broker License Act, *Finance Code*, Chapter 156, (the "Act") without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8654). The new subsection requires that mortgage brokers licensed under the Act provide annual reports about their activity subject to the Act as well as the activity of each of the loan officers under their sponsorship.

Background and Summary of Factual Basis for the Rules

The Act became effective September 1, 1999. It requires that mortgage brokers and the loan officers who work for them meet certain requirements, that they obtain licenses, that they adhere to certain standards of conduct, and that they provide required disclosures to mortgage loan applicants. The Act charges the Commissioner with oversight of the Act and directs that the Commissioner promulgate regulations (the "regulations") to implement the Act.

HB 1636, 77th Legislature, placed authority to promulgate regulations under the Act with the Finance Commission, effective September 1, 2001. HB 1636 also created a new §156.213 of the Act requiring annual reports by mortgage brokers. This amendment became effective September 1, 2001. This new section implements §156.213 of the Act requiring annual reports by mortgage brokers.

The new rule was reviewed with the Mortgage Broker Advisory Committee on October 9, 2001, and with the Finance Commission on October 19, 2001. The Finance Commission approved the proposed amendment to the Regulations for publication for public comment, and it was published for public comment in the November 2, 2001, issue of the *Texas Register*. No written comments were received.

The mortgage Broker Advisory Committee reviewed the amendment for final adoption and advised the Commissioner and the Finance Commission that the amendment should be adopted without changes to the form in which it was published.

The amendment is adopted under the authority of §156.102 to adopt regulations to implement the Act and §156.213 requiring that mortgage brokers licensed under the Act provide annual reports about their activity.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107964
Timothy K. Irvine
General Counsel
Texas Savings and Loan Department
Effective date: January 6, 2002
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TITLE 10. COMMUNITY DEVELOPMENT

PART 1. TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

CHAPTER 1. ADMINISTRATION
SUBCHAPTER A. GENERAL POLICIES AND PROCEDURES

10 TAC §1.7, §1.8

The Texas Department of Housing and Community Affairs (TDHCA) adopts new §1.7 and §1.8, without changes as published in the November 9, 2001, issue of the *Texas Register* (26 TexReg 8935), therefore, the sections will not be republished.

The new sections are necessary to comply with §2306.0321 of the Texas Government Code, as added by SB 322, 77th Session of the Texas Legislature which establishes a process whereby the program funding decisions of TDHCA staff may be appealed to the executive director and to TDHCA's board of directors and whereby such decisions of the executive director may be appealed to the board.

No comments were received concerning the new sections.

The new sections are adopted under the Texas Government Code, Chapter 2306.

No other code, article or statute is affected by the new sections.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 12, 2001.

TRD-200107831
Ruth Cedillo
Acting Executive Director
Texas Department of Housing and Community Affairs
Effective date: January 1, 2002
Proposal publication date: November 9, 2001
For further information, please call: (512) 475-3726

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TITLE 22. EXAMINING BOARDS

PART 9. TEXAS STATE BOARD OF MEDICAL EXAMINERS

CHAPTER 163. LICENSURE

22 TAC §163.13

The Texas State Board of Medical Examiners adopts new §163.13, concerning Expedited Licensure Process, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8657) and will not be republished.

No comments were received regarding adoption of the rule.

The new section is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107968
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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CHAPTER 166. PHYSICIAN REGISTRATION

22 TAC §§166.1 - 166.6

The Texas State Board of Medical Examiners adopts amendments to §§166.1-166.6, concerning physician registration, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8658) and will not be republished.

The adoption makes changes regarding general cleanup. This adoption also amends CME temporary license, SB 1300 (which allows a 30-day grace period to practice with an expired permit) and voluntary charity care provided to indigent populations.

Elsewhere in this issue of the *Texas Register* , the Texas State Board of Medical Examiners contemporaneously adopts the rule review of Chapter 166, concerning Physician Registration.

No comments were received regarding adoption of the rules.

The amendments are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107969
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Effective date: January 6, 2002
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For further information, please call: (512) 305-7016

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CHAPTER 173. PHYSICIAN PROFILES

22 TAC §173.1

The Texas State Board of Medical Examiners adopts an amendment to §173.1, concerning Physician Profiles, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8661) and will not be republished.

This amendment deletes several items from the profile requirements.

The following comments were received:

The American Osteopathic Association requested that the designation of physician gender be deleted from the physician profiles. The board considered the comment, but determined that it was in the best interest of the public to leave this in the profile.

The American Osteopathic Association also requested that medical malpractice histories and descriptions of formal complaints against a physician be deleted from the profile. These items are statutorily required and cannot be deleted.

The amendment is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Donald W. Patrick, MD, JD
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Texas State Board of Medical Examiners
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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CHAPTER 175. FEES, PENALTIES, AND APPLICATIONS

The Texas State Board of Medical Examiners adopts amendments to §§175.1-175.3 and the repeal and replacement of §175.4, and the repeal of §175.5, concerning Fees, Penalties and Applications, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8662) and will not be republished.

Elsewhere in this issue of the *Texas Register* , the Texas State Board of Medical Examiners contemporaneously adopts the rule review of Chapter 175, concerning Fees, Penalties and Applications.

No comments were received regarding adoption of the rules.

22 TAC §§175.1 - 175.3

The amendments are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107971
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Effective date: January 6, 2002
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For further information, please call: (512) 305-7016

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22 TAC §175.4

The repeal is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Effective date: January 6, 2002
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For further information, please call: (512) 305-7016

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22 TAC §175.4

The new section is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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22 TAC §175.5

The repeal is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 183. ACUPUNCTURE

22 TAC §§183.2 - 183.6, 183.12 - 183.14, 183.16 - 183.21

The Texas State Board of Medical Examiners adopts amendments to §§183.2-183.6, 183.12-183.14 and 183.16-183.21, concerning Acupuncture, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8665) and will not be republished.

The changes are pursuant to SB 643 concerning the definition of acupuncture and acupuncturist and the authority of an acupuncturist to treat alcoholism and chronic pain without referral. The amendments will also update Occupation Code cites.

No comments were received regarding adoption of the amendments.

The amendments are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 185. PHYSICIAN ASSISTANTS

22 TAC §§185.2, 185.7, 185.17, 185.19, 185.21, 185.29, 185.30

The Texas State Board of Medical Examiners adopts amendments to §§185.2, 185.7, 185.17, 185.19, 185.21, and new §185.29, §185.30 concerning Physician Assistants, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8679) and will not be republished.

The changes to Chapter 185 relate to employment guidelines pursuant to SB 1166 and changes concerning temporary licenses, automatic suspension and temporary suspensions pursuant to HB 3421.

No comments were received regarding adoption of the rules.

The amendments and new section are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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CHAPTER 187. PROCEDURE

The Texas State Board of Medical Examiners adopts the repeal of §§187.1-187.16, 187.17-187.24, 187.25-187.30, 187.31-187.41 and new §§187.1-187.9, 187.10-187.21, 187.22-187.34, 187.35-187.42 and §§187.43-187.44, concerning Procedure and Procedural Rules, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8683) and will not be republished.

The chapter is repealed and replaced to update procedures for formal and informal board proceedings. The new chapter is titled Procedural Rules.

No comments were received regarding adoption of the rules.

SUBCHAPTER A. GENERAL PROVISIONS

22 TAC §§187.1 - 187.16

The repeals are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. PREHEARING

22 TAC §§187.17 - 187.24

The repeals are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER C. HEARING

22 TAC §§187.25 - 187.30

The repeals are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER D. POSTHEARING

22 TAC §§187.31 - 187.41

The repeals are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 187. PROCEDURAL RULES

SUBCHAPTER A. GENERAL PROVISIONS AND DEFINITIONS

22 TAC §§187.1 - 187.9

The new sections are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107983
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Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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SUBCHAPTER B. INFORMAL BOARD PROCEEDINGS

22 TAC §§187.10 - 187.21

The new sections are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107984
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Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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SUBCHAPTER C. FORMAL PROCEEDINGS AT SOAH

22 TAC §§187.22 - 187.34

The new sections are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107985

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Texas State Board of Medical Examiners
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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SUBCHAPTER D. FORMAL BOARD PROCEEDINGS

22 TAC §§187.35 - 187.42

The new sections are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107986
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Executive Director
Texas State Board of Medical Examiners
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Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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SUBCHAPTER E. PROCEEDINGS RELATING TO PROBATIONERS

22 TAC §187.43, §187.44

The new sections are adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Executive Director
Texas State Board of Medical Examiners
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Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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CHAPTER 188. COMPLAINT PROCEDURE NOTIFICATION

22 TAC §188.1

The Texas State Board of Medical Examiners adopts an amendment to §188.1, concerning Complaint Procedure Notification, without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8700) and will not be republished.

The amendment is necessary to make updates pursuant to the Texas Occupations Code cites. The amendment also corrects Spanish translation.

No comments were received regarding adoption of the rule.

The amendment is adopted under the authority of the Occupations Code Annotated, §153.001, which provides the Texas State Board of Medical Examiners to adopt rules and bylaws as necessary to: govern its own proceedings; perform its duties; regulate the practice of medicine in this state; and enforce this subtitle.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107988
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Executive Director
Texas State Board of Medical Examiners
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 305-7016

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PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 283. LICENSING REQUIREMENTS FOR PHARMACISTS

22 TAC §283.10

The Texas State Board of Pharmacy adopts amendments to §283.10, concerning Requirements for Application for a Pharmacist License Which Has Expired. The amendments are adopted with changes to the proposed text as published in the September 14, 2001, issue of the *Texas Register* (26 TexReg 7046).

The amendments increase the number of continuing education (CE) hours a pharmacist must obtain to reinstate a license which has expired. The increase is consistent with SB 768, Acts of the 77th Legislature, which increased the amount of CE required to renew a pharmacist's license to practice pharmacy from 24 to 30 hours every two years.

Board staff recommended a change to the amendment to clarify the effective date of the amendment. The Board concurs with this recommendation and made the appropriate change.

No comments were received.

The amendments are adopted under §§551.002, 554.051, and 559.053 (as amended by SB 768, Acts of the 77th Texas Legislature) of the Texas Pharmacy Act (Chapters 551 - 566, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051 as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §559.053 as authorizing the Board to increase the amount of CE required to reinstate a pharmacist's license to practice pharmacy.

The statutes affected by this rule: Chapters 551 - 566, Texas Occupations Code.

§283.10. Requirements for Application for a Pharmacist License Which Has Expired.

(a) Expired less than 90 days. If a person's license has been expired for 90 days or less, the person may renew the license by:

(1) paying to the board the required renewal fee and a fee that is one-half of the examination fee for a license; and

(2) reporting completion of the required number of contact hours of approved continuing education.

(b) Expired more than 90 days. If a person's license has been expired for more than 90 days but less than one year, the person may renew the license by:

(1) paying to the board all unpaid renewal fees and a fee that is equal to the examination fee for a license; and

(2) reporting completion of the required number of contact hours of approved continuing education.

(c) Expired for one year or more. If a person's license to practice pharmacy in Texas has been expired for one year or more, the person may not renew the license and shall apply for a new license.

(d) Reexamination. The board may issue a new license to a person if the person submits to reexamination and complies with the requirements and procedures for obtaining an original license as specified in §283.7 of this title (relating to Examination Requirements).

(e) Alternatives to reexamination. In lieu of reexamination as specified in subsection (d) of this section, the board may issue a license to a person whose license has been expired for one year or more, if the person meets the requirements of subsection (f) or (g) of this section and has not had a license granted by any other state suspended, revoked, canceled, surrendered, or otherwise restricted for any reason.

(f) Persons practicing pharmacy in another state. Beginning January 1, 2002, the board may issue a license to a person who was licensed as a pharmacist in Texas, moved to another state, is licensed in the other state, and has been engaged in the practice of pharmacy in the other state for the two years preceding the application if the person meets the following requirements:

(1) makes application for licensure to the board on a form prescribed by the board;

(2) submits to the board certification that the applicant:

(A) is licensed as a pharmacist in another state and that such license is in good standing;

(B) has been continuously employed as a pharmacist in that state for the two years preceding the application; and

(C) has completed a minimum of 30 contact hours of approved continuing education during the preceding two license years;

(3) passes the Texas pharmacy jurisprudence examination with a grade of 75 (the passing grade may be used for the purpose of licensure for a period of two years from the date of passing the examination); and

(4) pays to the board the examination fee set out in §283.9 of this title (relating to Fee Requirements for Licensure by Examination and Reciprocity).

(g) Persons not practicing pharmacy. Beginning January 1, 2002, the board may issue a license to a person who was licensed as a pharmacist in this state, but has not practiced pharmacy for the two years preceding application for licensure under the following conditions.

(1) The person's Texas pharmacist license has been expired for less than 10 years, the person shall:

(A) make application for licensure to the board on a form prescribed by the board;

(B) pass the Texas pharmacy jurisprudence examination with a grade of 75 (the passing grade may be used for the purpose of licensure for a period of two years from the date of passing the examination);

(C) pay the examination fee set out in §283.9 of this title; and

(D) complete approved continuing education and/or board-approved internship requirements according to the following schedule:

(i) if the Texas pharmacist license has been expired for more than one year but less than two years, the applicant shall complete 15 contact hours of approved continuing education;

(ii) if the Texas pharmacist license has been expired for more than two years but less than three years, the applicant shall complete 30 contact hours of approved continuing education;

(iii) if the Texas pharmacist license has been expired for more than three years but less than four years, the applicant shall complete 45 contact hours of approved continuing education;

(iv) if the Texas pharmacist license has been expired for more than four years but less than five years, the applicant shall complete 45 contact hours of approved continuing education and 500 hours of internship in a board-approved internship program;

(v) if the Texas pharmacist license has been expired for more than five years but less than six years, the applicant shall complete 45 contact hours of approved continuing education and 700 hours of internship in a board-approved internship program;

(vi) if the Texas pharmacist license has been expired for more than six years but less than seven years, the applicant shall complete 45 contact hours of approved continuing education and 900 hours of internship in a board-approved internship program;

(vii) if the Texas pharmacist license has been expired for more than seven years but less than eight years, the applicant shall complete 45 contact hours of approved continuing education and 1,100 hours of internship in a board-approved internship program;

(viii) if the Texas pharmacist license has been expired for more than eight years but less than nine years, the applicant shall complete 45 contact hours of approved continuing education and 1,300 hours of internship in a board-approved internship program; and

(ix) if the Texas pharmacist license has been expired for more than nine years but less than 10 years, the applicant shall

complete 45 contact hours of approved continuing education and 1,500 hours of internship in a board-approved internship program.

(2) Any hours of approved continuing education earned within two years prior to the applicant successfully passing the Texas pharmacy jurisprudence examination may be applied towards the continuing education requirement.

(3) Any hours worked as a licensed pharmacist in another state during the two years prior to the applicant successfully passing the Texas pharmacy jurisprudence examination may be applied towards the internship requirement.

(4) All requirements for licensure shall be completed within two years from the date the applicant successfully passes the Texas pharmacy jurisprudence examination.

(5) If the person's Texas pharmacist license has been expired for 10 years or more, the applicant shall apply for licensure by examination as specified in §283.7 of this title and §283.4 of this title (relating to Internship Requirements).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Executive Director/Secretary
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TITLE 25. HEALTH SERVICES

PART 1. TEXAS DEPARTMENT OF HEALTH

CHAPTER 229. FOOD AND DRUG

SUBCHAPTER J. MINIMUM STANDARDS FOR NARCOTIC TREATMENT PROGRAMS

The Texas Department of Health (department) adopts amendments to §§229.142, 229.143, 229.144, 229.145, 229.147, 229.150, 229.151, 229.152, the repeal of §229.148, and new §§229.148 and 229.153 concerning minimum standards for narcotic treatment programs (NTP). Sections 229.142, 229.145, 229.148, 229.150, 229.152, and 229.153 are adopted with changes to the proposed text as published in the July 27, 2001, issue of the *Texas Register* (26 TexReg 5579). Sections 229.143, 229.144, 229.147, and 229.151 are adopted without changes and therefore will not be republished.

The amendments, repeal, and new rules clarify and update minimum standards for narcotic treatment programs in order to conform with current federal requirements promulgated by the Substance Abuse and Mental Health Services Administration (SAMHSA). In addition, as a result of the comments received by the department the following changes were made. A definition for program sponsor was added in §229.142. The requirement to have standing orders approved by SAMHSA was deleted in §229.142. Eligibility for ownership of an NTP was further clarified in §229.145. The release of medical records was changed from 30 days to 15 days from the date of request in §229.148. A requirement was added to have physicians document the reason for patient admission into short-term detoxification treatment rather than long-term detoxification treatment in §229.148. The term urinalysis was substituted with drug abuse test to allow for alternative testing for illicit and licit drugs in §229.148. The requirement for the number of random yearly drug abuse tests performed was changed in §229.148. A requirement to have a physical examination and laboratory tests be performed for patients who are re-admitted after three months from the time they are discharged was added to §229.148. The provision that allowed physicians to authorize a two-week supply of unsupervised use beyond what the patient is eligible was deleted in §229.148. A requirement to have written approval by the department for additional unsupervised use was added in §229.148. The requirement of clinics to reveal medical records to anyone other than a regulatory authority in a related administrative or court proceeding was deleted in §229.148. Electronic mail and facsimile were added as a form of communication to notify the department of patient status change in §229.150. Typographical and grammatical errors were noted and the necessary corrections were made in §§229.145, 229.148, 229.152, and 229.153.

The following comments were received regarding the proposed sections. The commenters were Aeschbach Associates, Best Recovery Health Care, Texas Clinic, Toxicology, Center for Health Care Service, Drug Dependence Associates, and Adult Rehabilitation Services.

Comment: Concerning §§229.142 - 229.153, a commenter stated that narcotic treatment programs would be better referred to as opioid treatment programs to reflect the current language at the federal level.

Response: The department agrees, however, the change must be followed by amending the Health and Safety Code (the Act). In the interim, the department would recognize narcotic treatment programs as opioid treatment programs. No change was made as a result of the comment.

Comment: Concerning §229.142, a commenter suggested that the regulations should define "authorized health care provider" and how that person is to be supervised.

Response: The department disagrees that the term should be defined and believes that the proposed language provides the information. The language of the rules provides ample authority for supervision at their level. No change was made as a result of the comment.

Comment: Concerning §229.142, a commenter stated that it was unnecessary for the federal and state regulatory authorities to approve physician standing orders. In addition, the proposed regulations do not provide a process for approving physician standing orders.

Response: The department agrees that the requirement for federal approval on physician standing orders is not necessary and has eliminated the language in new §229.142(26). However, the department disagrees that physician standing orders should not be subjected to a review process by the department. A majority of the clinics have licensed vocational nurses performing medical duties that would be considered outside their scope of practice

under other patient care settings. For this reason, it is necessary for the department to review and approve physician standing orders that would be enacted by the authorized health care provider. The department agrees that criteria for the physician standing orders should be included in the regulations; however, since this would be a significant change, it will be considered the next time the rules are amended. In the interim, the department would continue to review and approve standing orders on a case-by-case basis using criteria established by accreditation bodies.

Comment: Concerning §229.142 and §229.148(b)(3), a commenter stated that the content of the status report should be defined in the regulations.

Response: The department disagrees inasmuch as the information collected can be used for statistical analysis, which can be subject to change when collaborating with other governmental agencies. The department needs this flexibility in determining what statistics to analyze. No change was made as a result of the comment.

Comment: Concerning §229.145(a), a commenter suggested that there should be an expiration date to complete an application for an NTP permit.

Response: The department agrees with the commenter, however, this would result in a significant change to the proposed regulations. The department will consider introducing an application expiration date the next time the rules are amended. No change was made as a result of the comment.

Comment: Concerning §229.145(a)(4), two commenters expressed concern with the current language that excludes individuals from ownership of an NTP. One commenter suggested that the two-year requirement until individuals with a history of opiate or alcohol usage may submit an application be changed to ten years. The other commenter suggested that the language be revised to include all individuals that are addicted and/or have a history of addiction within the last year be prohibited from ownership of an NTP.

Response: The department disagrees but has made changes to final §229.145(a)(4) for clarification purposes. The Health and Safety Code allows the department to determine criteria for the issuance of permits. The department's experience has shown that the two-year requirement is neither so burdensome as to prohibit otherwise qualified ownership, nor so lenient as to permit someone with an addiction to own a treatment program.

Comment: Concerning §229.148, a commenter suggested the use of electronic physician signatures for medical orders in lieu of written signatures.

Response: While the department agrees and recognizes the increasing involvement of technology in health care, this would be a significant change to the proposed rules; therefore, the department will consider approval of electronic signatures the next time the rules are amended. No change was made as a result of the comment.

Comment: Concerning §229.148(a)(1)(B), a commenter stated that the requirement to notify the department of personnel changes within seven days was excessively restrictive and recommended notification to the department within 30 days.

Response: The department disagrees since the information is reviewed to determine staff load and to perform background checks. The department believes it is important and necessary to verify staff credentials in a timely manner. No change was made as a result of the comment.

Comment: Concerning §229.148(a)(1)(D) and §229.148(k)(4), a commenter stated that the requirement to have certain documents in the personnel records such as job description, employment application, performance evaluation, etc. is outside the authority of the department.

Response: The department disagrees since the Health and Safety Code §466.004(a)(2) allows the department to determine which records are kept by the clinic and these types of records tell the department if the NTP is consistently training and working with its personnel. No change was made as a result of the comment.

Comment: Concerning §229.148(a)(3)(A)(iii), a commenter expressed concern that the term "neglect" is misleading and superfluous since clients are outpatients who come and go freely; staff should not be responsible for client crises, medical needs, etc.

Response: The department disagrees since the term is in the context of treatment of opiate addiction. The department believes that the clinic staff should be responsible for client crises, medical needs, etc. that pertains to the patient's treatment. No change was made as a result of the comment.

Comment: Concerning §229.148(a)(3)(A)(v) and §229.148(a)(3)(A)(vii), a commenter expressed concern with patients refusing treatment plans and suggested proposed language to include patient accountability for those who fail to pay for services.

Response: The department disagrees and believes rendering payment for services is a risk of doing business. The department's authority is over the NTP, not over the patient. No change was made as a result of the comment.

Comment: Concerning §229.148(b)(4), two commenters expressed concern with the requirement to have the patient waiting room and the dispensing area separated. The concern of one commenter is that the requirement is not practical except in large clinics. The other commenter stated that the requirement was in the jurisdiction of the Drug Enforcement Administration (DEA) and not the department.

Response: The department disagrees since the Health and Safety Code §466.004(b)(2) allows the department to determine criteria for the issuance of permits. In addition, the requirement was included to be consistent with DEA's regulations, 21 CFR §1301.74(k)(1). No changes were made as a result of the comments.

Comment: Concerning §229.148(d), a commenter stated that medical directors and program physicians should not be required to have training programs.

Response: The department disagrees since the treatment of opiate addicts is a specialty; therefore, medical staff should have knowledge and experience in the field of addiction medicine. The department believes a variance should only be considered to those physicians who have the required addiction medicine training. No change was made as a result of the comment.

Comment: Concerning §229.148(d)(1), a commenter stated that it is not appropriate for the department to require 12 clock hours of annual staff training as part of staff development.

Response: The department disagrees since past inspections have revealed that clinic personnel are not routinely updated with changes in regulations and best practices. In reviewing the amount of training necessary for the staff to be appraised of regulations and best practices, 12 hours of time is necessary to cover all areas. No change was made as a result of the comment.

Comment: Concerning §229.148(d)(2), a commenter stated that it is unnecessary to require the program sponsor or program director to be a licensed health care professional, credentialed counselor, or have worked in the field of substance abuse a minimum of three years. In addition, the requirement conflicts with the new federal regulations.

Response: The department disagrees since the Health and Safety Code allows the department to determine criteria for the issuance of permits. Although §229.152 adopts the federal regulations, a definition for program sponsor has been included in §229.142(25) for the purpose of clarification. The department disagrees with the commenter that eligibility for ownership of an NTP conflicts with the federal regulations. The definition for program sponsor in the proposed regulations is identical to the federal definition. The proposed language does not state that the program sponsor must be a physician, but that the individual is a licensed health care professional, which includes registered nurses, pharmacists, etc. The department also included criteria for ownership of an NTP by a corporation in §229.148(3), which resulted in the re-numbering of the subsection.

Comment: Concerning proposed §229.148(d)(5), renumbered as §229.148(d)(6), a commenter stated that registered nurses are appropriate counselors and should be exempted from the requirements of obtaining a counseling license.

Response: The department disagrees and believes that registered nurses are highly qualified for direct patient care but not necessarily in psychotherapy. Counseling licenses are issued specifically for counseling services that must be provided. No change was made as a result of the comment.

Comment: Concerning §229.148(e), a commenter expressed concern that the proposed language poorly addresses non-medical personnel making medical decisions.

Response: The department disagrees and believes the regulations adequately address the limitations and supervision of non-medical personnel performing medical duties. The proposed regulations allow a physician to delegate certain medical duties to a health care professional certified or licensed in accordance with applicable Texas state regulations. This authorized health care provider practices under the supervision of the physician. All medical orders and physical examinations are reviewed by the physician and signed within 72 hours. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(2), a commenter expressed concern that the initial screening process appears to lack specificity and suggested the new federal language regarding medical criteria be adopted.

Response: The department disagrees with the commenter that the proposed regulations lack specificity for the initial screening process. In §229.152, the department adopted the federal regulations and in doing so, all federal requirements are enforced unless otherwise specified. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(5), a commenter expressed concern that NTPs should not be required to obtain certain information prior to the transfer of a patient from another clinic that is located outside Texas.

Response: The department disagrees since such information (daily dose, length of time in continuous treatment, last date of administration, etc.) is necessary in order to ensure the patient continues on their previous regimen. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(5), a commenter expressed concern that the proposed language failed to prevent patients from transferring to another clinic due to financial and/or unsupervised use privileges.

Response: The department disagrees since the program can determine if the patient is "shopping" for unsupervised use privileges during the intake. Financial matters of operating a clinic such as patient inability or unwillingness to pay, are not within the authority of the department. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(5), a commenter suggested that screening performed by program staff other than the physician should determine the likelihood of eligibility for admission; admission to treatment should be made only by the physician.

Response: The department agrees with commenter, but believes the proposed language clearly states that the physician makes the final determination of patient admission to treatment. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(5)(E), one commenter stated that the release of medical records within 30 days conflicts with the Medical Practice Act, which requires the release of patient medical records within 15 days.

Response: The department agrees and has made the necessary changes in §229.148(e)(5)(E) to require clinics to release patient medical records within 15 days from the date of the request.

Comment: Concerning §229.148(e)(5)(E)(i), a commenter stated that the requirement for physical examination and laboratory tests are more stringent for patients who transfer to another clinic than for a patient who is re-admitted.

Response: The department agrees and has made changes to final §229.148(e)(8) by requiring a physical examination and laboratory tests be performed for patients who are re-admitted after 3 months from the time they were discharged.

Comments: Concerning §229.148(e)(8), a commenter suggested removing the requirement for a patient to have a face-to-face meeting with the program physician no later than one week after admission.

Response: The department disagrees since numerous patient complaints received by the department and routine inspections have shown a lack of physician involvement resulting in a compromise of patient care. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(9)(B), a commenter stated that patients should be allowed to read and submit their results from the Mantoux test. Requiring the patients to return to the clinic to have the test read by a trained health care professional is an inconvenience to the patient and discriminatory.

Response: The department disagrees since pursuant to the Center for Disease Control and Prevention the result for the Mantoux test must be read by a trained health care professional. Patients may incorrectly read results. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(10), a commenter suggested that the admission laboratory test should include a Hepatitis C test.

Response: The department disagrees since performing this test would result in a substantial increase in the cost to treat each patient. The proposed regulations require clinics to obtain a patient liver function profile to screen for abnormalities. Additional tests are requested at the judgment of the program physician. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(10), a commenter expressed concern regarding the additional required lab work, which includes CBC, urinalysis, and liver function tests. The lab work is unwarranted and would increase physician liability if tests were not properly evaluated.

Response: The department disagrees since the federal guidelines for accreditation recommend such lab work to assess organ systems. Organ system assessment is a part of proper patient care since narcotic and opioid treatment affects organ systems. Programs without primary care on-site must refer patients for laboratory tests and follow-up results. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(10), a commenter suggested that a broad chemistry analysis (SMAC) be included as part of the minimum laboratory tests performed during admission.

Response: The department disagrees since such lab work is not listed in the federal guidelines for accreditation. The department supports the decision of a physician should she/he determine that additional lab work is necessary. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(12), a commenter expressed concern that the regulations penalize patients on long-term detoxification by not allowing additional unsupervised doses to be dispensed for a day the clinic is closed due to a holiday.

Response: The department disagrees since the proposed language states that patients in long-term detoxification treatment are subjected to the same requirements as patients in comprehensive maintenance treatment regarding unsupervised use. No change was made as a result of the comment.

Comment: Concerning §229.148(e)(12), a commenter suggested deleting the required statement that short-term detoxification was not sufficient prior to admission to long-term detoxification. Short-term treatment is unsuccessful regarding addiction medicine and the justification should be required when selecting this treatment plan.

Response: The department agrees since statistics have shown a high relapse for short-term detoxification treatment and the majority of clinics do not offer short-term detoxification. Proposed changes to the regulations include deletion of documentation in §229.148(e)(12) that short-term detoxification was not a sufficiently long enough treatment prior to admission into long-term detoxification treatment. In addition, a requirement to have physicians document in the patient record justification for patient admission to short-term detoxification was added to §229.148(e)(11).

Comment: Concerning §229.148(f)(l), a commenter suggested that the initial treatment plan should be completed only by the physician.

Response: The department disagrees since licensed counselors have been trained to perform such duties and completion of treatment plan entries is within the scope of their duties. No change was made as a result of the comment.

Comment: Concerning §229.148(h)(1), several commenters stated that drug testing for licit and illicit drugs should not be limited to urinalysis. The federal regulations do not specify methods for screening such drugs. In addition, there are other drug abuse tests that have demonstrated to be effective.

Response: The department agrees and has made changes to final §229.148(h) to allow for drug abuse tests other than urinalysis.

Comment: Concerning §229.148(h)(1)(A), several commenters expressed concern with performing monthly random drug testing when the federal regulations required only eight per year. In addition, mandating monthly tests would eliminate the intent to have random drug testing for those patients attending the clinic once per month.

Response: The department agrees and has made the necessary changes that require monthly random drug abuse tests in the initial year of treatment and eight random drug abuse tests yearly thereafter in §229.148(h)(1)(A).

Comment: Concerning §229.148(h)(l)(B)(v), a commenter suggested that the language be revised to state that a drug screen refusal should not be considered the same as a drug screen positive for illicit substances.

Response: The department disagrees and believes that a refusal being considered a positive result will be a deterrence for patients to refuse drug-screening tests. No change was made as a result of the comment.

Comment: Concerning §229.148(h)(1)(C), a commenter stated that the requirement for testing for methadone metabolite and benzodiazepines is too excessive.

Response: The department disagrees with the commenter. Testing for methadone metabolite determines patient adherence to treatment and testing for benzodiazepines screens for drug-drug interaction. No change was made as a result of the comment.

Comment: Concerning §229.148(i), a commenter suggested that patients with very stable high doses should be restricted to less than weekly attendance for gradual tapering of their dose.

Response: The department disagrees since the guidelines for unsupervised use, established by the federal authorities, are not based on patient dose. The department believes that the time in which to initiate dose tapering should be individualized and not dependent solely on the patient's dose. In addition, such restriction would appear to penalize patients who are on a stable high dosage. No change was made as a result of the comment.

Comment: Concerning §229.148(i)(3), a commenter expressed concern that the maximum 14 days of unsupervised use authorized by the medical director or program physician conflicts with the federal regulations.

Response: The department agrees and has eliminated the proposed language "of more than a two week" and added "an additional" supply to conform with the federal regulations in §229.148(i)(3).

Comment: Concerning §229.148(i)(3), a commenter suggested that further clarification was needed for the approval of additional unsupervised use beyond what the patient is eligible.

Response: The department agrees and has clarified the final §229.148(i)(3) by including the word "written" for approval from the SMA.

Comment: Concerning §229.148(i)(3), a commenter expressed concern that the regulations do not permit patients to courtesy dose at another clinic for greater than 14 days.

Response: The department disagrees since the proposed language states courtesy dosing greater than 14 days is permitted with prior approval from the department. No change was made as a result of the comment.

Comment: Concerning §229.148(i)(6), two commenters expressed concern with the requirement for patients to have a secure container for unsupervised use. One commenter stated that establishing security of drugs is a criterion of the eight criteria required for each patient to meet prior to receiving unsupervised medication. The other commenter suggested that a secure container should apply to only large numbers of unsupervised use.

Response: The department disagrees with the commenters. The department believes that any amount of medication for unsupervised use must be secure such that accessibility is limited only to whom the medication is prescribed. The department recognizes that the eight criteria address patient security of medication; however, it applies only to the patient's home and not at all times. No changes were made as a result of the comments.

Comment: Concerning §229.148(j)(2), a commenter expressed concern that patients who are non-compliant should not be terminated from treatment without a face-to-face meeting with the physician.

Response: The department agrees and has made the necessary change to final §229.148(j)(2) by removing serious noncompliance as a reason for involuntary discharge and inserting it in §229.148(j)(4), other types of discharge.

Comment: Concerning §229.148(j)(4), two commenters expressed concern with the requirement to have the clinic humanely detoxify the patient in the event of non-payment of services. The department should fund continuation of treatment when instances of patient non-payment arise.

Response: The department disagrees with the commenter's suggestion that clinics be allowed to terminate patients without detoxification or appropriate referral. Termination of treatment without detoxification could result in the patient experiencing severe withdrawal symptoms. The department does not support such medical practice and believes financial recovery for services is a risk of doing business. No changes were made as a result of the comments.

Comment: Concerning §229.148(k)(1)(D), a commenter stated that the requirement to release client records in an administrative or court hearing compromises the patient's confidentiality.

Response: Although the department cannot determine when a court may subpoena medical records, we do agree that this is not an area to be addressed in the rules and we have deleted the proposed language in §229.148(k)(1)(D)(vi).

Comment: Concerning §229.148(k)(2), a commenter stated that inspections of receipt, storage, and distribution of narcotic medication is outside the authority of the department.

Response: The department disagrees since the Health and Safety Code §466.004 allows the department to review documents, which would ensure the proper use of approved narcotic drugs in the treatment of narcotic dependent persons. No change was made as a result of the comment.

Comment: Concerning §229.150(e)(1), a commenter requested removal of telephone notification to the department of changes in patient status.

Response: The department disagrees but has made a change to final §229.150(e)(1) by including notification by electronic mail and facsimile.

Comment: Concerning §229.150(e)(2)(D)(i), a commenter stated that requiring patients to provide only Texas issued identification for admission appears discriminatory.

Response: The department disagrees since alternative forms of identification such as a United States passport and military identification are acceptable. The department believes identification issued by other states cannot be verified at the time of admission. No change was made as a result of the comment.

25 TAC §§229.142 - 229.145, 229.147, 229.148, 229.150 - 229.152, 229.153

The amendments and new rules are adopted under Health and Safety Code, §145.011, which provides the department with the authority to adopt necessary regulations pursuant to the enforcement of Chapter 145; and §12.001, which provides the Texas Board of Health (board) with the authority to adopt rules for the performance of every duty imposed by law on the board, the department, and the commissioner of health.

§229.142. Definitions.

The following words and terms, when used in the sections of this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Administer - The direct application of a prescription drug by ingestion or any other means to the body of a patient by: a licensed practitioner, an agent of the practitioner, supervised by and under the order of the practitioner; or, the patient, at the direction of or in the presence of a practitioner.

(2) Agent - A pharmacist, registered nurse, licensed practical/vocational nurse, physician's assistant, or any other health care professional authorized by federal and state law to administer or dispense narcotic drugs.

(3) Approved narcotic drug - A drug approved by the United States Food and Drug Administration for maintenance and/or detoxification of a person physiologically addicted to opiate class of drugs.

(4) Approved narcotic drug permit - A permit issued by the Texas Department of Health to an applicant to operate a narcotic treatment program (NTP) which provides an approved narcotic drug for maintenance and/or detoxification and rehabilitative services to opioid addicted individuals.

(5) Approved to treat (ATT) - The maximum number of patients the NTP is allowed to treat at any point in time under the approved permit. This number is based on a maximum of 50 patients for each counselor employed by the program.

(6) Board's formal hearing procedures - The formal hearing procedures of the Texas Department of Health in Chapter 1 of this title (relating to Texas Board of Health) for conducting hearings on denial of application, suspension, or revocation of permit.

(7) Central registry - A process in which an NTP shall share patient identifying information about individuals who are applying for or undergoing detoxification or maintenance treatment on an approved narcotic drug to a central record system at the Texas Department of Health, Drugs and Medical Devices Division, Austin, Texas.

(8) Chemical dependency counseling - Face-to-face interactions between patients and counselors to help patients identify, understand, and resolve issues and problems related to chemical dependency.

(9) Chemical dependency counselor - A qualified credentialed counselor, as defined in Title 40, Texas Administrative Code (TAC), Chapter 150, or, counselor intern working under direct supervision of a licensed counselor or physician.

(10) Counselor intern (CI) - A person pursuing a course of training in chemical dependency counseling as defined in 40 TAC, Chapter 150.

(11) Department - The Texas Department of Health.

(12) DEA - Drug Enforcement Administration.

(13) Dispense - Preparing, packaging, compounding, or labeling for delivery a prescription drug in the course of professional practice to an ultimate user by or pursuant to the lawful order of a practitioner.

(14) FDA - Food and Drug Administration.

(15) Fee certificate - A document issued annually by the department after payment by the narcotic treatment program of the required fee based on the number of patients approved to treat.

(16) Hospital - A health care facility licensed by the department as a general hospital or a special hospital under the Health and Safety Code, Chapter 241; or a health care facility licensed by the Texas Mental Health and Mental Retardation as a private mental hospital under Health and Safety Code, Chapter 577; or a hospital directly operated under the authority of other statutes of the state.

(17) Medical director - A physician, licensed to practice medicine in the jurisdiction in which the program is located, who assumes responsibility for the administration of all medical services performed by the NTP, including ensuring that the program is in compliance with all federal, state, and local laws and regulations regarding the medical treatment of narcotic addiction with a narcotic drug.

(18) Medication unit - A facility established as part of, but geographically dispersed (i.e., separate) from a narcotic treatment program from which licensed private practitioners and community pharmacists are permitted to administer and dispense a narcotic drug, and are authorized to collect samples for drug testing or analysis for narcotic drugs.

(19) Narcotic drug - A drug as defined in Texas Controlled Substances Act, Health and Safety Code, §481.002(29)(A)-(D) and Title 42, Code of Federal Regulations (CFR), Part 8.

(20) Narcotic treatment program (NTP) - An organization which has been issued an approved narcotic drug permit by the department and the permit has not been suspended, revoked, or surrendered to the department.

(21) Person - An individual, corporation, organization, government or governmental subdivision, agency, business trust, partnership, association, or any other legal entity.

(22) Practitioner - As defined in Health and Safety Code, Chapter 481.

(23) Program director - An individual who provides overall administrative management to the NTP under guidelines established by the permit holder and the medical director.

(24) Program physician - A licensed physician who will provide medical treatment and counsel to the patients of an NTP under the supervision of the medical director.

(25) Program sponsor - A person named in the application for an NTP permit who is responsible for the operation of the narcotic treatment program and who assumes responsibility for all its employees, including any practitioners, agents, or other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units. The program sponsor need not be a licensed physician but shall employ a licensed physician for the position of medical director.

(26) Standing orders - Written instructions prepared by a licensed physician pursuant to the rules of the Texas State Board of Medical Examiners relating to standing delegation orders, as described in 22 TAC §§193.1-193.6, and shall be approved by the State Methadone Authority (SMA).

(27) State Methadone Authority (SMA) - The department, Drugs and Medical Devices Division.

(28) Status Report - An annual report submitted by the permit holder on a form provided by the department. The content of the report is determined by the department.

(29) SAMHSA - Substance Abuse and Mental Health Services Administration.

§229.145. Application, Fees, Permits.

(a) Application.

(1) A complete narcotic drug treatment application provided by the Texas Department of Health (department) must be submitted to the State Methadone Authority (SMA) to apply for an approved narcotic drug permit to operate a narcotic treatment program (NTP).

(2) A complete application filed in accordance with this subsection for an NTP will be reviewed and evaluated by the department, in accordance with §229.281 of this title (relating to Processing Permit Application Relating to Food and Drug Operation). An application shall not be considered complete until an application for an NTP has been submitted to the Drug Enforcement Administration (DEA), and to the Substance Abuse and Mental Health Services Administration (SAMHSA). If the program application is denied by the department, the applicant shall have an opportunity for a hearing pursuant to §229.147 of this title (relating to Denial of Application; Suspension or Revocation of Narcotic Drug Permit).

(3) A person acquiring an NTP currently operating under department approval must submit a new application in accordance with this subsection and an initial fee as required in subsection (b)(1) of this section. A narcotic drug permit will be issued to a new owner or new location and the permit issued to the previous owner or location shall be

void and surrendered to the department by certified or registered mail within 24 hours following receipt of the new approved narcotic drug permit.

(4) Individuals who are currently chemical dependent and/or have a history of chemical dependency on any substances that are subjected to abuse within two years of application for a permit, are not eligible for ownership of an NTP.

(5) The number of patients that a clinic is approved to treat is in direct proportion to the number of counselors employed by that clinic. This proportion is a maximum of 50 patients for each counselor. The NTP may exceed the counselor to patient ratio on a temporary basis to permit hiring of new staff when new admissions cause a ratio imbalance or when current staff leave and must be replaced.

(6) Applicants must provide to the department complete information for evaluation of criteria concerning location, funding, compliance history, and competency to operate an NTP.

(A) Scope. The department intends that new NTP locations be established to serve diverse patient populations without singular regard to proximity of location to an existing program(s). The department has established criteria to prevent competition for patients among NTPs in the same area that may result in increased noncompliance with state and federal regulations and compromised patient care.

(B) Criteria. An applicant must affirmatively demonstrate the following:

(i) serviceability of the program at the proposed location by providing the department the following:

(I) a map showing proximity of the proposed NTP to existing programs within a three-mile radius;

(II) a description of how the new program will ensure it will provide treatment services for an underserved population and not duplicate treatment services for existing patients in treatment at an established program in the area;

(III) copies of planned promotional materials, advertisements, and other techniques to publicize the proposed program; and

(IV) procedures that will be used to identify whether a patient is enrolled in another clinic;

(ii) the source and adequacy of financial assets necessary to operate the program;

(iii) if applicable, the compliance history of the applicant, which includes any issues reported to the department by SAMHSA, DEA or any other regulatory agency;

(iv) adequate planning and organizational structure demonstrated by full and complete answers submitted to all questions in the application materials; and

(v) a statement that the applicant has read, understood and agreed to follow all federal and state regulations concerning operation of an NTP.

(b) Fees and fee assessments.

(1) Initial fee. A nonrefundable initial fee of $700 must be submitted along with the complete application for the purpose of evaluation, inspection, and processing of the request to operate an NTP in accordance with subsection (a) of this section. An application will not be considered unless the application is accompanied by the initial fee. A nonrefundable initial fee of $100 shall be submitted for each medication unit requested in the initial application.

(2) Annual patient fee. Upon issuance of the permit, the permit holder shall submit a fee of $20 for each patient which the NTP is approved to treat no later than 30 days after the permit is issued. A fee certificate will be issued for a 12-month period from date of issuance of the permit. The current annual renewal patient fee certificate is transferable until its expiration date only in the following circumstances:

(A) to the permit holder of a program which relocates with no change of ownership; or

(B) to a new permit holder of a program which changes ownership at an existing location.

(3) Annual renewal fee and current status report. A nonrefundable annual renewal fee of $20 for each patient which the NTP is approved to treat shall be submitted by the permit holder to the department by filing a renewal form and current status report provided by the department prior to the expiration of the current fee certificate. A program that files a renewal fee after the expiration date must pay an additional delinquency fee of $3 per patient ATT. A program that files a current status report after the expiration date must pay a delinquency fee of $250. A fee certificate will be issued for a 12-month period from the expiration date.

(A) A fee of $20 per patient shall be submitted in the event the permit holder requests approval to increase the number of patients approved to treat during the current fee-paid year. In the calculation of the fee, temporary transfer patients shall not be considered as approved to treat patients by the program providing temporary treatment.

(B) An increase in the number of patients must be justified by demonstrating that the facility and staff are adequate to treat the increased number of patients.

(4) Medication unit fee. A nonrefundable annual renewal fee of $100 shall be paid for each medication unit the permit holder may operate.

(c) Permit.

(1) All NTPs, persons, or organizations are required by the Health and Safety Code, Chapter 466, to obtain an approved narcotic drug permit in order to provide treatment to patients with a primary diagnosis of an opiate addiction.

(2) An approved narcotic drug permit shall be issued by the department subsequent to federal and state approval of an application as required in subsection (a) of this section, and payment of a fee as required in subsection (b)(1) of this section which will provide authorization to operate an NTP.

(3) Failure to pay the appropriate fee as required in subsection (b) of this section is grounds for suspension, revocation, or denial of a permit as provided in §229.147 of this title (relating to Denial of Application; Suspension or Revocation of a Narcotic Drug Permit).

(4) A permit issued by the department for the operation of an NTP is valid only for the location of the NTP stated on the permit. A permit issued by the department is not transferable from one facility to another facility and must be surrendered to the department if the person holding the permit sells or otherwise conveys the facility to another person. If the permit holder sells or otherwise conveys the facility to another person or changes the location of the facility, a new application must be submitted as required in subsection (a) of this section and the fees must be paid as required in subsection (b) of this section. The previous permit must be surrendered to the department as specified in subsection (a)(3) of this section.

(5) A permit holder requesting to move an NTP to another location must submit a new application for a new permit as required in subsection (a) of this section, and pay the initial fee in accordance with subsection (b)(1) of this section. The previous permit must be surrendered to the department as specified in subsection (a)(3) of this section.

(6) An approved narcotic drug permit issued by the department shall remain in effect until suspended or revoked by the department or surrendered by the permit holder.

(7) The approved narcotic drug permit and the current certificate must be posted in a conspicuous location within the premises of the NTP.

(8) Methadone, or any other drug approved by the FDA for the treatment of opiate addiction, are the only drugs which shall be used in NTPs for patients with opiate addiction.

§229.148. State Operational Requirements.

(a) Management and administration.

(1) Human resources management.

(A) The narcotic treatment program (NTP) shall employ a sufficient number of qualified personnel to fulfill the service objectives of the program and to satisfy the intent of this section.

(B) Each NTP shall notify the State Methadone Authority (SMA) within seven days, in writing, of any change in the employment status of any of its program personnel. For new hires, the employee's home address and telephone number, copies of a current Texas driver's license and verification of professional licensure shall be provided with this notification. In addition, copies of a curriculum vitae, physician permit, Drug Enforcement Administration (DEA) certificate, and Texas Department of Public Safety registrations shall be provided for physicians. Notice of change of medical director or program sponsor must be given prior to the change or on the date the change occurs.

(C) Employees who are currently or formerly addicted to drugs of abuse and/or opiates (including methadone); or alcohol within two years; are considered risks to the security of drug stocks and shall not have access to the drug stocks or to the drug dispensing area.

(D) The NTP shall develop job descriptions for all staff members which include job duties and responsibilities, dates of regular review for continuing appropriateness, and documentation that the descriptions are provided to the individual staff member.

(2) Program operations.

(A) Each NTP shall provide medical and rehabilitative services and programs. These services should normally be made available at the primary facility, but the program sponsor may enter into a formal documented agreement with private or public agencies, organizations, or institutions for these services if they are available elsewhere. The program sponsor, in any event, must be able to document that medical and rehabilitative services are fully available to patients. Any service not furnished at the primary facility is required to be listed in any application for program approval submitted to the SMA. The addition, modification, or deletion of any program service is required to be reported immediately to the SMA.

(B) Each program must notify the SMA in writing of clinic closure due to holidays, training, and emergencies.

(C) Each program must provide a written response to a warning letter issued by the SMA within 15 days of the receipt of the letter.

(D) Each program must be able to provide observed daily dosing six days a week.

(3) Patients' rights and grievance procedures.

(A) Each program shall develop and implement written policies regarding the patients' rights that include the following:

(i) the right to receive a written copy of these rights, which include the address and telephone number of the department, prior to admission;

(ii) the right to a humane environment that provides reasonable protection from harm and appropriate privacy for personal needs;

(iii) the right to be free from physical and verbal abuse, neglect and exploitation;

(iv) the right to be treated with dignity and respect;

(v) the right to be informed about the individualized plan of treatment and to participate in the planning, as able;

(vi) the right to be promptly and fully informed of any changes in the plan of treatment;

(vii) the right to accept or refuse proposed treatment;

(viii) the right to have personal information and medical records kept private;

(ix) the right to make a complaint and receive a fair response from the facility within a reasonable amount of time; and

(x) the right to complain directly to the department.

(B) Each program shall have a written grievance procedure for patients and others to present complaints, either orally or in writing, and to have their complaints addressed and resolved as appropriate in a timely manner.

(C) Each program shall maintain documentation of grievances and complaints and the resolution in the patient's file.

(b) Facilities and clinical environmental.

(1) Each facility shall have adequate and appropriate space and equipment to meet the objectives of the program and the needs of each person receiving services.

(2) Each facility shall be in compliance with all applicable local health, safety, sanitation, building and zoning requirements.

(3) All buildings and grounds must be constructed, maintained, repaired and cleaned so that they are not hazardous to the health and safety of the patients and staff.

(4) The patient medication area must be physically separate from the waiting area.

(5) Counseling areas, bathrooms, and medical examination areas must be designed to ensure patient privacy.

(c) Risk management.

(1) Each program shall develop and maintain a written plan to ensure the continuity of patient treatment in the event that an emergency or disaster disrupts the program's functions. This plan shall include a requirement for a program representative to notify the department of the disruption in function.

(2) The NTP sponsor must report to the department any patient death. The program shall report orally and in writing within two weeks of the program's knowledge of the death. A detailed account of

any adverse reaction to an approved narcotic drug will be maintained in the patient treatment record.

(3) Security of drug stocks.

(A) Any theft, break-in, or diversion of drug stocks from the clinic must be reported to the SMA within 48 hours of discovery of the event.

(B) Adequate security is required to be maintained over drug stocks, and over the manner in which it is administered or dispensed. The program is required to meet the security standards for the distribution and storage of controlled substances as required by the DEA, Department of Justice (21 CFR 1301).

(4) Staff shall complete an incident report for all significant patient incidents including, but not limited to: violation of patients' rights, accidents and injuries, medical emergencies, behavioral and psychiatric emergencies, medication errors, medication adverse events, diversion, illegal or violent behavior, loss of a patient record, and release of confidential information without patient consent. The treatment facility shall ensure full documentation of the event is placed in the patient file; prompt investigation and review of the situation surrounding the event; implementation of timely and appropriate corrective action; and ongoing monitoring of any corrective actions until all corrections have been made.

(d) Professional staff credentials and development.

(1) Each program shall have and follow written policies and procedures for training program staff. A minimum of 12 clock hours of training or instruction must be provided annually for each staff member who provides treatment or services to patients. Such training must be in subjects that relate to the employee's assigned duties and responsibilities. Programs shall maintain records that each staff member has received the required annual training and be able to present copies of these records to the department upon request.

(2) The program sponsor shall:

(A) be a licensed health care professional or qualified credentialed counselor or have worked in the field of substance abuse a minimum of three years;

(B) have at least one year in the management or administration of direct services to persons with substance abuse problems; and

(C) submit a list of educational levels and work experience to the SMA upon employment.

(3) A legal entity organized and operating under the laws of this state shall:

(A) have at least one year experience in the management or administration of direct services to persons with substance abuse problems;

(B) employ a program director that is a licensed health care professional or qualified credentialed counselor or have worked in the field of substance abuse a minimum of three years; and

(C) submit a list of educational levels and work experience for the program director to the SMA upon employment.

(4) Medical director.

(A) The medical director shall be licensed to practice medicine in Texas and in accordance with 22 Texas Administrative Code (TAC), Chapter 163, and shall have worked in the field of addiction medicine a minimum of two years.

(B) Programs that are unable to secure the services of a medical director who meets the requirements of subparagraph (A) of this paragraph may apply to the SMA for a variance. The SMA has the discretion to grant such a variance for the two years experience in the field of addiction medicine when there is a showing that:

(i) the program has made good faith efforts to secure a qualified medical director, but has failed;

(ii) the program can secure the services of a licensed physician who is willing to serve as medical director and participate in an in-service training plan;

(iii) the program has developed an in-service training plan which is acceptable to the SMA;

(iv) the program has obtained the services of a medical consultant who meets the requirements of subparagraph (A) of this paragraph above and will be available to oversee the in-service training of the medical director and the delivery of medical services at the program requesting the variance.

(5) Physicians.

(A) The program physician(s) other than the medical director shall be licensed to practice medicine in Texas and in accordance with 22 TAC, Chapter 163, and shall have worked in the field of addiction medicine a minimum of one year.

(B) Programs that are unable to secure the services of a physician who meets the requirements of subparagraph (A) of this paragraph regarding the 1 year experience in the field of addiction medicine may apply to the SMA for a variance. The SMA has the discretion to grant such a variance when there is a showing that:

(i) the program has made good faith efforts to secure a qualified physician, but has failed;

(ii) the program can secure the services of a licensed physician who is willing to serve as program physician and participate in an in-service training plan;

(iii) the program has developed an in-service training plan which is acceptable to the SMA; and

(iv) the program employs a qualified medical director who has the experience and credentials specified in paragraph (3)(A) of this subsection or has completed the in-service training program specified in paragraph (3)(B) of this subsection.

(6) Counseling staff shall meet the requirements of a qualified credentialed counselor or counselor intern in Texas as defined in 40 TAC, Chapter 150, unless exempted.

(7) Nursing staff shall be licensed to practice in Texas and in accordance with 22 TAC, Chapter 217 or 22 TAC, Chapter 235.

(8) Pharmacists shall be licensed to practice in Texas and in accordance with 22 TAC, Chapter 283.

(9) Other health care professionals must be licensed in Texas and in accordance with applicable Texas state regulations.

(e) Patient admission and assessment.

(1) Voluntary participation. The person responsible for the program shall ensure that:

(A) a patient voluntarily chooses to participate in a program;

(B) all relevant facts concerning the use of the narcotic drug used by the program are clearly and adequately explained to the patient;

(C) all patients, with full knowledge and understanding of its contents, sign an informed written consent to treatment; and

(D) a parent, legal guardian, or responsible adult designated by the state authority (e.g., "Emancipated minor laws") consents in writing for the treatment of patients under the age of 18.

(2) Screening. All applicants for admission must be initially screened by a health care professional certified or licensed in accordance with applicable Texas state regulations to determine eligibility for admission. No applicant may be processed for admission until it has been verified that he or she meets all applicable criteria, and that the sources and methods of verification have been recorded in the applicant's file. The screening process must include:

(A) verification, to the extent possible, of an applicant's identity including name, address, date of birth, and other identifying data;

(B) history of narcotic dependence, evidence of current physiologic dependence, and a physical examination;

(C) medical history, including HIV status, pregnancy, current medications (prescription and non-prescription), and active medical conditions;

(D) patient history including, but not limited to, psychological and sociological background, educational and vocational achievements, and current mental status exam; and

(E) determination if the applicant needs special services and determination that the program is capable of addressing these needs either directly or through referral.

(3) Exceptions.

(A) Pregnant patients, regardless of age, who have had a documented opiate dependency in the past and who may return to opiate dependency may be admitted to treatment and placed on a maintenance regimen. For such patients, evidence of current dependence on opiates is not needed if a program physician certifies in writing the pregnancy and finds treatment to be medically justified. Pregnant patients are required to be given the opportunity for, and should be encouraged to access prenatal care either by the program or by referral to appropriate health-care providers.

(B) A person who has resided in a penal or chronic care institution for one month or longer may be admitted to maintenance treatment within six months after release from such an institution without documented evidence of opiate dependency, provided the person would have been eligible for admission prior to incarceration or institutionalization, and the admission is medically justified. The medical justification must be documented in the patient's record.

(C) Applicants under 18 years of age are required to have had two documented attempts at short-term detoxification or drug-free treatment to be eligible for maintenance treatment. No person under 18 years of age may be admitted to a maintenance treatment program unless a parent, legal guardian, or responsible adult designated by the state authority completes and signs an informed written consent form. A person under 18 years of age shall not be given an initial dose of narcotic drug until the results of the admission drug test for drugs of abuse are reviewed by the physician. All documents must be kept in the patient's record.

(D) Under certain circumstances, a patient who has been treated and later voluntarily detoxified from comprehensive maintenance treatment may be readmitted to maintenance treatment without evidence to support findings of current physiologic dependence, up to two years after discharge, if the program attended is able to document prior narcotic drug comprehensive maintenance treatment of six months or more, and the admitting program physician, in his or her reasonable clinical judgment, finds readmission to comprehensive treatment to be medically justified. For patients meeting these criteria, the quantity of take-home medication, if take-home medication is permitted for the narcotic drug, will be determined in the reasonable clinical judgment of the program physician, but in no case may the quantity of take-home medication be greater than would have been allowed at the time the patient voluntarily terminated previous treatment. The admitting program physician or a program employee under supervision of the admitting program physician must enter in the patient's record documented evidence of the patient's prior treatment and evidence of all decisions and criteria used relating to the admission of the patient and the quantity of take-home medication permitted. The admitting program physician shall date and sign these entries in the patient's record or review the health-care professional's entries therein before the program administers any medication to the patient. In the latter case, the admitting program physician shall date and sign the entries in the patient's record made by the health-care professional within 72 hours of administration of the initial dose to the patient.

(4) Assessment. Each patient admitted to the program must be evaluated by the medical director or program physician and clinical staff who have been determined to be qualified by education, training, and experience to perform such assessments. The purpose of such assessments shall be to determine whether maintenance treatment, detoxification, or drug free treatment will be the most appropriate treatment modality for the patient. The evaluation must include an assessment of the patient's needs for other services including, but not limited to, medical, psychosocial, educational, and vocational. A signed and dated statement by the program physician, that he or she has reviewed all documented evidence to support a one year history of opiate dependence and current opiate dependence, and that in his or her reasonable clinical judgment, the applicant fulfills the requirements for admission to the program is required to be recorded in the patient's file prior to the administration of an any narcotic drug to the patient.

(5) Transfer of patients.

(A) The admitting program shall obtain from the patient an authorization for disclosure of confidential information, pursuant to 42 CFR, §§2.31-2.34, for the purpose of obtaining accurate and current information concerning the patient's treatment at the former program.

(B) The program physician or an appropriately trained health care professional supervised by the admitting program physician shall consider data obtained from the transferring program that verifies the amount of time the patient has spent satisfactorily adhering to the eight criteria found in subsections (i)(1)(A)-(H) of this section in determining if the patient may continue the same frequency of clinic attendance permitted at the former program immediately before transferring to the new program.

(C) The program physician shall not allow the patient to attend the clinic less frequently than the most recent schedule allowed at the former program unless:

(i) copies of the patient's records are obtained to sufficiently document the patient's satisfactory adherence to federal and state regulations for the required time in treatment; and

(ii) the physician has completed an evaluation of the patient that includes consideration of the eight criteria in subsections (i)(1)(A)-(H) of this section and the additional criteria for attendance as found in 42 CFR, §8.12(i).

(D) At a minimum, an agent of the practitioner from the admitting program shall document in the patient file and an agent of the

practitioner from the transferring program must provide the following information before the initial dose of narcotic drug is administered to a transfer patient:

(i) the last date and amount of narcotic drug administered or dispensed at the former program;

(ii) the length of time in continuous treatment;

(iii) the most recent record of clinic attendance;

(iv) the name, address, and telephone number of the program contacted;

(v) the date and time of the contact; and

(vi) the name of the program employee furnishing the information.

(E) Medical records.

(i) Patients who have had a physical examination and laboratory tests within the past three months may be admitted without a new physical examination and laboratory tests, unless the program physician requests it. The admitting program shall obtain copies of these results within 15 days of admission. If records are not obtained within 15 days, the program shall consider the patient a new patient and fulfill the minimum standards for admission.

(ii) The transferring program must supply patient medical records necessary to fulfill the requirements of paragraph (5)(B)-(D) of this section in response to a written request from the patient. The program shall furnish copies of medical records requested, or a summary or narrative of the records, including records received from a physician or other health care provider involved in the care or treatment of the patient, pursuant to a written consent for release of the information as provided by subparagraph (A) of this paragraph, except if the physician determines that access to the information would be harmful to the physical, mental, or emotional health of the patient, and the program may delete confidential information about another patient or family member of the patient who has not consented to the release. The information shall be furnished by the program within 15 days after the date of receipt of the request. If the program denies the request, in whole or in part, the program shall furnish the patient a written statement, signed and dated, stating the reason for the denial. A copy of the statement denying the request shall be placed in the patient's record.

(F) Fees. The transferring program responding to a request for medical records shall be entitled to receive a reasonable fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first 20 pages and $.15 per page for every page thereafter. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery. The program providing copies of requested medical records or a summary or a narrative of such records shall be entitled to payment of a reasonable fee prior to release of the information, unless the information is requested by a licensed Texas health care provider for purposes of emergency or acute medical care. In the event the program receives a proper request for copies of medical records or a summary or narrative of the medical records for purposes other than for emergency or acute medical care, the program may retain the requested information until payment is received. In the event payment is not routed with such a request, the program shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received. A copy of the letter regarding the need for payment shall be made part of the patient's medical record. Medical records requested pursuant to a proper request for release may not be withheld from the patient, the patient's authorized agent, or the patient's designated recipient for such records based on a past due account for medical care or treatment previously rendered to the patient.

(6) For record keeping purposes, if a patient misses appointments for two weeks or more without notifying the clinic, the episode of care is considered terminated and is to be so noted in the patient's record. An exception determination would be in circumstances where the patient can provide documentation of continuation of care. The documentation must be maintained in the patient's record. This does not mean that the patient cannot return for care. If the patient does return for care and is accepted into the program, the patient is considered a new patient and is to be so noted in the patient's record. Cumulative time spent by the patient in treatment is counted toward the number of years of treatment, provided there has not been a continuous absence of 90 days or more.

(7) Dual enrollment. There is a danger of drug dependent persons attempting to enroll in more than one NTP to obtain quantities of drugs for the purpose of self-administration or illicit marketing. Therefore, drugs shall not be provided to a patient who is known to be currently receiving drugs from another treatment program without prior approval from the SMA. Patients who are known to be enrolled in more than one NTP at a time will be forced to choose one clinic for treatment. That patient must then begin treatment as a completely new patient, including attending the clinic on a daily basis or a minimum of six days per week, for a period of six months.

(8) Medical Evaluation. Each patient is required to have a medical evaluation by a program physician or an authorized health-care professional under the supervision of a program physician on admission to a program. A patient is required to have a face-to-face meeting with the program physician no later than one week after admission. A patient readmitted within three months after discharge does not require a repeat physical examination unless requested by the program physician. The admission medical evaluation must be documented in the patient's record and shall include at a minimum:

(A) a medical history including the required history of opiate dependence;

(B) evidence of current physiologic and/or psychologic dependence unless excepted under sections (e)(3)(A)-(D);

(C) investigation of the organ systems for possibilities of infectious disease, pulmonary, hepatic, and cardiac abnormalities, and dermatologic sequelae of addiction;

(D) examination of the patient's general appearance, head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and neurological assessment;

(E) determination of the patient's vital signs (temperature, pulse, blood pressure, and respiratory rate); and

(F) the program physician's overall impression of the patient.

(9) Intradermal tuberculosis test.

(A) Programs shall follow the Mantoux technique, using 0.1 ml of purified protein derivative (PPD) tuberculin containing five tuberculin units (TU) injected into the volar surface of the forearm.

(B) Reaction to the Mantoux test shall be read by a trained health care worker 48 to 72 hours after the injection.

(C) Results should be recorded in millimeters (mm) in the patient's record.

(D) Patients who had negative tuberculin skin tests on admission must be retested each year and results recorded in the patient's record.

(E) Patients with a positive skin test must have further diagnostic evaluation as designated by the Centers for Disease Control and Prevention (CDC).

(F) Documented verification of follow-up on all patients referred for tuberculosis evaluation must be placed in the patient's record.

(G) Patients with previously positive PPD shall not be retested. The program shall obtain verification of diagnostic evaluation and therapeutic follow-up, including preventive treatment or treatment of tuberculosis. The patient shall be referred for further evaluation if disposition cannot be verified. Documentation of the above shall be placed in the patient's record.

(H) Immuno-suppressed populations shall be evaluated periodically as indicated to rule out active tuberculosis, particularly after contact with persons known to be infectious. HIV-infected persons with a positive tuberculin skin test (equal to or greater than 5 mm of indurations) should have a chest x-ray and be evaluated by a clinician to rule out active tuberculosis. HIV-infected individuals who have symptoms suggestive of tuberculosis shall be referred for chest x-ray and clinical evaluation regardless of their tuberculin skin test status.

(10) Minimum required laboratory tests. All biological samples must be analyzed by a laboratory approved under the Clinical Laboratory Improvement Amendments (CLIA) and all applicable Texas state standards. For those tests requiring a blood sample, if in the reasonable clinical judgment of the program physician, a patient's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained, the lab tests may be omitted; however, an attempt to perform the required laboratory tests must be made annually or the patient must be referred to a medical facility that is able to draw blood. The following tests must be performed and documented:

(A) CBC and differential;

(B) routine and microscopic urinalysis;

(C) liver functions profile (SGOT, SGPT); and

(D) serological test for syphilis.

(11) Short-term detoxification. A patient may be admitted to short-term detoxification regardless of age. The program physician shall document in the patient record the reason for admitting the patient to short-term detoxification. Take-home medication is not allowed during short-term detoxification. A history of one year opiate dependence is not required for admission to short-term detoxification. No test or analysis is required except for the initial drug screening test, and a tuberculin skin test. The initial treatment plan and periodic treatment plan evaluation required for comprehensive maintenance patients are not necessary for short-term detoxification patients. A primary counselor must be assigned by the program to monitor a patient's progress toward the goal of short-term detoxification and possible drug-free treatment referral. The narcotic drug is required to be administered daily by an agent authorized by the physician in reducing doses to reach a drug-free state over a period not to exceed 30 days. All other requirements of comprehensive maintenance treatment shall apply.

(12) Long-term detoxification. A patient may be admitted to long-term detoxification regardless of age. The narcotic drug is required to be administered daily in reducing doses to reach a drug-free state over a period not to exceed 180 days. The patient is required to be under observation while ingesting the drug at least six days a week. Initial and random monthly drug screening tests must be performed on each patient. Initial and monthly treatment plans are required. All other requirements of comprehensive maintenance treatment shall apply.

(13) Denial of admission. If in the reasonable clinical judgment of the medical director a particular patient would not benefit from treatment with a narcotic drug, the patient may be refused such treatment even if the patient meets the admission standards.

(f) Treatment planning.

(1) Initial treatment plan. The primary counselor shall enter in the patient's record the counselor's name, the contents of the patient's initial assessment, and the initial treatment plan. The primary counselor shall make these entries immediately after the patient is stabilized on a dose or within four weeks after admission, whichever is sooner. The initial treatment plan is required to contain a statement that outlines:

(A) realistic short-term treatment goals which are mutually acceptable to the patient and the program;

(B) behavioral tasks a patient must perform to complete each short-term goal;

(C) the patient's requirements for education, vocational rehabilitation, and employment;

(D) the medical psychosocial, economic, legal, or other supportive services that a patient needs;

(E) the frequency with which these services are to be provided and/or the source to which the patient will be referred to receive the necessary services; and

(F) the treatment plan must be signed and dated by the primary counselor and the patient.

(2) Periodic treatment planning. The program physician or primary counselor shall review, reevaluate, and alter where necessary each patient's treatment plan at least once each 90 days during the first year of treatment, and at least twice a year thereafter. The treatment plan must be signed and dated by the primary counselor and the patient. At least once a year, the program physician shall review the treatment plan documented in each patient's record, and ensure that each patient's progress or lack of progress in achieving the treatment goals is entered in the patient's record by the primary counselor.

(3) The program supervisory counselor or physician shall review and countersign all treatment plans formulated by counselor interns.

(4) Counseling sessions. Frequency and content of counseling sessions with patients shall be in keeping with patient needs and modality of treatment.

(g) Approved narcotic drugs.

(1) Methadone. The program medical director or program physician shall prescribe methadone in accordance with 42 CFR, §8.12(h)(3-4). If opiate abstinence symptoms are not suppressed, the physician may administer additional methadone, within a scope that ensures patient safety, and taking into consideration the pharmacokinetic properties of the methadone. The medical director shall take into consideration the drug manufacturer's dosing instructions and current best practices when prescribing and administering. Methadone shall be administered or dispensed in oral form only when used in an outpatient treatment program. Hospitalized patients under care for a medical or surgical condition are permitted to receive methadone in parenteral form when the attending physician judges it advisable. All forms of methadone shall be dispensed in such a way as to reduce its

potential for parenteral abuse and to differentiate it from other narcotic drugs (i.e., contrasting color and taste), unless prior SMA approval is obtained.

(2) Levo-alpha acetyl methadol (LAAM). The program medical director shall prescribe LAAM in accordance with drug manufacturer's dosing instructions and current best practices.

(3) A narcotic drug may be administered or dispensed only by an agent of the practitioner. The licensed practitioner assumes responsibility for the amounts of narcotic drugs administered or dispensed and shall record and countersign all changes in dosage schedules. If the program keeps the record of administration and dispensing of narcotic drugs separate from the patient's file, the program shall transfer data from the dosing record to the patient's file at least monthly.

(h) Testing for licit and illicit drug use. The physician shall ensure that test results are not used as the sole criterion to force a patient out of treatment, but are used as a guide to change treatment approaches. The program shall ensure that when test results are used, presumptive laboratory results are distinguished from results that are definitive.

(1) Drug abuse tests. Analysis of such tests shall be performed in a laboratory approved under the Clinical Laboratory Improvement Amendments (CLIA) and all applicable Texas state standards.

(A) The program shall ensure that an initial drug test or analysis is performed for each new patient, including permanent transfer patients, before the initial or maintenance dose is administered, and at least monthly random tests or analyses are performed on each patient in comprehensive maintenance treatment for the initial year of treatment and eight random drug abuse tests yearly thereafter. When a sample is collected from each patient for such test or analysis, it must be done in a manner that minimizes opportunity for falsification.

(B) The program must have and follow written procedures for the screening of test samples for licit and illicit drugs. The procedures shall describe in sufficient detail a plan for collection, storage, handling and analysis of test samples. The procedures shall further describe the program's response to test results that include at least the following:

(i) training for staff members of the importance and relevance of reliable and timely drug abuse test procedures and reports, the purpose of conducting drug abuse tests, and the significance of the results;

(ii) a protocol for collection of test samples that minimizes the opportunity for falsification and incorporates the elements of randomness and surprise;

(iii) storage of test samples in a secure place to avoid substitution;

(iv) a requirement for disclosure of test sample results to the patient and documentation in the patient record of program and patient response to the test results; and

(v) if a patient refuses to provide a test sample, that shall be considered the same as a positive result for illicit drugs. Such refusals shall be documented in the patient record.

(C) Each sample must be analyzed for opiates, methadone, methadone metabolite, amphetamines, cocaine, barbiturates, and benzodiazepines. In addition, if any other drug or drugs have been determined by a program to be abused in that program's locality, or as otherwise indicated, each sample must be analyzed for any of those drugs as well. If a program proposes to change a laboratory used for such testing or analysis, the program shall notify the SMA in writing and provide copies of any contracts or agreements.

(2) Prescription Medications. The patient record shall contain adequate documentation of any prescription drug, other than methadone, that a patient may be taking, including the name of the drug, the prescription number, the dose, the reason for prescribing, the name of the prescribing doctor, the pharmacy's name and telephone number, the date it was prescribed, and the length of time the patient is to be taking the drug.

(i) Unsupervised use.

(1) The program physician shall comply with 42 CFR, §8.12(i) regarding the dispensing of take-home doses of medication. The program physician shall adhere to the following criteria in determining whether a patient is responsible in handling narcotic drugs:

(A) absence of recent abuse of drugs (opioid or non-narcotic), including alcohol;

(B) regularity of clinic attendance;

(C) absence of serious behavioral problems at the clinic;

(D) absence of known recent criminal activity;

(E) stability of the patient's home environment and social relationships;

(F) length of time in comprehensive maintenance treatment;

(G) assurance that take-home medication can be safely stored within the patient's home; and

(H) whether the rehabilitative benefit to the patient derived from decreasing the frequency of clinic attendance outweighs the potential risks of diversion of narcotic drugs.

(2) Take-home protocol. Regardless of time in treatment, a program physician may deny or rescind the take-home medication privileges of a patient if any of the eight criteria found in subsections (i)(1)(A)-(H) of this section are not met.

(3) Treatment program decisions on dispensing opioid treatment medications to patients for unsupervised use beyond that set forth in 42 CFR, §8.12(i)(1) shall be determined by the medical director or program physician only. In any event, a patient may not be given an additional supply of narcotic drugs beyond their current unsupervised use without prior written approval from the SMA.

(4) Packaging. Take-home medication must be packaged in special packaging as required by 16 CFR, §1700.14 in accordance with the Poison Prevention Packaging Act (Pub. L. 91-601, 15 U.S.C., 1471 et seq.) to reduce the chances of accidental ingestion.

(5) Labeling. The take-home medication must be labeled with the following:

(A) Clinic name, address, and telephone number;

(B) The word "METHADONE" in larger capital letters;

(C) The phrase "Date Dispensed" or "Dispensed On";

(D) The phrase "To Be Taken On";

(E) Client's name;

(F) Physician's name;

(G) Label should contain some warning similar to the following:

(i) "WARNING: This drug may be FATAL to any person other than to whom prescribed";

(ii) "Law Prohibits Transfer To Any Person Other Than For Whom Prescribed"; and

(H) Mixing and diluting directions in accordance with its approved product labeling.

(6) Patients must provide a secure storage container for all take-home medications.

(j) Discharge from treatment.

(1) Voluntary discharge. If a patient decides to discontinue treatment, the program shall ensure that the patient receives medical withdrawal or appropriate transfer or referral. The program shall not try to keep a client in treatment by coercion, intimidation or misrepresentation.

(2) Involuntary discharge and termination from treatment. Involuntary discharge from treatment is an action of last resort. Involuntary discharge occurs in response to behavioral problems where a threat to the well-being of the program, staff, or other patients outweighs the potential risk of harm to the individual patient.

(3) Discharge against medical advice. The patient has the right to discontinue treatment when he or she chooses to do so. The program shall explain the risks of leaving treatment. The physician, or agent of the practitioner, shall have a face-to-face consultation with the patient. The physician shall determine the schedule for withdrawal from opiate maintenance therapy to ensure humane withdrawal. The program shall document the issue that caused the patient to seek discharge, and shall provide full documentation in the patient's record of steps taken to avoid discharge.

(4) Other types of discharge. Discharge for non-payment of fees, serious non-compliance, or other reasons shall be determined by the program physician only. The physician, or agent of the practitioner, shall have a face-to-face consultation with the patient. The physician shall determine the schedule for withdrawal from opiate maintenance therapy to ensure humane withdrawal and shall document the reason for the discharge in the patient's record.

(k) Record keeping and documentation.

(1) Patient records.

(A) The medical director or authorized physician shall sign or countersign and date all records within 72 hours of the occurrence of the action or order. The documents that require signature include, but are not limited to: all medical orders, changes in medical orders, changes in dosage schedule, changes in dose, exceptions to mandatory take-home schedule, the rationale for allowing exceptions to the mandatory take-home schedule, review of the eight point criteria prior to altering a schedule of take-home medication, exceptions due to special circumstances, findings from the admission medical evaluation, exceptions to the minimum requirements for admission into treatment, all admission evaluations performed by health care professionals, all medical evaluations performed by health care professionals, yearly treatment plans, initial medical orders, and any other record required by the SMA.

(B) All patient records must be maintained in a secure room, locked file cabinet, safe or other similar container when not in use; and, accessibility shall be limited to staff directly involved in patient care.

(C) The program shall ensure that accurate records traceable to specific patients are maintained showing dates, quantity, and batch or code marks of the drug dispensed. These records must be retained for a period of three years from the date of dispensing. An adequate record must be maintained for each patient. The record is required to contain a copy of the signed consent, the date of each visit, the amount of drug administered or dispensed, the results of each test or analysis for drugs, any significant physical or psychological disability, the type of rehabilitative and counseling efforts employed, an account of the patient's progress, and other relevant aspects of the treatment program. For recordkeeping purposes, if a patient misses appointments for two weeks or more without notifying the program, the episode of care is considered terminated and is to be so noted in the patient's record. This does not mean that the patient cannot return for care. If the patient does return for care and is accepted into the program, this is considered a readmission and is to be so noted in the patient's record. In calculating the number of years of comprehensive maintenance treatment, the period is considered to begin on the first day the medication is administered, or on readmission if a patient has had a continuous absence of 90 days or more. Cumulative time spent by the patient in more than one program is counted toward the number of years of treatment, provided there has not been a continuous absence of 90 days or more.

(D) Confidentiality.

(i) The program must comply with the provisions of 42 CFR, Part 2, and all applicable Texas statutes and regulations, governing confidentiality of patient records.

(ii) The program shall implement a written policy to protect client records and other client identifying information from loss, tampering, and unauthorized access or disclosure.

(iii) The program shall limit access to the records to staff with job duties requiring their use.

(iv) The staff shall keep records locked at all times unless an authorized person is continuously present in the immediate area.

(v) The staff shall have an effective tracking system and shall ensure that each record is returned to the file at the end of each day or shift.

(vi) A treatment program or medication unit or any part thereof, including any facility or any employee, shall permit a duly authorized employee of SAMHSA or the department to have access to and to copy all records on the use of narcotic drugs in accordance with the provisions of 42 CFR, Part 2.

(E) All notations by NTP personnel on patient files and other files kept by the NTP for purposes of this chapter shall be typed, printed, or legibly handwritten so that any regulatory authority can read the writing.

(F) An NTP may not refuse to allow an inspection or otherwise interfere with personnel of the SMA in the performance of their duties, including the photocopying of patient records during an inspection. It is a violation for an NTP not to fully cooperate in any inspection by the SMA.

(2) Records on the receipt, storage, and distribution of narcotic medication are subject to inspection under federal and Texas controlled substances laws.

(3) Personnel records shall contain results of annual tuberculosis testing. Each employee working in an NTP must receive an intradermal skin test using the Mantoux technique at the start of employment and annually thereafter. Programs shall follow the Mantoux

technique, using 0.1 ml of purified protein derivative (PPD) tuberculin containing five tuberculin units (TU) injected into the volar surface of the forearm. Reaction to the Mantoux test shall be read by a trained health care worker 48 to 72 hours after the injection. Results should be recorded in millimeters (mm) and documented in the employee's file. Employees who had negative tuberculin skin tests at the start of employment must be retested each year and results recorded in the employee's file. Employees with a positive skin test must have further diagnostic evaluation as designated by the Centers for Disease Control and Prevention (CDC). Documented verification of follow-up on all employees referred for tuberculosis evaluation must be placed in the employee's file. Employees with previously positive PPD shall not be retested. The program shall obtain verification of diagnostic evaluation and therapeutic follow-up, including preventive treatment or treatment of tuberculosis. The employee shall be referred for further evaluation if disposition cannot be verified. Documentation of the above shall be placed in the employee's file.

(4) Personnel records shall also contain a job description, employment application, verification of credentials, evidence of a current driver's license, job performance evaluation completed annually and reviewed with the individual, and any other information required by law.

§229.150. Central Registry.

(a) The permit holder shall participate in the central registry for the purpose of sharing patient identifying information as requested by the department to prevent multiple enrollment of patients in narcotic treatment programs (NTPs).

(b) A narcotic drug shall not be provided to a patient who is known to be currently enrolled in another NTP except when the patient is a temporary transfer patient.

(c) The patient shall always report to the same NTP unless prior approval is requested by the parent NTP's program physician or program director for the patient to receive treatment as a temporary transfer patient at another NTP. In any event, a patient may not be authorized more than two weeks away from their home clinic without prior approval from the State Methadone Authority (SMA).

(d) A central registry shall be established by the department which shall maintain a record of the patient's identification and the NTP to which each patient is enrolled. Information shall be maintained in accordance with confidentiality requirements in the Code of Federal Regulations, Title 42, Part 2, and Title 42, §8.12(g).

(e) Each NTP shall report to the central registry specific information.

(1) The following changes in patient status: new patient, readmitted to the same clinic, admitted from another NTP as a permanent transfer patient, transferred to another narcotic maintenance or detoxification program, deceased patient, or discharged (terminated) from maintenance or detoxification treatment shall be identified and reported to the central registry located at the Texas Department of Health, Drugs and Medical Devices Division, by telephone, electronic mail, or facsimile on the day the action occurs and written documentation must be submitted within a 24-hour period (or the next state working day immediately following weekends or holidays).

(2) Each NTP's verbal and written report to the central registry shall identify and provide the following information for each patient:

(A) name, address, and telephone number of the NTP, and approved narcotic drug permit number;

(B) date action was taken (MO-DA-YR);

(C) action taken identified as:

(i) new patient, readmitted patient (NP);

(ii) terminated patient (TP);

(iii) permanent transfer-in patient (TIP);

(iv) permanent transfer-out patient (TOP); or

(v) deceased patient (DP); and

(D) patient identification as follows:

(i) Upon admission, the patient must be identified with a current Texas state driver's license, United States passport, military identification card, or Texas state-issued identification card containing a photograph of the patient or other identification approved by the SMA. If a patient is not able or willing to furnish the required documents, the program shall contact the SMA within 72 hours to access the Central Registry to check for possible duplicate enrollment and to discuss acceptable, alternate forms of identification. Photocopies of each of these documents must be maintained in the patient's record. The program shall document in the patient's file attempts to induce the patient to obtain state identification.

(ii) An identification number shall be constructed using the following code numbers for the patient:

(I) color of eyes: Brown (1), Blue (2), Green (3), Hazel (4), Gray (5), and Other (6);

(II) date of birth stated in number digits with two digits for the month, day, and year (example: January 9, 1953--010953);

(III) gender: male (1) and female (2); and

(IV) race: White (1), Black (2), Hispanic (3), Asian (4), American Indian (5), and Other (6).

(iii) An example of a patient identification number in accordance with clause (ii) of this subparagraph for a patient with blue eyes, date of birth--January 9, 1953, male, and white is 201095311. Patients with the same identification code will be assigned an alphabetical extension by the SMA (for example 201095311A, 201095311B, etc.).

§229.152. Federal Regulations.

The Texas Department of Health adopts by reference the federal regulations on "Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction" found in Title 42, Code of Federal Regulations, Part 8. A copy of these regulations is indexed and filed in the Drugs and Medical Devices Division, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756.

§229.153. Enforcement.

(a) Denial, Suspension or Revocation of Permit. Except for Emergency Orders under the Health and Safety Code, §466.041, after notice to an applicant or a permit holder and after the opportunity for a hearing, the department may:

(1) deny an application of the person if the person fails to comply with this chapter or the rules establishing minimum standards for the issuance of a permit adopted under this chapter; or

(2) suspend or revoke the permit of a person who has committed a Level I, II, or III violation as defined in subsection (d) of this section.

(b) Administrative Penalty. If a person violates this chapter, a rule adopted under this chapter, or an order or permit issued under this

chapter, the commissioner may assess an administrative penalty against the person.

(c) Criteria for the assessment of administrative or civil penalties. Administrative penalties will be assessed in accordance with the following criteria:

(1) history of previous violations;

(2) seriousness of the violation;

(3) hazard to the health and safety of the public; and

(4) demonstrated good faith.

(d) Severity levels.

(1) Severity Level I, penalty of $7,500-10,000, covers violations that are most significant and have a direct negative impact on the public health and safety including, but not limited to, adulteration, misbranding, or false advertising that results in fraud.

(2) Severity Level II, penalty of $5,000-7,500, covers violations that are very significant and have an impact on the public health and safety including, but not limited to, adulteration, misbranding, or false advertising that results in fraud.

(3) Severity Level III, penalty of $2,500-5,000, covers violations that are significant and which, if not corrected, could threaten the public and have an adverse impact on the public health and safety including, but not limited to, adulteration, misbranding, or false advertising that results in fraud.

(4) Severity Level IV, penalty of $1,250-2,500, covers violations that are of more than minor significance, and if left uncorrected, would lead to more serious circumstances.

(5) Severity Level V, penalty of $500-1,250, covers violations that are of minor safety or fraudulent significance.

(e) Severity of a violation. The severity of a violation may be increased if the violation involves deception, fraud, or other indication of willfulness. In determining the severity of a violation, there shall be taken into account the economic benefit gained through noncompliance.

(f) Adjustments to penalties. The department may make adjustments to the penalties listed in subsections (e), (f), or (g) of this section for any one of the following factors.

(1) Previous violations. The department may consider previous violations. The penalty may be reduced or increased within the specified range of each severity level for past performance. Past performance involves the consideration of the following factors: whether the previous violation was identical or similar to the current violation; how recent the previous violation was; the number of previous violations; and the violator's response to previous violation(s) in regard to correction of the problem.

(2) Demonstrated good faith. The department may consider good faith effort(s) of the violator to correct the violations and demonstrate compliance with the department's rules and regulations as a basis to reduce the proposed penalty. The penalty may be reduced within the specified range of each severity level if good faith efforts to correct a violation have been, or are being made. The department on a case-by-case basis will determine good faith effort. All good faith effort(s) to comply with the department's rules and regulations must be fully documented by the violator to merit consideration from the department as to whether to reduce the proposed penalty.

(3) Hazard to the health and safety of the public. The department may consider the hazard to the health and safety of the public. The penalty may be increased within the specified range of each severity level when a direct hazard to the health and safety of the public is involved. It shall take into account, but need not be limited to, the following factors:

(A) whether any death(s), disease or injuries have occurred from the violation;

(B) whether any existing conditions contribute to a situation that could expose humans to a health hazard;

(C) the impact that the hazard has on various segments of the population such as children, surgical patients, and the elderly; and

(D) whether the consequences would be of an immediate or long-range hazard.

(g) Hearings, appeals from, and judicial review of final administrative decisions under this section shall be conducted according to the contested case provisions of the Government Code, Chapter 2001, and the board's formal hearing rules found in Chapter 1 of this title.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 11, 2001.

TRD-200107778
Susan K. Steeg
General Counsel
Texas Department of Health
Effective date: December 31, 2001
Proposal publication date: July 27, 2001
For further information, please call: (512) 458-7236

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25 TAC §229.148

The repeal is adopted under Health and Safety Code, §145.011, which provides the department with the authority to adopt necessary regulations pursuant to the enforcement of Chapter 145; and §12.001, which provides the Texas Board of Health (board) with the authority to adopt rules for the performance of every duty imposed by law on the board, the department, and the commissioner of health.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 11, 2001.

TRD-200107779
Susan K. Steeg
General Counsel
Texas Department of Health
Effective date: December 31, 2001
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For further information, please call: (512) 458-7236

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER Y. STANDARDS FOR LONG-TERM CARE INSURANCE COVERAGE UNDER INDIVIDUAL AND GROUP POLICIES

28 TAC §§3.3803 - 3.3805, 3.3810, 3.3819, 3.3821, 3.3829, 3.3831, 3.3832, 3.3837, 3.3839, 3.3844

The Commissioner of Insurance adopts amendments to §§3.3803 - 3.3805, 3.3810, 3.3819, 3.3821, 3.3829, 3.3831, 3.3832, 3.3837, 3.3839, and 3.3844 concerning standards for long-term care insurance coverage under individual and group policies. Sections 3.3803, 3.3804, 3.3829, 3.3831, and 3.3844 are adopted with changes to the proposed text as published in the November 9, 2001 issue of the *Texas Register* (26 TexReg 9019). Sections 3.3805, 3.3810, 3.3819, 3.3821, 3.3832, 3.3837, and 3.3839 are adopted without changes and will not be republished.

These amendments provide definitions and procedures necessary to implement House Bill 2482 enacted by the 77th Legislature, which added Texas Insurance Code Article 3.70-12, §5A. House Bill 2482 authorizes the department to adopt rules to stabilize long-term care insurance premium rates. The rules are necessary to ensure that: initial rates are adequate; any rate schedule increases after policy issuance are justified, adequate, and reasonable in relation to benefits provided policy/certificate holders; the policies/certificates contain appropriate terms; and policy/certificate holders affected by rate schedule increases are protected.

In accordance with the requirements of HB 2482, the rules are to be consistent with nationally recognized models relating to the stabilization of long-term care premium rates. The amendments make Subchapter Y consistent with the rating practices and consumer disclosure amendments of the Long-Term Care Insurance Model Regulations promulgated by the National Association of Insurance Commissioners (NAIC) in October 2000 (10/00 Model Regulations) and the corresponding provisions of the Long-Term Care Insurance Model Act promulgated by the NAIC in April 2000 (4/00 Model Act).

The following changes were made in response to comments and to correct typographical and clerical errors: A comma was removed from §§3.3803 and 3.3804(a) to clarify that the phrase "rider attached to" modifies both annuity contracts or certificates and life insurance policies or certificates. Paragraphs (2), (3), and (9) of §3.3829(b) were changed to clarify that if an insurer chooses not to use the disclosure form promulgated by the department, the insurer's form must present the disclosure information in the same order as that set forth in §3.3829(b)(2). The reference to subparagraph (B) in §3.3829(b)(2)(D)(ii) was replaced with a reference to subparagraph (C). The reference to paragraph (3) in §3.3831(b)(1)(B)(iv)(IV)(-b-) has been deleted. The word "Except" in §3.3844(d)(2) was deleted to clarify that the provisions of subsection (d)(2) apply to policies or certificates with attained age rating. The words "loss ratio" were deleted from §3.3844(d)(6) to clarify that the premiums referenced in paragraph (6) will be subject to all the requirements of §3.3831. In §3.3844(g)(1), the word "a" was added before the word "Substantial" in the phrase "Triggers for Substantial Premium Increase" to correct a typographical error.

The amendments to §3.3803 clarify the types of policies, certificates, and riders to which Subchapter Y applies. The amendments clarify that the subchapter applies to policies defined in Insurance Code Article 3.70-12, §2(4) and long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state. The amendments also clarify the types of policies to which the subchapter does not apply. The amendments to §3.3804 clarify that long-term care riders attached to life insurance policies or certificates or annuity contracts or certificates must comply with the provisions of Subchapter Y. They also add definitions for attained age rating, exceptional premium rate increases, level premium long-term care policy, long-term care benefit classifications, qualified actuary, and similar policy forms and expand the definition for group long-term care insurance and make a clarifying change to the definition of home health agency.

New subsection (b) to §3.3805 clarifies that life insurance policies or certificates or annuity contracts or certificates to which a long-term care rider is attached are subject to the statutes and regulations applicable to those policies, contracts or certificates; however, the long-term care rider attached to those forms is subject to Subchapter Y. New subsection (c) to §3.3810 specifies when the term "level premium" may be used.

The amendments to §3.3819 clarify that reserves for long-term care policies must be determined in accordance with Subchapter GG of Chapter 3. The amendment to §3.3821 clarifies that the section's provisions apply to group long-term care coverage under group policies described in Insurance Code Article 3.50, §1(6).

Amendments to §3.3829 provide for required rating disclosures in the policy and at the time of application; require the applicant to sign an acknowledgement that disclosure was provided; authorize the use of a standard form prescribed by the department or, if the prescribed form is not used, require the insurer to file the form with the department; require notice of premium rate schedule increases and identify the timing of such notice; and amend the title of the section for consistency with the amendments to the section.

The amendments to §3.3831 clarify applicability of loss ratio standards and identify the type of information an insurer must provide to the department in connection with an initial premium rate filing and when the information must be provided. The amendments also describe the requirements for premium rate increases, including the information insurers must provide to the department prior to the provision of notice to the insured; the method by which premium rate schedule increases must be determined; and the information that the insurer must file with the department annually for the three years following implementation of the increase. The amendments contain additional requirements for insurers if the revised premium rate schedule is greater than 200% of the initial premium rate schedule. The amendments also provide that the department may require an insurer to take certain action if the insurer's actual experience following a rate increase does not match projections.

The amendments to §3.3831 also identify additional information that insurers are required to file with the department for policies or certificates that are eligible for contingent benefit upon lapse. For certain types of rate increase filings, the amendments require the department to determine if significant adverse lapsation has

occurred or is anticipated and to determine if a rate spiral exists. If a rate spiral exists, the department may require the insurer to take certain action. The amendments also authorize the department to take additional action upon a determination that an insurer has exhibited a persistent practice of filing inadequate initial premium rates. The amendments clarify that specific provisions of the subsection do not apply to certain types of group insurance.

The amendment to §3.3832(b)(12) replaces the former telephone number for the Texas Department of Aging with the current telephone number. The amendments to §3.3832(b)(15) require disclosure of contingent lapse benefit upon rejection of a nonforfeiture offer, and make necessary clerical changes. The amendment to §3.3837(a) adds paragraph (5), which clarifies when insurers are to file the annual rate filing required by Insurance Code Article 3.70-12, §4(b). The amendment to §3.3839(a) adds paragraph (6), which requires that the terms "non-cancellable" and "level premium" be used only to describe policies and certificates that conform to §3.3810.

The amendments to §3.3844 clarify that the section applies to contingent benefits as well as to nonforfeiture benefits, and also require an insurer, on or after July 1, 2002, to provide contingent benefits upon lapse to policyholders and certificate holders who decline to purchase policies that contain nonforfeiture benefits. The amendments also require that if a group policyholder decides to offer nonforfeiture benefits to the certificate holder, the certificate must provide either the nonforfeiture benefit or the contingent benefit upon lapse. The amendments clarify when the contingent benefit upon lapse becomes effective and provide that it is subject to the requirements of §3.3831. In addition, the amendments to §3.3844 delete the definition for attained age rating because that definition now is contained in §3.3804. The amendments clarify when the contingent benefit upon lapse is triggered and what the insurer is required to do when the benefit is triggered, and provide a method an insurer that purchased or otherwise assumed long-term care policies from another insurer must utilize to determine whether contingent nonforfeiture upon lapse provisions are triggered.

GENERAL: One commenter expressed support for the proposed amendments as drafted, noting that the amendments track the most recent amendments to NAIC Long-Term Care Insurance Model Regulation. The commenter requested that if adoption of the rule is delayed beyond January 1, 2002, the effective dates in various sections of the rule be amended accordingly. Most other commenters supported the proposed amendments with some changes.

AGENCY RESPONSE: The department appreciates the commenters' support. As the rules were adopted prior to January 1, 2002, no change to the dates has been made.

GENERAL: A commenter stated that TDI omitted the penalty section of the NAIC Long-Term Care Insurance Model Act. The commenter indicated an understanding that this was done because Texas law provides for penalties for violating insurance laws that are at least as stringent as those in the model act. The commenter recommended that a description of the administrative penalties set forth in the Texas Insurance Code be included in the rule.

AGENCY RESPONSE: The department acknowledges the commenter's understanding that Texas law provides penalties at least as stringent as the NAIC Long-Term Care Insurance Model Act and the model regulation. The department does not believe it is necessary to describe the penalties in this rule as they are set forth in the Texas Insurance Code and both insurers and agents are subject to them.

Section 3.3804(a): A commenter stated that §3.3804(a) is unclear and asked if the phrase "rider attached to" applies to annuity contracts or certificates or only to life insurance policies or certificates.

AGENCY RESPONSE: The phrase "rider attached to" modifies both annuity contracts or certificates and life insurance policies or certificates. To clarify this issue, the department has removed the comma between the words "certificate" and "or annuity contract," so that it reads, "a rider attached to a life insurance policy or certificate or annuity contract or certificate." A similar change has been made to §3.3803.

Section 3.3829(b)(2)(C): A commenter stated that the language in §3.3829(b)(2)(C) implies that there is more than one "schedule" at any time, which is not the case.

AGENCY RESPONSE: The department disagrees that a change is necessary. There may be situations when an insurer would issue more than one schedule, such as when an applicant is applying for joint coverage.

Section 3.3829(b)(2)(D)(ii): A commenter suggested that the reference in §3.3829(b)(2)(D)(ii) to subparagraph (B) should be replaced with a reference to subparagraph (C).

AGENCY RESPONSE: The department agrees and has changed the clause accordingly.

Section 3.3829(b)(8): A commenter recommended that insurers be required to use only the disclosure form promulgated by TDI as it would create uniformity for consumers who are trying to compare available plans; without such uniformity, the commenter notes, the disclosure requirements do not give consumers the tools they need to better understand what each company is offering and to make appropriate comparisons.

AGENCY RESPONSE: The department appreciates the commenter's concerns; however, due to the language in Section 9B(5)(b) of the NAIC Long-Term Care Insurance Model Regulation and §3.3829(b)(3), which allow insurers to provide additional explanatory information related to the rate increase, the department does not agree with requiring an insurer to use only the disclosure form promulgated by the department. In an effort to promote uniformity, the department has changed §3.3829(b)(2), (3) and (9) to require insurers to present disclosure information in the same order as set forth in §3.3829(b)(2). Additionally, §3.3829(b)(8) requires insurers who elect not to utilize the prescribed form to submit their disclosures to the department. The department's review will ensure compliance with the rule.

Section 3.3829(b)(9): A commenter suggested that §3.3829(b)(9) be amended to refer to only "the information required by paragraph (2)(C)," because the other aspects of paragraph (2) are either irrelevant ((2)(A) and (2)(E) which relate only to (2)(E) disclosure) or need to be more specific to the actual rate increase ((2)(B) and (2)(D)).

AGENCY RESPONSE: The department disagrees that the paragraph should refer only to the information required by paragraph (2)(C). While the department recognizes that some of the information required in the other provisions of paragraph (2) will already have been provided, the department believes that it is a benefit to consumers to be provided with full disclosure prior to

the implementation of a premium rate schedule increase. In addition, the reference to the information required by paragraph (2) is similar to the NAIC Long-Term Care Insurance Model Regulation.

Section 3.3831(b)(1): A commenter stated that this section appears to require existing policy forms first issued prior to the effective date of the rules to satisfy the initial filings requirements of the section even though the insurer is not making any changes to its existing forms or premium rates. The commenter stated that the intent of the section was made clear by the NAIC in its Guidance Manual. The commenter also clarified that all policies sold after the effective date are subject to the premium rate increase requirements of the section.

AGENCY RESPONSE: The rule requires that all policies issued on or after July 1, 2002 comply with the requirements of the rule. This provision is consistent with the requirements of the NAIC Long-Term Care Insurance Model Regulation. HB 2482 and the amendments to the NAIC Long-Term Care Insurance Model Regulation were enacted to stabilize long-term care insurance premium rates by ensuring that initial rates are adequate and any rate schedule increases after policy issuance are justified, adequate, and reasonable in relation to benefits provided. If insurers are exempted from reviewing existing rates, such initial rates may be inadequate, prompting rate increases after policy issuance. This effect would be contrary to the intent of HB 2482 and the amendments to the NAIC Long-Term Care Insurance Model Regulation.

The department acknowledges the language contained in the NAIC Guidance Manual for Rating Aspects of the Long-Term Care Insurance Model Regulation (the "Guidance Manual") but recognizes that the Guidance Manual has not been finalized. The department will continue to monitor adoption of the Guidance Manual and any revisions to the NAIC Long-Term Care Insurance Model Act and model regulation for possible future rulemaking.

Section 3.3831(b)(1)(B)(iv)(IV)(-b-): A commenter noted that item (-b-) includes a reference to paragraph (3), which does not exist.

AGENCY RESPONSE: The department agrees and has removed the reference to paragraph (3).

Section 3.3831(b)(2): A commenter stated that the phrase "at any time" in §3.3831(b)(2) is inconsistent with §3.3831(2)(B).

AGENCY RESPONSE: The department believes the commenter intended to refer to §3.3831(b)(2)(B); however, there does not appear to be any inconsistency between the two provisions. The terminology "at any time" was used to stress the need for insurers to maintain documentation and to clarify that, at any time, the department may request an actuarial demonstration to substantiate any rate filing after the effective date of the rule and the insurer must be prepared to submit such documentation. For example, the department may request this documentation after the effective date of the rules in certain instances such as when an insurer acquires a block of business and submits a rate increase for that business or submits an actuarial certification as allowed by §3.3831(b)(1)(B) and subsequently submits a rate increase.

Section 3.3831(c): A commenter stated that in several places, §3.3831(c) allows insurers to provide different disclosures to certain group policyholders to meet the description in §3.3831(c)(2)(K). The commenter recommended that insurers be required to disclose to all individuals insured under long-term care policies, and not just the group policyholders. The commenter stated that according to subparagraph (K), if the employer is paying only 20% of the premium, the insurer does not have to provide the disclosure to the consumer. The commenter noted that the disclosures could have a significant impact on whether an employee chooses to purchase or retain a policy since the consumer would bear most of the cost of the premium increase.

AGENCY RESPONSE: The department believes the commenter has misinterpreted this subsection. While §3.3831(c)(2)(C) and (D) require the insurer to provide to group policyholders described in §3.3831(c)(2)(K) updated and lifetime projections, it does not exempt the insurer from the disclosure of premium rate increases that must be given to all policyholders or certificate holders pursuant to §3.3829(b)(9).

Section 3.3832(b)(15)(A): A commenter suggested that Figure No. 2 of §3.3832(b)(15)(A) should be revised to clarify the maximum daily benefit. Because two examples are provided, the commenter noted, the figure should clarify that the amount per day cannot exceed the amount for the policy prior to exercise of the nonforfeiture option.

AGENCY RESPONSE: The department disagrees that the figure should be changed. The figure is provided as an example and not a requirement. Consequently, insurers have the option of providing their own numerical examples.

Section 3.3837(a)(5): A commenter stated that it and the department previously established that the LTC Experience Exhibit (Forms A, B, and if necessary C), would meet the documentation requirement of Insurance Code Article 3.70-12, §4(b).

AGENCY RESPONSE: The department acknowledges that if an insurer files with the department the LTC Experience Exhibit A, B, and C, such would meet the requirements of the loss ratio documentation required by Article 3.70-12, §4. To meet the other requirements of this law, an insurer must file its rates and rating schedules; however, if the insurer has not changed rates since the previous annual report, the insurer may file a certification to that effect.

Section 3.3844: A commenter stated that the department did not include a provision of the NAIC Long-Term Care Insurance Model Regulation related to nonforfeiture benefits that should have been included. Specifically, the commenter requested that a statement be included in §3.3833(a) that clarifies that the nonforfeiture requirements of the long-term care rules do not apply to life insurance policies or riders containing accelerated long-term care benefits.

AGENCY RESPONSE: The department disagrees that such a statement is necessary. A life insurance policy or rider containing accelerated long-term care benefits is not considered long-term care coverage. Those policies or riders would only be required to comply with laws applicable to life insurance coverage and accelerated death benefits. Section 3.3805(b) clarifies that the life insurance policy or certificate or annuity contract or certificate, which could include any rider providing accelerated benefits for long-term care, is subject to all statutes and regulations applicable to such policy or certificate. Only a long-term care rider, not a rider providing accelerated death benefits, attached to a life insurance policy is subject to this subchapter.

Section 3.3844(a): Because there is no requirement to offer contingent benefits upon lapse if the applicant accepts the nonforfeiture offer, a commenter suggested that the phrase "and Contingent Benefits Upon Lapse" be deleted from the caption to §3.3844(a) and that the subsection be split into two paragraphs.

AGENCY RESPONSE: The department disagrees with the recommended changes. The department believes that the language in the subsection is sufficiently clear and that the suggested changes are unnecessary.

Section 3.3844(d)(2): A commenter suggested that the word "Except" in §3.3844(d)(2) be deleted.

AGENCY RESPONSE: The department agrees and has made the recommended change.

Section 3.3844(d)(6): A commenter recommended that the phrase "loss ratio standards and other requirements" replace the phrase "loss ratio requirements" in §3.3844(d)(6) to clarify that some policies will be subject to a 60% loss ratio while others will be subject to the combined loss ratio test for rate increases.

AGENCY RESPONSE: The department did not incorporate the language suggested by the commenter, but has changed the section to clarify that premiums charged for policies or certificates containing nonforfeiture benefits or contingent benefits upon lapse will be subject to all of the requirements of §3.3831.

Section 3.3844(g)(1): A commenter noted that an "a" was missing before the word "Substantial" in §3.3844(g)(1).

AGENCY RESPONSE: The department agrees and has made the recommended change.

For: American Council of Life Insurers. For, with changes: Health Insurance Association of America; Golden Rule Insurance Company; Consumers Union; and the Office of Public Insurance Counsel.

The amendments to Subchapter Y are adopted under Insurance Code Article 3.70-12 and §36.001. Article 3.70-12 provides that the department may adopt rules that are necessary and proper to implement the article. Under Section 7 of that article, any rules adopted by the commissioner regarding long-term care insurance shall include requirements no less favorable than the minimum standards for long-term care insurance adopted in any model laws or regulations relating to minimum standards for benefits for long-term care insurance and in accordance with all applicable federal law. New Article 3.70-12, §5A, enacted pursuant to House Bill 2482, authorizes the commissioner to adopt rules that are consistent with nationally recognized models relating to the stabilization of long-term care insurance premium rates and consumer disclosures. It further authorizes the commissioner to adopt rules that contribute to the uniformity of state laws and that protect consumers. Section 36.001 provides that the Commissioner of Insurance may adopt rules to execute the duties and functions of the Texas Department of Insurance as authorized by statute.

§3.3803. Applicability and Scope.

In accordance with Insurance Code Article 3.70-12, this subchapter applies to all long-term care insurance policies as that term is defined in §2(4) of the article, and riders attached to life insurance policies or certificates or annuity contracts or certificates delivered or issued for delivery in this state except:

(1) certificates delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state; or

(2) a policy which is not designed, advertised, marketed, or offered as long-term care or nursing home insurance.

§3.3804. Definitions.

(a) Except as otherwise provided by law or this subchapter, no long-term care insurance policy, certificate, group hospital service corporation subscriber contract, rider attached to a life insurance policy or certificate or annuity contract or certificate may be delivered or issued for delivery in this state, unless it complies with, and contains definitions in conformance with, this subchapter.

(b) The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Activities of daily living--Bathing, continence, dressing, eating, toileting and transferring, as those terms are defined in this subsection.

(2) Acute condition--The individual's medical condition is medically unstable. Such an individual requires frequent monitoring by medical professionals, such as physicians and registered nurses, in order to maintain his or her health status.

(3) Adult Day Care--A social and health-related services program provided during the day in a community group setting, for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the home.

(4) Adult Day Care Facility--Provider of Adult Day Care services, operated pursuant to the provisions of the Human Resources Code, Chapter 103 (concerning licensing and quality of care requirements in the provision of adult day care).

(5) Applicant--The person who seeks to contract for benefits or services, in the instance of an individual long-term care insurance policy; or the proposed certificate holder or enrollee, in the instance of a group long-term care insurance policy.

(6) Attained age rating--A schedule of premiums starting from the issue date which increases with age at least one percent per year prior to age 50, and at least three percent per year beyond age 50.

(7) Bathing--Washing oneself by sponge bath or in either a tub or shower, including the task of getting into or out of the tub or shower.

(8) Care--Terms referring to care, such as "home health care," "intermediate care," "maintenance or personal care," "skilled nursing care," and other services, shall be defined in relation to the level of skill required, the nature of the care, and the setting in which the care must be delivered.

(9) Certificate--Any certificate issued under a group long-term care insurance policy, which certificate has been delivered or issued for delivery in this state. For purposes of these sections, the term:

(A) Also includes any evidence of coverage issued pursuant to a group health maintenance organization contract for long-term care health coverage.

(B) Does not include certificates that are delivered or issued for delivery in this state under a single employer or labor union group policy that is delivered or issued for delivery outside this state.

(10) Continence--The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag).

(11) Dressing--Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(12) Eating--Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(13) Exceptional premium rate increases--Increases filed by an insurer as exceptional and for which the department determines the need for the premium rate increase is justified:

(A) due to changes in laws or regulations applicable to long-term care coverage in this state; or

(B) due to increased and unexpected utilization that affects the majority of insurers of similar long term care products.

(14) Group long-term care insurance--A long-term care insurance policy or certificate of group long-term care insurance which is delivered or issued for delivery in this state, and issued to an eligible group as defined by the Insurance Code Article 3.51-6, §1(a), or a long-term care rider issued to an eligible group as defined by Insurance Code Article 3.50 §1.

(15) Home health agency--A business which provides home health service and is licensed by the Texas Department of Health.

(16) Home health care services--Medical or nonmedical services provided to ill, disabled or infirm persons in their residences. Such services may include homemaker services, assistance with activities of daily living, respite care services, case management services, and maintenance or personal care services.

(17) Level premium long-term care policy--A non-cancellable long-term care policy.

(18) Long-term care benefit classifications--Institutional long-term care benefits only, non-institutional long-term care benefits only, or comprehensive long-term care benefits.

(19) Long-term care insurance contract--Any insurance policy, group certificate, rider to such policy or certificate, or evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A) which is advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense-incurred, indemnity, prepaid, per diem or other basis, and which provides insurance protection only for one or more necessary or medically necessary services of the following types, administered in a setting other than an acute care unit of a hospital: diagnostic, preventive, therapeutic, curing, treating, mitigating, rehabilitative, maintenance or personal care. The term "long-term care insurance contract" shall not include any insurance policy, group certificate, subscriber contract, or evidence of coverage which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. The term includes a policy or rider, other than a group or individual annuity or life insurance policy that provides for payment of benefits based on the impairment of cognitive ability or the loss of functional capacity.

(20) Maintenance or Personal Care Services--Any care the primary purpose of which is the provision of needed assistance under §3.3818 of this title (relating to Standards for Eligibility for Benefits), including the protection from threats to health and safety due to impairment of cognitive ability.

(21) Medicare--"The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(22) Mental or Nervous Disorder--A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(23) Policy--Any policy, contract, subscriber agreement, rider, or endorsement, delivered or issued for delivery in this state by an insurer, fraternal benefit society, nonprofit group hospital service corporation, or health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapter 20A).

(24) Preexisting Condition--A condition for which medical advice was given or treatment was recommended by, or received from, a physician within six months before the effective date of coverage.

(25) Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(26) Qualified long-term care insurance contract--A long-term care insurance contract meeting the requirements as contained in Internal Revenue Code of 1986, §7702B(b).

(27) Qualified long-term care services--As the term is defined in Internal Revenue Code of 1986, §7702B(c).

(28) Similar policy forms--All of the long-term care insurance policies and certificates issued by an insurer in the same long-term care benefit classification as the policy form being considered. Those certificates issued or delivered pursuant to one or more employers or labor union organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, are not considered similar to certificates or policies otherwise issued as long-term care insurance, but are similar to other comparable certificates with the same long-term care benefit classifications.

(29) Toileting--Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

(30) Transferring--Sufficient mobility to move into or out of a bed, chair or wheelchair or to move from place to place, either via walking, a wheelchair or other means.

§3.3829. Required Disclosures.

(a) Required Disclosure of Policy Provisions.

(1) Long-term care insurance policies and certificates shall contain a renewability provision as required by §3.3822 of this title (relating to Minimum Standard for Renewability of Long-term Care Coverage). Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder under a long-term care insurance policy and/or certificate, all riders or endorsements added to a long-term care insurance policy and/or certificate after the date of issue or at reinstatement or renewal, which reduce or eliminate benefits or coverage in the policy and/or certificate, shall require

a signed acceptance by the policyholder. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage are required by law. Where a separate additional premium is charged for benefits in connection with riders or endorsements, such premium charge shall be set forth in the policy, certificate, rider, or endorsement.

(3) A long-term care insurance policy and certificate which provides for the payment of benefits on standards described as usual and customary, reasonable and customary, or words of similar import, shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(4) If a long-term care insurance policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy or certificate and shall be labeled as "Preexisting Condition Limitations."

(5) Long-term care insurance applicants shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(6) A long-term care insurance policy or certificate containing any limitations or conditions for eligibility other than those prohibited in the Insurance Code, Article 3.70-12, or §3.3824 of this title (relating to Preexisting Conditions Provisions) shall set forth a description of such limitations or conditions in a separate paragraph of the policy and certificate and shall label each paragraph "Limitations or Conditions on Eligibility for Benefits."

(7) Long-term care insurance policies and certificates shall appropriately caption and describe the nonforfeiture benefit provision, if elected.

(8) Long-term care insurance policies and certificates shall contain a claim denial provision which shall be appropriately captioned. Such provision shall clearly state that if a claim is denied, the insurer shall make available all information directly relating to such denial within 60 days of the date of a written request by the policyholder or certificate holder, unless such disclosure is prohibited under state or federal law.

(9) A long-term care insurance policy and certificate which includes benefit provisions under §3.3818(b) of this title (relating to Standards for Eligibility for Benefits) shall disclose, within a common location and in equal prominence, a description of all benefit levels payable for the coverage described in §3.3818(b). Criteria utilized to determine eligibility for benefits shall be disclosed in all long-term care insurance policies and certificates, in the manner prescribed by §3.3818.

(10) If the insurer intends for a long-term care insurance policy or certificate to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is intended to be a qualified long-term care contract as defined by the Internal Revenue Code of 1986, §7702B(b)."

(11) If the insurer does not intend for the policy to be a qualified long-term care insurance contract as defined by the Internal Revenue Code of 1986, §7702B(b), the policy or certificate shall include disclosure language substantially similar to the following. "This policy is not intended to be a qualified long-term care insurance contract. This long-term care insurance policy does not qualify the insured for the favorable tax treatment provided for in the Internal Revenue Code of 1986, §7702B."

(12) A long-term care policy or certificate which provides for increases in rates shall include a provision disclosing that notice of an upcoming premium rate increase will be provided no later than the 45th day preceding the date of the implementation of the rate increase.

(b) Required disclosure of rating practices.

(1) Other than non-cancellable policies, the required disclosures of rating practices, as set forth in paragraph (2) of this subsection, shall apply to any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates issued under a group long-term care policy delivered or issued for delivery in this state and issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations that was in effect on January 1, 2002, in which case this subsection shall apply on the policy anniversary following January 1, 2003.

(2) Insurers shall provide the following information in the same order as set forth in this paragraph to the applicant at the time of application or enrollment or, if the method of application does not allow for delivery at that time, the information shall be provided at the time of delivery of the policy or certificate:

(A) a statement that the policy may be subject to rate increases in the future;

(B) an explanation of potential future premium rate revisions, including an explanation of contingent benefit upon lapse, and the policyholder's or certificate holder's option in the event of a premium rate revision;

(C) the premium rate or rate schedules applicable to the applicant that will be in effect until a request is made for an increase;

(D) a general explanation for applying premium rate or rate schedule adjustments that shall include:

(i) a description of when premium rate or rate schedule adjustments will become effective (e.g., next anniversary date, next billing date, etc.); and

(ii) the right to a revised premium rate or rate schedule as provided in subparagraph (C) of this subsection if the premium rate or rate schedule is changed;

(E) Information regarding each premium rate increase on this policy form or similar policy forms over the past 10 years for this state or any other state that, at a minimum, identifies:

(i) the policy forms for which premium rates have been increased;

(ii) the calendar years when the form was available for purchase; and

(iii) the amount or percent of each increase. The percentage may be expressed as a percentage of the premium rate prior to the increase, and also may be expressed as minimum and maximum percentages if the rate increase is variable by rating characteristics.

(3) Subsequent to the information required by paragraph (2) of this subsection, insurers may, in a manner that is not misleading, provide in addition to the information required in paragraph (2)(E) of this subsection, explanatory information related to the rate increases.

(4) Insurers may exclude from the disclosure required by paragraph (2)(E) of this subsection premium rate increases that only apply to blocks of business acquired from other nonaffiliated insurers or the long-term care policies acquired from other nonaffiliated insurers when those increases occurred prior to the acquisition.

(5) If an acquiring insurer files for a rate increase either on a long-term care policy form acquired from a nonaffiliated insurer, or on a block of policy forms acquired from a nonaffiliated insurer on or before January 1, 2002 or the end of the 24-month period after the date of the acquisition of the block or policies, the acquiring insurer may exclude that rate increase from the disclosure. However, the nonaffiliated selling insurer shall include the disclosure of that rate increase in accordance with paragraph (2)(E) of this subsection.

(6) If the acquiring insurer in paragraph (5) of this subsection files for a subsequent rate increase, even within the 24-month period, on the same policy form acquired from a nonaffiliated insurer or block of policy forms acquired from a nonaffiliated insurer referenced in paragraph (5), the acquiring insurer shall make all disclosures required by paragraphs (2)(E), (3), (4) and (5) of this subsection.

(7) An applicant shall sign an acknowledgement at the time of application that the insurer has made the disclosure(s) required under paragraph (2) of this subsection. If due to the method of application the applicant cannot sign an acknowledgement at the time of application, the applicant shall sign no later than at the time of delivery of the policy or certificate.

(8) An insurer may use such form as the department prescribes to comply with the requirements of this section. Persons may obtain the required form by making a request to the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9107 or 333 Guadalupe, Austin, Texas 78701, or by accessing the department website at www.tdi.state.tx.us. Insurers who elect not to use the prescribed form shall file the disclosure form with the Life/Health Division of the department for review 60 days prior to use.

(9) An insurer shall provide notice of an upcoming premium rate schedule increase to all policyholders or certificate holders, as applicable, at least 45 days prior to the implementation of the premium rate schedule increase by the insurer. The notice shall include the information required by paragraph (2) of this subsection in the same order as set forth in paragraph (2) when the rate increase is implemented.

§3.3831. Standards and Rates.

(a) Loss ratio standards. Except as noted in subsections (b) and (c) of this section, this subsection shall apply to all long-term care insurance policies and certificates.

(1) Benefits provided under long-term care insurance policies and certificates shall be deemed reasonable in relation to premiums charged if the expected loss ratio is at least 60%, calculated in a manner which provides for adequate reserving of the long-term care insurance risk. In evaluating the expected loss ratio, due consideration shall be given to all relevant factors, including:

(A) statistical credibility of incurred claims experience and earned premiums;

(B) the period for which rates are computed to provide coverage;

(C) experienced and projected trends;

(D) concentration of experience within early policy duration;

(E) expected claim fluctuation;

(F) experience refunds, adjustments, or dividends;

(G) renewability features;

(H) all appropriate expense factors;

(I) interest;

(J) experimental nature of the coverage;

(K) policy reserves;

(L) mix of business by risk classification; and

(M) product features such as long elimination periods, high deductibles, and high maximum limits.

(2) Prior to the use of any long-term care policy or certificate form in this state, every insurer shall submit to the commissioner an actuarial memorandum for each such policy which includes claim experience data and assumptions made thereon to sufficiently explain how the rates for such policy form are calculated. The actuarial memorandum submitted shall at least provide information which includes premium rate tables and/or schedules for each risk class and any fees, assessments, dues, or other considerations that will be included in the premium.

(b) Initial premium rate filing.

(1) Sixty days prior to the use of any long-term care policy or certificate to be issued in this state on or after July 1, 2002, an insurer shall submit the following information to the department:

(A) a copy of the disclosure form required by §3.3829(b) of this subchapter (relating to Required Disclosures);

(B) an actuarial memorandum or certification which includes at least the following:

(i) a statement that the initial premium rate schedule is sufficient to cover anticipated costs under moderately adverse experience and that the premium rate schedule is reasonably expected to be sustainable over the life of the form with no future premium increases anticipated;

(ii) a statement that the policy design and coverage provided have been reviewed and taken into consideration;

(iii) a statement that the underwriting and claims adjudication processes have been reviewed and taken into consideration;

(iv) a complete description of the basis for contract reserves that are anticipated to be held under the form, to include:

(I) sufficient detail or sample calculations provided so as to have a complete depiction of the reserve amounts to be held;

(II) a statement that the assumptions used for reserves contain reasonable margins for adverse experience;

(III) a statement that the net valuation premium for renewal years does not increase (except for attained-age rating where permitted); and

(IV) a statement that the difference between the gross premium and the net valuation premium for renewal years is sufficient to cover expected renewal expenses; or, if such a statement cannot be made, a complete description of the situations where this does not occur. The description may include a demonstration of the type and

level of change in the reserve assumptions that would be necessary for the difference to be sufficient;

(-a-) an aggregate distribution of anticipated issues may be used as long as the underlying gross premiums maintain a reasonably consistent relationship;

(-b-) if the gross premiums for certain age groups appear to be inconsistent with this requirement, the department may request a demonstration under paragraph (2) of this subsection based on a standard age distribution; and

(v) either a statement or comparison as follows:

(I) a statement that the premium rate schedule is not less than the premium rate schedule for existing similar policy forms also available from the insurer except for reasonable differences attributable to benefits; or

(II) comparison of the premium schedules for similar policy forms that are currently available from the insurer with an explanation of the differences. An insurer will not be required to provide a comparison of every age and set of benefits, period of payment or elimination period; instead, a broad range of expected combinations designed to provide a fair presentation is to be provided.

(2) The department may request, and the insurer shall provide, at any time, an actuarial demonstration that benefits are reasonable in relation to premiums. If requested:

(A) the actuarial demonstration shall include either premium and claim experience on similar policy forms, adjusted for any premium or benefit differences, relevant and credible data from other studies, or both; and

(B) the period in subsection (b)(1) of this section does not include the period during which the insurer is preparing the requested information.

(c) Premium rate schedule increases. This subsection applies to premium rate increases for any long-term care policy or certificate delivered or issued for delivery in this state on or after July 1, 2002, except for certificates under a group long-term care insurance policy issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, which was in force on July 1, 2002, the provisions of this section shall apply on the policy anniversary following January 1, 2003.

(1) Exceptional premium rate increases.

(A) Exceptional premium rate increases are subject to the requirements of paragraph (2) of this subsection in addition to subparagraphs (B) and (C) of this paragraph.

(B) The department may request a review by an independent qualified actuary or a professional actuarial entity of the basis for a request that an increase be considered an exceptional premium rate increase.

(C) The department, in determining that the necessary basis for an exceptional premium rate increase exists, shall determine any potential offsets to higher claims costs.

(2) All premium rate schedule increases.

(A) An insurer shall submit a pending premium rate schedule increase, including an exceptional premium rate increase, to the department not later than the 60th day preceding the date of the notice to the policyholders, and shall include:

(i) information required by §3.3829(b) of this subchapter;

(ii) certification by a qualified actuary that:

(I) no further premium rate schedule increases are anticipated if the requested premium rate schedule increase is implemented and the underlying assumptions, which reflect moderately adverse conditions, are realized;

(II) the premium rate filing is in compliance with the provisions of this section;

(iii) an actuarial memorandum justifying the rate schedule increase request that includes:

(I) lifetime projections of earned premiums and incurred claims based on the filed premium rate schedule increase and the method and assumptions used in determining the projected values, including reflection of any assumptions that deviate from those used for pricing other forms currently available for sale, subject to the following:

(-a-) annual values for the five years preceding and the three years following the valuation date shall be provided separately;

(-b-) the projections shall include the development of the lifetime loss ratio, unless the rate increase is an exceptional increase;

(-c-) the projections shall demonstrate compliance with subparagraph (B) of this paragraph; and

(-d-) for exceptional premium rate increases:

(-1-) the projected experience shall be limited to the increases in claims expenses attributable to the approved reasons for the exceptional premium rate increase; and

(-2-) in the event the department determines, as provided in paragraph (1)(C) of this subsection that offsets may exist, the insurer shall use appropriate net projected experience;

(II) disclosure of how reserves have been incorporated in this rate increase whenever the rate increase will trigger contingent benefit upon lapse;

(III) disclosure of the analysis performed to determine why a rate adjustment is necessary, which pricing assumptions were not realized and why, and what other actions taken by the insurer have been relied on by the actuary; and

(IV) a statement that policy design, underwriting and claims adjudication practices have been taken into consideration;

(V) composite rates reflecting projections of new certificates in the event that it is necessary to maintain consistent premium rates for new certificates and certificates receiving a rate increase;

(iv) a statement that renewal premium rate schedules are not greater than new business premium rate schedules except for differences attributable to benefits, unless sufficient justification is provided to the department; and

(v) sufficient information for review of the premium rate schedule increase by the department.

(B) All premium rate schedule increases shall be determined in accordance with the following:

(i) exceptional premium rate increases shall provide that 70% of the present value of projected additional premiums from

the exceptional premium rate increase will be returned to policyholders in benefits;

(ii) premium rate schedule increases shall be calculated such that the sum of the accumulated value of incurred claims, without the inclusion of active life reserves, and the present value of future projected incurred claims, without the inclusion of active life reserves, will not be less than the sum of the following:

(I) the accumulated value of the initial earned premium multiplied by 58%;

(II) 85% of the accumulated value of prior premium rate schedule increases on an earned basis;

(III) the present value of future projected initial earned premiums multiplied by 58%; and

(IV) 85% of the present value of future projected premiums not in subclause (III) of this subparagraph on an earned basis;

(iii) If a policy form has both exceptional premium rate increases and other increases, the values in subclauses (II) and (IV) of clause (ii) of this subparagraph will also include 70% for exceptional rate increase amounts; and

(iv) All present and accumulated values used to determine rate increases shall use the maximum valuation interest rate for contract reserves as specified in Subchapter GG of this chapter. The actuary shall disclose as part of the actuarial memorandum the use of any appropriate averages.

(C) For each rate increase that is effected, the insurer shall file for review by the department updated projections, as defined in paragraph (2)(A)(iii)(I) of this subsection, annually for the next three years on the anniversary of the implementation of the rate increase, and shall include a comparison of actual results to projected values. The department may extend the period for filing updated projections to more than three years if actual results are not consistent with projected values from prior projections submitted by the insurer. For group insurance policies that meet the conditions in subparagraph (K) of this paragraph, the projections required by this paragraph shall be provided to the policyholder in conjunction with filing the projections with the department.

(D) If any premium rate in the revised premium rate schedule is greater than 200% of the comparable rate in the initial premium schedule, the insurer shall file for review by the department, every five years following the end of the required period in subparagraph (C) of this paragraph, lifetime projections, as defined in paragraph (2)(A)(iii)(I) of this subsection. For group insurance policies that meet the conditions in subparagraph (K) of this paragraph, the projections required by this paragraph shall be provided to the policyholder in conjunction with filing the projections with the department.

(E) If the department determines that the actual experience following a rate increase does not adequately match the projected experience filed by the insurer and that the current projections under moderately adverse conditions demonstrate that incurred claims will not exceed proportions of premiums specified in subparagraph (B) of this paragraph, the department may require the insurer to implement any of the following:

(i) premium rate schedule adjustments; or

(ii) other measures to reduce the difference between the projected and actual experience.

(F) In determining whether the actual experience adequately matches the projected experience under subparagraph (E) of this paragraph, consideration shall be given to paragraph (2)(A)(iii)(V) of this subsection, if applicable.

(G) If the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse, the insurer shall file:

(i) a plan, subject to the department's approval, for improved administration or claims processing designed to eliminate the potential for further deterioration of the policy form requiring further premium rate schedule increases, or both, or to demonstrate that appropriate administration and claims processing have been implemented or are in effect; otherwise the department may impose the condition in subparagraph (H) of this paragraph; and

(ii) the original anticipated lifetime loss ratio, and the premium rate schedule increase that would have been calculated according to subparagraph (B) of this paragraph had the greater of the original anticipated lifetime loss ratio or 58% been used in the calculations described in paragraph (2)(B)(ii)(I) and (III) of this subsection.

(H) For a rate increase filing that meets the criteria in clauses (i)-(iii) of this subparagraph, the department shall review, for all policies included in the filing, the projected lapse rates and past lapse rates during the 12 months after the date each increase becomes effective to determine if significant adverse lapsation has occurred or is anticipated:

(i) the rate increase is not the first rate increase requested for the specific policy form or forms;

(ii) the rate increase is not an exceptional premium rate increase; and

(iii) the majority of the policies or certificates to which the increase is applicable are eligible for the contingent benefit upon lapse.

(I) In the event significant adverse lapsation has occurred, is anticipated in the filing, or is evidenced in the actual results as presented in the updated projections provided by the insurer after the date of the requested rate increase, the department may determine that a rate spiral exists. Following the determination that a rate spiral exists, the department may require the insurer to offer to all in force insureds subject to the rate increase, without underwriting, the option to replace existing coverage with one or more reasonably comparable products being offered by the insurer or its affiliates.

(i) The offer shall:

(I) be subject to the approval of the department;

(II) be based on actuarially sound principles, but not be based on attained age; and

(III) provide that maximum benefits under any new policy accepted by an insured shall be reduced by comparable benefits already paid under the existing policy.

(ii) The insurer shall maintain the experience of all the replacement insureds separate from the experience of insureds originally issued the policy forms. In the event of a request for a rate increase on the policy form, the rate increase shall be limited to the lesser of:

(I) the maximum rate increase determined based on the combined experience; and

(II) The maximum rate increase determined based only on the experience of the insureds originally issued the form plus 10%.

(J) If the department determines that the insurer has exhibited a persistent practice of filing inadequate initial premium rates for long-term care insurance, the department may, in addition to the

provisions of subparagraph (H) of this paragraph, prohibit the insurer from any of the following:

(i) filing and marketing comparable coverage for a period not to exceed five years; or

(ii) offering all other similar coverages and limiting marketing of new applications to the products subject to recent premium rate schedule increases.

(K) Subparagraphs (E), (H) and (I) of this paragraph shall not apply to group insurance issued to one or more employers or labor organizations, or to a trust or to the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees or a combination thereof or for members or former members or a combination thereof, of the labor organizations, where:

(i) the policies insure 250 or more persons, and the policyholder has 5,000 or more eligible employees of a single employer; or

(ii) the policyholder, and not the certificate holders, pays a material portion of the premium, which shall be not less than 20% of the total premium for the group in the calendar year prior to the year during which a rate increase is filed.

§3.3844. Nonforfeiture and Contingent Benefits.

(a) Required Offering of Nonforfeiture Benefits and Contingent Benefits upon Lapse. No insurer or other entity may offer a long-term care insurance policy or certificate in this state unless such insurer or other entity also offers to the prospective insured, or to the group policyholder, the option to purchase a policy that contains nonforfeiture benefits. On or after July 1, 2002, in the event a policyholder or certificate holder declines the option to purchase a policy that contains nonforfeiture benefits, the insurer shall provide contingent benefits upon lapse as described in subsection (g) of this section. In the event a group policyholder elects to make the nonforfeiture benefit an option to the certificate holder, a certificate shall provide either the nonforfeiture benefit or the contingent benefit upon lapse.

(b) Nonforfeiture Benefit Provisions.

(1) The nonforfeiture provision shall provide for a benefit available in the event of a default in the payment of any premiums. The amount of the benefit may be adjusted subsequent to being initially granted only as necessary to reflect changes in claims, persistency, and interest as reflected in changes in rates for premium paying contracts approved by the commissioner for the same contract form.

(2) The nonforfeiture provision shall be clearly and conspicuously captioned.

(c) Nonforfeiture Benefit Options. Insurers shall offer at least one of the following nonforfeiture options:

(1) reduced paid-up;

(2) extended term;

(3) shorten benefit period; or

(4) other offerings approved by the U.S. Secretary of Health and Human Services as provided by the Internal Revenue Code §7702B(g)(4)(B).

(d) Nonforfeiture and Contingent Benefit Standards/Requirements.

(1) Except as provided in paragraph (2) of this subsection, no policy or certificate shall begin a nonforfeiture benefit later than the end of the third year following the policy or certificate issue date. The contingent benefit upon lapse shall be effective during the first three years as well as thereafter.

(2) For a policy or certificate with attained age rating, the nonforfeiture benefit shall begin on the earlier of:

(A) The end of the tenth year following the policy or certificate issue date; or

(B) The end of the second year following the date the policy or certificate is no longer subject to attained age rating.

(3) Nonforfeiture credits may be used for all care and services qualifying for benefits under the terms of the policy or certificate, up to the limits specified in the policy or certificate.

(4) All benefits paid by the insurer while the policy or certificate is in premium paying status and in the paid up status will not exceed the maximum benefits which would have been payable if the policy or certificate had remained in premium paying status.

(5) There shall be no difference in the minimum nonforfeiture benefits as required under this section for group and individual policies.

(6) Premiums charged for a policy or certificate containing nonforfeiture benefits or a contingent benefit upon lapse shall be subject to the requirements of §3.3831 of this title (relating to Standards and Rates) treating the policy as a whole.

(7) To determine whether the contingent nonforfeiture upon lapse provisions are triggered, a replacing insurer that purchased or otherwise assumed a block or blocks of long-term care insurance policies from another insurer shall calculate the percentage increase based on the initial annual premium paid by the insured when the policy was first purchased from the original insurer.

(8) A qualified actuary shall certify as to the reasonability of rates charged for each nonforfeiture benefit and the reserving required by §3.3819 of this title (relating to Requirement for Reserve) shall include reserving for the nonforfeiture options.

(e) Additional Requirements for Shortened Benefit Period. An insurer offering a shorten benefit period shall comply with the following:

(1) The shortened benefit period shall provide paid-up long-term care insurance coverage after lapse. The same benefits (amounts and frequency in effect at the time of lapse but not increased thereafter) will be payable for a qualifying claim, but the lifetime maximum dollars or days of benefits shall be determined as specified in paragraph (2) of this subsection.

(2) The standard nonforfeiture credit will be equal to 100 percent of the sum of all premiums paid, including the premiums paid prior to any changes in benefits. The insurer may offer additional shortened benefit period options, as long as the benefits for each duration equal or exceed the standard nonforfeiture credit for that duration. However, the minimum nonforfeiture credit shall not be less than thirty (30) times the daily nursing home benefit at the time of lapse. In either event, the calculation of the nonforfeiture credit is subject to the limits specified in the policy or certificate.

(f) Disclosure of Nonforfeiture Benefits. The application or a separate form shall include an election to accept or reject the nonforfeiture benefit. The rejection notice shall state: "I have reviewed the outline of coverage and the explanation of nonforfeiture benefits and I reject the nonforfeiture option." The agent shall provide information to assist the prospective policyholder in accurately completing the rejection statement.

(g) Contingent Nonforfeiture Benefits.

(1) The contingent benefit on lapse shall be triggered every time an insurer increases the premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of the insured's initial annual premium set forth in Triggers for a Substantial Premium Increase based on the insured's issue age, and the policy or certificate lapses within 120 days of the due date of the premium so increased. Policyholders shall be notified at least 45 days prior to the due date of the premium reflecting the rate increase. Figure: 28 TAC §3.3844(g)(1)

(2) On or after the effective date of a substantial premium increase as set forth in paragraph (1) of this subsection, the insurer shall:

(A) offer to reduce policy benefits provided by the current coverage without the requirement of additional underwriting so that required premium payments are not increased;

(B) offer to convert the coverage to a paid-up status with a shortened benefit period in accordance with the terms of subsection (e) of this section. This option may be elected at any time during the 120-day period referenced in paragraph (1) of this subsection; and

(C) notify the policyholder or certificate holder that a default or lapse at any time during the 120-day period referenced in paragraph (1) of this subsection shall be deemed to be the election of the offer to convert in subparagraph (B) of this paragraph.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107967
Lynda Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: January 6, 2002
Proposal publication date: November 9, 2001
For further information, please call: (512) 475-6327

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CHAPTER 7. CORPORATE AND FINANCIAL REGULATION

SUBCHAPTER A. EXAMINATION AND FINANCIAL ANALYSIS

28 TAC §7.18

The Commissioner of Insurance adopts amendments to §7.18 concerning the adoption by reference of the Accounting Practices and Procedures Manual (Manual). The adoption of the amendments is made with one change to the text as proposed in the November 9, 2001 issue of the *Texas Register* (26 TexReg 9029).

The amendment to §7.18 is necessary to update the version of the Manual previously adopted by the department. The Manual is designed to provide a nationwide standard method of accounting which most insurers, including health maintenance organizations, will be required to use for statutory financial reporting guidance, thus creating a more consistent regulatory environment. The section adopts the Manual by reference with deference to Texas statutes, regulations and to exceptions enumerated in the section. A new version of the Manual is published periodically by the National Association of Insurance Commissioners (NAIC) to update the guidance which addresses new statutory issues and new generally accepted accounting principles as they develop. A public hearing on the proposed amendments was held on November 26, 2001.

The adopted section provides more efficient regulation of insurance and a decrease in costs to insurers that are currently required to file multiple financial statements in multiple states. The adoption of the March 2001 Manual will provide for a more consistent regulatory environment and will provide a single source for accounting guidance. The amended section updates the adoption by reference of the Manual by adopting by reference the March 2001 version of the Manual. Seven new statements of statutory accounting principles (SSAPs) have been adopted by the NAIC and are included in the March 2001 version of the Manual. The adopted amendment also changes the list of exceptions and additions to the Manual as follows: SSAP No. 6 concerning uncollected premium balances is amended by clarifying the starting date used to determine the admissibility of uncollected premium balances. The Commissioner also adopts SSAP No. 81 concerning software revenue recognition; SSAP No. 82 concerning the costs of computer software developed or obtained for internal use and web site development costs; SSAP No. 83 concerning mezzanine real estate loans and SSAP No. 84 concerning health care receivables and receivables under government insured plans. While SSAP Nos. 81 - 84 are not included in the March 2001 version of the Manual, they are considered part of the March 2001 version of the Manual under the NAIC procedures for the adoption of SSAPs. Subsection (c)(1) is changed from the proposal to clarify that SSAP Nos. 81 - 83 are to be applied to examinations conducted as of January 1, 2002 and thereafter and also shall be used to prepare all financial statements filed with the department for periods after January 1, 2002. The adoption of the amendment repeals the deferment of the effective date for the establishment of an Interest Maintenance Reserve and an Asset Valuation Reserve for Texas domestic insurers which have not previously established the reserves by deleting these provisions in paragraphs (1) and (2) in §7.18(c). The Commissioner deferred the establishment of the reserves for one year in response to comments when the adoption of the Manual was proposed in 2000; therefore, these subsections are no longer necessary. When new versions of the Manual are made available by the NAIC, the Commissioner will consider the new version and, if he deems appropriate, propose for public comment adoption of the new version, with any necessary modifications, by rule.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Insurance Code Articles 1.11, 1.15, 1.32, 3.01, 3.33, 5.61, 6.12, 8.07, 20A.22, 21.28-A, 21.39, 21.49-1, and §§32.041 and 36.001. Article 1.15 mandates that the department of insurance examine the financial condition of each carrier organized under the laws of Texas or authorized to transact the business of insurance in Texas and, by rule, adopt procedures for the filing and adoption of examination reports. Article 1.11 and §32.041 authorize the Commissioner to provide required financial statement forms. Article 21.39 authorizes the Commissioner to adopt rules for establishing reserves applicable to each line of insurance recommended

by the NAIC. Article 1.32 authorizes the Commissioner to establish standards for evaluating the financial condition of an insurer. Article 20A.22 authorizes the Commissioner to promulgate rules as are necessary to carryout the provisions of the Texas Health Maintenance Organization Act. Article 5.61 provides that reserves shall be computed in accordance with rules adopted by the Commissioner for the purpose of adequately protecting insureds. Article 21.28-A authorizes the Commissioner to adopt rules necessary to accomplish the purposes of the article. Articles 6.12, 8.07 and 3.01 authorize the Commissioner to adopt rules defining electronic machines and systems, office equipment, furniture, machines and labor saving devices and the maximum period for which each such class may be amortized. Article 3.33 authorizes the Commissioner to adopt such rules, minimum standards, or limitations as may be appropriate for the implementation of the article. Article 21.49-1 authorizes the Commissioner to issue rules, and orders necessary to implement the provisions of the article. Section 36.001 authorizes the Commissioner to adopt rules for the conduct and execution of the powers and duties of the department only as authorized by statute.

§7.18. NAIC Accounting Practices and Procedures Manual.

(a) The purpose of this section is to adopt statutory accounting principles, which will provide independent accountants, industry accountants and department analysts and examiners guidance as to how to properly record business transactions for the purpose of accurate statutory reporting. The March 2001 version of the National Association of Insurance Commissioners Accounting Practices and Procedures Manual (Manual) will be utilized as the guideline for statutory accounting principles in Texas to the extent the Manual does not conflict with provisions of the Texas Insurance Code or rules of the department. The Commissioner reserves all authority and discretion to resolve any accounting issues in Texas. When making a determination on the proper accounting treatment for an insurance or health plan transaction the Commissioner shall refer to the sources in paragraphs (1)-(6) of this subsection in the respective order of priority listed. Furthermore, §§ 3.1501-3.1505, 3.1605, 3.1606, 3.7004, 7.7, 7.85 and 11.803 of this title (relating to Annuity Mortality Tables, General Requirements, Required Opinions, Contract Reserves, Subordinated Indebtedness, Audited Financial Reports and Investments, Loans and Other Assets), preempt any contrary provisions in the Manual.

(1) Texas statutes;

(2) department rules;

(3) directives, instructions and orders of the Commissioner;

(4) the Manual;

(5) other NAIC handbooks, manuals, and instructions, adopted by the department; and

(6) Generally Accepted Accounting Principles.

(b) The Commissioner adopts by reference the March 2001 version of the Accounting Practices and Procedures Manual published by the NAIC, with the exceptions and additions set forth in subsections (c) and (d) of this section, as the source of accounting principles for the department when examining financial reports and for conducting statutory examinations and rehabilitations of insurers and health maintenance organizations licensed in Texas, except where otherwise provided by law. This adoption by reference shall be applied to examinations conducted as of January 1, 2002 and thereafter and also shall be used to prepare all financial statements filed with the department for periods after January 1, 2002.

(c) The Commissioner adopts the following exceptions and additions to the Manual:

(1) In addition to the statements of statutory accounting principles in the Manual, Statement of Statutory Accounting Principle number 81 concerning software revenue recognition, finalized March 26, 2001, Statement of Statutory Accounting Principle number 82 concerning the costs of computer software developed or obtained for internal use and web site development costs, finalized March 26, 2001, and Statement of Statutory Accounting Principle number 83 concerning mezzanine real estate loans adopted by the NAIC Accounting Practices and Procedures Task Force dated October 18, 2001, are adopted by reference and shall be used to prepare all financial statements for years ending on and after January 1, 2002. Statement of Statutory Accounting Principle number 84, concerning certain health care receivables and receivables under government insured plans, adopted by the NAIC Accounting Practices and Procedures Task Force dated October 18, 2001, is adopted by reference and shall be used to prepare all financial statements for years ending on and after December 31, 2001.

(2) Retrospective premiums must be billed within 60 days of computation and audit premiums must be billed within 60 days of the completion of the audit in determining the beginning date from which the ninety day period is calculated to determine admissibility of uncollected premium balances under Statement of Statutory Accounting Principle number 6.

(3) Electronic machines, constituting a data processing system or systems and operating systems software used in connection with the business of an insurance company acquired after December 31, 2000, may be an admitted asset as permitted by Texas Insurance Code Articles 3.01, 6.12, 8.07, and any other applicable law and shall be amortized as provided by the Manual. All such property acquired prior to January 1, 2001, may be an admitted asset as permitted by Texas Insurance Code Articles 3.01, 6.12, 8.07, and any other applicable law, and shall be amortized in full over a period not to exceed ten years.

(4) Furniture, labor-saving devices, machines, and all other office equipment may be admitted as an asset as permitted by Texas Insurance Code Articles 3.01, 6.12, 8.07, and any other applicable law and, for such property acquired after December 31, 2000, depreciated in full over a period not to exceed five years. All such property acquired prior to January 1, 2001, may be an admitted asset as permitted by Texas Insurance Code Articles 3.01, 6.12, 8.07, and any other applicable law, and shall be depreciated in full over a period not to exceed ten years.

(5) Written premiums for all property and casualty contracts, other than contracts for workers' compensation, shall be recorded as of the effective date of the contract rather than on the effective date of the contract as stated in Statement of Statutory Accounting Principles number 53.

(6) Goodwill, as reported on a regulated entity's statutory financial statements as of December 31, 2000, and any additional goodwill acquired thereafter, beginning January 1, 2001, shall be admitted as an asset and accounted for as permitted by Statements of Statutory Accounting Principles numbers 61 and 68. All other amounts of goodwill, including, but not limited to, such amounts that may have been previously expensed, shall not be allowed as an admitted asset. However, notwithstanding the provisions of Statements of Statutory Accounting Principles numbers 61 and 68, all methods of non-insurer subsidiary and affiliate valuation permitted by Article 21.49-1 §6A may be used for the purposes of goodwill calculation.

(7) All certificates of deposit, of any maturity, may be classified as cash and are subject to the accounting treatment contained

in Statement of Statutory Accounting Principles number 2, notwithstanding the provisions of Statement of Statutory Accounting Principles number 26.

(8) Agents balances of insurers licensed only in Texas that use a managing general agency to produce a majority of their business are not subject to Statement of Statutory Accounting Principles number 6 until January 1, 2002.

(d) A farm mutual insurance company, statewide mutual assessment company, local mutual aid association, or mutual burial association that has less than $5 million in annual direct written premiums need not comply with the Manual.

(e) This section shall not be construed to either broaden or restrict the authority provided under the Texas Insurance Code to insurers, including health maintenance organizations.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 12, 2001.

TRD-200107793
Lynda Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
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Proposal publication date: November 9, 2001
For further information, please call: (512) 463-6327

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PART 2. TEXAS WORKERS' COMPENSATION COMMISSION

CHAPTER 126. GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

28 TAC §§126.5 - 126.7

Texas Workers' Compensation Commission (the commission) adopts amendments to §§126.5-126.7 concerning Required Medical Evaluations, with changes to the proposed text published in the August 31, 2001 issue of the *Texas Register* (26 TexReg 6547).

The amendments are adopted in response to HB-2600 which amended §408.004(a) and (c) of the Texas Labor Code. Furthermore, the bill amended Chapter 408, Subchapter A by adding §408.0041, Designated Doctor Examination and making amendments to other sections of the chapter relating to the use of designated doctors. In essence, the bill limits the use of an insurance carrier (carrier) selected doctor for a Required Medical Examination (RME) to only the resolution of issues regarding the appropriateness of the health care received by an injured employee (employee), and similar issues. Carriers, however, are permitted to have an RME doctor evaluate Maximum Medical Improvement (MMI) and permanent whole body impairment only after a designated doctor examination for those issues has taken place. Thus, it was necessary to review and amend existing rules to ensure consistent and clear application of the mandate. The commission's medical advisor has consulted on and provided recommendations regarding these rules.

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order, which includes the preamble which, in turn, includes the rule. This preamble contains a summary of the factual basis for the amendments to the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the amendments, and the reasons why the commission disagrees with some of the comments and proposals.

Changes made to the proposed amendments are in response to public comment received in writing and at a public hearing held on October 2, 2001, and are described in the summary of comments and responses section of this preamble. Other changes were made for consistency or to correct typographical or grammatical errors, and to address issues identified by the Commission during its reexamination of the proposed amendments while considering the comments provided by the public.

Changes in the proposed text are found in §126.5(a), (b), (c), (d), (g); §126.6(a), (b), (d), (f), (h); §126.7(b), (g), (h), (j), (k).

Adopted §126.5 -- Entitlement and Procedure for Requesting Required Medical Examinations

Adopted §126.5(a) adds references to Texas Labor Code §408.151 and new §408.0041 to make it clear that the commission may authorize RMEs for reasons consistent with those subsections, as well as §408.004. In addition, language was added relating to the consequences of an RME report which was not obtained in accordance with the subsection. If a carrier does not comply with the requirements for requesting and scheduling examinations (including those that the employee agrees to), the carrier and the commission are not allowed to act with respect to benefits, based on the RME doctor's opinion. This approach eliminates any incentive for not complying with the rule. The language referencing "medical advisor or a division of the commission" was changed to " or the commission." Under §408.004, the term used is "the commission." Further, except in very limited circumstances, the commission is attempting to conform its rules to refer to "the commission" rather than specific divisions.

Adopted §126.5(b) establishes the carrier's entitlement to have a doctor of its choice examine the employee at different points in the claim. Adopted subsection (b)(1) applies to RMEs prior to the employee reaching the 2nd anniversary of entitlement to supplemental income benefits (SIBs) and does not apply to RMEs for the evaluation of MMI or impairment. Also, the language was modified to clarify that the carrier's first RME may be requested at any time after the date of injury and that the Commission may approve no more than three RME's before the expiration of 180 days. Adopted subsection (b)(2) applies to RMEs for the purpose of evaluating MMI and/or impairment. It states that the carrier is entitled to an RME for this purpose only after there has been a designated doctor examination for the same purpose. The language in subsection (b)(1) was modified to clarify that the carrier's first RME may be requested at any time after the date of injury and that the Commission may approve no more than three RME's before the expiration of 180 days.

Adopted §126.5 (c) includes the requirement that a doctor performing an RME on or after September 1, 2003 be on the commission's Approved Doctor List (ADL). In addition, the subsection provides that if the purpose of the RME is to evaluate MMI or permanent impairment, the doctor must be authorized to do so. The subsection references adopted §130.1(a) of this title

(relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) as the place where such authorization is described.

Section 126.5 (c) was changed from the proposal in two ways. First, the effective date of the subsection was changed to coincide with the beginning of the new biennium. Second, the commission received numerous comments on proposed §§180.20 and 180.23 of this title (relating to Application for Registration / Commission Approved Doctor List and Commission Required Training for Doctors/Certification Levels, respectively)) which dealt with the Approved Doctors List and the types of training the doctors will have to get to be authorized to serve in various roles. The Chapter 180 rules were proposed concurrently with §§126.5-126.7 and these rules were proposed with language consistent with the requirements of the proposed Chapter 180 rules.

Because the Chapter 180 rules will not be considered for adoption at the same time as §§126.5-126.7, §126.5(c) were changed to allow the commission the flexibility to adjust the final version of the Chapter 180 rules without conflicting with this rule. In addition, the concept of who is authorized to assign impairment ratings is fully covered in §130.1 which is being adopted concurrently with this rule.

Adopted §126.5(d) addresses employee's attendance at examinations requested by a carrier and provides more detail regarding the process. The request must be made in writing with a copy of the request form that the carrier intends to file with the commission. This will help ensure that the employee knows what is being requested. The rule requires that the carrier wait 10 days before filing the request with the commission (10 days after the date it is sent to the employee) unless the carrier receives the employee's response prior to that date. Following this, the carrier can file the request with the commission but does not have to submit a second copy to the employee because this would be redundant and because the commission will send a copy of the approved or denied request to the employee when it has been processed. Additionally, language referencing subsection (g) was added to this section to further clarify the requirement.

There is an exception to the requirement that an attempt be made to obtain the employee's agreement prior to the commission ordering an examination. This exception occurs when the carrier is seeking an RME for an evaluation of MMI and/or impairment after a designated doctor examination for the same issues has occurred. In this case, the statute makes it clear that the carrier is fully entitled to an RME. Further, the addition of a waiting period of up to 10 days unnecessarily delays the resolution of a dispute.

Under adopted §126.5(g), the qualifier "if any" was added to the sentence to ensure consistency with the wording of other rules.

Adopted §126.6 -- Order for Required Medical Examination

Adopted §126.6 (a) references the fact that the employee or the employee's representative can request an RME. This statement has been deleted from the subsection because it is not supported by §408.004 of the Texas Labor Code. The language used clarifies that an agreement between the parties for an RME, has the same effect as the commission's order only if the carrier has a right for the examination under §126.5. Previously, carriers were obtaining the employee's agreement to attend an examination by the carrier's choice of doctor and not reporting these examinations to the commission as required by previous §126.5. Their justification is that this is not a "required medical examination" but rather is an "independent medical examination" (or IME). This activity was a violation of the previous rule. In addition, failing to report RME's to the commission prevents the commission from monitoring RME requests as required by the Texas Labor Code. Therefore, an agreement for an examination that the carrier is not entitled to does not have the effect of an order and the carrier is thus not entitled to suspend benefits if the employee fails to attend the examination.

Adopted §126.6(b) changes the previous requirement that the examination be scheduled "as soon as possible" to require that the examination be scheduled to occur within 30 days of receipt of the order. This is designed to reduce disputes or allegations that the examination was not scheduled quickly enough. In addition, the language is now clearer and allows the commission to grant an exception to the rescheduling requirements

Adopted §126.6(c) addresses an employee's treating doctor's attendance at an RME. The language prohibits treating doctors from advising the employee not to cooperate with the examination.

Adopted §126.6(d) required the addition of the qualifier "if any" after the "employee's representative" phrase to ensure consistency throughout the rules.

Adopted §126.6(e) changes the RME doctor's reporting requirements relating to MMI and/ or impairment. Because HB-2600 only provides for a RME for this purpose after a designated doctor examination for the same purpose, this subsection applies only in that situation. In addition, the RME doctor is to explain why the designated doctor's opinion regarding MMI was incorrect or is no longer valid if the RME doctor disagrees with the designated doctor. This is intended to simplify dispute resolution.

Adopted §126.6(g) adds the reference to the Texas Labor Code §408.0041.

Adopted §126.6(h) adds language to clarify the employee's duty to contact the RME doctor's office to reschedule an examination. This clarification was necessary because employees often found that RME doctors would refuse to reschedule the examination. The RME doctor's refusal to reschedule an examination allowed the carrier to suspend benefits and made it hard for the employee to get them reinitiated. However, the phrase "including a designated doctor examination" was deleted from the first sentence in subsection (h) of this section to maintain the separation between the provisions regarding RME and designated doctors.

Also added is a time-frame for the carrier to reinitiate benefits when the employee submits to the RME. Previously, there was some confusion regarding when the carrier has to reinitiate the benefits. Adopted §126.6 clarifies that reinitiation shall occur within seven days of the employee attending the examination or within seven days of the date the carrier finds out that the employee attended the examination whichever is later. The amended timeframe is based upon the carrier's knowledge of attendance because it was the employee's noncompliance that caused the benefits to be suspended and thus the carrier should not have to go to extra effort to restart them. The employee is the one who will want their benefits reinitiated and therefore the employee will have an incentive to call the carrier and tell the adjuster. Carriers would also learn the employee attended upon receipt of the RME doctor's report. The RME order specifies that TIBs can be suspended for failure to attend an RME and thus the employee should be aware of the consequences of their actions.

Adopted §126.6(j) adds language to clarify that the commission has the discretion to order a RME more than 75 miles from the employee's residence.

Adopted §126.7 -- Suspension of Temporary Income Benefits Based On the Opinion of a Carrier-Selected Required Medical Examination Doctor.

Adopted §126.7(b) adds language regarding applicability of the section based on the carrier's intent to suspend or reduce temporary income benefits (TIBs). The subsection further provides conditions under which a carrier may not suspend TIBs. The intent is to ensure that carriers do not have RME doctors evaluate employees for MMI and/or impairment prior to a designated doctor examination for the same purpose. Additionally, the carriers have an additional motivation to comply with adopted §126.5 relating to setting up the RME appointments. Under adopted §126.7(b)(1)(B), the phrase "permanent whole body impairment" was deleted and replaced with "determined that the injured employee was not at MMI" to clarify the conditions under which a carrier may intend to reduce or suspend TIBs. The other changes to this subsection are designed to prevent repeated disputes. When an employee returns to an RME doctor for an examination, the doctor may refuse to change his opinion from the prior examination, even if the designated doctor disagreed with the prior opinion and the designated doctor's opinion had resolved the dispute. In these cases, the employee must re-dispute an opinion that was already held to be invalid. Therefore, the adopted subsection contains language to state that the rule does not apply in this situation.

Adopted §126.7(c) is amended to change the process for filing the notice of intent to suspend benefits. Now that there is a designated doctor involved in the claim prior to the RME doctor, and because it will be the designated doctor's opinion that the RME doctor is disagreeing, the process has been modified to require that a copy of the notice of intent and the RME doctor's report be forwarded to the designated doctor to evaluate.

Adopted subsections (d), (g), (h), and (k) of this section modify the rule to bring the designated doctor into the process when the RME doctor has disagreed with the designated doctor. Under adopted §126.7(g)(1), the word "its" was deleted and replaced with "the carrier's" to ensure a clear understanding of the sentence's meaning. Adopted subsection (d) also includes language allowing the carrier to act based upon either the treating or designated doctor's agreement with the RME doctor's opinion.

Under adopted §126.7(j), the last sentence was modified to clarify that reimbursement from the subsequent injury fund includes benefits, which were not recoverable "from" or convertible to IIBs.

The following groups provided comments indicating general support for the amendments, and submitted recommendations or requested clarification on some issues: American Insurance Association and the Texas Mutual Insurance Company.

The following group provided comments indicating general opposition for the amendments, but submitted recommendations or requested clarification on some issues: Insurance Council of Texas.

The following groups did not indicate either support nor opposition for the amendments, but submitted recommendations or requested clarification on some issues: Argonaut Insurance Company; South West Medical Examiners; Service Lloyds Insurance; the State Office of Risk Management; and Flahive, Ogden & Latson.

The commission also received comments that indicated support for or opposition to the amendments from individuals who did not list the groups or associations with whom they were affiliated.

Summaries of the comments and commission responses are as follows:

Comments on §126.5

Comment: Commenter stated that the entire rule does not clearly address the carrier's right to address issues other than appropriateness of care issues with an IME physician. Accordingly, many physicians will not give MMI, will not give a return to work, or will not give enough detail on why an injured worker cannot work and why they are not at MMI. The commenter further stated that all control is now given to the treating physician with no true accountability and that something needs to be in place to help carriers in these situations. Commenter felt the IME process is being taken away.

Response: The commission disagrees. Amended Texas Labor Code §408.004(a) provided specific language regarding issues to be resolved through a carrier selected doctor and those issues to be resolved through a commission selected designated doctor. Proposed amendments to §126.5 merely elaborate on the legislative mandate by providing the process for requesting an examination through a carrier selected doctor. It is the carrier's responsibility to indicate the issue(s) to be resolved when making the request for an examination.

Comment: Several commenters suggested that there should be consistency within §126.5(a) and §126.6(a) regarding the injured employee or representative requesting a medical examination, and questioned the statutory requirement regarding the injured employee's request for an RME.

Response: The commission agrees that the intent of legislature was not for an injured employee to invoke amended §408.004 of the Texas Labor Code to request a RME, but to separate the issues to be addressed by the carrier selected doctor and the commission selected designated doctor. The injured employee's treating doctor can perform the examination or refer the injured employee to another doctor.

Comment: Commenter suggested changing the §126.5(a) "medical advisor, or a division of the commission" language to "or the commission." Commenter stated that TWCC does not have to regulate through a rule how it does business with itself and doing so limits TWCC's flexibility.

Response: The commission agrees. Under Texas Labor Code §408.004, the term used is "the commission." Further, except in very limited circumstances, the commission is attempting to conform its rules to refer to "the commission" rather than specific divisions.

Comment: Commenter suggested added language after the word "section" under §126.5(a) to include, "or that does not meet the reporting requirements of §130.1(d)" as part of the non-compliance effect.

Response: The commission disagrees. The intent of the last sentence under §126.5(a) is to clarify the carrier's entitlement and responsibilities when requesting RMEs by a doctor of their choice and not to enforce the requirements of §130.1(d).

Comment: Commenter disagreed with limiting the carrier's selected doctor to addressing appropriateness of care issues only (§126.5(b)(1)). Further, commenter stated that injured workers choose physicians/chiros that will keep them off work and the doctors do not respond to carrier requests to address MMI/IR. Accordingly, there will be an increase in TIBs paid due to this rule.

Response: The commission disagrees. The statutory language is very specific regarding the RME and designated doctor process. Nevertheless, a carrier can request an examination by a doctor of its choice for issues regarding maximum medical improvement and impairment ratings after a designated doctor has examined the injured employee and provided an opinion. Further, the injured employee has the right to receive treatment from a doctor chosen from the approved doctors list. It is important to note that TWCC has been given additional authority under Article 1 to regulate providers as it relates to quality of care issues.

Comment: Commenter suggested adding clarifying language in §126.5(b)(1) to specify when the 180-day time frame begins. Commenter suggested, "...Pursuant to Texas Labor Code 408.004, to resolve any questions about the appropriateness of the health care received by the injured employee (employee), and similar issues. The carrier's first RME may be requested at any time after the date of Injury. A subsequent examination may be requested once every 180 days after the first examination and must be performed by the same doctor unless otherwise approved by the commission."

Response: The commission agrees. Language has been added to §126.5(b)(1) to clarify the time-frames required for the first and subsequent RME examinations.

Comment: Commenter suggested a change from "180 days to 90 days" because the carrier should be entitled to an exam with a doctor of their choice every quarter regardless of the issues to be addressed. Further, it was suggested the term "same doctor unless approved by the commission" be deleted because the carrier should be able to change the RME doctor as they see fit. The commenter also requested deletion of "a request for a different doctor without sufficient grounds" from subsection (f)(2).

Response: The commission disagrees. There were no statutory changes to §408.004. The language under this section is specific regarding the 180-day requirement, using the same doctor for a subsequent examination, and regarding unreasonable requests.

Comment: Commenter suggested that the carrier's and employer's rights to a second opinion on return to work status, MMI and impairment prior to the two-year. anniversary are taken away. Commenter indicated there will be an increase of BRCs and CCHs, thus increasing costs.

Response: The commission disagrees. Nothing in the rules impedes carriers from requesting examinations to resolve issues. With the new legislation, the carrier may request an examination by a doctor of their choice for issues regarding appropriateness of care and similar issues, including return to work. The carrier may also request an examination by a doctor of its choice for issues regarding maximum medical improvement and or impairment rating, after a designated doctor has made an examination and provided an opinion.

Comment: Commenter suggested, under §126.5(c), selecting alphabetically from Level 2 or Level 3 list. Commenter was of the opinion that three RMEs is badgering and one is sufficient. Commenter asked the commission to be more specific about who has presumptive weight under §126.5 (b)(2) and to specify the reason the Commission would grant an exception to the approved doctor's list as provided in §126.5 (c). Commenter also suggested that, under subsection (d)(2), RME requests to employees be sent certified mail.

Response: The commission disagrees. An alphabetically selected doctor will deprive a carrier of their choice of doctor. However, the rule requires the doctor selected to be on the commission's approved doctors list and to have received the required training. In regard to RMEs, the statutory language that covers the 180-day requirement did not change. Texas Labor Code §408.0041(b) provides that the report of the designated doctor has presumptive weight unless the great weight of the evidence is to the contrary. The commission may grant exceptions to the requirement that a doctor be on the ADL on a case-by-case basis. For example, when an injured employee moves out of state and the doctor chosen is not on the approved doctor's list. The carrier can decide how to send the request as stated in §126.5(g).

Comment: Commenter indicated that although the rule specifies verifiable means and gives examples, the U.S. Post Office certificate of mailing is used and commenter questions whether this mode satisfies the requirement. The commenter also faxes the Form-69 to another doctor within the clinic in the same building and questioned if this action was necessary.

Response: If the certificate of mailing constitutes delivery confirmation, it is a verification that the information was delivered. It is the responsibility of the certifying doctor to submit the report by verifiable means. The type of verifiable means is the doctor's decision. In the scenario presented, the information could simply be delivered by hand and a confirmation of delivery obtained rather than an inter-office facsimile transmission.

Comment: Commenter suggested deleting "or similar issues" from §126.5(b) (1) and replacing it with "or questions regarding diagnosis." Commenter questioned the basis for the need to change employee's diagnosis and who will be contacted for that opinion, and for treatment extended to another body part or extent of injury (§126.5(b)(1)(B) and (C) respectively). Commenter also suggested changing the response period under §126.5(d)(2) from 10 to seven days.

Commenter stated that the 10 days period should run from the date that the employee receives the notice, because there may be an great period of time between the dates. Another commenter suggested the response should be within seven days of receipt.

Response: The commission disagrees. Section 408.004 of the Texas Labor Code specifically provides that the commission may require an employee to submit to medical examinations to resolve a question about the appropriateness of health care or "similar issues." The proposed rule however, provides some reasons for which a carrier may seek a medical opinion from a doctor of their choice, within the 180-day time frame. The rule specifically states that the carrier may request an examination by a doctor of their choice to resolve questions regarding the appropriateness of healthcare received by the employee and similar issues. The ten days for the employee to respond to the request includes mail time, and it gives the employee ample time to consider the request.

Comment: Commenter suggested deleting "to determine if the employee's medical condition is a direct result of the impairment resulting from a compensable injury" language from §126.5(b)(3). Commenter stated that the commission has mixed together the provisions of subsections (a) and (c) of Texas Labor Code §408.151 about what medical exams carriers and the commission may not require in a manner that is incorrect for both carriers and TWCC. Commenter stated that §408.151(a) only limits the carrier to any type of medical exam for SIBs to an annual exam and no more. Accordingly, §408.151(a) provides two conditions under which the limitation is applicable. Commenter stated that under §408.151(c), if the two conditions are met, TWCC may only require the injured employee to be examined to determine whether the employee's medical condition is a direct result of impairment from a compensable injury. However, if there is a SIBs dispute and these conditions exist, the carrier may not require the injured employee to be examined by a doctor of its choosing or a designated doctor.

Commenter further suggested there are a great number of SIBs disputes regarding the injured employees ability to return to work, and it is rare that there is a designated doctor appointed to resolve the dispute. Commenter stated that if there was a designated doctor appointed, it should end the dispute in most cases because of the presumptive weight given to the designated doctor.

Response: The commission disagrees. The language used in §126.5(b)(3) is consistent with Texas Labor Code §408.151 and should not be deleted. The proposed rule gives the specific examples provided in §408.151(a) and (c). Also, §408.151(b) is specific about directing an injured employee to be examined by a designated doctor chosen by the commission when there is a dispute about the employee's medical condition and the ability to return to work.

Comment: Commenter recommended that the language in §126.5 (d) be changed to refer the carrier to the appropriate subsection by adding "the commission shall not require an employee to submit to a medical examination at the carrier's request until the carrier has made an attempt to obtain agreement of the employee for the examination as required by §126.5(g)."

Response: The commission agrees. Suggested language referencing the appropriate subsection further clarifies the sentence. Section 126.5(d) has been changed accordingly.

Comment: Commenters requested clarification of 126.5(d)(2) regarding whether the commission agrees that §102.4 of this title (relating to General Rules for Non-Commission Communications) is not applicable and the carrier shall count 10 calendar days from the date the carrier sends the request to the employee seeking agreement for the examination. Commenter proposed to change the response period to five days because 10 days is long and will delay the provision of appropriate medical care. Since the rule does not address the method by which the commission is to be informed of an employee's response, commenters requested specific guidance regarding verbal responses to carrier attempts to obtain employee agreements to examinations. Commenter suggested that the 10 days should run from the date the employee receives the notice. Another commenter stated that providing the claimant five days to respond to the carrier's request is more than ample time for the claimant to respond.

Response: The commission disagrees that clarification is necessary. Section 102.4, of this title, applies except for the number of days given for the response. The ten days period includes mail time and it also allows the injured employee time to consider the request for the examination. Section 126.5(g) and (h) provide that the carrier shall send a copy of the request for a medical examination to the injured employee and shall maintain copies of the request for a medical examination order as well as verifiable proof of the successful transmission. Nothing in the rule prevents a carrier from making verbal contact with the claimant. However, the rule is specific as far as required documentation. When the carrier transmits its request to the commission, it will note the employee's response on the request.

Comment: Commenter suggested adding the qualifier "if any" at the end of the statement "the employee and employee's representative" in §126.5(g).

Response: The commission agrees. To ensure consistency, the qualifier has been added.

Comment: Commenter suggested removing the reference for "verifiable proof" under §126.5(h). Commenter was of the opinion that the means of delivery and level of expense necessary to verify receipt of documentation should remain an individual or business decision and should not be regulated unless regulation is in the best interest and common good of system participants. Additionally, commenter suggested that the requirement appears inconsistent with §102.4 and §102.5 of the commission rules.

Response: The commission disagrees. The goal of §126.5(g) and (h) is not to regulate how the carrier makes delivery of the request to the injured employee, but to ensure the carrier has verifiable proof that the request was delivered. The rule provides samples of "verifiable proof." The provision is not inconsistent with §102.4 and §102.5. Further, the rule provides that if the carrier violates the request and notification process, the carrier is not entitled to use the report by the RME doctor. The commenter's suggestion would eliminate the commission's ability to verify compliance with the rule, requiring proof that the request for RME is sent to the employee and the employee's representative eliminates disputes regarding whether notice was properly given.

Comment: Commenter wanted to know the penalty for an unreasonable request under §126.5(h).

Response: When the commission determines that a request is unreasonable, the request is denied.

Comments on §126.6

Comment: Commenter requested clarification regarding when an RME doctor can address return to work issues. Commenter cites part of Texas Labor Code §408.004 and the 180-day time period where the carrier can request an RME. Further the commenter asks that "similar issues" be defined and requests information/clarification about what would happen if an RME doctor decides to perform an impairment rating or return the examinee to work as a result of that exam.

Response: The commission disagrees that additional language is necessary. Amended §408.004 (a) of the Texas Labor Code provides specific language regarding issues to be resolved through a carrier selected doctor and those issues to be resolved through a commission selected designated doctor. Section 126.6(f) provides the requirements regarding return to work issues, while §126.5(a) provides the action to be taken when a RME doctor decides to perform an impairment rating, which was not authorized. Further, the legislation did not

provide a definition for "similar issues" under §408.004. It is the carrier's responsibility to indicate the issue(s) to be resolved when making the request for an examination. Return to work is a valid issue for the RME doctor to review and there are no limits other than those that limit the approval of an RME in general.

Comment: Several commenters suggested deleting "the injured employee, the employees representative" language from §126.6(a) because they do not need the entitlement to request an RME. The claimant and their attorney already get to pick and change treating doctors as many times as they want. Commenters felt there was no statutory basis for adding the language and the commission did not have the authority to extend an insurer's financial liability to a required medical examination not provided for by the Texas Labor Code. Commenters cite §408.004, which requires an employee submit to a medical examination at the request of the insurance carrier. There is no need since the claimant has the choice of selecting his or her own treating doctor. Commenters provided summaries of court decisions and added that allowing an injured employee or the injured employee's representative to request an RME would not keep with the spirit of HB-2600 to reduce costs associated with medical benefits.

Response: The commission agrees that the purpose of §408.004 was not to allow an injured employee to request a RME, but to separate the issues to be addressed by the carrier selected doctor and the commission selected designated doctor. The injured employee's treating doctor can perform the examination or refer the injured employee to another doctor.

Comment: Commenter suggested changing the §126.6(a) "or a division of the commission" language to "or the commission." Commenter stated that TWCC does not need to regulate through a rule how it does business with itself, and doing so limits the commission's flexibility.

Response: The commission agrees. This issue has been previously addressed.

Comment: Several commenters suggested adding language to clarify the scheduling of examinations. Commenters felt that the 30 days after receipt of order implies that the doctor must examine the claimant within 30 days, and that it is the appointment that should be made within the 30-day period. Another commenter suggested examinations to be scheduled within 30 days for an examination within 60 days after receipt of order with at least 10 days notice to the employee and employee's representative, if any. The commenter's reasoning was that doctors might not always be available to actually examine the claimant within this time period. Otherwise, this would result in an inappropriate and unauthorized limitation of an insurer's statutory right to obtain an RME order. Additionally, the order should explain to the injured worker that a claimant who fails to collect certified mail, may be deemed to have received the notice. Commenters also mentioned an inconsistency with subsection (h)(1)(ii) which provides for a rescheduled examination to occur no later than the latter of the seventh day after the originally scheduled date or the doctors first available date, with the provision that the field office must approve an extension beyond seven days in the event the appointment cannot be scheduled.

Commenters also suggested that the "first available appointment date" language should be contained in §126.6(b) because it is often impossible for a doctor (especially a traveling doctor), to see a claimant within seven days of the original appointment, thus creating unnecessary burden on field office personnel. Approval should only be required in the event that the appointment is later than the first available date.

A commenter further suggested that the rule should provide for verifiable means consistent with §126.5(h) and that telephonic notification is sufficient if documented as required by §102.4 of this title. Commenter added that notice to the claimant's representative should be deemed as notice to the claimant. Another commenter suggested 14 days rather than seven for a rescheduled exam to occur.

Response: The commission disagrees. This rule addresses the resolution of specific questions that can affect indemnity and medical benefits. Therefore, a timely resolution is necessary to ensure quality of care and cost containment. The examination should occur within 30 days. If the doctor is not available, the carrier should either pick a different doctor, or wait until the doctor chosen is available before making the request. The commission disagrees with the suggestion to consider a notice is deemed received when an injured worker fails to collect certified mail. There may be many circumstances surrounding the injured worker's failure to receive certified mail, and this situation should be treated on a case-by-case basis. Further, the rule does not require the use of certified mail. "Verifiable means" can be through the Postal Service's "Delivery Confirmation" method, which does not require signature of the recipient to document receipt. Therefore, the carrier must send a copy of the request to the employee and the employee's representative, if any. The carrier is also required to maintain copies of the request as well as verifiable proof. Pursuant to §126.5(d)(2), the carrier may call the employee to get the employee's agreement, however, the carrier must first send the request to the employee in writing.

Additionally, the commission disagrees that there is an inconsistency in §126.6(h)(1)(ii). This section applies to the carrier's presumption that the employee did not have good cause because he/she failed to contact the RME doctor's office to reschedule the examination, while §126.6(b) provides the specific time frame for the rescheduled examination.

The commission further disagrees that "first available appointment date" language is necessary since it is the carrier who requests and makes the appointment. Accordingly, the commission determines if the examination shall be ordered and shall issue the order within seven days. No burden to the field offices is expected.

Comment: Several commenters requested that the amended rules specify the criteria for allowing a commission extension beyond seven days and require the commission to send a letter informing all parties the specific reasons when an extension is granted. The reasoning is that allowing extensions may become prone to abuse, delaying necessary examinations for no purpose. Commenters suggested deleting the "unless an extension is granted by the commission's field office" language. Commenters added that this would result in no hardship since Texas Labor Code §408.004(e) allows the commission to determine if the claimant had "good cause" for failing to attend the examination. It was also suggested that the days allowed for notice to the employee be decreased from 10 to seven and the rescheduled examination date from seven to 14 days.

Response: The commission disagrees. The rule is specific in determining when to schedule the examination. Furthermore, the carrier should be able to find a doctor of their choice to conduct the examination within the required timeframe. Extensions for rescheduled examinations are necessary in

the event that there is a rescheduling conflict. Request for extensions will be reviewed on case-by-case basis to determine whether "good cause" exists to reschedule the examination. The commission disagrees with changing the time frame for notice and rescheduling examinations dates.

Comment: Commenter suggested deletion of subsection (c) because the treating doctor does not need to be present at the RME. Section (d) should be deleted or allow the carrier to have a representative at the designated doctor appointment (either a case manager or an RME doctor). It is also suggested deletion of "commission finds" language under subsection (h)(3) because the carrier can make this determination without assistance from the commission.

Response: The commission disagrees. The amended legislation did not change the statutory language addressing the issues presented. Section 408.004(d) allows the employee to have his/her treating doctor present at the examination. Also, new §408.0041 of the Texas Labor Code does not allow for a case manager or RME doctor to be present at a designated doctor's examination. Furthermore, §408.004(e) allows the commission to make a "good cause" determination for the failure to submit to the examination.

Comment: Commenter suggested changing the statement "The employee's treating doctor, chosen under Texas Workers' Compensation Act (the Act) Texas Labor Code 408.022, may be" to "The employee may have a doctor..."in §126.6(e). Commenter stated that the Act does not limit the employee to only the possibility of having the treating doctor present and cited §408.004(d), which indicates "a doctor of the employee's choice," which is not a term of art limiting it to the treating doctor.

Response: The commission disagrees. The language in §408.004(d) is referring to the employee's treating doctor since §408.023 allows the employee to choose the treating doctor.

Comment: Commenter suggested that regarding suspension of temporary income benefits, the word "including" should be changed to "or" under §126.6(h), or to eliminate this provision because it is already contained in §130.6(c) of this title, and the RME and designated doctors provisions are better separated. Commenter further suggested that the provision contained in §408.004(e) regarding suspension of temporary income benefits (TIBs) is supplemented by §408.0041(h), which provides that a claimant is not entitled to "compensation" if the claimant fails to attend an appointment required by this "chapter" (i.e., 408). Therefore, the carrier is clearly allowed to suspend TIBs, and the section provides that the claimant is not entitled to any compensation (SIBs, IIBs, or is only receiving medical benefits) during the period that he or she has failed to attend an RME or designated doctor appointment. Commenter added that the reference to section §134.6 under §126.6(j) is confusing. Subsections 134.6(a) and (b)(1) clearly have no applicability to RME appointments and the reference should be to §134.6 (b)(2) and (3), and (c) (d) and (e).

Response: The commission agrees that to ensure consistency, RME and designated doctor provisions should be kept separated, therefore the designated doctor reference under §126.6(h) has been deleted. The commission also agrees that Texas Labor Code 408.004(e) and (h) indicate the employee is not entitled to TIBs during and for a period in which the employee fails to submit to an examination. It further states that a carrier may suspend TIBs, unless the commission determines that the employee had good cause to miss the examination. However, given that the statute only provides for the suspension of TIBs under this subsection, and not the suspension of other benefits, the difference in language between §408.004(e) and (h) is not designed to prevent the employee from receiving any benefits. In addition, the reference to §134.6 of the commission rules is adequate since it relates to travel expenses that may be incurred by an injured worker because of the carrier's request for an examination.

Comment: Commenter suggested changing §126.6(h)(3) to "An employee is not entitled to TIBs under this section during and for a period in which the employee fails to submit to an examination unless the commission determines that the employee had good cause for the failure to submit to the examination." Commenter cited Texas Labor Code 408.004(e) and stated that under the Act, an injured worker is not entitled to TIBs if the injured worker does not attend the exam without good cause and TIBs suspension by the carrier is not a requirement. Commenter stated that TWCC cannot and should not add an additional requirement that the carrier must suspend TIBs payments before the injured workers lose their entitlement for the periods they failed to attend an exam without good cause. Commenter further stated that there needs to be a provision that when an injured worker who has missed a scheduled appointment, whether for good cause or not, a new appointment must be promptly set. Further, it would seem that it should at least be set with the same degree of promptness as the scheduling of the appointment at the carrier request, 30 days per subsection (b).

Response: The commission disagrees. The commission is not mandating the suspension of TIBs. The language used under §126.6(h)(3) is basically the same language in §408.004 (e) of the Texas Labor Code, but it provides a procedure a claimant may pursue to obtain those TIBs a carrier elected to suspend pursuant to §126.6(h). Additionally, §126.6(h) provides provisions for rescheduling of examinations.

Comment: Commenter suggested adding the qualifier "if any" in §126.6(d) at the end of the statement ending with "the employee and employee's representative."

Response: The commission agrees. To ensure consistency, the qualifier has been added.

Comment: Commenter suggested that because some doctors are not capable of receiving reports by facsimile or electronic transmission under §126.6 (f), language such as "if the treating doctor has a facsimile number or email address, otherwise,..." should be added

Response: The commission disagrees. The section provides that the RME doctor can send the Work Status Report by other verifiable means. Further, Commission rule 102.4(d) of this title requires providers to have facsimile lines.

Comment: Several commenters suggested that travel should be changed to allow up to 100 miles instead of 75. Another commenter suggested travel should be changed to 20 or 25 miles due to hardship.

Response: The commission disagrees. The rule allows for travel over 75 miles, if good cause exists.

Comments on §126.7

Comment: Commenter stated that the carrier selected doctor (under §126.7 (3)(c)(2)) can be carrier friendly, and suggested that RME doctors must be given all medical documentation prior to the examination. Commenter also asked for clarification of "great weight of the evidence."

Response: The commission disagrees. Amended Texas Labor Code §408.004(a) provides specific language regarding issues to be resolved through a carrier selected doctor. The carrier is required to provide medical information to the examining doctor. Additionally, commission rule 133.2 covers the sharing of medical reports. Section 408.0041(b) provides that the report of the designated doctor has presumptive weight unless the great weight of the evidence is to the contrary. The section does not define "great weight of the evidence" and this is an issue which is decided at a hearing level on a case-by-case basis.

Comment: Commenter suggested deleting "the opinion upholds or otherwise matches a prior opinion by the RME doctor which was previously considered under this section" language under §126.7(b)(2)(C). Commenter contends the commission has no right to tell the RME doctor this and that the doctor's medical opinion is as good as any other the claimant might hunt down for their benefits.

Response: The commission disagrees. The intent is that a carrier may not suspend or reduce TIBs when the RME doctor's opinion is the same as a previously obtained opinion, which was addressed by a designated doctor to resolve the dispute.

Comment: Commenter suggested adding language to indicate that any MMI/IR should be final within 90 days regardless if it is the first or the tenth and regardless of the doctor assigning the MMI/IR.

Response. The commission disagrees. The amended rules require that only an authorized doctor may certify maximum medical improvement and assign an impairment rating.

Comment: Commenter suggested deletion of the language giving the designated doctor's opinion presumptive weight unless the great weight of the evidence is to the contrary (c)(2). Commenter also suggested that the carrier should have the right to address the type of doctor who is a designated doctor.

Response: The commission disagrees. The presumptive weight issue is a statutory requirement under §408.0041(e). Additionally, the statute is clear regarding the selection of a designated doctor and it does not provide for input by the parties.

Comment: Commenter suggested that the rule should provide that if a benefit review conference (BRC) is held under this section and neither the claimant nor treating doctor have expressed disagreement with the report of the RME prior to or at the conference, that an interlocutory order not be issued, and a designated doctor will not be automatically appointed. According to the commenter, at some BRCs the treating doctor failed to state any type of disagreement with the report of the RME doctor, and the claimant has failed to attend the hearing. Nevertheless, the carrier is ordered to continue benefits and a designated doctor appointed. The commenter contends that in the absence of a dispute, a designated doctor should not be selected. To automatically send the claimant to a designated doctor, with the attendant costs, unnecessarily adds cost to the system.

Another commenter suggested that although §126.7(h) provides for the issuance of an interlocutory order in the event that a BRC is not held within 14 days, neither the subsection nor the rule as proposed provides for the scheduling of a BRC as mandated by §408.004(f). The provision, however, states that the interlocutory order is effective "until a benefit review conference is held." According to the commenter, this indicates the duty of the commission to schedule a conference regardless of whether an interlocutory order is automatically issued. It is the commenter's opinion that the provision does not require the appointment of a designated doctor under these circumstances, and it is unnecessary to do so if there is no express disagreement by the treating doctor or claimant.

Response: The commission disagrees. The expedited benefit review language is a statutory requirement under §408.0041(j). The issuance of an interlocutory order is to be considered on a case-by-case basis.

Comment: Commenter suggested that §126.7(b) is wordy as proposed and should be changed to "This subsection applies as follows:" Commenter further suggested that the phrase "and permanent body impairment" under §126.7(b)(1)(B), be changed to "and determined that the claimant was not at MMI." The reasoning is that if the designated doctor had previously determined the claimant at MMI and assigned an impairment rating, the carrier is already paying IIBs, and there are no TIBs to suspend. It was further suggested that the term "the carrier's" be used instead of the possessive pronoun "its," under subsection 126.7(g)(1) because it is unclear to what noun the pronoun is referring. Commenter recommended changing the last sentence under §126.7(j) to "and which were not recoverable from or convertible to IIBs".

Response: The commission disagrees that the introduction used is wordy. The commission agrees with the language change to "and determined that the injured worker was not at MMI." The commenter is correct in that the carrier would be paying IIBS if the designated doctor assigned an impairment rating. In §126.7(g)(1), the "its" refers to the carrier and not the notice. However, the language was changed to ensure clear understanding. The commission agrees to the suggested language relating to "recoverable from or convertible to IIBs" and has revised subsection (j).

Comment: Commenter suggested amending the language of subsection (j) because it does not track with the intent of the Texas Legislature as expressed under §410.209 of the Labor Code where the word "shall" makes reimbursement mandatory and the word "may" in subsection (j) gives the appearance that it is the policy of the commission that the reimbursement of an insurance carrier is permissible but not mandatory. Commenter suggested deleting "may be eligible for reimbursement" and substituting the words "shall be reimbursed."

Response: The commission disagrees. The language under §410.209 requires the Subsequent Injury Fund to reimburse an insurance carrier where a commission order or decision is reversed or modified. Often, however, requests for reimbursement are based on something other than a reversed or modified order or decision, or the request includes amounts paid which are ineligible for reimbursement. Therefore, the use of the "may" language allows the commission to ensure that the request and amount of reimbursement comply with the statute.

Comment: Commenter suggested removal of the requirement for attaching copies of previously provided RME reports to carrier notices to suspend or reduce TIBs pursuant to proposed §126.7(c). According to commenter, the reports are duplicative in that they are already required per proposed §126.6(e) and (f).

Response: The commission disagrees. The specific requirement of §126.7(c) is to ensure the injured employee and/or the employee's representative receive a copy of the report when the carrier intends to suspend or reduce TIBs based on the RME doctor's opinion. The requirement under §126.6(e) refers to an RME report subsequent to a designated doctor's examination. Additionally, §126.6(f) references the filing of the Work Status

Report when a RME doctor determines that the injured employee can return to work with or without restrictions.

Comment: Commenter suggested adding the word "to" in the phrase "return to work" in subsection (b)(3).

Response. The commission agrees. The word has been added.

The amendments are adopted pursuant to the Texas Labor Code §402.061 which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act; the Texas Labor Code, §401.011 which contains definitions used in the Texas Workers' Compensation Act; the Texas Labor Code, §401.024, which provides the commission the authority to require use of facsimile or other electronic means to transmit information in the system; the Texas Labor Code, §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form and manner and procedure for transmission of information to the commission; the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §406.010, that authorizes the commission to adopt rules regarding claims service; the Texas Labor Code, §408.004 as amended by the 77th Texas Legislature, which provides for Required Medical Examinations; Texas Labor Code §408.0041 as adopted by the 77th Texas Legislature, which provides for the commission assignment of a designated doctor; the Texas Labor Code §408.023, as amended by the 77th Texas Legislature, which requires the commission to develop a list of approved doctors and lay out the requirements for being on the list; the Texas Labor Code §408.0231, which provides the commission with the responsibility for maintenance of the list; the Texas Labor Code, §408.025, which requires the commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code §408.102, which provides that temporary income benefits continue until the injured employee reaches maximum medical improvement; the Texas Labor Code §408.122, as amended by the 77th Texas Legislature, which requires that designated doctors meet specific qualifications; the Texas Labor Code §408.123, which requires a doctor certifying maximum medical improvement to file a report and which requires a certification of MMI and assignment of an impairment rating by a doctor other than the treating doctor be sent to the treating doctor who must indicate either agreement or disagreement with the certification of the evaluation; the Texas Labor Code §408.124, which provides the commission the authority to by rule adopt the fourth edition of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association to determine the existence and degree of an injured employee's impairment; the Texas Labor Code §408.125, as amended by the 77th Texas Legislature, which provides the process for disputing impairment ratings; the Texas Labor Code §408.151, which provides for required medical examinations for supplemental income benefits; and the Texas Labor Code §415.0035, as passed by the 77th Texas Legislature, that establishes administrative violations for repeated administrative violations or for a provider failing to submit required medical reports.

The amendments are adopted pursuant to the Texas Labor Code §§402.061, 401.011, 401.024, 402.042, 402.061, 406.010, 408.004, 408.0041, 408.023, 408.0231, 408.025, 408.102, 408.122, 408.123, 408.124, 408.125, 408.151, and 415.0035.

§126.5. Entitlement and Procedure for Requesting Required Medical Examinations.

(a) The commission may authorize a required medical examination (RME) for any reason set forth in the Texas Workers'Compensation Act (the Act), Texas Labor Code, §408.004, §408.0041, or §408.151 at the request of the insurance carrier (carrier),or the commission. The request shall be made in the form and manner prescribed by the commission. A carrier is not entitled to take action with respect to benefits based on, and the commission shall not consider, a report of an RME doctor that was not approved or obtained in accordance with this section.

(b) carriers are entitled to RMEs by a doctor of their choice in accordance with this subsection as follows:

(1) Pursuant to Texas Labor Code §408.004, once every 180 days, to resolve any questions about the appropriateness of the health care received by the injured employee (employee), or similar issues. The carrier's first RME may be requested at any time after the date of injury. A subsequent examination may be requested once every 180 days after the first examination and must be performed by the same doctor unless otherwise approved by the commission. For dates of injury on or after September 1, 1997, the commission may approve no more than three RMEs at the carrier's request before the expiration of 180 days in the event that a medical opinion is needed to determine if:

(A) there has been a change in the employee's condition;

(B) there is a need to change the employee's diagnosis;

(C) the treatment should be extended to another body part or system, or if the extent of injury has changed;

(D) the compensable injury is a producing cause of additional problems or conditions;

(E) disability exists, because of newly discovered information; or

(F) a proposed surgery is necessary to treat the compensable injury.

(2) Pursuant to Texas Labor Code §408.0041, for the purpose of evaluating a designated doctor's determination on maximum medical improvement (MMI) and/or permanent whole body impairment rating. A carrier is entitled to an examination under this subsection only upon receipt of a Report of Medical Evaluation from a Designated Doctor under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Rating).

(3) Pursuant to Texas Labor Code §408.151, to determine if the employee's medical condition is a direct result of the impairment resulting from a compensable injury. For the purposes of this subsection, the carrier may not require an employee to submit to an RME more than once per year if:

(A) an employee is receiving supplemental income benefits on or after the second anniversary of the date of the employee's initial entitlement to supplemental income benefits, and

(B) in the preceding year, the employee's medical condition resulting from the compensable injury had not improved sufficiently to allow the employee to return to work during that year.

(c) On or after September 1, 2003, the doctor selected to perform an RME must be on the commission's approved doctors list and, if the purpose of the examination is to evaluate MMI and/or permanent impairment, be authorized to assign impairment ratings under §130.1(a) of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(d) Except for an examination under subsection (b)(2) of this section, the commission shall not require an employee to submit to a medical examination at the carrier's request until the carrier has made an attempt to obtain the agreement of the employee for the examination as required by subsection (g). The carrier shall notify the commission in the form and manner prescribed by the commission of any agreement or non-agreement by the employee regarding the requested examination. An examination of an employee by a doctor selected by the carrier shall be requested as follows:

(1) Prior to requesting an RME from the commission, the carrier shall send a copy of the request to the employee and the employee's representative (if any) in the manner prescribed by subsection (g) of this section in an attempt to obtain the employee's agreement to the examination.

(2) The carrier shall give the employee ten days to agree to the examination. The ten-day period begins from the date the carrier sends the request to the employee and the employee's representative (if any). Though the employee has ten days to respond to the request, the carrier is not prohibited from contacting the employee by telephone to discuss the request with the employee and obtain the employee's response.

(3) The carrier shall send the request to the commission after either obtaining the employee's answer to the request or when the employee fails to respond after the ten-day period.

(e) The commission shall monitor all carrier requests for medical examinations that are requested before the expiration of the 180-day period subsection (b)(1) of this section through statistical analysis, audits, or other appropriate means.

(f) An unreasonable request for an additional medical examination under subsection (b) of this section includes:

(1) a request for an additional examination for a reason which does not comply with this section

(2) a request for a different doctor without sufficient grounds

(3) a request which would result in a violation of subsection (b) of this section; and

(4) a request which provides false, incomplete, or misleading information.

(g) The carrier shall send a copy of the request for a medical examination order required by subsection (d) of this section to the employee and the employee's representative (if any) by facsimile or electronic transmission if carrier has been provided with a facsimile number or email address for the recipient, otherwise, the carrier shall send the request by other verifiable means.

(h) The carrier shall maintain copies of the request for a medical examination order and shall also maintain verifiable proof of successful transmission of the information. For these purposes, verifiable proof includes, but is not limited to, a facsimile confirmation sheet, certified mail return receipt, delivery confirmation from the postal or delivery service, or a copy of the electronic transmission.

§126.6. Order for Required Medical Examination.

(a) When a request is made by the insurance carrier (carrier), or the commission, for a medical examination, the commission shall determine if an examination should be ordered. The commission shall issue an order granting or denying the request within seven days of the date the request is received by the commission. A copy of the order shall be sent to the employee, the employee's representative (if any), and the carrier. The order shall explain the potential loss of benefits and penalty exposure for failing to attend the examination as well as the need to reschedule a missed examination. An agreement between the parties for an examination under §126.5 of this title (relating to Entitlement and Procedure for Requesting Required Medical Examinations) that the carrier has a right to, has the same effect as the commission's formal order.

(b) All examinations ordered must be scheduled to occur within 30 days after receipt of order, with at least 10 days notice to the employee and the employee's representative (if any). If a scheduling conflict exists, the employee and the doctor shall contact each other. The doctor or the employee who has the scheduling conflict must make contact at least 24 hours prior to the appointment. The 24 hours requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency. The rescheduled examination shall be set for a date within seven days of the originally scheduled examination, unless an extension is granted by the commission's field office. In this event, the examining doctor shall notify the carrier and the 10 days notice requirement does not apply to a rescheduled examination.

(c) The employee's treating doctor, chosen under the Texas Workers' Compensation Act (the Act), Texas Labor Code, §408.022, may be present at an examination scheduled with a doctor selected by the carrier. The employee's treating doctor may observe the conduct of the examination, and may consult with the examining doctor about the course of the employee's treatment. The employee's treating doctor shall not otherwise participate in, impede, or advise the employee not to cooperate with the examination. In initially scheduling the examination, a reasonable attempt shall be made to accommodate the schedule of the treating doctor if the employee wants the treating doctor to attend the examination and the treating doctor is willing to do so. However, once an examination is scheduled based on the treating doctor's availability, the examination shall not be delayed, canceled, or rescheduled due to the treating doctor's scheduling conflicts unless:

(1) the required medical examination (RME) doctor agrees to the rescheduling; or

(2) the examination was canceled by the RME doctor.

(d) If the RME doctor, selected by a carrier, refuses to allow the treating doctor to attend the examination, the carrier shall cancel the appointment and request that another doctor be approved for the RME. If reasonable notice is not provided to the employee and the employee's representative (if any), the carrier shall be liable for any reasonable travel expenses incurred by the employee and for the payment for the treating doctor's attendance at a refused appointment. This subsection shall not apply to situations where the treating doctor is not able to attend the examination due to any form of scheduling conflict.

(e) An RME doctor who, subsequent to a designated doctor's examination, determines the employee has reached maximum medical improvement or who assigns an impairment rating, shall complete and file the report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by Doctor Other than A Treating Doctor). Otherwise, the RME doctor shall not certify MMI or assign an impairment rating. If the RME doctor disagrees with the designated doctor's opinion regarding MMI, the RME doctor's report shall explain why the RME doctor believes the designated doctor was mistaken or why the designated doctor's opinion is no longer valid. Other reports shall be completed according to applicable rules for consultant medical reports as described in §133.104 of this title (relating to Consultant Medical Reports) and shall be sent to the carrier, employee,

the treating doctor, and commission no later than 10 days after the examination.

(f) An RME doctor who determines that the employee can return to work immediately with or without restrictions is required to file a Work Status Report, as described in §129.5 of this title (relating to Work Status Report) within seven days of the date of the examination of the employee. This report shall be filed with the treating doctor and the carrier by facsimile or electronic transmission. In addition, the RME doctor shall file the report with the employee and the employee's representative (if any) by facsimile or by electronic transmission if the RME doctor has been provided with a facsimile number or email address for the recipient, otherwise, the RME doctor shall send the report by other verifiable means.

(g) A doctor who conducts an examination solely under the authority of an order issued according to this rule shall not be considered a designated doctor under the Texas Labor Code, §408.0041, §408.122 or §408.125. Examinations with a designate doctor are not subject to any limitations under the provisions for RMEs.

(h) A carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend an RME.

(1) In the absence of a finding by the commission to the contrary, a carrier may presume that the employee did not have good cause to fail to attend the examination if:

(A) by the day the examination was originally scheduled to occur the employee has both:

(i) failed to submit to the examination; and

(ii) failed to contact the RME doctor's office to reschedule the examination to occur no later than the later of the seventh day after the originally scheduled examination date or the doctor's first available appointment date; or

(B) after rescheduling the examination as provided in subsection (h)(1)(A)(ii) of this section, the employee failed to submit to the rescheduled examination.

(2) If, after the carrier suspends TIBs pursuant to this section, the employee submits to the required medical examination, the carrier shall reinitiate temporary income benefits as of the date the employee submitted to the examination. The re-initiation shall occur no later than the seventh day following the latter of:

(A) the date the carrier was notified that the employee had attended the examination; or

(B) the date that the carrier was notified that the commission found that the employee had good cause for not attending the examination.

(3) An employee is not entitled to TIBs for a period during which the carrier suspended benefits pursuant to this section unless the employee later submits to the examination and the commission finds or the carrier determines that the employee had good cause to fail to attend the appointment.

(i) An employee who, without good cause, fails or refuses to appear at the time scheduled for an examination authorized by this section may be assessed a Class D administrative penalty under the Act, §408.004(f). An employee who fails to submit to an examination at the carrier's request when the carrier selected doctor refuses to allow the treating doctor to attend the examination or when the RME doctor cancels the examination does not commit an administrative violation and shall not have benefits suspended for failing to attend that particular appointment.

(j) The commission shall order examinations requiring travel of up to 75 miles from the employee's residence, unless the treating doctor certifies that such travel may be harmful to the employee's recovery. Travel over 75 miles may be authorized if good cause exists to support such travel. The carrier shall pay reasonable travel expenses incurred by the employee in submitting to any required medical examination, as specified by §134.6 of this title (relating to Travel Expenses).

§126.7. Suspension of Temporary Income Benefits Based On the Opinion of a Carrier-Selected Required Medical Examination Doctor.

(a) As used in this section, "required medical examination doctor" refers to an insurance carrier-selected (carrier) required medical examination (RME) doctor and "notice of intent" refers to the notice of suspension described in Texas Labor Code, §408.004(f).

(b) This subsection provides for the applicability of this section.

(1) This section only applies to a carrier's intent to suspend or reduce temporary income benefits (TIBs) solely because:

(A) the RME doctor finds that the injured employee (employee) can return to work without restrictions and/or

(B) the RME doctor has certified maximum medical improvement (MMI) and assigned an impairment rating after a designated doctor previously evaluated the employee for MMI and determined that the injured employee was not at MMI.

(2) A carrier may not suspend or reduce TIBs or otherwise apply the process described in this section based solely on a RME doctor's opinion if:

(A) the RME doctor certified MMI and/or assigned an impairment if the carrier was not entitled to the examination under the Texas Labor Code §408.0041 and §126.5 of this title (relating to Entitlement to and Procedure for Requesting Required Medical Examinations);

(B) the RME doctor's opinion was otherwise obtained in violation of §126.5 of this title; or

(C) the opinion upholds or otherwise matches a prior opinion by the RME doctor which was previously considered under this section.

(3) The effect of an RME doctor's opinion that the employee can return to work with restrictions is governed by §129.6 of this title (relating to Bona Fide Offers of Employment).

(c) If a carrier intends to suspend or reduce TIBs based on the opinion of an RME doctor, the carrier shall send the notice of intent and a copy of the RME doctor's report by facsimile or electronic transmission as provided by this subsection. If the carrier has not been provided with a facsimile number or email address for the employee or the employee's representative (if any), the report and notice shall be sent by other verifiable means. The notice of intent will contain language prescribed by the commission. The notice of intent shall not be sent to the commission except as permitted by subsection (e) of this section.

(1) If the RME doctor found that the employee is able to return to work without restriction immediately, the notice and report shall be sent to the treating doctor, the employee and the employee's representative (if any).

(2) If the RME doctor found that the employee has reached MMI, the notice and report shall be sent to the treating doctor, the designated doctor, the employee and the employee's representative (if any). For the purposes of this section, the designated doctor's response shall have presumptive weight unless the great weight of other medical evidence is to the contrary.

(d) The carrier is permitted to suspend or reduce TIBs under this subsection if:

(1) the treating doctor indicates with the RME doctor's release to return to work without restrictions (in which case the carrier shall maintain documentation of the treating doctor's agreement and shall pay income benefits in accordance with this title and the rest of this section does not apply); or

(2) either the treating doctor or the designated doctor indicates agreement with the RME doctor's certification of MMI (in which case the carrier shall maintain documentation of the agreement and shall pay income benefits in accordance with this title and the rest of this section does not apply).

(e) If subsection (d) of this section does not apply, the carrier may file the notice of intent with the commission on the eighth day after transmitting the RME doctor's report and notice of intent as required by subsection (c).

(f) The carrier may suspend or reduce TIBs in accordance with the RME doctor's opinion on the 14th day after the date the carrier filed the notice of intent with the commission as permitted by subsection (e) of this section, unless an interlocutory order is entered in accordance with Chapter 140 of this title (relating to Dispute Resolution) or is automatically entered pursuant to subsection (h) of this section. For the purpose of this subsection, filed means received.

(g) Upon receipt of a notice of intent filed as permitted by subsection (e) of this section, the commission shall:

(1) review the notice and the carrier's potential for an unrecoupable overpayment;

(2) attempt to obtain the treating doctor's and the designated doctor's opinion (if the RME doctor certified MMI) regarding the RME doctor's opinion; and

(3) schedule the issue for a benefit review conference (BRC) as needed to determine whether an interlocutory order should be issued to require the carrier to continue to pay TIBs. A BRC under this subsection is not subject to the notification requirements provided in Chapter 141 of this title (relating to Benefit Review Conference

(h) If a carrier files with the commission a notice of intent as permitted by subsection (e) of this section and a BRC is not held within 14 days of the commission receiving the carrier's notice, an interlocutory order will be automatically entered which requires the carrier to continue to pay TIBs in accordance with Chapter 129 of this title (relating to Temporary Income Benefits) and which expires upon the earlier of:

(1) the date the commission holds a BRC;

(2) the date the carrier receives the designated doctor's response to the RME doctor's report if one was not previously received;

(3) the date otherwise indicated on the order;

(4) the date the carrier is permitted to suspend payment of TIBs based on the employee's failure to attend a subsequent RME as outlined in §126.6(h) of this title (relating to Order for Required Medical Examinations), if a subsequent examination is ordered; or

(5) the date the employee reaches MMI based on 104 weeks elapsing from the date that income benefits accrued or the employee reaches MMI as extended by the commission due to spinal surgery considerations as provided by Texas Labor Code §408.104.

(i) A carrier that suspends TIBs pursuant to this section based on the RME doctor's certification of MMI, shall initiate impairment income benefits (IIBs) in accordance with the Act and this title.

(j) A carrier that makes an unrecoupable overpayment pursuant to an interlocutory order may be eligible for reimbursement from the subsequent injury fund. An unrecoupable overpayment for the purpose of reimbursement from the subsequent injury fund includes only those benefits that were overpaid by the carrier pursuant to an interlocutory order which were not owed to the employee and which were not recoverable from or convertible to IIBs.

(k) The carrier shall maintain copies of the notice of intent and report sent to the treating doctor, designated doctor, employee, employee's representative (if any), and commission and shall also maintain verifiable proof of successful transmission of the information. For these purposes, verifiable proof includes, but is not limited to, a facsimile confirmation sheet, certified mail return receipt, or a copy of the electronic transmission.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

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CHAPTER 130. IMPAIRMENT AND SUPPLEMENTAL INCOME BENEFITS

The Texas Workers' Compensation Commission (the commission) adopts amendments to §§130.1-130.4, new §130.5, amendments to §130.6 and §130.110, and the repeal of current §130.5, with changes to the proposed text published in the August 31, 2001 issue of the *Texas Register* (26 TexReg 6560).

The amendments, new rule, and repeal are adopted in response to HB-2600, which amended §408.004(a) and (c), of the Texas Labor Code. Furthermore, the bill amended Chapter 408, Subchapter A by adding §408.0041, Designated Doctor Examination, and making amendments to other sections of this chapter relating to the use of designated doctors. In essence, the bill limits the use of an insurance carrier (carrier) selected doctor for a Required Medical Examination (RME) to only the resolution of issues regarding the appropriateness of the health care received by an injured employee (employee), and similar issues. Carriers, however, are permitted to have an RME doctor evaluate Maximum Medical Improvement (MMI) and permanent whole body impairment only after a designated doctor examination for those issues has taken place.

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

Changes made to the proposed amendments are in response to public comment received in writing and at a public hearing held on October 2, 2001, and are described in the summary of comments and responses section of this preamble. Other changes were made for consistency or to correct typographical or grammatical errors, and to address issues identified by the Commission during its reexamination of the proposed amendments while considering the comments provided by the public.

Adopted §130.1 - Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment

Adopted amendment to subsection (a) adds the concept of "authorized doctor" to the existing concept of "certifying doctor." As noted, the changes in HB-2600 grant the commission additional authority to regulate doctors in the system including mandating training for the various roles that doctors can play in the system. Proposed rules in Chapter 180 require doctors to have training on MMI/impairment or to obtain specific, one-time authorization by exception to certify MMI or assign an impairment rating. The language in this section is reflective of these requirements. Additionally, on or after September 1, 2003, authorizations will be broken into two categories. One category will cover doctors who have been through the commission training on impairment rating, and are thus fully certified/authorized, or who have been granted authorization by exception to assign an impairment rating. These doctors will be able to certify MMI and assign impairment ratings in any case where the doctor is serving in the appropriate role. The other category will cover doctors who are only authorized to determine whether an employee has permanent whole body impairment and is intended to cover only treating doctors. These doctors will be authorized to certify MMI only if they find that the employee does not have permanent impairment. If the doctor finds that the employee does have permanent impairment the doctor will have to either get permission from the commission by exception or will have to refer the employee to a fully authorized doctor who shall evaluate the employee for MMI and assign an impairment rating.

Another change proposed in chapter 180 and reflected in adopted subsection (a) of §130.1, is that only treating doctors, designated doctors, or RME doctors (after a designated doctor examination) are permitted to be certifying doctors on a claim. The only exception to this occurs when the treating doctor chooses or is required to have another doctor perform an evaluation to certify MMI and assign an impairment rating in the treating doctor's stead.

There are several reasons for the proposal to limit the number of doctors performing MMI/impairment evaluations on a claim. The first relates to cost. MMI/impairment evaluations cost hundreds of dollars and the value of multiple evaluations is questionable, especially when considering that a designated doctor's opinion carries presumptive weight. Second, multiple examinations are burdensome on employees who must arrange and attend the examinations, and on employers who must cover the employee's lost time during the evaluations (assuming the employee had returned to work). Furthermore, multiple examinations can delay the resolution of disputes.

The treating doctor's examination is clearly necessary. A designated doctor's evaluation is necessary when there is a question or dispute, and a carrier is entitled to an RME examination after the designated doctor's evaluation. These three doctors' opinions are generally all that are needed for the determination of MMI/impairment. Adopted §130.1(a) also prohibits non-authorized doctors from certifying MMI and/or assigning impairment ratings, provides that their opinions are invalid, and provides that an unauthorized doctor should not be paid for their evaluations or reports.

The language under adopted subsection (c)(4) of new §131.1 of this title was modified to specify that if the certifying doctor chooses to use another health care provider to perform the testing required by the AMA Guides for an impairment rating, on or after September 1, 2003, the other health care provider is required to have the training required by §180.23 of this title (relating to Performance Review Of Insurance Carriers.) Testing performed by an untrained health care provider is not reimbursable.

Because the rule requires that all certifying doctors be trained, it is only logical to extend the training requirements to those who conduct the testing upon which the ratings will be based. This concept currently applies to designated doctor examinations. The adopted rule extends the requirement to all evaluations of impairment.

The language under adopted §130.1 (c)(2)(C) was modified to ensure that ratings assigned using the incorrect edition of the AMA guide shall not be considered valid.

Adopted amendment to §130.1(d) was modified to ensure that after September 1, 2003, a doctor who receives an exception from the commission must include a copy of the authorization with the narrative report.

Adopted §130.2 - Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by the Treating Doctor

Adopted amendment to subsection (a) of §130.2 clarifies a treating doctor's responsibilities regarding certification of MMI and assignment of impairment rating. As discussed previously, if the treating doctor is not authorized to certify MMI or assign impairment ratings, the doctor shall make a referral to a doctor who is authorized. A treating doctor is also permitted to make such a referral even if the treating doctor is authorized to do MMI and impairment evaluations. However, if the treating doctor does so, then the referral doctor's evaluation becomes the treating doctor's evaluation. Another amendment to this subsection relates to certifying MMI and assigning impairment ratings in claims where the injury was extremely minor. In the past, the rules required a treating doctor to certify MMI and evaluate the employee for permanent whole body impairment - even if the employee's injury was so minor as to require no treatment. These minor injuries are commonly referred to as: "treat and release" cases by the medical community.

Given the cost of an MMI/Impairment examination and the lack of value to the system that it provides in such minor injury cases, it is an appropriate cost saving to the system to eliminate the necessity of MMI/Impairment examinations in these cases. Further, there is little reason to require an employee who has already returned to work in this type of situation to attend an additional appointment with the doctor. However, an employee who wishes to have an examination should not be denied one.

Adopted amendment to §130.2(b) is merely a clean up and requires that certification of MMI and assignment of impairment rating be conducted in accordance with the requirements of §130.1. Adopted §130.1 is the main rule for certifications and other rules such as §130.2, add requirements applicable to specific circumstances.

Adopted amendment to §130.2(c) update the citation to the Workers' Compensation Act.

Adopted amendment to §130.2(d) adds language regarding the treating doctor's responsibility to conduct an examination upon receipt of the commission's notice from §130.2(c). This was implied by the prior rule, but the additional language was added for clarification.

Adopted amendment to §130.2 (e) provides that a carrier may suspend TIBs if a report of medical evaluation has not been received by the date of statutory MMI. It also allows for a carrier to make a reasonable assessment, and if so, to initiate impairment income benefits (IIBs) within five days of making the assessment. The carrier shall continue to pay IIBs until the assessment is superseded by an impairment rating assigned in accordance with adopted §130.1. This is an important clarification because, by statute, an employee is no longer entitled to receive TIBs upon reaching MMI. However, there are often cases where the employee reaches statutory MMI, but there has been no impairment rating assigned. Assuming that the employee will have entitlement to IIBs, an impairment rating is necessary to determine the amount that should be paid. Additionally, language was added to indicate that either the carrier or the employee may request the appointment of a designated doctor under adopted new §130.5.

Adopted §130.3 Certification of Maximum Medical Improvement by a Doctor Other Than the Treating Doctor

The prior rule governs the duties of a doctor other than the treating doctor or the designated doctor when certifying MMI. In these cases, the doctor was to file a copy of the report with the treating doctor and the treating doctor was to file his agreement or disagreement with the certifying doctor's report. The rule now provides a similar process for the designated doctor's report.

Adopted amendment to §130.3(a) changes the reference to adopted §130.1 to be consistent with its title change. In addition, clarifying language was added relating to compliance with adopted §130.1 and the subsection was expanded to apply to designated doctors.

Adopted §130.4 Presumption that Maximum Medical Improvement has been Reached and Resolution when MMI has not been Certified

Adopted amendment to §130.4(a) provides a clear definition of statutory MMI and a note that the rule does not apply if the employee has reached statutory MMI.

Adopted amendment to this section provides the conditions under which a carrier may presume that an employee has reached MMI and invoke the procedure outlined in the rule. The changes also make the requirements consistent with adopted §130.1, as indicated in other rules in this chapter.

The adopted conditions are similar to those that exist under the prior rule with differences resulting from the changes in the Statute. The rule now allows for the appointment of a designated doctor without a prior certification of MMI by another doctor.

Eliminated from the requirements is the statement that the employee's condition not be an occupational disease. With the changes in the Statute, the clarification in this rule that the treating doctor shall not certify MMI without an examination of the employee, and the proposal that certifications of MMI and impairment ratings don't become final (such language was removed from §130.5), this exception to the ability to presume MMI is not necessary. Also removed is the requirement that the employee be seen at least twice after the employee has accrued TIBs. The reasons for this change are the same as those for the deletion of the exception for occupational diseases.

Two grounds for invoking the presumption of MMI procedure are added. First, the carrier can invoke the procedure on or after the date that a designated doctor estimated that the employee would reach MMI (assuming that a designated doctor had made such an estimate). Second, the carrier can invoke the procedure four weeks on or after the date the employee should have been able to return to work without restriction. This language was modified to indicate that it is four weeks past the point that the claim has become a Work Release Outlier Claim as defined by commission rule. The commission anticipates proposal of a diagnosis based Work Release Guideline at the same time or shortly after this rule is adopted and this guideline will provide a single standard that can be used by all system participants.

Adopted amendment to §130.2 (d) requires the treating doctor to evaluate the employee's condition and complete and file the medical evaluation report as required by adopted §130.1. It also provides that if the employee is found to have permanent impairment but the treating doctor is not authorized to assign an impairment rating or certify MMI in those instances where the employee has permanent impairment (§130.1(a) governs authorization), the treating doctor is to refer the employee to a doctor who is authorized and who will comply with the requirements of the section.

The prior rule required the treating doctor to complete and file a Report of Medical Evaluation within seven days of the date of the examination. The prior seven-day time frame was not an adequate period to contact an employee (particularly one who may not be in current treatment), schedule and conduct an examination as required by §130.1, and file the report of medical evaluation. The adopted amendment changes the requirement to mandate conducting the examination within 14 days of receipt of the request from the carrier and filing the report within seven working days of that date. The commission also added language that covers the situation where the treating doctor is not authorized to evaluate MMI or impairment.

Adopted amendment to §130.4(e) allows the assignment of a designated doctor rather than the scheduling of a benefit review conference. The commission feels it is ultimately the designated doctor's opinion that is needed to resolve a dispute in this area.

Repeal of Current §130.5 - Impairment Rating Disputes and Adopted New §130.5 -- Entitlement and Procedure for Requesting Designated Doctor Examinations Related to Maximum Medical Improvement and Impairment Rating

The prior §130.5 is repealed and replaced with new §130.5 which clearly outlines entitlement to, and process for, requesting designated doctor examinations relating to MMI and impairment ratings. The prior addressed filing of disputes of impairment ratings. However, the language is not necessary as it is largely duplicative of statutory provisions. Further, the amended provisions allow delays in dispute resolution by permitting a carrier to begin payment of IIBs based upon a reasonable assessment but not requiring the carrier to file a notice of dispute of the rating it disagrees with for 21 days.

In addition, the prior rule did not require the appointment of a designated doctor in the event the carrier made reasonable assessment. This would have left the question of the employee's permanent whole body impairment unresolved and could have adversely affect the employee's benefits.

The prior rule provided for finality of certifications of MMI and impairment ratings. First, the commission believes that the language in the prior rule was appropriate given the statutory provisions at the time that the rule was originally adopted in 1991. In particular, the commission's use of a finality provision was important because the commission held that carriers could not suspend TIBs based upon a carrier-selected doctor's certification and rating unless the employee agreed to it or the rating became final. This changed slightly as a result of legislation passed by the 76th Texas Legislature. Now, given the changes made by HB-2600 which substitute designated doctor examinations for RME exams, and given that designated doctor's opinions regarding MMI and impairment have presumptive weight, the commission no longer believes that the concept of finality is important to the system.

Adopted new §130.5 is based largely upon provisions currently contained in prior §130.6. The prior §130.6 was very long and cumbersome. The commission is splitting the prior rule in two to simplify it. Adopted §130.5 sets out the requirements for requesting a designated doctor; selecting the doctor; scheduling the examination; delivering records to the designated doctor; and disputing the report of the designated doctor. The rule essentially covers everything about the dispute and examination except for the duties of the designated doctor and the employee's duties regarding the examination itself (which are contained in adopted §130.6).

Adopted new §130.5(a)-(c) govern the applicability of the rule.

Adopted new §130.5(a) requires the commission to order medical examinations by a designated doctor at the request of the carrier, the injured employee or a division of the commission and requires requests for designated doctors to be made in the form and manner prescribed by the commission.

Adopted new §130.5(b) provides the conditions under which a designated doctor will be assigned and the issues to be resolved. This rule applies to questions relating to MMI and impairment. Additionally, language was added to clarify that the designated doctor should also resolve questions regarding maximum medical improvement and/or the existence and amount of permanent impairment.

Adopted new §130.5 (c) provides for a certification of MMI and/or impairment to be invalid if it was not obtained in accordance with adopted §126.5 of this title (relating to Entitlement And Procedure For Requesting Required Medical Examinations), or if it was assigned by a doctor who was not authorized to certify MMI and impairment.

Adopted new §130.5 (d) provides the commission's provisions for selecting and scheduling an examination by a designated doctor as specified under new §408.0041 of the Texas Labor Code. The subsection also lists what information shall be contained on the order. There are differences between the provisions in this rule and the prior provisions of §130.6. These differences are primarily driven by HB-2600, which changed the timeframes for ordering an examination and removed the provision that allowed for a designated doctor to be chosen based upon the agreement of the employee and the carrier.

Other differences are due to HB-2600's requirement that the designated doctor selected be experienced in the treatment and procedures used by the doctor treating the employee's medical condition as opposed to the prior requirement that the designated doctor merely be of the same discipline and licensing as the treating doctor. Language regarding appropriate credentials was also added.

Another difference is the specific timeframe for the treating doctor and carrier to send the employee's medical records to the designated doctor. Prior §130.6 did not have a specific timeframe for the records to be forwarded. The prior rule merely stated that if the designated doctor did not have the records three days prior to the examination, the commission was to be contact for assistance in obtaining the records. Therefore, the new §130.5(d)(3) requires delivery of the records not later than the fifth working day prior to the date of the examination. It also requires the designated doctor to contact the commission if the records were not received by the third working day prior to the date of the examination. The reason for this change is to ensure consistency by using working days in both requirements. Further, carriers and doctors are free to use any method of delivery they choose but must ensure timely delivery.

Adopted new §130.5(e) provides the condition and timeframe for a request of a subsequent designated doctor appointment. The statute provides that such a request is limited to one per 60 days unless there is good cause. Additionally, adopted §130.4 can be used to establish good cause although it may not be the only method.

Adopted new §130.5 (f) provides the procedure for filing a dispute with the commission when either party is not satisfied with the designated doctor's opinion regarding MMI and or impairment rating.

Adopted §130.6 Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings

Adopted §130.6 focuses on the duties of the designated doctor and the employee relating to the conduct of the examination itself. Therefore all provisions of the prior rule that addressed setting up the examination, choosing the doctor, forwarding the records, etc., were deleted, but were replaced by similar provisions in new §130.5, as previously discussed.

Adopted amendment to §130.6(a) provides an overview section that explains the applicability of the rule and some general provisions relating to presumptive weight. This amendment makes it clear that presumptive weight applies only to MMI and impairment and only to those issues that are actually in question or dispute. Thus if the only issue in dispute is impairment, the designated doctor's opinion about MMI is not given presumptive weight. Likewise, other opinions of the designated doctor are not given presumptive weight even if the designated doctor was asked by the commission to provide an opinion on a matter.

Further, the opinion of the designated doctor is given presumptive weight rather than the report of the doctor. This clarifies that if the designated doctor discovers an error in his/her report and amends it, the subsequent report is also given presumptive weight. This also allows requests for clarification when a question arises relating to the designated doctor's opinion.

Adopted amendment to §130.6(c) provides the conditions under which a carrier may suspend TIBs if an employee, without good cause, fails to attend a designated doctor examination. The language is virtually identical to provisions in adopted §126.6 of this title (relating to Order For Required Medical Examinations), which is proposed elsewhere in this issue of the Texas Register.

Adopted amendment to subsection (d) of §130.6 requires the designated doctor to address the issues in question and any issues the commission may request the designated doctor to consider. It also requires the designated doctor to provide an estimated date the employee may reach MMI if the issue of MMI was in question and if the designated doctor found the employee not to be at MMI. This estimated date is very important for two reasons. The first is that it helps establish if there would be good cause to return to a designated doctor in less than 60 days. The second reason relates to the fact that the dispute resolution on MMI has been slightly complicated by placing the RME examination after the designated doctor's examination. For example, the designated doctor could find that an employee is not at MMI and then the carrier's RME doctor could find MMI a couple of weeks later during the RME. The RME doctor would essentially argue that they agree that the employee had not reached MMI at the time of the designated doctor's examination but that he had reached MMI by the time of the RME. By having an estimated MMI date from the designated doctor, the commission will be more able to resolve disputes in this situation. Additionally, language was added requiring the designated doctor to identify the reasons that he/she does not believe the employee to have reached MMI.

Another change relates to disputes of MMI when the treating doctor has already certified the employee to be at MMI. Many designated doctors are unwilling to certify an employee to have reached MMI on a date prior to the designated doctor's examination of the employee. This has led to MMI being inappropriately extended in some cases. A certification of MMI requires an evaluation of the prior medical records. From that evaluation, the designated doctor should be able to determine at what point the employee's condition was no longer improving. Although additional training for doctors should improve the accuracy of MMI certifications and alleviate the problem, there may still be doctors who are unwilling to certify the employee to be at MMI prior to a date that doctor actually examined the employee. To help address this situation, the rule requires the designated doctor to provide an explanation with clinical documentation when the designated doctor finds the employee to have reached MMI on a date later than the date the treating doctor finds the employee to have reached MMI.

Another change has to do with assigning impairment ratings when there are questions about the extent of injury. It is not uncommon for designated doctors to assign impairment ratings when the extent of injury is in dispute. It is also not uncommon for the designated doctor to include additional conditions in the impairment rating that the carrier was not aware of prior to the designated doctor's examination. This has caused problems in the past because the designated doctor's report currently has presumptive weight and the carrier is required to pay all accrued benefits in accordance with the designated doctor's report within 5 days of receiving the report. In those instances that the designated doctor turns out to have inappropriately extended the injury through the impairment rating, the carrier will often end up overpaying benefits to the employee with no recourse for reimbursement.

On the other hand, sometimes the rating will not include a condition that is later determined to be part of the compensable injury. In order to get the impairment rating modified to include the additional condition, another examination by the designated doctor would often be needed. During this time, the employee's benefits might be delayed. Therefore, if there does not appear to be consensus on extent of injury (either through an active dispute or an obvious difference between what the medical reports and narratives show), the doctor will rate the impairment both ways so that when the dispute of extent of injury is resolved, there will be no delay in the provision of benefits. The carrier would be required to pay IIBs in accordance with the designated doctor's rating based upon the conditions that the carrier believes are part of the compensable injury (preventing overpayments) and then pay per the other rating if it is later determined that the compensable injury includes the disputed conditions (preventing delays). With the new provisions of HB-2600 that allow the carrier and the treating doctor to provide a narrative that describes their assessment of the employee's condition, designated doctors should have little problem determining if they need to evaluate the employee's condition in multiple ways.

Adopted §130.6(f) clarifies the existing prohibition against a provider assisting a designated doctor if the provider previously examined or treated the employee within the past 12 months (for any condition), or previously examined or treated the employee for the medical condition needing evaluation by a designated doctor.

Another change provides that if the designated doctor chooses to use another health care provider to perform range of motion and strength testing required by the AMA Guides, that doing so shall not extend the amount of time that the designated doctor has to file the report required by the rule. Range of motion and strength training are basic requirements for evaluating impairment resulting from nearly every condition. Treating doctors and RME doctors often utilize other providers to provide such testing but use of other health care providers does not extend the time to file their reports

The commission added language that makes it clear that the designated doctor is ultimately responsible for compliance with the section regardless of whether they choose to have other health care providers assist them. This is not a change from current rules.

Adopted amendment to §130.6(g) clarifies that (unlike amended subsection (f)), special testing does extend the amount of time that the designated doctor has to file the report by up to seven working days if the designated doctor needs to refer the employee to another provider to conduct these tests. This testing does not include standard range of motion and strength training. This sort of testing (and thus extensions) is expected to be infrequent.

Adopted amendment to subsection (i) of this section establishes a date by which a designated doctor must respond to a commission's request for clarification. It also considers the designated doctor's response to have presumptive weight as it is part of the doctor's opinion. Currently, there is no specific timeframe for responding to a request for clarification. This can delay resolutions of disputes for months while the commission must re-request clarification, call the doctor's office to ask for the information, or issue orders. Language was added to ensure that if in order to respond to the request for clarification, the designated doctor has to reexamine the employee, the doctor shall make him/herself available to conduct the examination within 10 working days of receiving the request (even if it means traveling back to the location of the examination) and shall respond to the request for clarification not later than the fifth working day following the reexamination.

Adopted amendment to §130.6(j) addresses records that the designated doctor must maintain. Added to the required records

is documentation of the date the commission was contacted when the carrier or treating doctor have not provided medical records within five days prior to the scheduled date of an examination.

Adopted §130.110 - Return to Work Disputes During Supplemental Income Benefits; Designated Doctor

Section 130.110(n) was deleted because it was redundant to provisions in other rules and it references rules that are being amended or deleted.

At the same time §§130.1-130.6 were proposed, the commission proposed new rules relating to the approved doctors list and the types of training the doctors will have to get in order to be authorized to serve in various roles (specifically through §180.20 and §180.23 of this title (relating to Application for Registration / Commission Approved Doctor List and Commission Required Training for Doctors/Certification Levels, respectively)). The commission proposed that all treating doctors and required medical examination doctors would have to have impairment rating training (except for those doctors who provided care infrequently).

The commission's intent was to try to improve the quality of impairment ratings assigned to injured employees and to reduce disputes within the system. However, the commission received a number of comments that suggested that many doctors want to actively participate in the system but they are not interested in assigning impairment ratings. They argued that the commission's goals would be better met if doctors were not forced to engage in a practice they either felt uncomfortable with or were otherwise uninterested in performing (i.e., assigning impairment ratings) but instead referred their cases to doctors who were comfortable and interested in the practice.

The commission generally agrees with these comments but was concerned that the result could be a system where every single claim gets forwarded to a doctor certified to assign impairment ratings even if there was obviously no permanent impairment and that this would unnecessarily add to costs in the system (through unnecessary impairment rating examinations). The commission believes, and its Medical Advisor concurs, that doctors can determine whether a person has permanent impairment as a result of the compensable injury without utilizing the AMA Guides. The purpose of the AMA Guides is largely to quantify the amount of impairment the employee may have. The guides can also be used to help settle a dispute as to whether the employee has permanent impairment. However, any doctor who has been sufficiently trained can determine whether an employee has permanent whole body impairment as a result of the compensable injury.

The commission is still finalizing the proposed rules that these comments were addressing but generally agrees with these specific comments and plans to revise the proposed structure set up by §180.20 and §180.23. However, several of the §§130.1-130.6 rules made reference to the proposed structure, and thus need to be modified in advance of the final adoption of §180.20 and §180.23.

Therefore, the commission has modified a number of subsections of the Chapter 130 rules to address these comments. The key change is in §130.1(a). In that subsection, the commission has provided that on or after September 1, 2003 (which was changed from the proposed August 1, 2003 to coincide with the beginning of the new biennium in case the Legislature makes additional modifications to the ADL during the next legislative session), authorizations will be broken into two categories. One category will cover doctors who have been through the commission training on impairment rating, and are thus fully certified/authorized, or who have been granted authorization by exception to assign an impairment rating. These doctors will be able to certify MMI and assign impairment ratings in any case where the doctor is serving in the appropriate role.

The other category will cover doctors who are only authorized to determine whether an employee has permanent whole body impairment and is intended to cover only treating doctors. These doctors will only be authorized to certify MMI if they find that the employee does not have permanent impairment. If the doctor finds that the injured worker does have permanent impairment the doctor will have to either get permission from the commission by exception or will have to refer the employee to a fully authorized doctor who shall evaluate the employee for MMI and assign an impairment rating.

It is worth noting that treating doctors who have full authorization to certify MMI and assign impairment ratings have the option of making a referral to another doctor to do the impairment rating. Should the treating doctor make such a referral, the treating doctor is not to file his or her own certification since it would be superfluous to the referral doctor's certification and only add cost to the system without resolving the dispute. If the treating doctor (or employee or carrier) disagrees with the date of MMI and/or impairment rating assigned by the referral doctor, the proper avenue is to request a designated doctor.

Other changes were made to: §130.1(c)(4), the title of §130.2, §130.2(a), §130.4(d) and §130.5(a) based upon the changes in §130.1(a).

The following groups provided comments indicating general support for the amendments, and submitted recommendations or requested clarification on some issues: Insurance Council of Texas and the Texas Mutual Insurance Company.

The following groups provided comments indicating general opposition for the amendments, but submitted recommendations or requested clarification on some issues: Texas Medical Association.

The following groups did not indicate either support or opposition for the amendments, but submitted recommendations or requested clarification on some issues: Service Lloyds Insurance and Flahive, Ogden & Latson.

The commission also received comments that indicated support for or opposition to the amendments from individuals who did not list what groups or associations they were affiliated with.

Summaries of the comments and commission responses are as follows:

Comments on §130.1

Comment: Commenter suggested adding to §130.1(a)(2) that an authorized doctor will submit a copy of their certification with the MMI and IR or it is considered invalid. Another commenter suggested that when the reporting requirements are not met, the report is invalid.

Response: The commission disagrees. The information regarding whether a doctor has the appropriate certification level will be available on the commission's Approved Doctor's list on the commission's website. In some cases, the commission will grant

a doctor who is not certified to assign an impairment rating an exception on a per case basis and the commission does agree that that documentation of this exception should be provided with the rating. But the commission does not agree that failure to provide the documentation with the report should invalidate the doctor's opinion. The commission has modified subsection (d)(1)(B) to require a copy of an exception granted by the commission by adding the following:

(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 commission.

Comment: Commenter suggested adding language to subsection (c)(1) indicating that a zero percent impairment is valid as long as the certifying doctor applied the AMA guides.

Response: The commission disagrees. Such a change is not necessary because it is redundant to the requirements of the statute that define how an impairment rating is to be determined. If a rating is assigned in violation of the AMA Guides, then it is invalid. Additionally, if the AMA Guides violation is a simple one, it may be possible to correct the rating instead of invalidating it.

However, as described, the commission believes that doctors can determine whether a person has permanent impairment as a result of the compensable injury without utilizing the AMA Guides. The purpose of the AMA Guides is largely to quantify the amount of impairment the employee may have. The guides can also be used to help settle a dispute as to whether the employee has permanent impairment.

Comment: Commenter suggested adding the word "valid" at the end of the sentence under subsection (c)(2)(C).

Response: The commission disagrees. The suggestion could result in multiple ratings assigned with the same edition of the AMA Guides being argued to be "valid". The commission instead changed the language to ensure that ratings using the incorrect edition of the AMA guide shall be considered invalid:

(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.

Comment: Commenter requested clarification of subsection(c)(4) as it relates to Level 2 certification and medical specialists such as psychologists, opthalmologists, and pulmonologist, who can provide accurate testing needed to objectively establish an impairment rating. Commenter stated this requirement is inconsistent with §130.6(g) and §130.110(l), in which the designated doctor can refer out to other providers and there is no requirement that they have Level 2 training. Commenter suggested added language to allow these other providers to render MMI and IR as long as the designated doctor concurs, or allow for exceptions for specialty evaluations by healthcare providers not eligible for Level 2 certification in special circumstances.

Response: The commission agrees that the concepts in subsection (c)(4) are inconsistent with the requirements in subsection §130.6(g) and §130.110(l) and has modified §130.1(c)(4) for consistency. The new language reads as follows:

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 employee is evaluated, has had the impairment rating training module required by §180.23 (relating to Commission Required Training for Doctors/Certification Levels) 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.

Comment: Commenter recommended the rules state the effect of noncompliance with the reporting requirements of §130.1(d)(1)(B). Commenter suggested language such as "a certification of MMI and assignment of impairment rating are invalid if not contained in a Report of Medical Evaluation and narrative report which do not include all the information required by subsection (d)(B)."

Response: The commission disagrees. Section 130.1 provides the specific requirements, including assignment of an impairment rating, reporting and documentation. Failure to provide the necessary documentation is an administrative violation. The issue of whether such a failure invalidates a rating is a matter to be decided through dispute resolution. In some cases, it could invalidate the report. However, the Commission does not agree that failure to provide the information on the TWCC-69 form automatically invalidates the certification and/or the rating, especially if the narrative clearly identifies the date of MMI and the rating.

Comment: Commenter stated that under subsection (d)(2) there is inconsistency with the filing of a report within seven days when it appears that in other sections, the doctor has ten days. Commenter also disagrees with the requirement that non-authorized doctors who perform MMI and/or assign impairment ratings shall not be paid. Finally, the commenter suggested that there should be a mechanism in place to review the reports, decisions, impairment ratings, and determinations of maximum medical improvement performed by designated doctors in the system.

Response: The commission disagrees. Section 130.1(d)(2) refers to the filing of a Report of Medical Evaluation under this section. No other section requires this type of report to be filed within ten days. Regarding the issue of paying for impairment ratings that are invalid, the Commission can find no rational justification for paying for services that are provided in violation of the rule and that are not usable. Further, the commission is required to monitor all parties in the system and designated doctors shall be monitored to ensure that they act in compliance with the statute and rules and provide quality opinions.

Comment: Commenter suggested that in order to be consistent with other rules, §130.1(d)(2) should read "seven calendar days" rather than "seven working days."

Response: The commission disagrees. The suggestion is beyond the scope of the proposal and would require a separate proposal. Further, the commission changed the filing requirements from seven calendar days to seven working days when it simultaneously changed the requirements for filing with the carrier to either fax or other electronic transmission. The idea was that by removing the five-day mailing time (which meant that a timely report might not be received until 12 calendar days after the examination) it would be possible to give the doctors slightly more time to file the report but reduce the maximum time for a timely report to be received by the carrier (10 calendar days except during a week with a holiday).

Comment: Commenter suggested that a certification that an injured worker has not reached MMI, is as significant as a determination that an injured worker has reached MMI. The section needs to be modified to include certifications that an injured worker is not at MMI. Such certifications should be done under the same requirements for a certification that MMI has been reached. Not at MMI certifications are crucial for the dispute resolution process.

Response: The commission disagrees. While a finding that the employee is not at MMI may be important, this section is only designed to address the situation where a doctor believes that the employee has reached MMI and is determining whether there is permanent impairment. It is not intended to address the situation where the doctor finds the injured worked has not reached MMI. Other rules address the processes and procedures regarding attainment of MMI and the assignment of impairment ratings.

Comment: Commenter suggested that the process of determining who is the treating doctor be addressed first. Commenter suggested that the first doctor who sees a patient should not automatically become the treating physician. Rather it should be the practitioner most involved in the care, and therefore most responsible for the outcome obtained by the patient.

Response: The commission disagrees. This comment relates to requirements covered under §126.9 of this title (relating to Choice of Treating Doctor and Liability for Payment), and it is beyond the scope of this section. However, Texas Labor Code §408.022 provides specific requirements for choosing a treating doctor, while Texas Labor Code §408.023 provide the duties and responsibilities of a treating doctor. It is up to the injured employee to choose the treating doctor.

Comment: Commenter requested clarification either through the Preamble, commission procedure, or advisory regarding filing requirements dealing with specific forms such as TWCC-21, TWCC-26, TWCC-28, and TWCC-69.

Response: Although the comment is beyond the scope of this rule, the appropriate commission staff will be notified of the request for clarification.

Comments on §130.2

Comment: Commenter requested clarification regarding whether the carrier can request and commission will order a designated doctor examination of an injured employee on the sole basis of the injured employee approaching statutory MMI and the treating doctor has not provided an impairment rating consistent with Chapter 408, Subchapter G of the Texas Labor Code. Commenter recommended adding a sentence to §130.2(e) to allow the carrier to request the commission order a designated doctor examination when neither the commission nor carrier receives a report by the date of statutory MMI. Commenter stated that carriers may be reluctant to make a reasonable assessment of impairment rating at statutory MMI because an overpayment in this situation would be considered an "unrecoupable" voluntary overpayment.

Commenter also suggested changing the carrier's requirement to initiate IIBs from "five" to "seven" days because it is more consistent with other payment initiation time frames and will reduce confusion.

Response: The commission agrees with the suggestion to specify that a designated doctor can be assigned if the employee reaches statutory MMI without an impairment rating being assigned by the treating doctor. The commission has added language that directs the carrier to §130.5 to request a designated doctor in this situation.

The statutory language regarding initiation of IIBs did not change. Per §408.121 of the Labor Code, the carrier shall begin to pay IIBs not later than the fifth day after the date of receipt of the Report of Medical Evaluation.

Comment: Commenter requested clarification of §130.2(d) when or if the TWCC fails to send the notice. Commenter suggested that the employee should not be penalized because the treating doctor fails to certify MMI since the doctor did not receive the notice.

Response: The commission disagrees. There is no alternative to this process. By statute, the commission is required to provide a notice that informs the treating doctor that the employee will be reaching statutory MMI soon and advice the doctor of his/her responsibilities under Texas Labor Code Chapter 408. If the treating doctor fails to do so, the doctor is in violation. With the new statutory requirements, this situation should not happen as often, because now the employee or the carrier can request a designated doctor to assign an impairment rating. However the commission has modified the subsection to have the commission send a copy of the letter to the employee as well to ensure that the employee is aware of the situation and could prompt their doctor about it as well.

Commission Comment: In reviewing the rule for adoption, it was noticed that subsection (c) of §130.2 referenced "temporary income benefits" instead of "TIBs" and referenced "injured employee" instead of "employee" even though the abbreviations had been introduced in subsection (a) of this section. Therefore subsection (c) was changed.

In addition, the commission noticed that subsection (d) used the term "statutory MMI date" but did not define it. Therefore the commission modified this subsection to reference §130.4 where statutory MMI is defined.

Finally, the commission realized that injured employees are not sent a copy of the 98 week notice and believed that if they were provided a copy of the letter, they might proactively contact their treating doctor to set up the appointment required by the subsection. This could then improve the compliance of treating doctors. Therefore, the commission added language that stated that the notice would be provided to the employee as well.

Comments on §130.3

Comment: Commenter asked what the procedure was in the event that the treating doctor is out of town when a doctor other than the treating doctor certifies MMI/IR under §130.3 (b)(2).

Response: It is the commission's opinion that the treating doctor is responsible to either agree or disagree with the certification. The treating doctor needs to ensure that his or her responsibilities are met in the doctor's absence. Additionally, failure to comply with the requirement may result in a possible administrative violation. However, each case is determined based on the facts surrounding the case.

Comments on §130.4

Comment: Commenter stated that nothing in §408.0041 imposes the additional burden that the carrier has to wait on the treating doctor before requesting a designated doctor to determine whether the claimant is at MMI or to provide, at

its expense, evidence from a doctor in which it has no confidence. If it is indicated in §130.4(c) that the carrier may either request a status report from the treating doctor, or request the appointment of a designated doctor, then subsection (e) is not necessary.

Another commenter questioned §130.4(c) regarding the carrier's request that the treating doctor provide a report on the claimant's medical status as it relates to MMI. Commenter stated that §408.0041 does not require this step prior to requesting a designated doctor. Commenter also stated that although the reasons listed in subsection (b) are a useful guideline, are not mandated by the statute. Therefore, subsection (c) should indicated that a carrier may EITHER request a status report from the treating doctor, OR request the appointment of a designated doctor pursuant to §408.0041. Commenter stated that there are often situations where a carrier may have no confidence in the claimant's treating doctor and does not wish to go through the expense of the treating doctor providing an impairment rating evaluation as opposed to going directly to an independent designated doctor.

Response: The commission disagrees. The intent of this section is to comply with the requirements of Labor Code §408.102(b) under which the commission is required to adopt rules relating to the presumption of MMI. While it can be argued that this provision of the statute was largely marginalized by the addition of §408.0041 of the Labor Code, it still exists and this section is intended to comply with its requirements.

Additionally, the commission wants to promote communication between the carrier and treating doctor. The section establishes the requirements for a carrier to presume when an employee has reached MMI based on specific criteria. Subsection (e) was designed to expedite the designated doctor process in the event that the treating doctor fails to comply with the request under subsection (c). Accordingly, the carrier may request a designated doctor to resolve questions regarding MMI and/or impairment. The language in §130.4(e) is not meant to limit a carrier's right to request a designated doctor under §408.0041.

Comment: Commenter suggested that under §130.4(b)(1), the number of days between missed examinations should be reduce from "60" to "30" because it would be reasonable for the carrier to presume MMI when an employee establishes a pattern of missed examinations. Commenter also stated that this will help reduce carrier overpayments and is consistent with the fundamental goals of HB-2600.

Another commenter suggested changing the dates under §130.4(b)(1) from 60 and 90 to 20 and 30 respectively. Commenter stated the carrier can see that all injured workers receive appropriate medical care and some are not a drain to the system. This way, the carrier can start the process of presumption of MMI and would not have to wait a month. .Another commenter stated that two examinations is too soon because most muscle and soft tissue injuries take six to eight weeks to resolve and suggested a change to 90 days from the injury or after two visits.

Response: The commission disagrees. The intent of this section is to establish the requirements for a carrier to presume when an employee has reached MMI based on specific criteria. The commenter's suggested timeline does not provide for those instances where the injured employee is at a point in the claim where it is adequate to see a doctor once a month, which is at the doctor's discretion and not uncommon. Nevertheless, the carrier has the option to request the assignment of a designated doctor in accordance with §408.0041.

Comment: Commenter suggested an instructional booklet so injured workers are aware of their responsibilities regarding §130.4 (b)(1).

Response: The comment is outside the scope of this section, however the proper commission staff will be notified for consideration.

Comment: Commenter referenced the work release guidelines and suggested the number of days for a carrier to presume MMI to "seven days" under §130.4(b)(4). Commenter stated that requiring the carrier to wait an additional four weeks past the point indicated in the commissions' work release guidelines, would promote overpayment.

Another commenter suggested that if the injured worker is two weeks past the point indicated in the work release guidelines, the employee should be released to return to work without restrictions.

Response: The commission disagrees. An ability to return to work without restriction is not the same thing as MMI, particularly if the employee has a job that has very light demands. Further, since this section does not limit the carrier's right to request a designated doctor but rather provides guidance for carriers to presume that MMI has been reached, carriers have the ability to avoid overpayments. However, it is worth noting that when the language in this subsection was proposed, it was anticipated that the commission would propose rules relating to the use of work release guidelines in general but it was not clear what form that these rules might take. However, with the proposal of §§134.1100 - 134.1103, the proposed language in §130.4(b)(4) was modified slightly to match these sections. Until the commission adopts a definition of "work release outlier claim", subsection (b)(4) will not be applicable.

Comment: Commenter suggested adding to §130.4 (c) the word "shall" to change the sentence to, "A carrier permitted by subsection (b) of this section to invoke this procedure shall request the treating doctor to provide..." Commenter stated this promotes consistency within Chapter 130 rules.

Response: The commission disagrees. The intent of this section is to comply with the requirements of §408.102(b) under which the commission is required to adopt rules relating to the presumption of MMI. The rule establishes the requirements for a carrier to presume when an employee has reached MMI based on specific criteria. The carrier has the option to invoke this rule, or request a designated doctor per §408.0041. The commission did add clarifying language to ensure that system participants did not read this subsection in such a way that it is presumed that carriers are not permitted to contact treating doctors about MMI under other circumstances. They are so permitted though doing so does not require the treating doctor to file a response under this section.

Comments on §130.5

Comment: Commenter stated that §130.5(b) did not include the situation where the carrier has identified conditions which would appear to suggest that the claimant has reached MMI, and wishes to proceed directly to a designated doctor without waiting on the report of the treating doctor. There are often situations where a carrier may have no confidence in the claimant's treating doctor and does not wish to go though the expense of the treating doctor providing an impairment rating evaluation as

opposed to going directly to an independent designated doctor. In those situations, the carrier would only be providing, at its expense, evidence for the claimant to attack the opinion of the designated doctor. Should the claimant wish to then develop evidence to overcome the presumptive weight to be given to the designated doctor's report, then he or she can be responsible for doing so.

Response: The commission agrees that the proposed language under subsection (b) of this section gives the indication that the section does not apply under the example given by the commenter. Therefore the language was changed to be more consistent with HB-2600.

Comment: Commenter requested a definition for "similar qualifications," and suggested selection of a designated doctor should be from the same city where the TWCC office is located. Commenter requested clarification regarding the designated doctor treating similar types of injuries and further requested a definition for "similar qualifications." Commenter also suggested that the designated doctor should be selected from the same city where the TWCC office is located.

Response: The commission disagrees. The statute requires the commission to base the selection of the designated doctor on the treatments and procedures used by the doctor treating the workers' compensation injury. The term "similar qualifications" is used in §408.0041. Further, the statute does not require the commission to limit selection of a designated doctor to a given geographic area. However, it has been common practice to first attempt to select a designated doctor close to the claimant's residence, but often times it is impossible because there are no designated doctors available, specifically in small cities. With the demands of the new statute regarding selection criteria, this may be harder still.

Comment: The commission received several comments suggesting that §130.5 ensure that the designated doctor originally selected to resolve the issues of MMI and/or IR remains the designated doctor for future disputes. A commenter was of the opinion that any examination after the first one is actually a "reexamination" as opposed to an "examination" that would invoke the requirements of §408.0041. The commenter stated that a separate section, Texas Labor Code §408.122(b) also was amended to use the language regarding the selection criteria for MMI and IR disputes, and is not tied to a particular examination or reexamination. Commenter added that this section existed prior to the 2001 legislative amendments, except for different selection criteria, and had not previously been interpreted to require the appointment of a different designated doctor upon reexamination simply because the claimant changed treating doctors. Therefore the amendments should not create complications where they are not necessary. Commenter suggested that should a different body part or treatment protocol be used by the time of the reexamination, the originally selected designated doctor can remain responsible for coordinating referrals to other doctors as necessary. The section could provide, however, that if the original doctor is unwilling or unable to comply with requests for reexamination, another doctor could be selected through the selection process.

Commenter suggested the addition of paragraph (5) to §130.5(d). Language suggested was: "A doctor selected under this section shall serve as the designated doctor for all dispute(s) raised under this section unless that doctor is unable or unwilling to act in that capacity." Commenter stated this language is consistent with §130.110(f).

Response: The commission agrees that the original designated doctor should remain responsible for addressing similarly related disputes and that only when the designated doctor becomes unqualified should the commission select another designated doctor for the purpose of conducting a subsequent exam. Therefore §130.5(d)(2) has been modified to accomplish this. The language is written to allow he designated doctor to remain in that role as long as the doctor is still qualified (based upon qualifications, training and experience, scope of licensure, etc.) and available. The root paragraph of subsection (d)(2) now reads:

(2) If at the time the request is made, the commission has previously assigned a designated doctor to the claim, the commission shall use that doctor again if the doctor is still qualified as described in this subsection and available. Otherwise the commission shall select the next available doctor on the commission's Designated Doctor List who:

Comment: One commenter expressed concern over the language used under §130.5(d)(2)(C) and questioned whether this allow a provider of another discipline to review a physician. Commenter was of the opinion that that physicians should only be reviewed by physicians who are trained, qualified and experienced in the treatment under scrutiny. Another comment suggested deleting the language under subsection (d)(2)(C) because the designated doctor should only be familiar with the treatment and procedures used by the doctor treating the patient's medical condition.

Another commenter stated that §130.5(d)(2)(C) as written, is subject to the same abuse seen under current §130.6. Commenter stated this is where a claimant is certified as having reached MMI by a treating doctor, and is dissatisfied. The claimant then changes to a treating doctor licensed by a different board, and a designated doctor is selected according to the qualifications of the subsequent treating doctor. Commenter suggested that to avoid this, language should be added that the designated doctor is trained and experienced with the treatment and procedures used by the doctor treating the patient's medical condition at the time the disputed certification was made, as opposed to the time the dispute is made. This is similar to the concept contained in current §130.110(f).

Response: The commission agrees with the commenter regarding the specific requirements under §408.122(b) for selecting a designated doctor. However, nothing in the rules indicates that it is the commission's interpretation that when a claimant changes treating doctors, a different designated doctor will be appointed. What is clear, however, is that the statute requires the commission to base the selection of the designated doctor on the treatments and procedures used by the doctor treating the workers' compensation injury. Some have suggested that this translates to the "treating doctor". The commission disagrees with this interpretation. The treating doctor may be only one of several doctors treating the employee. For example, an employee could have a chiropractor as the treating doctor and be receiving physical medicine from that doctor while also receiving prescription medication from a referral doctor who is a medical doctor. Therefore the commission would either need to pick one of the doctors as "the doctor treating the patient's medical condition" or would need to take into account all the forms of treatment that the employee is receiving from all doctors treating the condition. The commission believes that statutory language is designed to ensure that designated doctors are familiar with the type of injury the employee has and the general types of treatment provided to the employee.

Additionally, per §408.022(d), a change of doctors may not be made to secure a new impairment rating. Under §408.0041, if an employee is not satisfied with the MMI and/or impairment rating given by the treating doctor, the employee may request a designated doctor be appointed to resolve the issues. However, the commenter's point is moot. As noted already, designated doctors are going to be assigned based upon a number of factors, but the licensure of the treating doctor will not be one of them.

The language used under §130.5(d)(2)(C) is mandated by statute and the it requires consideration of three things: the appropriateness of credentials relative to the issue in question and the employee's medical condition; the training and experience of the designated doctor as they relate to the treatments and procedures used by the doctor treating the employee; and the scope of practice of the designated doctor compared to the treatments and procedures used.

With the input of the commission's medical advisor, the commission has developed a system whereby the training and experience of designated doctors in providing several broad but key treatment categories (such as physical medicine, prescription medication, therapeutic injections, etc.) to key injury areas is captured in a profile. The commission will then ascertain the types of treatment the employee received to each injury area involved in the compensable injury and whether the treatment is ongoing and match this up with the designated doctor profiles to identify the eligible doctors and select the next one on the list.

The commission will consider treatment the employee is continuing to receive to be primary selection criteria and treatment given but where the doctor released the patient from their care (such as when a surgeon releases the employee to a physical medicine and rehabilitation doctor or chiropractor following surgery) to be secondary selection criteria. Primary selection criteria will allow the commission to ensure that the selected doctor meets the requirements of the statute regarding training and experience and scope of practice and secondary selection criteria will help ensure that the doctor's credentials are appropriate to the issue in question.

Comment: Commenter stated that under §130.5(d)(2), the statement: "whose credentials are appropriate for the issue in question and the injured employee's medical condition", was omitted from the list of requirements for being a designated doctor. Commenter suggested the requirement should be added now or not later than the date the statue becomes effective. However, whether or not it is added, it is a requirement that TWCC must be prepared to meet when designated doctors are appointed in the future.

Response: The commission agrees that subsection(d)(2) should follow the criteria per §408.0041 and has modified the language to more closely mirror the statute. Subsection (d)(2)(C) now reads:

(C) has credentials appropriate to the issue in question, is trained and experienced with the treatment and procedures used by the doctor treating the patient's medical condition, and whose scope of practice includes the treatment and procedures performed.

Comment: Commenter stated that §130.5(d)(1) does not indicate what constitutes a "valid" request. Commenter stated that §408.0041 merely requires that the carrier or the claimant "request" the appointment of a designated doctor, and that the commission "shall" order it.

Response: The commission disagrees. The intent of the section is to ensure requests are made in accordance with §408.0041. For example, the request has to be made to resolve a question about MMI and/or impairment. A person cannot request a designated doctor under §408.0041 solely to answer a question about relatedness.

Comment: Commenter suggested selecting a doctor who has not treated the employee for the injury under §130.5 (d)(2).

Response: The commission agrees but believes that the proposed language accomplishes this.

Comment: Several commenters suggested that there might be a conflict of interest for those doctors who have not been practicing for four or five years or who are no longer practicing. One commenter stated that the carrier might have influence over these doctors. Another commenter stated that the designated doctor cannot be impartial if he is paid hundreds of thousands of dollars by carriers for carriers examinations and this should be a disqualification. The commenter further stated that "all sources of income received by a DD should be reported. Additionally, commenter is of the opinion that TWCC appoints corrupted designated doctors intentionally.

Response: These comments are outside of the scope of this section and as it relates to disqualifying associations and qualifications for being on the designated doctor list that are being addressed under §180.21 of this title (relating to Commission Designated Doctor List). The commission is doing research on this issue and will address it in its consideration of adopting §180.21. However, selection of a designated doctor is a statutory requirement and new §408.001 of the Texas Labor Code provides the specific requirements.

Comment: Commenter suggested adding "or with peer reviewers identified by the insurance carrier" to §130.5(d)(4)(c) as provided under new §408.0041(d).

Response: The commission agrees with adding peer reviewers to §130.5(d)(4)(c) as peer reviewers are listed under §408.0041(d) as persons the designated doctor may choose to initiate contact with.

Comment: Several commenters suggested changing §130.5 (d)(3)(A) to reflect 10 days instead of five for the time the carrier and treating doctor have to provide medical records in their possession, because both carries and doctors must continue with their work. Additionally, a commenter suggested mail time should be considered.

Response: The commission agrees in part. The changes in the statute are designed to ensure that designated doctor examinations are held earlier. Examinations, to the extent possible, will be scheduled within 14 days of the date of the order is issued. The order then has to be received by the carrier and treating doctor who have to gather and send the documents to the designated doctor. As proposed, the section would require the designated doctor to notify the commission for assistance in obtaining the records if they are not received five days prior to the date of the examination. Therefore, the commission can't agree to giving the carrier and treating doctor 10 days to provide the records. However, the commission can agree that the time frame can be changed to require the documents to be delivered to the designated doctor no later than the fifth working day prior to the date of the examination. In many cases this could increase the amount of time to provide the records while not impacting the ability of

the designated doctor to contact the commission prior to the examination for help in obtaining the records.

Therefore, §130.5(d)(3) has been changed to require delivery of the records not later than the fifth working day prior to the date of the examination. Carriers and doctors are free to use any method of delivery they choose but must ensure timely delivery. At the same time, §130.5(d)(3) has been changed to require the designated doctor to contact the commission if the records were not received by the third working day prior to the date of the examination. The reason for this change was to ensure consistency by using working days in both requirements. The reason for the difference between 5 and 3 working days was to allow the designated doctor time to evaluate what, if any, records had been received and then what records had not been received.

Comment: Commenter suggested that under §130.5(d)(3)(B), the treating doctor (or referral doctor) should have access to the information a carrier is sending to the designated doctor(including return to work opportunities).

Response: The commission agrees in part however the commission believes that the suggestion should not be limited to the carrier's submission. The commission believes that the carrier should likewise have access to information submitted by the treating doctor. However, the commission believes that it would be redundant to require the carrier and the treating doctor to provide each other with copies of all documentation submitted to the designated doctor since that would involve exchanging medical records that both would likely already have. However, the injury analyses that are permitted by this section represent new documentation that neither will likely have and therefore may be useful for dispute resolution. Therefore subsection (d)(3)(B) was changed to implement this requirement. The subsection now reads:

(B) The treating doctor and carrier may also send the designated doctor an analysis of the employee's medical condition, functional abilities, and return-to-work opportunities. If the carrier sends an analysis to the designated doctor, the carrier shall send a copy to the treating doctor and if the treating doctor sends an analysis to the designated doctor the treating doctor shall send a copy to the carrier.

Comment: Commenter expressed concern over the commission's removal of the 90 days requirement to dispute the first certification of MMI and its long-range implication and impact to the system. Commenter suggested allowing a dispute of the first certification that is not disputed or assigned prior to the date of MMI when the impairment rating assigned after the date of statutory MMI was assigned by a designated doctor to resolve a dispute prior to the date of statutory MMI; the exam is to determine the impairment at the date of statutory MMI; or the statutory MMI date was extended per Texas Labor Code §408.104.

Commenter suggested adding language such as "The first certification of MMI and impairment rating assigned to an employee is final if the certification of MMI and/or impairment rating (IR) is not disputed prior to the date of statutory MMI as defined by Chapter 401, Subchapter B or Chapter 408, Subchapter F of the Texas Labor Code." Commenter further stated the commission should consider the appropriate impairment to be one that is assigned prior to or at statutory MMI and should not consider an impairment rating received after the date of statutory MMI unless one of the recommended exceptions apply.

Response: The commission disagrees. As noted in the proposal preamble, the ability to go straight to a designated doctor without first having a certification of MMI by another doctor should greatly increase the number of claimants with a designated doctor's opinion regarding MMI and impairment. Since the opinion of a designated doctor on such an issue has presumptive weight, it is not likely to be overturned and thus would end up "finalizing" the MMI/impairment issue.

Comment: Commenter noted that §130.5(f) ends with a comma as opposed to a period. Commenter suggested that pursuant to Labor Code §408.0041(j), a disputing party may also request an expedited benefit review conference. Therefore, this option should be listed.

Another commenter suggested that §130.5(f), needs to be more specific. Commenter stated that because the way it is written, it makes it easy to start a dispute for no cause. Commenter also stated that §130.5(f)(1) is pure harassment unless there is cause.

Response: The commission disagrees with the comments regarding subchapter (f)(1). The statutory language is specific under Texas Labor Code §408.0041(f) in that if the carrier is not satisfied with the opinion of the designated doctor, the carrier may request the commission to order an employee to attend an examination by a doctor selected by the carrier. Additionally, the option regarding the expedited benefit review conference is covered under subsection (f)(3). The Commission agrees that the first sentence in subchapter (f) needs to end with a period and has made the change.

Comment: Commenter stated that some designated doctors fail to submit reports in a timely manner creating problems that result in overpayments or a lapse in benefit payment. Although the commission has administrative alternatives, no guidance or procedure was established to reduce overpayments or prevent delays in benefit payments.

Commenter suggested moving proposed §130.5(f) to (g) and adding new subsection (f) that states, "The carrier is entitled to request assignment of a new designated doctor if the carrier or commission has not received the Report of Medical Evaluation from a selected designated doctor under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings) within 30 days of the date of the evaluation. If the Report of Medical Evaluation is not received within 30 days of the evaluation, the commission must reassign a new designated doctor to perform the examination and the carrier is not liable for payment of the original evaluation report." Commenter was of the opinion that this will allow the commission to assign a new designated doctor within a reasonable period of time, promote timely reporting, and relieve the carrier of liability when the designated doctor fails to submit the report.

Response: The commission disagrees. There are provisions in place in the event that reports are not received in a timely manner. If the commission determines on a case-by-case basis, that a designated doctor refuses to comply, the commission will take appropriate action and would determine if it is appropriate to select an alternate designated doctor. Carriers are reminded that their time-frame to pay the designated doctor for the examination does not begin until the doctor has submitted the required report. If carriers withhold payment prior to receiving the report, the commission would be more able to ensure prompt reporting. For example, if the commission found that a doctor had not

yet filed a report, the commission could remind the designated doctor that if a report is not received, it could result in the commission selecting a new designed doctor and that he/she would not be paid for the examination that was already conducted.

Comment: Commenter is of the opinion that the rules give carriers inappropriate latitude in challenging MMI/impairment, and that the rules encourage report intensive practices that will significantly expand paperwork requirements and provide disincentives for physicians to participate in the system.

Response. TWCC disagrees. The language in new §408.0041 is specific regarding the carrier's entitlement to request the commission to order an employee to attend an examination by a doctor of the carrier's choice, when the carrier is not satisfied with the opinion rendered by a designated doctor. Section 130.1 provides the reporting requirements and has not changed from the prior section. It is the commission's opinion that complete reports with necessary documentation expedite the process and prevents unnecessary disputes.

Comments on §130.6

Comment: Commenter suggested adding language to §130.6(a)(2) such as "at the time the designated doctor was appointed", at the end of the first sentence to avoid the situation where a designated doctor is selected for the issue of IR only, yet comments on the issue of MMI. Commenter stated that in those situations, a party may then "dispute" the previously undisputed determination of MMI. It is the commenter's opinion that currently proposed, the section is ambiguous in those instances, and it should be clear that the unrequested MMI date should not only not be given presumptive weight but should also be determined invalid and ignored as if not rendered. Accordingly, proposed §130.1(a)(2) provides that a certification of MMI by an unauthorized doctor is invalid. Therefore to the extent that such is permissible, the unrequested MMI date from a designated doctor should also be invalid.

Another commenter questioned what a designated doctor is requested to report to the commission.

Response: The commission disagrees. Proposed §130.6(d) addresses the designated doctors responsibilities regarding the issue(s) in question and the specific requirements. It is clear that the designated doctor's opinion is given presumptive weight for the issue in question only. In addition, §130.5 (d)(1)(B) provides that the commission order should explain the purpose of the designated doctor's examination and such information is currently provided on the order for an examination, Form EES-14.

Comment: Commenter stated concern over §130.6(a)(2), and is of the opinion that it dilutes presumptive weight given determinations by designated doctors. Commenter further stated that HB 2600 continued to provide presumptive weight in §408.122(c). Commenter also stated there is no legislative authority to eliminate this presumptive weight.

Response: The commission disagrees. The intent of §130.6(a)(2) is to ensure designated doctors address the issues in question only and do not provide information regarding other issues not in question. Presumptive weight is given to the designated doctor's opinion for the issue(s) in question. Since the statute does not have presumptive weight on other matters in disputes involving MMI or impairment, this language is appropriate. However, the commission would like the option of being able to get the designated doctor's opinion on other matters without having to grant that opinion presumptive weight.

Comment: Commenter suggested the commission should specify the criteria to allow an extension beyond seven days and require the commission sent a letter informing the parties that an extension was granted and stating the specific reasons or grounds for extension under §130.6(b).

Response: The commission disagrees. TWCC will evaluate the reasons given for the scheduled examination on a case-by-case basis to ensure good cause exists for the cancellation. Reasons for suspension of benefits are given under §130.6(c)(1)(A).

Comment: Commenter stated that under §130.6(c), in addition to the right of the carrier to suspend temporary income benefits, §408.0041(h) of the Labor Code provides that the claimant is not entitled to "compensation" (as defined in §401.011 of the Labor Code) if the claimant fails to attend an appointment required by "this chapter" (i.e., Chapter 408 of the Labor Code). Commenter contended that although the carrier is clearly allowed to suspend TIBS, the section also provides that the claimant is not entitled to any other type of compensation during the period that he or she has failed to attend a designated doctor appointment without good cause. Commenter suggested that subsection (c)(2) should also reflect this requirement because it is particularly important in instances of medical disputes or where the claimant is not receiving temporary income benefits. Commenter added that a carrier's suspension of TIBs is absolutely not a requirement for loss of TIBs and that TWCC is changing the law.

Another commenter recommended deleting §130.6(c)(3) because an injured worker is not entitled to TIBs for any period that the injured worker failed to attend a properly TWCC ordered scheduled designated doctor exam without good cause. Commenter stated that is true whether or not the carrier suspended TIBs, and that an injured worker is not entitled to any benefits, not just TIBs. Commenter cited Labor Code §408.004(e) and §408.0041(h). Commenter suggested the addition of a subsection addressing that an injured worker is not entitled to benefits for the period the injured worker fails to attend a designated doctor exam without good cause to comply with the Act.

Response: The commission agrees that the injured employee should be made aware of the consequences for failure to attend a designated doctor examination. However, it would be more appropriate to include this language as part of the order (Form EES-14) to the injured employee. Further, as noted, the commission does not believe that the language allowing suspension of TIBs also allows the suspension of other forms of compensation. Regarding §130.6 (c)(3), Labor Code §408.0041(h) does state that the employee is not entitled to compensation during a period that the employee fails to submit to the examination, unless the commission determines that the employee had good cause. However, the actual language states that an "employee is not entitled to compensation, and an insurance carrier is authorized to suspend the payment of temporary income benefits, during and for a period in which the employee fails to submit to an examination." The statute does not provide the carrier with the authority to suspend all benefits (which, used in the general sense, includes medical benefits), merely TIBs. The commission believes that if the Legislature intended this subsection to apply to all benefits, it would not have limited the carrier's right to suspend to TIBs only.

Finally, the language in §130.6(c) addresses circumstances under which the carrier may presume that good cause does not exist. This language does not forbid the carrier from coming to the commission to ask for a finding of "no good cause" in other circumstances, which would then allow the suspension of TIBs.

Comment: Commenter suggested that §130.6(d) should provide that "an unrequested MMI date should not only not be given presumptive weight but should also be determined invalid and ignored as if not rendered. Further, it would be appropriate to reiterate that ignoring the requirement that the doctor shall confine the report to only the issues requested can subject the designated doctor to an administrative violation for failing to comply with a commission rule."

Response: Proposed §130.6(d) addresses the designated doctor's responsibilities regarding the issue(s) in question and the specific requirements. In addition, §130.5 (d)(1)(B) provides that the commission order should explain the purpose of the designated doctor's examination and such information is currently provided on the order for an examination, Form EES-14. The commission, by policy, no longer outlines violation information in every rule, as it would add multiple paragraphs to every rule in order to add language that is redundant to the statute. However, the commission agrees that failure by a system participant to comply with the statute or rules is not permissible and may be subject to enforcement action as permitted by statute.

Comment: Commenter suggested the commission should reconsider the language, which suggests the estimated date of MMI because this would put the designated doctor in a very tight spot.

Response: The commission disagrees. The examination of the injured employee and review and evaluation of the documentation provided should provide sufficient information for the designated doctor to make a reasonable estimate regarding expected maximum medical improvement. All too often, designated doctors are unwilling to certify MMI as having occurred on a date prior to the date the doctor actually saw the employee. The commission believes that this is contrary to the intent of the statute and believes that this requirement will help justify assigning a date of MMI that is different from that of the doctor who has been treating the employee and thus should have some sense of the actual progress of the employee. Further, estimating future MMI dates, while not binding, will help with claims management and possibly establish good cause for requesting a designated doctor examination less than 60 days after a prior exam.

In addition, an estimated date of MMI can also help with dispute resolution in the event that a carrier RME doctor finds the employee to be at MMI shortly after the date the designed doctor found the employee to not be at MMI. In such an event the commission would expect the RME doctor to be able document the specific change in the employee's condition that explains how the employee is now at MMI when the designated doctor found that the employee was not at MMI. The RME doctor's belief that the designated doctor was simply wrong is not likely to be sufficient to overcome the presumptive weight given to the designated doctor's opinion in the absence of specific medical evidence or demonstrable improvement in the claimant's condition since the designated doctor examination. To clarify this issue, subsection (d)(1) has been changed to read as follows:

(1) When there has been no prior certification of MMI, the designated doctor shall evaluate the employee for MMI, and if the doctor finds that the employee reached MMI, assign an impairment rating. If the designated doctor finds that the employee has not reached MMI, the doctor shall identify the reason that the designated doctor does not believe the employee to have reached MMI and estimate the date that the employee will reach MMI.

Comment: Commenter suggested that under §130.6(d), when TWCC asks the designated doctor to answer additional questions such as the extent of the compensable injury and contribution, it should be made absolutely clear that the designated doctor is entitled to additional fees for the additional work. Commenter stated that these added questions make the designated doctor's work clearly different from merely a MMI/IR certification. That is also true with respect to §130.6(5) where the DD is asked to give an IR based on two or more different combinations possibly attributed to be compensable injury.

Response: The commission disagrees. The medical fee guidelines provides for the reimbursement of determination of MMI and/or IR. However, the commission is expected to propose new guidelines shortly and the commenter's suggestion should be made if the commenter believes that the proposed reimbursement for designated doctor examinations is not sufficient.

Comment: Commenter suggested that under §130.6(g), the permissive word "may" be changed to the mandatory "shall". This may be necessary to avoid unnecessary delays and to remove the ambiguity, with respect to the requirement of the designated doctor to perform additional testing or referrals. Several commenters suggested deleting the last sentence under §130.6(g) because there may be instances when the added testing can't be scheduled and completed within the given time period. A commenter suggested changing the required time frame from seven to ten days. Another commenter stated that establishing a fixed maximum 7-day period for additional testing is not reasonable.

Response: The commission disagrees as the use of "may" in this sentence makes it clear that it is at the designated doctor's discretion to determine whether additional testing is necessary. However, the sentences that follow make it clear that "if" the doctor conducts such testing, how it is to be done to prevent delays. Additionally, extending the time period when added testing is necessary would affect the designated doctor's filing requirements.

Comment: Commenter suggested the commission establish and publish a procedure to provide remedy if the designated doctor fails to respond timely to the request for clarification. Specifically, steps to be taken if the designated doctor is no longer available for response. Commenter questioned whether the process must begin again, or if another doctor would be appointed for the sole purpose of clarifying the issue needing clarification.

Response: The commission agrees that language is necessary to ensure that designated doctors are available for follow-up questions and examinations and has added the following language to subsection (i) to address this situation:

If, in order to respond to the request for clarification, the designated doctor has to reexamine the employee, the doctor shall make him/herself available to conduct the examination within 10 working days of receiving the request (even if it means traveling back to the location of the examination) and shall respond to the request for clarification not later than the fifth working day following the reexamination.

Comment: Commenter suggested deleting the last sentence under §130.6(i) because a designated doctor's response has presumptive weight with respect to MMI/IR certification. Commenter stated that this provision is too broad and unnecessary since is already presented in §180.20 of this title.

Another commenter disagreed with §130.6(i), which provides that a clarification response is entitled to presumptive weight

as a part of the designated doctor's opinion. Commenter suggested that Appeals Panel decisions are replete with instances of commission employees at various levels of administrative responsibility sending clarification requests to the designated doctor, resulting in significant changes in the MMI date or IR. Then it is determined that it was an abuse of discretion to have sent this request, and the original report of the designated doctor is adopted. Commenter cited Appeal No. 971770 and on remand, Appeal No. 980355, for a particularly egregious example. Commenter contended that the carrier in the meantime is required to make substantial unrecoupable overpayments, which result in significant costs to the system. Commenter contends this is most often seen in situations where the claimant has received post-statutory MMI surgery. Commenter further suggested that when there is sufficient uncertainty in the case as evidenced by differing opinions of the same doctor, an opinion should not be afforded a presumption simply because it is the latest. Rather it should be deferred to a fact finder.

Response: The commission disagrees. The intent is to ensure that the doctor's clarification has presumptive weight. Too often people have argued that the initial report of the designated doctor is the one that has presumptive weight even if it contains an error that the doctor agrees needs to be corrected. If the designated doctor determines that the additional documentation is supportive of a change in his original recommendation, then the opinion should also carry presumptive weight. Further, §180.20 provides no guidance regarding presumptive weight of a designated doctor's opinion.

Comment: Commenter contended that although §130.6(k) requires the carrier to pay any accrued benefits based on the report of the designated doctor no later than five days after receipt, the subsection provides no reimbursement mechanism in the event that the report is subsequently overcome. Commenter recognized this concept is embodied in the current rule, but contended that nothing in the Labor Code authorizes the Commission to impose the additional burden that the carrier makes payment pursuant to the report of the designated doctor, in the absence of a specific order. Commenter stated that to the extent that there is no reimbursement mechanism, it is also an arguably impermissible taking in violation of the carrier's due process rights. Commenter suggested that this is entirely solvable, however, if the carrier is required to pay, not upon receipt of the designated doctor's report, but upon the receipt of an automatic interlocutory order issued by the Commission. That would then allow reimbursement from the Subsequent Injury Fund should the Commission or courts ultimately reject the report. Commenter further suggested that to effectuate this, the proposed subsection should be modified as follows: "Upon receipt of the designated doctor's report, or amendment, the Commission shall issue an interlocutory order requiring the carrier to pay any accrued income benefits, and to begin or continue to pay weekly income benefits in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the interlocutory order."

Another commenter suggested consistency with the Preamble by adding to §130.6(k) the sentence "In the event of an extent of injury dispute, the carrier should be required to pay in accordance with the designated doctor's rating based upon the conditions that the carrier believes are part of the compensable injury to prevent an overpayment and then pay pursuant to the other designated doctor's rating to prevent delays in benefit payments, if it is later determined that the compensable injury includes the disputed conditions." It was also suggested changing the carrier's time frame for payment from five days to seven to be consistent with other payment initiation requirements.

Response: The commission disagrees. Since designated doctors have presumptive weight on matters relating to MMI and impairment, they are rarely overturned. Therefore the risks described by the commenter are relatively limited. It is important to note that Texas Labor Code §408.0041 provides that if the carrier is not satisfied with the opinion of the designated doctor, the carrier may request the commission to order an employee to attend an examination by a doctor selected by the carrier.

Section 408.121(b) provides that a carrier shall begin payment of impairment income benefits within five days of the date the report is received. Additionally, §409.023 of the Labor Code requires carriers to pay benefits as and when they accrue. Thus the carrier is required to pay all accrued benefits. However, it is worth noting that in the instance where the designated doctor found that the employee was not at MMI, this finding does not equate to a finding that the employee had disability at the time of the examination. As such, carriers could timely dispute disability if they had reasonable grounds to do so.

However, the commission does agree with the suggested language regarding payment in the event of an extent of injury dispute. Subsection (k) has been modified to require the carrier to pay based upon the certification of MMI and rating assigned by the designated doctor that is consistent with the carrier's belief of what the compensable injury is. If multiple certifications/ratings are not assigned, carriers are not permitted to modify a certification or rating by the designated doctor. They may merely pick the one that corresponds to their belief of the extent of the compensable injury. The additional language reads:

If the designated doctor provided multiple certifications of MMI/impairment ratings by operation of subsection (d)(5), the carrier shall pay using the certification/rating assigned based on the conditions that the carrier believes are part of the compensable injury.

Comments on §130.110

The commission received numerous comments regarding §130.110. However, as noted in the preamble, the commission proposed deletion of subsection (n) only because it is redundant to provisions in other rules and otherwise had no plans to change the rule. Therefore the commission feels this section was not open for comment beyond the proposed change and believes that other changes would require reproposal to allow system participants the opportunity to consider the recommendations and comment. No comments were received on the proposed removal of subsection (n).

SUBCHAPTER A. IMPAIRMENT INCOME BENEFITS

28 TAC §§130.1 - 130.6

The amendments, new rule and repeal are adopted pursuant to the Texas Labor Code §402.061 which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act; the Texas Labor Code, §401.011 which contains definitions used in the Texas Workers' Compensation Act; the Texas Labor Code, §401.024, which provides the commission the authority to require use of facsimile or other electronic means to transmit information in the system; the Texas Labor Code, §402.042, which authorizes the

executive director to enter orders as authorized by the statute as well as to prescribe the form and manner and procedure for transmission of information to the commission; the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §406.010, that authorizes the commission to adopt rules regarding claims service; the Texas Labor Code, §408.004 as amended by the 77th Texas Legislature, which provides for Required Medical Examinations; Texas Labor Code §408.0041 as adopted by the 77th Texas Legislature, which provides for the commission assignment of a designated doctor; the Texas Labor Code §408.023, as amended by the 77th Texas Legislature, which requires the commission to develop a list of approved doctors and lay out the requirements for being on the list; the Texas Labor Code §408.0231, which provides the commission with the responsibility for maintenance of the list; the Texas Labor Code, §408.025, which requires the commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code §408.102, which provides that temporary income benefits continue until the injured employee reaches maximum medical improvement; the Texas Labor Code §408.122, as amended by the 77th Texas Legislature, which requires that designated doctors meet specific qualifications; the Texas Labor Code §408.123, which requires a doctor certifying maximum medical improvement to file a report and which requires a certification of MMI and assignment of an impairment rating by a doctor other than the treating doctor be sent to the treating doctor who must indicate either agreement or disagreement with the certification of the evaluation; the Texas Labor Code §408.124, which provides the commission the authority to by rule adopt the fourth edition of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association to determine the existence and degree of an injured employee's impairment; the Texas Labor Code §408.125, as amended by the 77th Texas Legislature, which provides the process for disputing impairment ratings; the Texas Labor Code §408.151, which provides for required medical examinations for supplemental income benefits; and the Texas Labor Code §415.0035, as passed by the 77th Texas Legislature, that establishes administrative violations for repeated administrative violations or for a provider failing to submit required medical reports.

The amendments, new rule and repeal are adopted pursuant to the Texas Labor Code §401.011, §401.024, §402.042, §402.061, §406.010, §408.004 §408.0041, §408.023, §408.0231, §408.025, §408.102, §408.122, §408.123, §408.124, §408.125, §408.151,§415.0035,

§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 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 carrier and approved by the commission 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 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 commission has certified to assign impairment ratings or otherwise given specific permission by exception to, is authorized to determine whether an employee has permanent impairment, assign an impairment rating, and certify MMI; and

(ii) a doctor whom the commission has not certified to assign impairment ratings or otherwise given specific permission by exception to is only authorized to determine whether an employee has permanent impairment and, in the event that that the 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 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 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.

(3) Certification of MMI is a finding made by an authorized doctor that an injured employee (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 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 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 commission 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 must be based on the employee's medical record and the certifying examination. 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 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 employee is evaluated, has had the impairment rating training module required by §180.23 (relating to Commission Required Training for Doctors/Certification Levels) 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 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 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 commission.

(2) A Report of Medical Evaluation under this rule shall be filed with the commission, employee, employee's representative, and the insurance carrier (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 carrier by facsimile or electronic transmission; and

(B) The Report of Medical Evaluation shall be filed with the commission, the employee and the 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.

§130.2. Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by the Treating Doctor.

(a) A treating doctor shall either examine the injured employee (employee) and determine if the employee has any permanent impairment as a result of the compensable injury as soon as the doctor anticipates that the employee will have no further material recovery from or lasting improvement to the work-related injury or illness, based on reasonable medical probability, or have another authorized doctor do so.

(1) A treating doctor who finds that the employee has permanent impairment but who is not authorized to assign impairment ratings (as provided in §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), shall make a referral to a doctor who is authorized to do so on behalf of the treating doctor. Even if the treating doctor is so authorized, the doctor may chose to have another authorized doctor evaluate the employee for maximum medical improvement (MMI) and impairment in the place of the treating doctor. However, this evaluation shall be considered to be the report of the treating doctor.

(2) Other than subsections (c) and (d) of this section, nothing in this section requires a treating doctor to schedule an examination if the employee has been released from treatment and is not receiving temporary income benefits (TIBs). For example, when the patient is treated and released without further treatment for a minor injury, the treating doctor is not required to schedule and conduct an examination for MMI and permanent impairment.

(b) A certification of MMI and assignment of an impairment rating shall be performed and reported in accordance with the requirements of §130.1 of this title. .

(c) The commission shall mail a notice to a treating doctor on the expiration of 98 weeks from the date the employee's TIBs began to accrue if the employee is still receiving temporary income benefits. The commission's notice shall advise the treating doctor of the requirements chapter 408, Subchapter G of the Texas Workers' Compensation Act, and this rule, and require that an impairment rating report be mailed to the commission no later than 104 weeks from the date temporary income benefits began to accrue. A copy of the notice shall be sent to the employee as well.

(d) Upon receipt of the commission's notice required in subsection (c) of this section, the treating doctor shall schedule and conduct an examination of the employee in accordance with §130.1 to certify a MMI date (if earlier than the statutory MMI date as defined in §130.4 of this title (relating to Presumption that Maximum Medical Improvement (MMI) has been Reached and Resolution when MMI has not been Certified)) and to assign an impairment rating. A treating doctor who is not authorized to certify MMI and assign impairment ratings, shall make a referral to a doctor who is authorized to do so on behalf of the treating doctor.

(e) If the carrier has not received a report of medical evaluation by the date of statutory MMI:

(1) the carrier may suspend TIBs and is not required to initiate impairment income benefits (IIBs) until such time as it receives a report of an impairment rating assigned in accordance with §130.1;

(2) the carrier or the employee may request the appointment of a designated doctor under §130.5 of this title (relating to Entitlement and Procedure for Requesting Designated Doctor Examinations related to Maximum Medical Improvement and Impairment Rating); and/or

(3) a carrier may make a reasonable assessment of what it believes the true impairment rating should be and, if it does so, shall initiate IIBs within five days of making the assessment. The carrier shall continue to pay IIBs until the assessment is paid in full or is superceded by an impairment rating assigned in accordance with §130.1.

§130.3. Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by A Doctor Other Than The Treating Doctor.

(a) A doctor, other than a treating doctor, who is authorized to certify that an employee has reached maximum medical improvement (MMI), must do so in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). In addition to complying with the filing requirements of §130.1, the certifying doctor shall file a copy of the Report of Medical Evaluation and the narrative with the treating doctor within the same timeframes for filing with the other persons that §130.1 requires.

(b) Upon receipt of the report identified in subsection (a) of this section, the treating doctor shall:

(1) indicate on the report either agreement or disagreement with the certification of maximum medical improvement and with the impairment rating assigned by the certifying doctor, and, in the case of a disagreement, explain the reasons for this disagreement; and

(2) within seven days of receipt, send a signed copy of the report indicating agreement or disagreement and including any required explanation to the commission, the employee and the employee's representative (if any), and the carrier.

(c) A treating doctor's agreement or disagreement under subsection (b) of this section does not require a separate examination of the employee prior to the issuance of the opinion and shall not be considered a certification as that term is used in §130.1 of this title.

(d) The reports required under this section to be filed with a doctor and carrier shall be filed by facsimile or electronic transmission. In addition, the doctor shall file the report with the employee and the employee's representative by facsimile or electronic transmission if the doctor has been provided the employer's facsimile number or email address; otherwise, the report shall be sent by other verifiable means.

(e) A doctor required to file a report under this section shall maintain the original copy of the Report of Medical Evaluation and narrative and documentation of the date, addressees, facsimile numbers/email addresses and means of delivery that the reports required under this section were transmitted or mailed including proof of successful transmission. In addition:

(1) a certifying doctor shall maintain documentation of:

(A) The date of the examination of the employee; and

(B) The date any medical records necessary to make the certification of MMI were received, and from whom the medical records were received; and

(2) a treating doctor who receives the certifying doctor's report shall maintain documentation of the date the report was received and the means by which the report was delivered to the treating doctor.

§130.4. Presumption that Maximum Medical Improvement (MMI) has been Reached and Resolution when MMI has not been Certified.

(a) This section does not apply if statutory maximum medical improvement (MMI) has been reached. Statutory MMI is the later of:

(1) the end of the 104th week after the date that temporary income benefits (TIBs) began to accrue; or

(2) the date to which MMI was extended by the commission through operation of Texas Labor Code §408.104.

(b) If there has not been a certification in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment) that an injured employee has reached MMI, an insurance carrier (carrier) may follow the procedure outlined in this section to resolve whether an employee has reached MMI. The carrier shall presume, only for purposes of invoking this procedure, that an employee has reached MMI, if:

(1) it appears that the employee has failed to attend two or more consecutively scheduled health care appointments and the number of days between the two examinations is greater than 60 except for laminectomy, spinal fusion or diskectomy in which case the number of days between the two examinations is greater than 90;

(2) the treating doctor has examined the employee at least twice for the same compensable injury after the date on which TIBs began to accrue, and the doctor's medical reports as filed with the insurance carrier for all examinations and reports conducted after the first of the two examinations, indicate a lack of medical improvement in the employees condition since the date of the first of the two examinations;

(3) the employee was previously found not to be at MMI by a designated doctor but the employee has reached the date the designated doctor estimated that the employee would reach MMI; or

(4) the employee is four weeks past the point that the claim has become a Work Release Outlier Claim as defined by commission rule.

(c) A carrier permitted by subsection (b) of this section to invoke this procedure may request the treating doctor to provide a report on the employee's medical status as it relates to MMI. Note - nothing in this section prohibits the carrier from contacting the treating doctor about whether the employee has reached MMI.

(d) The treating doctor shall evaluate the employee's condition within 14 days of receiving the request from the carrier under subsection (c) of this section. The evaluation shall be conducted in accordance with §130.1 of this title and the report filed within seven working days of the date of the examination. If the treating doctor determines that the employee has permanent impairment but is not authorized to certify MMI or assign an impairment rating, the doctor shall refer the employee to a doctor who is so authorized and this doctor shall comply with the requirements of this section, §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement by Doctor Other Than Treating Doctor).

(e) If the treating doctor fails to respond as required by this rule, or if the treating doctor certifies that the employee has not reached MMI, the carrier may request a designated doctor under §130.5 (relating to Entitlement and Procedure for Requesting Designated Doctor Medical Examination).

§130.5. Entitlement and Procedure for Requesting Designated Doctor Examinations related to Maximum Medical Improvement and Impairment Rating.

(a) The commission shall order a medical examination by a designated doctor at the request of the insurance carrier (carrier), an injured employee, the injured employee's representative (if any), the Medical Advisor, or a division of the commission. The request shall be made in the form and manner prescribed by the commission.

(b) This section shall be used to resolve questions about:

(1) a certification of maximum medical improvement (MMI) and/or an impairment rating (rating) assigned under §130.1 of this section (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment);

(2) the treating doctor's failure to certify the employee to have reached MMI under §130.4(d) (relating to Presumption that Maximum Medical Improvement has been Reached and Resolution when MMI has not been Certified); and

(3) other questions regarding maximum medical improvement and/or the existence and amount of permanent impairment.

(c) A certification of MMI and/or impairment rating assigned by a doctor selected by a carrier when the carrier was not entitled such an evaluation, or otherwise assigned in violation of §126.5 of this title (relating to Entitlement to and Procedure for Requesting Required Medical Examinations), or assigned by a doctor who is not authorized to certify MMI or assign an impairment rating is invalid and this section does not apply.

(d) The following provisions apply to selection and scheduling of an examination by a designated doctor:

(1) The commission, within 10 days of receipt of a valid request, shall issue a written order assigning a designated doctor; set up a designated doctor appointment for a date no earlier than 14 days, but no later than 21 days from the date of the commission order; and notify the employee and the carrier that the designated doctor will be directed to examine the employee. The commission's written order shall also:

(A) indicate the designated doctor's name, license number, practice address and telephone number, and the date and time of the examination;

(B) explain the purpose of the designated doctor examination and that the designated doctor's report has presumptive weight with respect to MMI and/or impairment as specified in the Texas Labor Code, §§408.0041, 408.122, and 408.125;

(C) order the employee to be examined by the designated doctor on the stated date and time; and

(D) require the treating doctor and carrier to forward all medical records in compliance with subsection (d)(3) of this section.

(2) If at the time the request is made, the commission has previously assigned a designated doctor to the claim, the commission shall use that doctor again, if the doctor is still qualified as described in this subsection and available. Otherwise, the commission shall select the next available doctor on the commission's Designated Doctor List who:

(A) has not previously treated or examined the employee within the past 12 months and has not examined or treated the employee with regard to a medical condition being evaluated in the designated doctor examination;

(B) does not have any disqualifying associations as specified in §180.21 of this title (relating to Designated Doctor List); and

(C) has credentials appropriate to the issue in question, is trained and experienced with the treatment and procedures used by the doctor treating the patient's medical condition, and whose scope of practice includes the treatment and procedures performed. In selecting a designated doctor, completed medical procedures may be considered secondary selection criteria.

(3) The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of a dispute under this section without a signed release from the employee.

(A) The treating doctor and carrier shall provide to the designated doctor copies of all the employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor.

(B) The treating doctor and carrier may also send the designated doctor an analysis of the employee's medical condition, functional abilities, and return-to-work opportunities. If the carrier sends an analysis to the designated doctor, the carrier shall send a copy to the treating doctor and if the treating doctor sends an analysis to the designated doctor, the treating doctor shall send a copy to the carrier.

(C) The treating doctor and carrier shall ensure that the required records and analyses (if any) are received by the designated doctor no later than the fifth working day prior to the date of the designated doctor examination. If the designated doctor has not received the medical records at least three working days prior to the examination, the doctor shall notify the commission's office that scheduled the examination. The appropriate commission staff may send an order to the treating doctor and/or carrier for the delivery of medical records to the designated doctor.

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

(A) only the employee or appropriate commission staff may communicate with the designated doctor about the case regarding the employee's medical condition or history prior to the examination of the employee by the designated doctor;

(B) after the examination is completed, communication with the designated doctor regarding the employee's medical condition or history may be made only through appropriate commission staff (an ombudsman is not considered appropriate staff to contact the designated doctor and should communicate with a designated doctor only through appropriate commission staff); and

(C) the designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury or with peer reviews identified by the carrier who examined the employee's claim.

(e) The carrier is not entitled to request a subsequent designated doctor appointment relating to MMI if the designated doctor previously found the employee to have not reached MMI, until the earliest of:

(1) the 60th day after the prior designated doctor examination was held; or

(2) the date the carrier is found by the commission to have good cause such as because "the employee reached the date the designated doctor estimated the employee would reach MMI."

(f) If either party wishes to dispute the report of the designated doctor, the party shall file the dispute with the commission.

(1) If the carrier is not satisfied with the opinion rendered by a designated doctor under this section, the carrier may request the commission to order an employee to attend an examination by a doctor selected by the carrier in accordance with §126.5 of this title.

(2) Either party may ask the commission to contact the designated doctor to answer specific questions provided by the requestor regarding the designated doctor's opinion.

(3) The commission shall resolve a dispute of the opinion of a designated doctor through the dispute resolution processes outlined in chapters 140 through 147 of this title.

§130.6. Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings.

(a) A designated doctor examination for maximum medical improvement (MMI) and/or permanent whole body impairment shall be conducted in accordance with this section.

(1) Any evaluation relating to either MMI, an impairment rating or both shall be conducted in accordance with §130.1 of this section (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment).

(2) The opinion of the designated doctor is given presumptive weight regarding MMI and impairment but only on the issue(s) in question or dispute. If the report contains the doctor's opinion regarding other issues (even those the commission has requested the doctor to consider), that portion of the opinion does not have presumptive weight.

(b) The designated doctor and the injured employee (employee) shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination unless an extension is granted by the commission's field office. Within 24 hours of rescheduling, the designated doctor shall contact the commission's field office and the insurance carrier (carrier) with the time and date of the rescheduled examination.

(c) A carrier may suspend temporary income benefits (TIBs) if an employee, without good cause, fails to attend a designated doctor examination.

(1) In the absence of a finding by the commission to the contrary, a carrier may presume that the employee did not have good cause to fail to attend the examination if:

(A) by the day the examination was originally scheduled to occur the employee has both:

(i) failed to submit to the examination; and

(ii) failed to contact the designated doctor's office to reschedule the examination to occur no later than the later of the seventh day after the originally scheduled examination date or the doctor's first available appointment date; or

(B) after rescheduling the examination as provided in subsection (c)(1)(A)(ii) of this section, the employee failed to submit to the rescheduled examination.

(2) If, after the carrier suspends TIBs pursuant to this section, the employee submits to the designated doctor examination, the carrier shall reinitiate TIBs as of the date the employee submitted to the examination unless the report of the designated doctor indicates that the employee has reached MMI. The re-initiation of TIBs shall occur no later than the seventh day following the latter of:

(A) the date the carrier was notified that the employee had attended the examination; or

(B) the date that the carrier was notified that the commission found that the employee had good cause for failure to attend the examination.

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

(d) The designated doctor shall address the issue(s) in question and any issues the commission may request the designated doctor to consider and confine the report as described in subsection (h) of this section to only those issues.

(1) When there has been no prior certification of MMI, the designated doctor shall evaluate the employee for MMI, and if the doctor finds that the employee reached MMI, assign an impairment rating. If the designated doctor finds that the employee has not reached MMI, the doctor shall identify the reason that the designated doctor does not believe the employee to have reached MMI, and estimate the date that the employee will reach MMI.

(2) When there has been a prior certification of MMI and impairment rating and only the MMI date is in question, the designated doctor shall evaluate the date the employee reached MMI and shall not assign an impairment rating. If the certification of MMI in question was the treating doctor's certification and the designated doctor finds that the employee either was not at MMI or reached MMI on a date later than the treating doctor, the designated doctor shall provide an explanation with clinical documentation to support why the employee had not reached MMI as of the date certified by the treating doctor.

(3) When the impairment rating is the only issue in question, the doctor shall assign an impairment rating without regard to the MMI date.

(4) When MMI and permanent whole body impairment are in question and the designated doctor determines that the employee has not reached MMI, the designated doctor shall not assign an impairment rating. Otherwise, the doctor shall certify MMI and assign an impairment rating.

(5) When the extent of the injury may not be agreed upon by the parties (based upon documentation provided by the treating doctor and/or carrier or the comments of the employee regarding his/her injury), the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account the various interpretations of the extent of the injury so that when the commission resolves the dispute, there is already an applicable certification of MMI and rating from which to pay benefits as required by the statute.

(e) When performing range of motion testing, if the AMA Guides specifies that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first testing unless there is no clinical basis for retesting and then the designated doctor shall document this in the narrative notes with the clinical explanation for not recommending re-examination.

(f) Range of motion, sensory, and strength testing should be performed by the designated doctor, when applicable. If this testing is not performed by the designated doctor, the health care provider performing the testing must have successfully completed commission-approved training, must not have previously treated or examined the employee within the past 12 months, and must not have not examined or treated the employee with regard to the medical condition being evaluated by the designated doctor. Use of another health care provider to perform testing under this subsection shall not extend the amount of time the designated doctor has to file the report and the designated doctor is responsible for ensuring that the requirements of this chapter are complied with.

(g) For testing other than that listed in subsection (f) of this section, the designated doctor may perform additional testing or refer employees to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required for the evaluation and rating, is not subject to preauthorization requirements in accordance with the Texas Labor Code, §413.014 (relating to Preauthorization) and additional testing must be completed within seven days of the designated doctor's physical examination of the employee. Use of another health care provider to perform testing under this subsection can extend the amount of time the designated doctor has to file the report by seven working days.

(h) The designated doctor shall complete and file a Report of Medical Evaluation in accordance with §130.1.

(i) The designated doctor shall respond to any commission requests for clarification not later than the fifth working day after the date on which the doctor receives the commission's request. The doctor's response is considered to have presumptive weight as it is part of the doctor's opinion. If, in order to respond to the request for clarification, the designated doctor has to re-examine the employee, the doctor shall make him/herself available to conduct the examination within 10 working days of receiving the request (even if it means traveling back to the location of the examination) and shall respond to the request for clarification not later than the fifth working day following the reexamination.

(j) The designated doctor shall maintain accurate records to reflect:

(1) the date and time of any designated doctor appointments scheduled with employees;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person or organization;

(5) the date the medical evaluation report was submitted to all parties in accordance with §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment);

(6) the name of all referral health care providers, date of appointments and reason for referral by the designated doctor; and

(7) the date the doctor contacted TWCC for assistance in obtaining medical records from the carrier or treating doctor.

(k) The insurance carrier shall pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the report or five days after receipt of an order by the commission, whichever is earlier. If the designated doctor provided multiple certifications of MMI/impairment ratings by operation of subsection (d)(5) of this section, the carrier shall pay using the certification/rating assigned based on the conditions that the carrier believes are part of the compensable injury.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

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Susan Cory
General Counsel
Texas Workers' Compensation Commission
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For further information, please call: (512) 804-4287

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28 TAC §130.5

The repeal is proposed under the Texas Labor Code, §401.011 which contains definitions used in the Texas Workers' Compensation Act; the Texas Labor Code, §401.024, which provides the commission the authority to require use of facsimile or other electronic means to transmit information in the system; the Texas Labor Code, §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form and manner and procedure for transmission of information to the commission; the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §406.010, which authorizes the commission to adopt rules regarding claims service; the Texas Labor Code, §408.004, as amended by the 77th Texas Legislature, which provides for Required Medical Examinations; Texas Labor Code §408.0041, as adopted by the 77th Texas Legislature, which provides for the commission assignment of a designated doctor; the Texas Labor Code §408.023, as amended by the 77th Texas Legislature, which requires the commission to develop a list of approved doctors and lay out the requirements for being on the list; the Texas Labor Code §408.0231, which provides the commission with the responsibility for maintenance of the list, the Texas Labor Code, §408,025, which requires the commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code, §408.102, which provides that temporary income benefits continue until the injured employee reaches maximum medical improvement; the Texas Labor Code, §408.122, as amended by the 77th Texas Legislature, which requires that designated doctors meet specific qualifications; the Texas Labor Code §408.123, which requires a doctor certifying maximum medical improvement to file a report and which requires a certification of MMI and assignment of an impairment rating by a doctor other than the treating doctor be sent to the treating doctor who must indicate either agreement or disagreement with the certification of the evaluation; the Texas Labor Code, §408.124, which provides the commission the authority to by rule adopt the fourth edition of the Guides to the Evaluation of Permanent Impairment " published by the American Medical Association to determine the existence and degree of an injured employee's impairment; the Texas Labor Code, §408.125, as amended by the 77th Texas Legislature, which provides the process for disputing impairment ratings; the Texas Labor Code §408.151, which provides for required medical examinations for supplemental income benefits; and the Texas Labor Code §415.0035, as passed by the 77th Texas Legislature, which establishes administrative violations for repeated administrative violations or for a provider failing to submit required medical reports. No other statutes are affected by the proposed repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Susan Cory
General Counsel
Texas Workers' Compensation Commission
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SUBCHAPTER B. SUPPLEMENTAL INCOME BENEFITS

28 TAC §130.110

The amendments, new rule and repeal are adopted pursuant to the Texas Labor Code §401.011, §401.024, §402.042, §402.061, §406.010, §408.004 §408.0041, §408.023, §408.0231, §408.025, §408.102, §408.122, §408.123, §408.124, §408.125, §408.151,§415.0035,

§130.110. Return to Work Disputes During Supplemental Income Benefits; Designated Doctor.

(a) This section applies only to disputes regarding whether an injured employee whose medical condition prevented the injured employee from returning to work in the prior year has improved sufficiently to allow the injured employee to return to work on or after the

second anniversary of the injured employee's initial entitlement to supplemental income benefits (SIBs). Upon request by the injured employee or insurance carrier, or upon its own motion, the commission shall appoint a designated doctor to resolve the dispute. The report of the designated doctor shall have presumptive weight unless the great weight of the other medical evidence is to the contrary. The presumptive weight afforded the designated doctor's report shall begin the date the report is received by the commission and shall continue:

(1) until proven otherwise by the great weight of the other medical evidence; or

(2) until the designated doctor amends his/her report based on newly provided medical or physical evidence.

(b) A dispute exists if there is conflicting medical or physical evidence that has not been previously considered in a prior dispute under this section that indicates the injured employee's medical condition has improved sufficiently to allow the injured employee to return to work. Medical evidence consists of medical reports or records that are generated as a result of a hands-on examination of the injured employee. Physical evidence may consist of, but is not limited to, videotaped activities, evidence of wage earning capabilities (i.e., payroll information), or reports from a private provider of vocational rehabilitation services or the Texas Rehabilitation Commission.

(c) A party who wishes to seek the appointment of a designated doctor to resolve the dispute shall make a request to the commission.

(d) The request for a designated doctor from an insurance carrier or an injured employee's representative must be in writing and provided to the commission in the form, format and manner prescribed by the commission. A request for a designated doctor from an unrepresented injured employee may be submitted in any manner.

(e) If a designated doctor has been appointed to resolve a prior dispute regarding maximum medical improvement and/or impairment rating, that doctor may not be appointed to resolve the dispute(s) regarding whether the injured employee's medical condition has improved sufficiently to allow the injured employee to return to work.

(f) The commission shall select the next available doctor from the commission's designated doctor list, which is, to the extent possible, in the same discipline and licensed by the same board of examiners as the injured employee's treating doctor of choice at the time of the finding of change in the injured employee's medical condition which would allow the injured employee to return to work and who has not previously treated or examined the injured employee with regard to the medical condition being evaluated by the designated doctor. A doctor selected under this section shall serve as the designated doctor for all dispute(s) raised under this section unless that doctor is unable or unwilling to act in that capacity.

(g) The designated doctor and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination unless an extension is granted by the field office managing the claim. Within 24 hours of rescheduling, the designated doctor shall contact the commission field office and the insurance carrier with the time and date of the rescheduled examination. If the designated doctor is not able to timely reschedule the examination, the designated doctor shall contact the commission field office and the insurance carrier within 24 hours of the refused examination. The commission shall then either grant an extension of not more than seven days or select a different designated doctor to perform the examination and resolve the dispute.

(h) The treating doctor and insurance carrier shall send to the designated doctor without the requirement of a signed release from the injured employee, all the employee's medical evidence in their possession relating to the medical condition to be evaluated by the designated doctor. Either party may submit with this medical evidence a videotape or other physical evidence it would like the designated doctor to review which may indicate the injured employee's medical condition has improved or has not improved sufficiently to allow the injured employee to return to return to work. The designated doctor is authorized to receive the employee's confidential medical and physical evidence provided by either party to assist in the resolution of whether the injured employee's medical condition has improved sufficiently to allow the injured employee to return to work. The medical evidence must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. The medical and physical evidence must be received by the designated doctor at least three days prior to the date of the appointment as specified in the commission order. If the medical evidence is marked, highlighted, altered, or unrelated to the medical condition to be evaluated by the designated doctor, the designated doctor shall notify the commission and report the noncompliance of the treating doctor and/or insurance carrier. If the designated doctor has not received the medical evidence at least three days prior to the examination, the designated doctor's office shall notify the commission at the appropriate field office and the appropriate commission staff will send an order to the treating doctor and/or insurance carrier for the delivery of medical evidence.

(i) To avoid undue influence on a person selected as a designated doctor in accordance with Texas Labor Code, §408.125, only the injured employee or an appropriate member of the staff of the commission may communicate with the designated doctor about the case regarding the employee's medical condition or history prior to the examination of the employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the injured employee's medical condition or history may be made only through appropriate commission staff members. An ombudsman and an ombudsman's assistant are not considered appropriate staff to contact the designated doctor and should communicate with a designated doctor only through appropriate commission personnel. The designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury.

(j) The designated doctor shall review all medical and physical evidence provided by the insurance carrier and treating doctor and shall perform a hands-on examination. The designated doctor shall give the evidence reviewed the weight he/she feels is appropriate. Following the examination, the designated doctor shall prepare a report, in the form and manner prescribed by the commission, of his/her findings regarding whether the injured employee's medical condition has improved sufficiently to allow the injured employee to return to work.

(k) The designated doctor shall file the report with the commission in the form and manner required by the commission, so that it is received by the commission not later than the seventh day after the completion of the examination of the injured employee. At the same time it is filed with the commission, the designated doctor shall provide a copy of the report by facsimile or electronic transmission to the injured employee, the injured employee's representative, if any, and the insurance carrier, unless the recipient does not have a means of receiving the transmission, in which case the report shall be sent by mail or personal delivery.

(l) The designated doctor may perform additional testing or refer the injured employee to other health care providers when deemed necessary to find whether the injured employee's medical condition has improved sufficiently to allow the injured employee to return to work. Necessary additional testing is not subject to the preauthorization requirements in the Texas Labor Code, §413.014 (relating to Preauthorization) and additional testing must be completed within seven days of the designated doctor's physical examination of the employee.

(m) The designated doctor shall maintain accurate records to reflect:

(1) the date and time of any designated doctor appointments scheduled with injured employees;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination and any testing;

(4) the date medical and physical evidence was received from the treating doctor or insurance carrier or any other person or organization;

(5) the date the medical evaluation/work status report was submitted to all parties in accordance with subsection (k) of this section; and

(6) the name of all referral health care providers, dates of referral, dates of appointments and testing dates results were received, and reason(s) for referral by the designated doctor.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 131. BENEFITS--LIFETIME INCOME BENEFITS

28 TAC §131.1

The Texas Workers' Compensation Commission (the commission) adopts amendments to §131.1 (concerning the initiation of lifetime income benefits) without changes to the proposed text published in the August 3, 2001 issue of the *Texas Register* (26 TexReg 5754).

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

Amendments to §131.1 are made in response to House Bill 2600 passed by the 77th Texas Legislature, 2001 which amended Texas Labor Code, §408.161(a) to include payment of lifetime income benefits for compensable injuries resulting in third degree burns that cover at least 40 percent of the body and require grafting, and for third degree burns covering the majority of either both hands or one hand and the face. This statutory provision is applicable to dates of injury on or after June 17, 2001. A previous statutory amendment (in 1997) is applicable to certain losses for dates of injury on or after September 1, 1997. Because eligibility for lifetime income benefits is determined in accordance with the statute and rules in effect on the date of injury, §131.1 has been amended to clarify the dates of injury to which each type of loss applies.

Because the permanent nature of such an injury is readily discernible prior to an injured employee reaching maximum medical improvement, the commission is amending the rule to require carriers to initiate lifetime income benefits after the eighth day of disability after the burn injury, or as soon as the qualification for lifetime income benefits is satisfied.

Amendments to §131.1 also replace references to statutory subsections with references to subsections of the rule. Existing citations in the rule to the Workers' Compensation Act have been updated to reflect codification of the Texas Labor Code.

Comments supporting the proposed amendments to §131.1 were received from the following groups: Texas Department of Transportation, JI Specialty Services, Inc., Insurance Council of Texas, and Nurse & Associates

Comments which did not specifically support or oppose the proposed amendments to §131.1 but recommended changes were received from the following groups: Texas A&M University System, Absolute Dance Studio and Texas Mutual Insurance Company

Summaries of the comments and commission responses are as follows:

Comment: Commenters disagreed that amended §131.1 should only apply to injuries on or after June 17, 2001. One commenter suggested that the rule should include injuries of this nature on or after September 1, 1997 if the employee is still receiving income benefits.

Response: The commission disagrees. House Bill 2600 provides that the change in Texas Labor Code §408.161(a) applies only to a claim for workers' compensation benefits based on a compensable injury that occurs on or after June 17, 2001. A claim based on a compensable injury that occurs before that date is governed by the law in effect on the date the compensable injury occurred.

Comment: Commenter believed any Texas worker that loses mobility of a limb should also be eligible for lifetime income benefits.

Response: The commission disagrees. Texas Labor Code §408.161 establishes the injury types eligible for lifetime income benefits. The qualification for lifetime income benefits is determined based on the nature and severity of the injury, not the loss of function.

Comment: Commenter was of the opinion that for third degree burns to be eligible for LIBs an injured employee should demonstrate, through medical documentation, a loss of function preventing the injured employee from retaining any type of employment.

Response: The commission disagrees. Texas Labor Code §408.161 determines the qualification for LIBs based on the nature and severity of the injury, not the loss of function.

Comment: Several commenters supported §131.1 as proposed.

Response: Staff agrees.

Comment: Commenter suggested removing type of injury (a)(7) from proposed subsection (b)(1) and adding this type of injury to proposed subsection (b)(2). Commenter contended that the permanent nature of a burn injury and the determination that the burn injury covers the majority of either both hands or one hand and the face would not be readily discernable shortly after the injury. In addition, commenter felt that determination for qualification shortly after the injury could result in underestimation of the extent of third degree burns by as much as 10 to 25 percent.

Response: The commission disagrees. The commission's Medical Advisor, after consultation with physician burn experts, has advised that an analysis of the portion of body burned is performed at the initial visit. A doctor should be able to evaluate the degree of burn and conclude whether grafting is necessary within three weeks of the burn. Therefore, the extent and degree of a burn, as well as the need for grafting to treat the burn may not always be discernible prior to the eighth day of disability; however, the qualification for LIBs as set forth by §131.1 will generally be met prior to an injured employee reaching maximum medical improvement. LIBs for injured employees meeting the qualification under §131.1(a)(7) should be initiated by the eighth day of disability or as soon as the qualifications are met.

Comment: Commenter suggested that subsection (b) be changed to initiate LIBs at the time the injured employee's injurious condition meets the qualification requirements established by the Act, regardless of which injury type identified by §131.1 the injured employee has suffered. Commenter stated that LIBs should not be paid continuously as of the first day of disability. There will be some instances where the injured worker has a deteriorating condition, has had some days of disability, returned to work, and later has the injurious condition deteriorate to the point of LIBs entitlement. Commenter felt, that at most, injured employees should be paid the difference between the TIBs, IIBs, and SIBs actually paid and the LIBs amount that would have been paid.

Response: The commission agrees in part. The permanency of some injuries, such as loss of feet or hands, are obvious and their qualification for LIBs is easily determined. The permanency of other injuries, such as an injury to the spine, may take a longer period to determine because additional improvement may be experienced following further treatment. As a result, some initiation periods for certain injury types eligible for LIBs are set following the assignment of maximum medical improvement. Texas Labor Code §401.011(30) defines maximum medical improvement as "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." As the commenter states, "except with respect to burns, all of the injurious conditions giving rise to LIBs entitlement could possibly result from deteriorating in nature with later surgical procedures." In the same way, some injuries may also improve over time. To prevent premature initiation of LIBs, determination of LIBs for certain injury types has been reserved for the point in time that no further material recovery is expected (date of MMI).

Any previous amount already paid by the carrier will be re-designated as LIBs. The carrier will only owe the difference between what was already paid to the injured employee and the amount due once the previous payments are converted to LIBs.

The amendment is adopted pursuant to the Texas Labor Code §402.061 which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act; the Texas Labor Code, §406.010, which authorizes the commission to adopt rules on claims service activities of insurance carriers; the Texas Labor Code, §408.081, which authorizes establishment of rules to pay monthly income benefits; the Texas Labor Code §408.082, which sets out when the right to income benefits accrues; and the Texas Labor Code §408.161, as amended by the 77th Texas Legislature, which describes eligibility for Lifetime Income Benefits.

The amendment is adopted pursuant to the Texas Labor Code, §402.061, §406.010, §408.081, §408.082, and §408.161.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107940
Susan Cory
General Counsel
Texas Workers' Compensation Commission
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CHAPTER 133. GENERAL MEDICAL PROVISIONS

The Texas Workers' Compensation Commission (the commission) adopts new §§133.305, 133.307, and 133.308 and the simultaneous repeal of existing §133.305, (concerning Medical Dispute Resolution) with changes to the proposed text published in the November 2, 2001 issue of the *Texas Register*(26 TexReg 8710). The new rules and repeal are adopted to comply with statutory revisions regarding medical dispute resolution in the workers' compensation system.

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order, which includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

House Bill 2600 (HB-2600), adopted during the 2001 Texas Legislative Session, amended §413.031 of the Texas Labor Code concerning medical dispute resolution. With respect to medical dispute resolution, HB-2600 addresses the following:

* the items for which medical dispute resolution is available;

* an injured employee's right to request review of a medical service for which preauthorization is sought by the health care provider and denied by the insurance carrier;

* disputes over the amount of payment due for services determined to be medically necessary and appropriate for treatment of a compensable injury;

* review of the medical necessity of a health care service requiring preauthorization under §413.014 of the Texas Labor Code;

* review of the medical necessity of a health care service provided under Chapter 408 or Chapter 413 of the Texas Labor Code;

* the dispute resolution process for a dispute in which the injured employee has paid for health care and been denied reimbursement by the carrier;

* billing for commission or independent review organization (IRO) review; and

* the appeal of a commission decision or an IRO decision.

The issues for which medical dispute resolution is available include disputes as to fees and disputes regarding medical necessity of health care. Some of the medical necessity reviews are prospective (prior to providing the health care), and some are retrospective (after the health care has been provided). The statute establishes the manner in which the reviews are to be conducted. Fee disputes will continue to be resolved by the commission, as they currently are. Prospective and retrospective medical necessity reviews shall be conducted by an IRO under Article 21.58C, Texas Administrative Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The statute also establishes the party that pays for commission review or the independent review; the identity of the party depends on the circumstances of the review and the decision reached by the commission or the IRO.

Changes made to the proposed rule are in response to public comment received in writing and at a public hearing held on November 14, 2001, and are described in the summary of comments and responses section of this preamble. Other changes were made for consistency or clarification, or to correct typographical or grammatical errors. Changes were made to the rules to correct spelling and punctuation errors, grammar and syntax. References to the "commission" and to the "division" in the rules as proposed were revised to reflect the appropriate entity.

The major revisions to the proposed rules were incorporated as a result of public comment and stakeholder input. Changes are designed to streamline medical dispute resolution into a single line dispute process to the extent possible, in which there are two types of disputes: medical fee and medical necessity. Under the adopted rules, the requestor simultaneously submits all initial requests for dispute resolution to the carrier or respondent with a copy to the commission for monitoring of carrier compliance. At that point, the carrier is held responsible for timely supplying additional information to the initial request and providing it to the requestor with a copy to the commission.

The division reviews the documents and determines if the dispute is: 1) medical fee only and will be addressed and resolved by the commission; 2) prospective medical necessity care and will proceed to independent review by an Independent Review Organization (IRO); 3) retrospective medical necessity with a medical fee component and will proceed to independent review at an IRO to resolve the medical necessity question, then if medical necessity has been established, the division will resolve the fee dispute and issue a single order to include the IRO decision; 4) an injured employee reimbursement dispute, and will determine which dispute process is appropriate for resolving the issues; 5) a carrier refund request and will determine which dispute process is appropriate for resolving the issues; 6) a commission refund order dispute and will advise the parties to pursue resolution at the State Office of Administrative Hearings (SOAH).

Also based upon public comment discussed below, the commission has revised the billing process. For retrospective reviews, the requestor must pay the IRO fee to the IRO before the IRO begins review of the case. The time frame in which the IRO must render a decision does not begin to run until the IRO receives the fee payment from the requestor. If the requestor is the prevailing party in the IRO decision, the commission will order the respondent to reimburse the IRO fee to the requestor within 10 days. If the respondent is the prevailing party in the IRO decision, there is no need to order any party to reimburse the other party. In an employee reimbursement dispute and in a preauthorization prospective necessity dispute, the carrier must pay the IRO fee to the IRO before the IRO begins review of the case. Upon receipt of an IRO assignment in a prospective dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO at the same time the carrier files the documentation requested by the IRO.

Commenters raised concerns that there would not be sufficient IRO capacity to handle the workers' compensation case volume as of January 2002. Commenters recommended that the commission provide interim procedures and provisions to accommodate and reduce the system-wide cost of the potential delays and backlogs while phasing in the IRO process and emphasize those disputes for which time is an element. Others recommended that the commission consider engaging independent, objective reviewers who are not affiliated with the commission, carriers or related third parties to conduct those reviews not able to be completed by IROs due to capacity limitations. The commission understands the concerns, but the legislature has mandated the review process for medical disputes and use of any alternate process will have to be by mutual agreement of the parties. The commission has taken steps in these rules, however, to attempt to reduce the burden on IROs, including changes in the billing process and in the determination of the nonprevailing party, while still complying with statutory intent. In the rules as adopted, the commission has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded. In addition, the rule as adopted allows the commission to assign disputes in accordance with the priorities established in the rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity. The commission encourages all parties to explore all options in resolving their medical disputes prior to requesting medical dispute resolution. The commission will, by TWCC advisory, provide information regarding an alternate process to which the parties may voluntarily use to resolve disputes in the event of insufficient IRO capacity.

Proposed §133.305 Medical Dispute Resolution - General

Previous §133.305 addressed medical dispute resolution pursuant to the statute in effect prior to the effective date of HB-2600. Because of the substantial statutory revisions, the commission has repealed former §133.305 and adopted a new §133.305. In addition, because the manner of review differs dependent on the

type of dispute, the commission has separated the medical dispute resolution provisions into three rules. The rule as adopted is titled "Medical Dispute Resolution - General." This adopted title more accurately describes the content of the section, as the adopted rule includes not only an expanded subsection of definitions, but supplementary information regarding the overall process concept, as well.

Section 133.305 Subsection (a) includes seven (7) definitions to provide clarification and facilitate an understanding of the various types of disputes and terminology incorporated into general usage in these rules. A definition of "initial request" was added based on public comments and other revisions to the rule that were also based on public comment. An initial request is initiated by the requestor for all types of disputes and the carrier or respondent is required to complete any missing information or documentation, including explanation of benefit documentation or prospective care denials. This information is vital to the division in order to establish a complete request for medical dispute resolution. Minor edits were made to the definition of respondent to clarify the purpose of the respondent and the issues the respondent is limited to in responding to a request for medical dispute resolution.

Proposed §133.305(b) stated the requirement to file two separate dispute requests if the health care in dispute had fee issues and medical necessity issues. In response to public comments critical of a "bifurcation" of the medical dispute process, subsection (b) was revised to allow for a single filing regardless of the type of medical dispute, and a single notice of decision to the parties. A request for medical dispute resolution must be filed with the commission and the carrier or respondent in the form, format and manner prescribed by the commission. The same form will be used for medical fee disputes, medical necessity disputes, and combined fee and necessity disputes. The carrier shall complete the remaining sections of the request form, provide any missing information or documentation required on the form, and file the form with the Medical Review Division (division) of the commission within three working days of the carrier's receipt of the initial request. If the request is for medical fee dispute only (i.e., it does not include a medical necessity dispute), the commission will notify the parties and require the requestor to send additional documentation relevant to the fee dispute to the division within 14 days. If the request is for a medical necessity dispute only, or if a request includes fee and necessity disputes, the commission will assign an IRO and the IRO and the commission will notify the parties.

The commission will review the request for IRO review, assign an IRO, and notify the parties and the IRO of the assignment. The commission will assign disputes on a rotating basis to the IROs certified by TDI, in accord with Insurance Code article 21.58C and TDI rules. The rule as adopted, however, allows the commission to assign disputes in accordance with the priorities established in the rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity. The IRO shall also notify the parties of the assignment, and require the parties to submit documentation directly to the assigned IRO. Documentation is to be received not later than the seventh day after the party's receipt of the IRO notice. The rule as proposed prohibited an IRO or a provider from requiring the written consent of the injured employee as a prerequisite to obtaining medical records relevant to the review. The adopted rule states that no IRO or provider is required to obtain a written consent from the employee. The IRO shall preserve confidentiality of individual medical records as required by law.

The IRO shall review and render a decision. If the dispute is a preauthorization dispute, the IRO shall send the IRO decision directly to the parties and the division. If the dispute is a retrospective review, the IRO shall send its decision to the division. The division will review the original dispute request and determine who the nonprevailing party is for purposes of paying the IRO fee. If there is no pending medical fee dispute for the services determined to be medically necessary by the IRO, the division will send the IRO decision to the parties. If there is a pending medical fee dispute for a service determined to be medically necessary, the division will send the parties an order stating which party is the nonprevailing party, and ordering any payment or reimbursement of the IRO fee as necessary, and also ordering the parties to send to the division within 14 days, documentation relevant to the fee dispute. The division will then process the medical fee dispute and send to the parties both the IRO medical necessity decision and the medical fee decision of the division.

Proposed §133.307 Medical Dispute Resolution of a Medical Fee Dispute

Section 133.307 amends the title to "Medical Dispute Resolution of a Medical Fee Dispute," which more closely reflects the content of the new rule. Subsection (a) states that the rule applies to a request for resolution of a medical fee dispute for which the initial dispute resolution request was filed on or after January 1, 2002. This complies with the HB-2600 provisions regarding the effective date of the statutory changes to Texas Labor Code §413.031. Dispute resolution requests filed prior to that date will be resolved in accordance with the rules in effect at the time the request was filed. The reference to the previously proposed separate filing of different types of disputes has been deleted. In compliance with §413.031(c) regarding disputes over the amount of payment due, the role of the commission is to adjudicate the payment given the relevant statutory provisions and commission rules. Medical necessity is not an issue in a medical fee dispute.

Subsection (b) states who may be a party to the different types of fee disputes without changes from proposal.

Subsections (c)-(e) set out the required content of an initial request and the time frames in which the various types of fee dispute requests must be filed. Subsection (c) provides explanation that the initial request for medical dispute resolution be filed timely and simultaneously with the carrier or respondent and with the commission. The carrier is required to review and screen the initial request in order to establish the dispute issues that determine the appropriate method for dispute resolution per the rules. The structure is streamlined so that a copy of all requests for medical dispute resolution is simultaneously filed with the commission and the carrier or respondent.

Subsection (d) incorporates changes to timeliness issues for jurisdiction of review and monitoring of carrier compliance with providing complete and accurate information to the initial request in the format of the TWCC-60a, The Request for Medical Dispute Resolution. The previous rule restricted medical dispute resolution to 1 year after the date of service. The new rule as proposed tied the deadline to the date of the carrier's denial action and the clock would not start until the carrier issued its final response to the request for reconsideration. Based upon public comment and stakeholder input, the rule as adopted retains the one-year from date of service deadline. The proposed deadlines created a window within which the request for dispute resolution must be filed. This constraint could cause some difficulties with

health care providers' billing cycles, and would increase the resources required by the commission, the health care provider, and the carrier to track the beginning and end dates of this constraint. However, the date of service is contained in numerous documents and the one-year deadline is an easily determined date. For disputes regarding carrier denials or reduction of payment, employee reimbursement, and provider denial or reduction of carrier request for refund of payment, the adopted rule reincorporates the one (1) year rule to limit the review of dispute date(s) of service.

The heading of subsection (e) has been changed from Complete Request to: Initial Request (General). The new adopted language includes the same requirements for legibility and simplicity in submission of a single copy of each document, and specific requirements to be included in the request. The submission of the initial request was greatly simplified by requiring only copies of the medical bills in dispute as originally submitted to the carrier, and a copy of each EOB or response to the refund request relevant to fee disputes, or if no EOB was received, convincing evidence of carrier receipt of the provider's request for an EOB from the carrier. Simplification of the request was also effected by the deletion of the requirement to submit supporting documentation of the request for and response to reconsideration of a denial if in the possession of the requestor, a copy of medical records, clinical notes, diagnostic test results, treatment plans and other documents, as well as a statement of the disputed issue(s) including a description of the health care for which payment is in dispute, a statement from the party regarding their position on the dispute issues, and justification for fair and reasonable reimbursement for which a maximum allowable reimbursement (MAR) has not been established. In the rule as adopted, the aforementioned documentation is "additional documentation" to be submitted at the direction of the division once a determination is made regarding the dispute type.

Subsection (e) also establishes the actions required by the carrier or respondent in completing a request for medical dispute resolution. In response to public comment, language in subsection (e) was further amended to establish the respondent's action upon receipt of the initial request, to include: completion of remaining applicable sections of the request form; provision of any required information missing from the form and absent EOBs not included with the initial request; and filing of the completed request with the division and requestor within three (3) working days of receipt of the initial request. Language also developed in response to comment includes instruction for certifying action of the respondent in the event that the provider's disputed billing or employee's reimbursement request relevant to the dispute, had never been received, or if the dispute had already been resolved.

The proposed language regarding the redaction of confidential information that might have pertained to other individuals not related to the injured worker's claim has been removed from this subsection and moved into subsection (g) as a more appropriate location. Also, the proposal made an allowance for the requestor to amend and resubmit the requests for which any of the required components were absent in the initial filing. These paragraphs were omitted from the adopted version because they are procedural elements which will be otherwise addressed by the commission.

Subsection (f) addresses an Employee Reimbursement Dispute when an injured employee has paid for health care out-of-pocket and is requesting reimbursement that the carrier has denied to the employee. Minor changes are incorporated to include: correcting the reference to the title of §134.600 to "Preauthorization, Concurrent Review, and Voluntary Certification of Health Care"; and the addition of the requirement for the injured employee to provide receipts as proof of payment. Further changes to this section eliminated the requirement for the injured worker to submit medical records, which are not commonly within their control, to support any questions of medical necessity for out of pocket expenses.

Subsection (g) addresses the division notice regarding the filing of the completed request both with the division and the requestor by transmission of a facsimile. Subsection (g) also establishes that the division review the copy of the completed request to determine whether the dispute addresses only medical fee disputes or medical necessity disputes that contain a medical fee component. The division will determine which track the dispute will take, either the process established in §133.307 for medical fee disputes to be addressed by the division, or that established in §133.308 for unresolved issued of medical necessity, which will be forwarded to an IRO.

Subsection (g) identifies the process for resolving a fee dispute at the commission. The division notifies the parties in a medical fee dispute to submit two (2) copies of additional documentation relevant to the dispute. In the proposed rule, the additional documentation was required when the request was initially submitted. As adopted, the additional documentation is required to be submitted to the division once the completed request has been received and assessed by the division. The additional information includes: documentation of a request for and response to reconsideration, or if carrier failed to respond to a request for reconsideration, convincing evidence of the carrier's receipt of that request; a copy of any pertinent medical records or other relevant documents; and a statement of the disputed issues; and documentation that justifies payment being sought as a fair and reasonable reimbursement if the disputed fee is for health care for which the commission has no established MAR. Subsection (g) also incorporates the language from proposed subsection (e) regarding the redaction of confidential information that might have pertained to other individuals not related to the injured worker's claim, with additional language establishing that any unredacted information or evidence shall not be considered in resolving a medical fee dispute. Adopted language further establishes that the additional required documentation must be received by the division within 14 days of the requestor's receipt of division notice.

Minor changes were made to subsections (h) and (i) which respectively establish the response to the requestor's additional documentation and the time parameters for that response. Subsection (h) states that respondent will respond to the requestor's additional documentation by submitting a response to both the division and the requestor, and subsection (i) establishes that a respondent who fails to timely respond, within 14 days after receipt of the requestor's additional documentation, waives the right to do so.

Subsection (j) establishes a "complete response", replacing the proposed "response" and sets out the content of the respondent's response to the requestor's additional documentation, required to be in the form and manner prescribed by the commission. Subparagraph (G) was added to require redaction of confidential information. As in subsection (g)(3)(E), the language prohibits consideration of unredacted information or evidence. Subsection (j) further is amended to establish that the response

shall address only the specific denial reasons presented to the requestor prior to the filing date of the initial request, and that any new denial reasons will not be considered in the review.

Subsection (k) sets out the required filing deadlines and filing requirements for responses to requests for medical fee dispute resolution. The rule as adopted requires the respondent to file the response within 14 days of receipt of the additional documentation.

Subsections (l) and (m) address requests from the division for additional information from either party and division dismissal of a request. As a result of public comment, clarification was made that a dismissal does not constitute a decision.

Subsections (n) and (o), respectively, address the decision issued by the division and the requirement for the division to post the decision on the commission website after confidential information has been redacted from the decision, as well as commission assessment of separate fees in accordance with Texas Labor Code §413.020.

Requirements for filing an appeal to the State Office of Administrative Hearings (SOAH) are addressed in subsection (p). The requirement for the appealing party to deliver a copy of the written request for a SOAH hearing to all other parties was moved from subsection (q) into this subsection.

Proposed §133.308 Medical Dispute Resolution by Independent Review Organizations

New §133.308 applies to the independent review of prospective or retrospective medical necessity disputes for which the initial dispute resolution request was filed on or after January 1, 2002. This complies with the HB-2600 provisions regarding the effective date of the statutory changes to Texas Labor Code §413.031. Dispute resolution requests filed prior to January 1, 2002 shall be resolved in accordance with the rules in effect at the time the request was filed.

HB-2600 requires that a review of the medical necessity of a health care service requiring preauthorization under Texas Labor Code §413.014 or commission rules be conducted by an IRO under Article 21.58C, Insurance Code, in the same manner as reviews of health maintenance organizations utilization review decisions. HB-2600 also requires that a retrospective review of the medical necessity of a health care service provided under Texas Labor Code Chapter 408 or Chapter 413 be conducted by an IRO under Article 21.58C, Insurance Code, in the same manner as reviews of health maintenance organizations utilization review decisions. These requirements are stated in subsection (a)(1).

Subsection (a)(2) has been revised from the rule as proposed to establish priority among the types of requests for which medical dispute resolution by an IRO is provided.

Subsection (b) states that an IRO performing independent review of health care provided in the workers' compensation system must be certified by the Texas Department of Insurance (TDI) pursuant to Article 21.58C of the Insurance Code. The IRO also must comply with TDI rules regarding certification of IROs. In addition, subsection (b) states that TDI rules in Title 28, Part 1, Chapter 12, Subchapters C through F apply to independent reviews in workers' compensation cases except as modified or noted in this subsection. In general, the modifications and exceptions are due to substantive differences in the Insurance Code and the Labor Code, including the need for different deadlines for action and terminology differences in the statutes and rules. In addition to Insurance Code provisions and TDI rules applicable to IROs, the Texas Labor Code and commission rules govern the independent review process and related substantive areas including: requests, filing, notification, time deadlines, parties, billing, payment, appeal from an adverse IRO decision, and other matters addressed in this rule.

The remainder of the layout of new §133.308 is similar to that of new §133.307. Subsection (c) states who may be a party to the various types of medical necessity disputes.

Subsections (d) - (h) set out: the filing and required contents of an initial request, the time frames in which the various types of medical necessity dispute requests must be filed, and the requirements for filing with the respondent or carrier and the commission. As with IRO reviews under TDI rules, the request must be filed with the carrier, who completes the required information and files the request with the commission. In addition, when the requestor files a copy of the request with the carrier, the requestor must also file a copy with the commission. This will enable the commission to monitor the timeliness of carrier filings with the commission.

A request for prospective review must be filed within 45 days after the carrier denied approval of the party's request for reconsideration of denial of health care that requires preauthorization or concurrent review. A request for retrospective necessity review must be filed no later than one (1) year after the date of service in dispute and filed with the commission and with the carrier or respondent. Subsection (f) establishes the required contents for an initial request to be complete. If the carrier has raised a dispute as to liability, compensability, or extent of injury, the request for an IRO will be held in abeyance until the issue has been resolved by final decision of the commission. Requestor must file with the initial request, proof that a Benefit Review Conference has been requested. Subsections (g) and (h) require the carrier or respondent to complete the remaining sections of the request form, provide any information missing from the form, and file the response (the form) with the commission and the requestor within three working days of receipt of the request. A request must be complete and must be timely filed with the carrier to be accepted for filing by the commission.

Subsections (i) and (j) address commission assignment of an IRO and notification. The commission will review the request for IRO review, assign an IRO, and send notice of the assignment to the IRO and the parties. The IRO shall also notify the parties of the assignment and require that documentation be sent directly to the IRO and received not later than the seventh day after the party's receipt of notice from the IRO.

Subsections (k) and (l) address confidentiality requirements and requests from the IRO for additional information. Rather than the proposed prohibition against requiring written consent of the injured employee, the rule as adopted states that no IRO or provider is required to obtain the written consent of the injured employee as a prerequisite to obtaining or releasing medical records. Time deadlines and payment of expenses for additional information are also addressed.

Subsection (m) addresses the statutory provision that allows an IRO performing a review of medical necessity to request that the commission order an examination by a designated doctor under Texas Labor Code Chapter 408. The request by the IRO must be made no later than 10 days after the IRO receives notification of assignment to the IRO. Based upon public comment, the commission increased the time from 3 days to 10 days, and has

revised the rule to provide that the cost of the designated doctor exam will be borne by the party who is liable for the IRO fee..

Subsections (n) and (o) state the time deadlines for an IRO to issue a decision, the required contents of the decision, and the requirement for an IRO to notify the parties and the commission of the IRO decision. Based upon public comment, the commission increased the time from 20 days to 30 days for retrospective reviews, and from 8 days to 20 days for prospective necessity disputes. Subsection (p) states the requirement that the commission post the IRO decision on the commission's Internet website after confidential information has been redacted from the decision.

Subsection (q) addresses which party is responsible for the IRO fee. In accordance with the statute, this varies dependent on whether the review is prospective or retrospective, and on who prevails in the IRO decision. In the rule as proposed, in retrospective necessity disputes other than an employee reimbursement dispute, and in a concurrent review prospective necessity disputes, the IRO was to identify and bill the nonprevailing party. Who prevailed on the main issue could be unclear in some instances, in which case the rule as proposed provided for the commission to advise the IRO of the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care would be the prevailing party.

Based upon public comment discussed below, the commission has revised the billing process for retrospective IRO reviews. For retrospective reviews, the requestor (defined as the party that timely files a complete request for medical dispute resolution) must pay the IRO fee to the IRO before the IRO begins review of the case. When the commission assigns an IRO, the notice to the parties will order the requestor to pay the IRO at the same time the requestor sends documents to the IRO for review. The time frame in which the IRO must render a decision does not begin to run until the IRO receives the fee payment from the requestor. If the requestor is the prevailing party in the IRO decision, the commission will order the respondent to reimburse the IRO fee to the requestor within 10 days. If the respondent is the prevailing party in the IRO decision, there is no need to order any party to reimburse the other party. In an employee reimbursement dispute and in a preauthorization prospective necessity dispute, the carrier must pay the IRO fee to the IRO before the IRO begins review of the case. The injured employee shall not be required to pay any portion of the cost of an IRO review. The IRO shall bill copy expenses to the party required to pay for the independent review; provided, however, that no copy costs shall be paid to the requestor. The party responsible for the IRO fee shall pay the designated doctor exam fee.

Upon receipt of an IRO assignment in a prospective dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO at the same time the carrier files the documentation requested by the IRO. In a retrospective dispute, the requestor shall remit payment to the assigned IRO at the same time the requestor files the documentation requested by the IRO. Upon receipt of an IRO decision in a retrospective necessity dispute other than an employee reimbursement dispute, and in a concurrent review prospective necessity dispute, the commission shall review the decision to determine the nonprevailing party. If the IRO decision as to the main issue in dispute is a finding of medical necessity, the requestor is the prevailing party. If the IRO decision does not find medical necessity with respect to the main issue in dispute, the respondent is the prevailing party. If the IRO decision does not clearly determine the prevailing party, the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party. The IRO shall bill copy expenses to the party liable for the independent review, provided, however, that no copy costs shall be paid to the requestor and the injured employee shall not be required to pay any portion of the cost of a review. Designated doctor examinations ordered by the commission at the request of an IRO, shall be paid by the carrier in accordance with the appropriate fee guideline.

IRO fees shall be paid in the same amounts as those set by TDI rules for tier one and tier two fees. In addition to the specialty classifications established as tier two fees in TDI rules, independent review by a doctor of chiropractic shall be paid the tier two fee. If the IRO has not received the fee within seven days of the party's receipt of notice from the IRO, the IRO shall notify the commission and the commission shall issue an order to pay the IRO fee. Failure to pay or refund the IRO fee may result in enforcement action as allowed by statute and rules, removal from the commission Approved Doctor list, and/or restriction of future requests for independent review. The party required to pay or refund the IRO fee is liable for that fee upon receipt of the commission order to pay or refund, regardless of whether an appeal of the IRO decision has been or will be filed. If the IRO decision is subsequently reversed or decided differently at a CCH or by a SOAH decision, the commission shall order a refund of the IRO fee to the party who prevailed by CCH or SOAH decision. The commission revised subsection (q)(2) as adopted to make it clear that the payment is a refund payment between the parties to the IRO Disputes. The requestor may be liable for the IRO fee if the request is withdrawn or the review is terminated prior to completion.

Subsection (r) reiterates the statutory provision that it is a defense for the carrier if the carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee. If an unresolved fee dispute issue exists at the time the IRO issues a decision of medical necessity, this subsection also clarifies that the carrier is not required to pay for the health care until the commission has resolved the medical fee dispute.

If an unresolved fee dispute issue exists at the time the commission receives an IRO decision finding medical necessity, subsection (s) states that the commission shall proceed to resolve the medical fee dispute in accordance with commission rules after receipt of the IRO decision.

Subsections (t)-(v) address appeals from an IRO decision. In accordance with HB-2600, an IRO decision in a prospective or a retrospective medical necessity dispute, with one exception for spinal surgery disputes, may be appealed by filing a written request for a SOAH hearing. The appeal must be filed with the commission; the commission then files the request for hearing with SOAH. The parties to the dispute must represent themselves before SOAH, and the IRO is not required to participate in the SOAH hearing. HB-2600 requires the commission to also post SOAH decisions on the commission's Internet website after confidential information has been redacted. Prospective necessity disputes regarding spinal surgery may appeal an IRO decision by requesting a Contested Case Hearing (CCH). This CCH and further appeals will be conducted in accordance with Chapters 140, 142, and 143 of this title.

Subsection (v) addresses the statutory provision that a party who has exhausted the party's administrative remedies and who is aggrieved by a final decision of SOAH may seek judicial review of the decision, which shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001 of the Government Code. In all appeals, the IRO decision has presumptive weight.

Subsections (w) and (x) were added to the rule as adopted in response to recommendations that the commission add provisions to the rule to address commission and TDI enforcement of IRO standards as they apply to workers' compensation reviews and to clearly provide for the commission to review, inspect, copy and/or compel production of documentation or other information as necessary to carry out it's duties and responsibilities under this rule, the Act, and other applicable statutes. The commission and TDI will also address in an MOU how complaints, violations and other enforcement-related issues will be handled between the agencies.

Comments generally opposing the proposed new rules were received from the following groups: Alliance of American Insurers; American Insurance Association, Southwest Region; Burns Anderson Jury and Brenner; Envoy Medical Systems, LLC; Flahive, Ogden & Latson; Independent Review Incorporated; Insurance Council of Texas; OccMed Group, PA; Practice; State Office of Risk Management; Texas Association of Business and Chambers of Commerce; Texas Chiropractic Association; Texas Department of Insurance; Texas Mutual Insurance Company; and WorkScripts, LP.

Comments seeking clarification and/or asking questions related to §133.305, §133.307 and §133.308 were received from the following groups or associations: Envoy Medical Systems, LLC; Indemni-Med Management, LLC; Independent Review Incorporated; Insurance Council of Texas; JI Specialty; Liberty Mutual Group; Pathfinder Consulting; Practice; Texas Department of Insurance; Texas Medical Association; and Texas Medical Foundation.

Comments expressing general concerns to §133.305, §133.307 and §133.308 were received from the following groups or associations: Alliance of American Insurers; Envoy Medical Systems, LLC; Independent Review Incorporated; Pathfinder Consulting; Research and Oversight Council on Workers' Compensation; Texas Medical Foundation; and WorkScripts, LP.

Comments making recommendations for changes to §133.305, §133.307 and §133.308 were received from the following groups or associations: Alliance of American Insurers; American Insurance Association, Southwest Region; Caldwell Fletcher Attorney at Law; Concentra; Envoy Medical Systems, LLC; EZRx Pharmacy Services; Flahive, Ogden & Latson; Indemni-Med Management, LLC; Independent Review Incorporated; Insurance Council of Texas; JI Specialty; Liberty Mutual Group; Research and Oversight Council on Workers' Compensation; State Office of Risk Management; Texas Chiropractic Association; Texas Department of Insurance; Texas Medical Association; Texas Medical Foundation; Texas Mutual Insurance Company; and WorkScripts, LP.

General Comments related to §§133.305, 133.307 and 133.308

COMMENT: Commenters expressed overall opposition to the proposed rules and recommended to withdraw rules as proposed and replace with a substitute rule. Commenters provided a re-structured and re-formatted substitute rule based on changes to the current §133.305. Commenter further expressed that there is no rationale for assuming that TWCC will benefit from the independent review process, which has been shown to be effective for the health maintenance organizations (HMO). There are no Independent Review Organizations (IRO) in Texas that have the ability to handle the volume of claims or the complexity of claims, which will be assigned.

RESPONSE: The commission disagrees. The rules need to be in place in January of 2002 because of the effective date of the statutory changes contained in HB-2600 regarding medical dispute resolution. The public was asked to comment on the rules as proposed. The submission of comments in the form of a totally different rule organization made it very difficult to respond to comments, as they were difficult to correlate to the rule as proposed. It would have been better to express the substantive comments in relation to the rules and subsections as proposed, and then include any suggested alternate organization for the rules. Having said this, the commission made every effort to respond to all comments on the substance of the rules, regardless of how they were presented in the comments. HB-2600 mandates new rule elements including the IRO process and these rules meets legislative mandates. The commission declines to adopt the one-rule substitutions that were recommended.

The use of the process and the capacity of existing IROs are beyond the control of commission rules, but the commission has been and continues to work toward the goal of sufficient capacity to handle the disputes in the method required by the statute. During the 77th Legislative session, a legislative council made inquiries of the existing IROs regarding their participation and ability to perform reviews for the workers' compensation system and were advised that capacity could be sufficiently increased prior to January of 2002; HB-2600 incorporated the required use of IROs for medical dispute resolution.

COMMENT: Commenter expressed disappointment and concern that the Commission ignored the expressed preference of the system stakeholders regarding changing the dispute resolution process.

RESPONSE: The commission's proactive approach at obtaining stakeholder perspective was and is an effort to explore all avenues in developing a process that is fair and equitable for all system participants. As a regulatory agency, the commission has fully and objectively considered all suggestions and comments of stakeholders and used its regulatory and substantive knowledge and expertise to propose and adopt rules that meet statutory requirements and are fair to all participants.

COMMENT: Commenter suggested that the vision of HB-2600 is to improve timely and appropriate adjudication of medical disputes. The adoption of proposed rules will result in increased administrative costs and responsibilities for the Commission, injured employees, health care providers and insurance carriers.

RESPONSE: The commission disagrees. The rules implement the process required by HB-2600 and do not impose any unnecessary process or costs above those imposed by the statutory process.

COMMENT: Commenter recommended that the commission monitor the overall quality of IRO decisions on a periodic basis and make referrals to TDI with a recommendation for action as appropriate. TDI and the commission should coordinate quality issues and agency roles through a Memorandum of Understanding (MOU).

RESPONSE: The commission agrees and has added language to the rule to state that the commission will monitor the IRO decisions and outcomes. The rule as adopted also contains language regarding enforcement by the commission and by TDI. The commission and TDI will establish a mechanism through an MOU to address complaints and issues regarding the IRO process for workers' compensation medical dispute resolution.

COMMENT: Commenter recommended that the commission address the concerns raised regarding the proposed rules and implement the rules by the January 1, 2002, statutory effective date.

RESPONSE: The commission agrees and has addressed issues raised in the comments received; adoption and implementation will occur by the statutory effective date.

COMMENT: Commenter stated that a bifurcated approach is too cumbersome and will cause confusion.

RESPONSE: The commission agrees in part and has amended the rules to process disputes on a single track to the extent possible. The commission does not agree that the two-track process as proposed would cause confusion, but the rule as adopted has been amended to streamline the process to allow a combined filing of a retrospective medical necessity dispute with a medical fee component dispute. The different statutory processes required for the various types of disputes prevent any more consolidation of process than has been done in the rules as adopted.

COMMENT: Commenter recommended language inclusion for the timely review and processing of a dispute within the Medical Review Division, including the appropriate case review method for processing of the dispute.

RESPONSE: The commission agrees in part. Commission agrees with recommendation for appropriate case review method for processing of the dispute within the IRO process and has amended language to reflect that the division will determine the appropriate process. Commission disagrees with incorporation of time constraints on the processing of fee disputes by the division because, unlike health care providers, carriers, and IROs, the commission has not had actual experience in implementing an IRO process for workers' compensation cases.

COMMENT: Commenters recommended that responses to medical dispute resolution include all defenses applicable to denials for preauthorization, concurrent review, payment of fees, reimbursement of medical fees paid to a healthcare provider by an injured employee and liability for refunds. Commenters further recommended that failure to raise all applicable defenses in a response shall result in a waiver of those defenses in subsequent proceedings.

RESPONSE: The commission agrees and provides clarification that the responses shall include all pertinent denial reasons in the response, and rule language has been amended in §133.307(j)(2) to reflect this. Language has been amended in subsection (j)(2) to clarify that any new defenses raised after filing for medical dispute resolution will not be considered in the review by the division. The commission does not control the process at the State Office of Administrative Hearings or in the courts.

COMMENT: Commenter recommended additional wording allowing legitimate, small and micro-businesses to receive proof of medical necessity from the health care providers when DME prescriptions go unpaid.

RESPONSE: Commission agrees. The supporting documentation for medical necessity is not in the control of the pharmacy or DME provider. In review of medical necessity disputes, the IRO is tasked with requesting relevant medical documentation from any party that may possess relevant information to the medical dispute. This would mean that the prescribing doctor may be compelled by the IRO to provide those pertinent records directly to the IRO reviewer in order to substantiate medical necessity in the dispute. This is addressed in §133.308(l).

COMMENT: Commenters requested inclusion of language stating that if a carrier fails to provide a copy of medical audit summaries and/or explanations of benefits, TWCC-62 form(s), and peer review report(s) relevant to the dispute that were not provided to the requestor in response to the request for reconsideration per §133.304(k), the division shall consider those services and actual charges on the relevant medical bills to be undisputed and unpaid by the carrier and shall order payment to the requestor for those services and/or charges.

RESPONSE: The commission disagrees. The IRO will make a decision based upon the information and documentation provided to it in compliance with the rules and the IRO request for information and documentation.

General Comments related to §133.305

COMMENT: Commenters do not support repealing existing §133.305. Section 133.305 should be amended to integrate the IRO process. Commenters stated that separate rules are not needed for medical fee disputes and prospective necessity disputes. The proposed rules are complex and burdensome and will have an impact not just on insurance companies but also on health care providers and injured workers and will significantly increase the costs associated with medical dispute resolution. Reference to §133.307 and §133.308 should be deleted.

RESPONSE: The commission disagrees. The separate rules provide clarification and facilitate the appropriate processes for dispute types. Costs and processes associated with each dispute type are mandated by legislation and the commission disagrees that separate designation by rule is preferable. The commission has amended the rules to process disputes on a single track to the extent possible. The commission does not agree that the two-track process as proposed would cause confusion, but the rule as adopted has been amended to streamline the process to allow a combined filing of a retrospective medical necessity dispute with a medical fee component dispute. The different statutory processes required for the various types of disputes prevent any more consolidation of process than has been done in the rules as adopted.

COMMENT: Commenter requested clarification regarding fees for the dispute types identified in this rule. Commenter would like to see the fees published so the public is informed.

RESPONSE: The commission disagrees. The fees for IRO review are as established by TDI rules. Publishing fees in these rules would require commission action each time fees are amended by the Texas Department of Insurance.

§133.305(a)

COMMENT: Commenters expressed the need to reformat and expand the number of definitions that are contained in the current proposed rule. A definition of key terms is important in the dispute process at the appeals level.

RESPONSE: The commission agrees in part. The commission disagrees with commenters re-formatting recommendation and declines to define the following terms as they are sufficiently referenced, or defined, or not used in the proposed rules: complete request; concurrent review dispute; decision; extent of injury; filed; health care provider refund order dispute; independent review; IRO; informal resolution conference, injured employee medical reimbursement dispute; insurance carrier refund request dispute; Medical dispute resolution, to include seven dispute types; medical fee dispute; party; prospective medical necessity dispute; retrospective medical necessity dispute; requestor; respondent; and SOAH. The term "Division" is already defined in §133.1 of this title (relating to Definitions) and will not be added to §133.305 (a).

COMMENT: Commenter recommended the inclusion of definitions for: "nonprevailing party - the party that fails to prevail in a dispute of a line item. If multiple line items are disputed, and each party to the dispute prevails on some of the line items, each party is a nonprevailing party to the extent of the percentage of the dollar amounts of the line items not awarded to that party." and "line item - a line item is a claim for payment for a service as it appears on the appropriate billing form submitted with the request for dispute resolution. A line item consists of a date of service, a CPT code (if applicable), the number of units of that CPT code (if applicable), and total dollar amount for the service allowed by the applicable medical fee guideline."

RESPONSE: The commission disagrees with commenter's recommended definition for a nonprevailing party, and the recommended method of determining who the prevailing/nonprevailing party is. This is provided in §133.308 (q)(2), pertinent to IRO billing. The commission further disagrees with the inclusion of a definition for a line item; although the concept is incorporated in the reference for nonprevailing party, the proposed term does not require a definition because it is a common billing term in the healthcare industry.

§133.305 (a)(1)

COMMENT: Commenters recommended adding the seven types of disputes to the definition of Medical Dispute Resolution.

RESPONSE: Commission agrees in part. These terms are incorporated in the terms defined in §133.305(a). However, the commission disagrees with the recommendation for additional definition language. Defining disputes in terms of categories and subcategories as proposed and adopted in subsection (a) gives a better perspective of the relationship of the various types of disputes, e.g., retrospective disputes and prospective disputes.

§133.305 (a)(2)

COMMENT: Commenters recommended language in the definition of a medical fee dispute to include that the dispute would clearly reflect the issues as related to relevant coding, fee schedule and reimbursement and for actions prior to the date the dispute is filed.

RESPONSE: The commission disagrees. Actions taken prior to the filing of medical dispute resolution are regulated by §133.304 of this title (relating to Medical Payments and Denials.)

COMMENT: Commenters recommended a definition for medical fee disputes to include the terms "prior to the date the dispute is filed".

RESPONSE: The commission disagrees with commenter's recommendation by definition, a fee dispute addresses health care that has already been provided. However the commission recognizes that language needs to be modified to reflect the statutory language "medically necessary and appropriate", and has replaced the term "reasonably necessary and appropriate".

Proposed §133.305 (a)(3)

COMMENT: Commenter pointed out that the referenced title §133.308 Medical Dispute Resolution Regarding Medical Necessity Disputes and Preauthorization Disputes is incorrect and should be titled appropriately.

RESPONSE: The commission agrees and has re-titled this rule as " §133.308 Medical Dispute Resolution by Independent Review Organizations."

COMMENT: Commenter questioned why there is no provision for situations where there is no denial, but rather a substitution or change of care.

RESPONSE: The commission clarifies that the situation described by the commenter is one that is not considered a dispute situation that requires a review by the division or IRO.

COMMENT: Commenter recommended the addition of "appropriate" to the first sentence.

RESPONSE: The commenter was not specific as to the placement of the term in the sentence. The commission believes the language proposed and adopted is compliant with the statutory language requirements for §413.031 in HB-2600.

§133.305 (a)(3)(A)

COMMENT: Commenter recommended that this section contain the updated title for §134.600 to match the adopted rule title.

RESPONSE: The commission agrees and has inserted the adopted title of §134.600 in this subsection. The referenced subsection has been moved to subsection (a)(5)(A).

§133.305 (a)(4)

COMMENT: Commenters recommended new language for the definition of a Retrospective Necessity dispute, including the terms "medically reasonable" and "necessary".

RESPONSE: The commission disagrees with commenter's recommendation, as the proposed and adopted language reflects statutory language in HB-2600.

§133.305 (a)(5)

COMMENT: Commenters recommended modifying the definition of "requestor" to exclude filing with the carrier and to include that a requestor shall include all components required on the TWCC-60a and subsection (e) of this section.

RESPONSE: The commission disagrees with commenter's recommendation to exclude filing with the carrier and with the recommendation that requestor include all the components from the TWCC-60a and complete request. Requestors sometimes do not possess all the components to complete the initial request, and that is why the commission requires the carrier or respondent to complete the TWCC-60 form and provide the missing EOBs or prospective review denials.

§133.305 (a)(6)

COMMENT: Commenter recommended language to re-define respondent, the current language in the rule is not pertinent to the rule as proposed.

RESPONSE: The commission agrees and has defined respondent as "the party that files a response to all the denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed; the party against whom relief is sought."

§133.305 (b)

COMMENT: Commenter recommended the removal of section (b). Simultaneous filing of fee and medical necessity disputes is not necessary and the procedure is intact and currently in place in Medical Review. Unnecessary costs would be incurred by filing simultaneously.

RESPONSE: The commission agrees in part and has removed the requirement to file separate disputes for medical necessity and medical fee disputes. Language has been amended to reflect this change. The commission disagrees with the statement that this process will incur unnecessary costs. Under the current process, requestors are required to file two copies with the commission for medical dispute resolution. The different statutory processes required for the various types of disputes prevent any more consolidation of process than has provided in the rules as adopted.

§133.307 (a) Applicability

COMMENT: Commenter suggested that integrating the fee for a medical necessity review into the independent medical review process resulted in clouding the independence of the medical necessity review. Fee and medical necessity must be kept distinct and separate in the order that the review is done with independence as put forth in the IRO statute, 21.58C.

RESPONSE: The commission disagrees. The commenter is confusing the IRO fee issue with the medical fee dispute process. The commission adjudicates medical fee reimbursement disputes. This is not a process that addresses IRO fees, billing or collecting, or decisions.

§133.307(a)(2)

COMMENT: Commenter recommended deletion of subsection (a)(2).

RESPONSE: The commission agrees. Subsection (a)(2) has been deleted. Based on changes as a result of public comment, medical fee and IRO dispute processes will not be separately initiated.

§133.307(b) Parties

COMMENT: Commenter recommended format similar to current rule, expanding the seven types of disputes and identifying who may be parties to the different types of disputes. Commenter also recommended additional language to the parties in a medical fee dispute. Commenter further recommended definition of "party" remains as defined in current §133.305.

RESPONSE: Commission agrees in part. These terms are incorporated in the terms defined in §133.305(a). Defining disputes in terms of categories and subcategories as proposed and adopted in (a) gives a better perspective of the relationship of the various types of disputes, e.g. retrospective disputes and prospective disputes. The commission disagrees to the recommendation that the definition of party remain the same. Each rule identifies the participating parties for the different processes.

§133.307 (c)

COMMENT: Commenter recommended that the request for a medical fee dispute be sent to the carrier as well as to the commission.

RESPONSE: The commission agrees and amends language as follows: "A request for medical dispute resolution of a medical fee dispute shall be timely filed with the carrier or respondent and the commission's Medical Review Division (division)."

§133.307 (d)

COMMENT: Commenters recommended that the commission not shorten the statute of limitations for filing a medical fee dispute. Commenters made various suggestions regarding the timeframes for submission of request for retrospective disputes including 45, 60, 90 days, one year, and 14 month limitations. Commenters objected to the narrowing of the time frame for filing a medical fee dispute.

RESPONSE: The commission acknowledges the suggested timeframes. As a result of public comment received regarding the possible hardships caused by the shorter timeframe, the commission has retained the one-year timeframe as is in the rule being repealed.

COMMENT: Commenter requested clarification as to how the commission will determine when the request for consideration is filed with the carrier.

RESPONSE: The commission determines that the need for clarification no longer exists due to the amendment to §133.307(d)(1) regarding time deadlines dating from date of service. Reconsideration is determined pursuant to the provisions in §133.304. The request is considered filed with the carrier and the division upon receipt of the initial request from the requestor no later than one year from the dates of service in dispute.

COMMENT: Commenter recommended adding a definition for "reconsideration" for the insurance carrier in the same way it is defined for the health care providers in §133.1, this would eliminate potential basis for confusion resulting in an untimely request.

RESPONSE: The commission disagrees. The process for resubmission for a "reconsideration" of a bill is outlined in the billing §133.304, Medical Payments and Denial. Also, §133.307(g)(3)(A) does refer to the fact that a request for and response to reconsideration of a reduction or denial of a bill is required.

COMMENT: Commenter requested to change 60 days to 45 days to be consistent with insurance carrier timeframes to respond.

RESPONSE: The commission disagrees. This subsection pertains to the carrier refund request in which the timeframes affect the carrier's ability to request refunds from a provider. However, the timeframe for submitting refund requests for medical dispute resolution has been amended to be the same as in §133.304 - not later than one year from the date(s) of service in dispute.

COMMENT: Commenter recommended that current §133.305 be amended to include the wording in this section regarding timeliness.

RESPONSE: The commission disagrees and addresses timeliness for specific dispute types within each rule, which apply to different types of disputes.

§133.307(e)

COMMENT: Commenter recommended inclusion of language in the requirements for a complete request to include convincing evidence of a health care provider request for an EOB or submission of a request for reconsideration.

RESPONSE: The commission disagrees. This rule allows the requesting provider the chance to complete a request with input from the carrier. In some circumstances, the request may be incomplete for reasons outside the control of the requestor. The respondent is required to provide the missing information.

COMMENT: Commenter recommended similar language contained in the current medical dispute resolution rule regarding the content of a complete request. Commenter recommended language to explicitly state when the division shall deem a request to be not properly filed.

RESPONSE: The commission agrees in part. However, the initial request cannot be determined to be complete until the carrier has had an opportunity for input, which may include missing elements such as the EOBs. The carrier's submission determines the completeness of the request after their input is incorporated into the request and forwarded to the division. The Division determines the request to be filed upon receipt of the initial request from the requestor. The respondent is required to provide the missing information.

COMMENT: Commenter recommended additional language for a complete request to include disputes involving issues other than preauthorization, and payment of 50% of the IRO fee payable to the Commission, who will forward to the IRO.

RESPONSE: The commission disagrees. Section 133.308, Medical Dispute Resolution by Independent Review Organizations, contains appropriate language to address payment of IRO fees for review of medical necessity issues. Payment of the IRO fee in the rules as adopted is required directly to the assigned IRO and in advance of the review.

§133.307 (e)(1)

COMMENT: Commenter recommended inclusion of language for a list of all the health care providers known to the requestor that have examined or provided health care or participated in the review of the proposed health care.

RESPONSE: The commission disagrees. Although this language is similar to the requirements for the list of other health care providers for processing in §133.308, this information is not appropriate or necessary for resolving medical fee disputes in this section.

§133.307 (e)(1)(A)

COMMENT: Commenters recommended inclusion of language explaining that prior to submission, a party must request reconsideration from the carrier for medical fee, prospective and retrospective medical necessity disputes.

RESPONSE: The commission agrees in part. The process for reconsideration of a bill is outlined §133.304, Medical Payments and Denial and in §134.600 of this title (relating to Preauthorization, Concurrent Review and Voluntary Certification of Health Care) and does not need to be addressed in this rule. However, the commission disagrees with the recommended language - the rule as adopted references reconsideration requests.

COMMENT: Commenters requested that the commission incorporate convincing proof of receipt such as certified mail or any other method that documents proof of delivery. RESPONSE: The commission disagrees. The commission does not want to limit convincing evidence to a specific means of verification. The commission will evaluate what is provided, whether it is certified mail, attempts documented in correspondence or log, facsimile transmission or other electronic means that can be verified. If the provider receives a check for partial payment without an explanation of benefits to explain the reduction of the submitted charges, this may be convincing evidence that the carrier received the bill for audit and payment but failed to explain their denial reasons in the required EOB. Note: The commission has moved this language to §133.307(g)(3)(A).

§133.307 (e)(1)(B)

COMMENT: Commenter recommended the commission elucidate on what "identical" means.

RESPONSE: The commission has removed the term "identical" from this section of the rule and replaced with "as originally submitted to the carrier" which is consistent with the language in the repealed rule §133.305.

§133.307 (e)(1)(C)

COMMENT: Commenters requested clarification of what the commission considers "convincing evidence".

RESPONSE: The commission disagrees. The commission did not want to limit convincing evidence to a specific means of verification. The commission will evaluate what is provided, whether it be certified mail, documented attempts in correspondence or log, facsimile transmission or other electronic means that can be verified. If the provider receives a check for partial payment without an explanation of benefits to explain the reduction of the submitted charges, this may be convincing evidence that the carrier received the bill for audit and payment but failed to explain their denial reasons in the required EOB. Note: The commission has moved this language to §133.307(g)(3)(A).

§133.307 (e)(1)(D)

COMMENT: Commenters pointed out that copies of records and notes are not available to pharmacies or DME providers. Commenters recommended that the rule require the commission to order health care providers to provide this information in a timely manner or extend the time frame for filing the dispute in order to obtain this information.

RESPONSE: Commission agrees in part. Commission recognizes that pharmacies and DMEs may not have the medical records and documentation to support their dispute. In requests for medical necessity disputes, IROs will directly request documentation from other health care providers for documentation relevant to the dispute. For fee disputes in which medical necessity is not an issue, documentation from the patient's medical records may not be necessary. The commission disagrees with extending the time frame for filing disputes for these entities because, in response to comments discussed elsewhere in this preamble, the commission has extended the time-frame for filing disputes for all entities to one year from the date of the service in dispute.

§133.307 (e)(1)(F)

COMMENT: Commenter recommended adding the language "and in accordance with §134.1(f), this would reduce confusion regarding the content of the documentation that is required.

RESPONSE: The commission agrees and has added this reference with regard to disputes involving fair and reasonable reimbursement. However, this language is located in the subsection (g).

Proposed§133.307 (e)(1)(H)

COMMENT: Commenter suggested that the fee for the review and actual medical expenses be suspended until final adjudication of a compensability dispute has been completed.

RESPONSE: The commission agrees. Requests for an IRO will be held in abeyance until the compensability dispute has been resolved by a final order of the commission. The commission will adjudicate medical fee issues presented and issue conditional orders that are enforceable pending the outcome of compensability and extent of injury issues. The commission's fee for medical dispute resolution is due at the time a conditional order is issued from the division.

COMMENT: Commenter recommended adding language directing the commission to refer issues of liability, compensability and extent of injury to the field office for adjudication.

RESPONSE: The commission agrees in part. The commission has added language to include that if a carrier has raised issues of liability, compensability and extent of injury issues, requests for an IRO will be held in abeyance until the compensability dispute has been resolved by a final order of the commission.

Proposed §133.307 (e)(3)

COMMENT: Commenter opposed allowing the requestor to amend an incomplete request and resubmit the request within the timeframes and recommended that the commission dismiss incomplete requests.

RESPONSE: The commission disagrees. The initial request cannot be determined to be complete until the carrier has had an opportunity for input, which may include missing elements such as the EOBs. The carrier's submission determines the completeness of the request after their input is incorporated into the request and forwarded to the division. The division determines the request to be filed upon receipt of the initial request from the requestor.

Proposed §133.307 (f)

COMMENT: Commenter questioned what determines the amount that is fair and reasonable and recommended that out-of-pocket reimbursement for prescriptions be reimbursed at the rate for generic and not name-brand prescriptions (unless no generic is available).

RESPONSE: The commission is addressing these issues in other rules applicable to reimbursement for generic, name brand and over-the counter prescriptions and will not duplicate that language in this rule. The commission will apply statutory, rules and applicable fee guidelines to resolve disputes related to these issues.

COMMENT: Commenters suggested additional requirements for injured employees filing for reimbursement for out-of-pocket health care expenses. Items for inclusion are documentation of medical necessity from the treating doctor, a position statement from the injured employee and documentation of the request from reimbursement from the insurance carrier and their response to the request.

RESPONSE: Commission disagrees in part. The elements identified in the proposed rule are sufficient in an employee medical fee reimbursement dispute. It is not the intent of the commission to burden the injured employee with additional requirements that are not within the control of the injured employee. Also, documentation of medical necessity is only required in a retrospective medical necessity dispute in which an IRO may request such supporting documentation from the prescribing doctor relevant to the dispute. The commission has added language to require receipts for out-of-pocket expenses in an employee medical fee reimbursement dispute. In retrospective medical disputes for out-of-pocket expenses incurred by an employee, an IRO will request the required medical documentation directly from the health care provider for a review of the medical necessity of the health care paid by the employee.

COMMENT: Commenter noted that the title for §134.600 referenced in this section is not consistent with §133.305 and should reflect the newly adopted name.

RESPONSE: Commission agrees and has revised the rule as adopted to reflect the adopted title of §134.600 Preauthorization, Concurrent Review and Voluntary Certification of Health Care.

Proposed §133.307 (g) Notice Filing

COMMENT: Commenter recommended concepts included in (g)(1). Commenter further stated all system participants should know the submission requirements of the parties, and know where it is stated and at what point in the dispute process the responding party shall be allowed to present its position.

RESPONSE: Commission agrees in part. Subsection (g)(1) has been amended due to public comment opposing the proposed filing of separate requests for medical fee and medical necessity disputes. This rule requires the carrier or respondent to provide input to the request initiated by the provider for review. In some circumstances, the request may be incomplete for reasons outside the control of the requestor. The concept for allowing the responding party to present its full position is addressed in subsection (j) of this section as adopted.

Proposed §133.307 (h) Response

COMMENT: Commenters expressed opposition to inclusion of §133.307 (h),(i),(j), and (k) in the rule, stating that these sections are a recapitulation of what is in the current rule, and the commission should not reinvent the wheel.

RESPONSE: Commission disagrees with commenter's opposition regarding inclusion of information on response, timeliness of response, complete response, and filing of response, as these are necessary components of the process as adopted.

Proposed §133.307 (i)

COMMENT: Commenter recommended that the respondent information shall be sent to the division via certified mail or transmission verified facsimile.

RESPONSE: Commission agrees. Submission of respondent information by certified mail or transmission verified facsimile would expedite review of dispute issues as well as determine timely receipt of response.

COMMENT: Commenter recommended replacing "request" in the first sentence with "response."

RESPONSE: The commission agrees and will amend language §133.307(i) to reflect commenter's recommendation.

Proposed §133.307 (j) Response

COMMENT: Commenter recommends that the carrier include in the response a copy of the relevant TWCC 60a.

RESPONSE: Commission agrees that copy of the TWCC-60a is part of the complete response and must be submitted. The carrier or respondent is required to provide any information missing on the form, before filing the request with the commission.

Proposed §133.307 (j)(1)(A)

COMMENT: Commenter recommends that the response filed should contain a list of all health care providers who have examined or provided health care or participated in the review of the proposed health care.

RESPONSE: The commission agrees in part. Input from both parties in a medical necessity dispute regarding participating health care providers who have either examined or participated in the utilization review of a patient is essential and is required in the IRO process rules, §133.308. However, the commission disagrees that this is necessary for processing medical fee disputes under this rule.

Proposed §133.307 (j)(1)(B)

COMMENT: Commenter recommends the addition of language to address medical bills that were not submitted with the original request.

RESPONSE: The commission recognizes commenter's concern regarding the presence of medical bills that were not submitted with the original dispute and are later submitted with a request for medical dispute resolution. Subsection (j)(1)(B) of this section specifically requires as part of a complete response, a copy of all medical bills relevant to the dispute and as originally submitted to the carrier for reimbursement. Medical bills that were not part of the original request are not to be submitted in the request for Medical Dispute Resolution, and the inclusion of such is inappropriate.

Proposed §133.307 (j)(1)(F)

COMMENT: Commenters recommended citing references to fair and reasonable found in §413.011 of the Texas Labor Code (TLC) and §134.1(f).

RESPONSE: Commission agrees with commenter's suggested language addition. Language has been added in subsection (j) to cite TLC 413.011 and §134.1.

Proposed §133.307 (j)(2)

COMMENT: Commenter recommended the deletion of this subsection due to being too expansive and will result in unintended consequences. Another commenter recommended amending the subsection to ensure that carriers can submit any relevant documentation supporting information regarding its previous payments or denials for the claim, or that the requestor may limit the issues in such a way as to prevent a respondent from presenting a valid and proper defense.

RESPONSE: The commission disagrees with commenter's recommendation to delete this subsection. The language in this section has been amended to clarify that responses shall address only the denial reasons presented to the requestor by the respondent prior to the date the initial request was filed with the division. The carrier's initial and reconsideration audits of the medical bills pursuant to §133.304 requires all defenses and/or denial reasons be explained to support non-payment. Responses shall not raise additional denial reasons after the filing of the initial request for medical dispute resolution.

Proposed §133.307(m) Dismissal

COMMENT: Commenters expressed concern regarding the language addressing the dismissal of a complete request and language does not address what action, if any, shall be taken in regards to an incomplete request. Commenter suggested that the mandatory "shall" would be more appropriate than the permissive "may" in this subsection.

RESPONSE: The commission disagrees that language addressing incomplete requests is necessary or appropriate because of the revisions in the rule as adopted that require the filing of an initial request. The commission disagrees with the recommendation to replace "may" with "shall" because circumstances may vary widely and discretion allows the commission to address them properly.

COMMENT: Commenter recommended language additions to subsection (m) to expand reasons for which the commission may dismiss a request. Commenter recommends inclusion of additional reasons for dismissal of a request to include that the requestor has exhausted the carrier appeal process and the requestor failed or refused to communicate with peer reviewer regarding the treatment plan.

RESPONSE: Commission disagrees with commenters recommended language. Language is sufficient as written. Subsection (m) clearly states the commission's option to dismiss a complete request include when good cause exists, and this would cover any unlisted situations for which dismissal may be appropriate. Current §133.304 outlines that a health care provider must complete the carrier's reconsideration process before filing for dispute resolution. A health care provider's communication with a peer reviewer regarding an injured employee's treatment plan may be voluntary, and should not prohibit the health care provider from utilizing the medical dispute process. These recommendations are included in the IRO rule, §133.308.

COMMENT: Commenter suggested that a screening process should exist to avoid inappropriate requests for medical dispute resolution without prior reconsideration appeal.

RESPONSE: Commission agrees. The adopted rule provides a screening process by which the initial request for dispute resolution is reviewed for compliance with §133.304 reconsideration requirements. This is the carrier's obligation with respect to the initial request in subsection (g). Lack of compliance by the requestor with the reconsideration requirements in §133.304 may result in the dismissal of the request per (m)(3) of this subsection.

Proposed §133.307 (m)(3)

COMMENT: Commenter recommended defining the phrase "good cause"; system participants should be informed what constitutes "good cause" for a dismissal.

RESPONSE: Commission disagrees that a definition for "good cause" is necessary in the dismissal process, as a good cause list cannot be all-inclusive and could jeopardize the requestors' rights to a review. The commission determines "good cause" on a case-by-case basis. "Good cause" is addressed in subsection (m)(5) of this section.

COMMENT: Commenter recommended that a definition of "proper submission" be provided and include an appropriate example.

RESPONSE: Commission disagrees. A proper submission is an initial request submitted in the form and format required by the

commission and the completeness of the request is determined after the carrier's or respondent's input to the initial request prior to forwarding to the division. This is addressed in subsection (e)(2) of this section.

Proposed §133.307 (n)

COMMENT: Commenters recommend that the Commission forward a copy of the medical dispute resolution decision to the parties' attorney to be consistent with other divisions' policies.

RESPONSE: Commission disagrees. The commission forwards the decision to the carrier via the carrier's representative per §156.1 of this title (relating to Carrier's Austin Representative). It is the carrier's responsibility to inform the appropriate parties of medical dispute resolution decisions.

COMMENT: Commenters indicate that the new rule should include language requiring the commission to post notice of all medical benefit SOAH and judicial review decisions on its website.

RESPONSE: Commission agrees in part. Per §133.307(n) as adopted and §133.308(t)(7), IRO decisions and SOAH decisions will be posted on the commission website after confidential information has been redacted. However, the commission disagrees with including in the rule a requirement for posting judicial review decisions, although the commission will keep this under consideration if experience shows this to be feasible in the future.

Proposed §133.307(o)

COMMENT: Commenter recommends that the response filed should include a statement that in disputes involving issues other than preauthorization, payment of 50% of the expected amount of the IRO fee is payable to the Commission, and the Commission will forward the payment to the IRO.

RESPONSE: The commission disagrees. It is inappropriate to include language regarding IRO fee in the medical fee process. Section 133.308 Medical Dispute Resolution by Independent Review Organizations, contains appropriate language to address payment of IRO fees for review of medical necessity issues. Payment of the IRO fee is required directly to the assigned IRO and in advance of the review.

COMMENT: Commenter recommended that the subsection should make it clear that not only does the Commission have the ability to assess a fee, the fee is in addition to the IRO fee. The Commission should also post notice of the specific fee on the TWCC website.

RESPONSE: Commission agrees in part. Subsection (o) as proposed needed clarification regarding the commission charges for review of a medical dispute in which all or part of the dispute regards medical fees. The word "separate" as been added to the rule as adopted to delineate from the IRO fees if a dispute includes both fee and necessity disputes. The commission already posts these separate fees on the website in the form of an Advisory Notice and the rule needs no new language.

Proposed §133.307 (q)

COMMENT: Commenter supports inclusion of the requirement for a party appealing the dispute decision to deliver a copy of the written request for a SOAH hearing

RESPONSE: Commission agrees. This requirement has been moved to subsection (p)(2) in the rule as adopted.

Proposed §133.308 General

COMMENT: Commenters suggested language for inclusion in a substitute rule regarding review of medical necessity disputes, re-defining the parties in the process of a review of medical necessity.

RESPONSE: The commission disagrees with the commenter's suggested language because it precludes the injured employee from access to retrospective medical necessity disputes for out-of-pocket expenses.

COMMENT: Commenter suggested that the main problem with the medical dispute resolution rule is that it appears to be overly complicated and recommends that the commission simplify the rule.

RESPONSE: The commission disagrees. The rules are not overly complicated. However, some modifications have been made to the IRO process to combine an IRO retrospective medical necessity decision with a commission decision in order to address the fee component for the same health care. The commission has amended the rules to process disputes on a single track to the extent possible. The commission does not agree that the two-track process as proposed would cause confusion, but the rule is amended to streamline the process to allow a combined filing of a retrospective medical necessity dispute with a medical fee component dispute. The different statutory processes required for the various types of disputes prevent any more consolidation of process than has been done in the rules as adopted.

COMMENT: Commenters recommended that the commission exempt pharmacies and DME providers from the IRO process.

RESPONSE: The commission disagrees. The requirement to submit disputes to an IRO is governed by the statute, which requires it for all health care medical necessity disputes in the workers' compensation system. Pharmacies and DME providers are health care providers and system participants and subject to the same statutory requirements for other health care providers for access to an IRO review for medical necessity disputes.

COMMENT: Commenter questioned whether an IRO is required to accept an assignment from TWCC. A review of the medical necessity of health care services requiring preauthorization under §413.014 or commission rules under that section shall be conducted by an independent review organization under Article 21.58(C) Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations (HMO). It should be noted however, that §413.051 of HB-2600 provides for "contracts" with review organizations and health care providers, and in §413.051(C) of HB-2600 provides that the Commission may "contract" with a health care provider including independent review organization to do "medical necessity reviews".

RESPONSE: The commission has discussed this issue with the Texas Department of Insurance (TDI), and the department and the commission are in agreement that IROs are required to accept assignment of workers' compensation cases. The independent review system was created by the legislature in 1999 for group health medical necessity reviews. In the 2001 legislative session, the legislature amended the Labor Code to require that a review of the medical necessity of health care provided pursuant to the Texas Workers' Compensation Act (Act) shall be conducted by an independent review organization under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations.

This legislative action enlarged the responsibilities of IROs certified pursuant to art. 21.58C and requires IROs to review decisions of medical necessity in the workers' compensation system. The interpretation suggested by the commenter would negate the legislative mandate that workers' compensation reviews be conducted in the same manner as reviews of utilization review decisions by health maintenance organizations. IRO reviews in group health are regulated by TDI, but TDI does not contract with the IROs. An obvious goal and favorable attribute of the IRO reviews is that independent entities and reviewers independently arrive at the decisions. A contractual relationship between the IROs and the commission could impact or appear to impact the objectivity of the IROs. In addition, the provisions of any contract between the commission and an IRO affecting other system participants would not be binding without separate agency rules. Also, provisions of any contract could cause confusion and provide a basis for attempts to delay or hinder the IRO review process mandated by statute. Finally, the commission has neither the funds nor the administrative support resources necessary to pay for large numbers of reviews and then seek reimbursement from a party to the review. The commission firmly believes that the rules as adopted implement the legislative intent and requirement that the reviews be conducted in the same manner as reviews of utilization review decisions by health maintenance organizations.

COMMENT: Commenter is concerned that certain provisions of the commission's proposed rule may have a negative impact on the function of IROs performing reviews for HMOs. Commenter further stated that any actions that may result in substantial disruption of this process are inconsistent with legislative intent. Commenter stated that the legislative intent of the IRO process for workers' compensation - reviews should be conducted in the same manner for health reviews, understanding that there would be differences, which could be addressed by commission contracts with IROs. Commenter expressed concern that if the commission is not going to contract with IROs, then the obligations and responsibilities of each party should be delineated in commission rules.

RESPONSE: HB-2600 requires that a review of the medical necessity of a health care service provided under chapters 413 or 408 of the Labor Code shall be conducted by an independent review organization under Article 21.58C, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. Because of the statutory differences in group health and workers' compensation, modification of the current process to fit workers' compensation cases is necessary. The commission has attempted to deviate from the existing TDI rules and process only as necessary, and believes the rules as adopted meet that objective. Subsections including (b), (o) of this section and others have been revised for clarity in this regard. The commission believes that the rules as adopted comply with the legislative direction that review of medical services be handled, conducted and decided by IROs independent of the commission. The commission believes that deviating from this process could involve the commission in parts of the IRO review that could cause confusion or provide a basis for attempts to delay or hinder the IRO review process mandated by statute. The commission understands the concerns, but use of any alternate process will have to be by mutual agreement of the parties. The commission has taken steps in these rules, however, to attempt to alleviate the burden on IROs, including changes in the billing process and in the determination of the nonprevailing party, while still complying with statutory intent.

COMMENT: Commenter suggested that under 28 TAC 19.1703 URA for the same medical event, a concurrent review is not changed into a retrospective by a denial of additional level of care or length of stay. Why should this be different where the only purpose is to avoid the cost of the IRO review?

RESPONSE: The commission agrees in part. Concurrent review for additional length of stay beyond what has been previously approved is considered a prospective care dispute unless treatment has been rendered after a request for concurrent review has been denied for medical necessity. This situation constitutes a retrospective medical necessity dispute if the carrier is not convinced that the medical documentation justifies the medical necessity of the additional length of stay. It is a different situation in this type of concurrent review in that care has been rendered, even after the carrier denial and no longer qualifies as prospective care. These would be subject to an IRO review for retrospective medical necessity and subject to nonprevailing party status and liability for the IRO fee.

COMMENT: Commenter recommended that the commission adopt stronger provisions in the proposed rules to allow for expedited reviews in situations where care is urgently needed.

RESPONSE: The commission disagrees. If the care meets the definition for emergency care as defined in §133.1, the proposed care is not subject to prospective IRO review.

COMMENT: Commenter recommended that rule language specify that an IRO request can only occur after all other carrier utilization management internal appeals processes have been exhausted and that language should obligate the health care provider to first utilize the carrier's internal reconsideration appeal process. Commenter expressed concern of non-authorized prospective and concurrent review requests for IRO's causing additional cost to the system. Commenter also recommended a temporary (six month) waiver for IRO review in referring injured employee to a required medical examination.

RESPONSE: The commission agrees in part. All appeals for reconsideration with the carrier must have been exhausted. The commission disagrees with commenter's recommendation to require use of all of a carrier's internal process, which may or may not be contrary to the requirements in §133.304 and §134.600. However, the commission encourages the parties to resolve issues prior to pursuing medical dispute resolution. There are prerequisite requirements for access to medical dispute resolution. The commission further disagrees with recommendation for temporary six-month waiver for IRO review in referring injured employee to a required medical examination. It is the independent determination of the IRO whether justification exists for a designated doctor exam.

COMMENT: Commenter suggested the title for §133.308 appears to be incorrect. Suggests caption to read "Medical Dispute Resolution Regarding Medical Necessity Disputes."

RESPONSE: The commission disagrees with the recommended title; however, the commission has re-titled the rule: Medical Dispute Resolution by Independent Review Organizations. .

COMMENT: Commenter recommended adequate fees to conduct an IRO review. If the volume of reviews exceeds the capacity of approved IROs, an alternative process should be developed to meet the statutory requirement for IROs. Commenter stated that the IROs have expressed reluctance to take on the commission's caseload and recommended that the commission

permit an alternative dispute resolution. The rule is quite long and difficult to navigate.

RESPONSE: The commission disagrees. During the 77th Legislative Session, inquiries were made of the existing IROs regarding their participation and ability to perform reviews for the workers' compensation system. It was determined that, given adequate notice, IRO capacity could be sufficiently increased and HB-2600 incorporated the use of IROs for medical dispute resolution. The IROs are required to accept workers' compensation disputes. Although an alternate process is not being provided in the rules, the commission by rule has prioritized the dispute types that will be forwarded to the IROs in the event that the IRO capacity is exceeded, and has attempted to reduce the burden on IROs. The commission disagrees that the rule is lengthy and difficult to navigate. The IRO process has been streamlined as much as possible in order to minimize any differences to the HMO model identified in HB-2600. In addition, the commission encourages all parties to explore all options in resolving their medical disputes prior to requesting medical dispute resolution. Given other mandates of HB-2600 the commission does not feel that it can commit resources to the IRC process. The commission has addressed the amount of the fee in responses to other comments in this document.

COMMENT: Commenter suggested the commission review all requests for medical dispute resolution.

RESPONSE: The commission disagrees in part. The carrier is required to consider the issues of the requestor in the initial request for IRO review submitted on the TWCC-60 to determine issues for medical dispute resolution versus the issues that have already been reviewed and resolved by the carrier. The commission agrees that the division will evaluate the completed TWCC-60 for proper filing and handling by the respondent and in medical dispute resolution.

COMMENT: Commenter recommended that the commission consider engaging independent, objective reviewers who are not affiliated with the commission, carriers or related third parties to conduct those reviews not able to be completed by IROs due to capacity limitations.

RESPONSE: The commission acknowledges the recommendation for an alternative medical opinion to resolve medical necessity issues; however HB-2600 mandates the use of an IRO in resolving workers' compensation medical necessity disputes in the same manner as reviews of utilization review decisions in HMOs. Any different process will have to be by agreement of the parties as discussed in the preamble.

COMMENT: Commenters recommended that the commission maintain the official record. Commenter recommended inclusion of a new section to address this. Commenter further recommended that the commission have the same retention period used by the IROs. Commenter recommended that the Division maintain a copy of the official record in a prospective medical necessity dispute.

RESPONSE: The commission disagrees with commenter's recommendation for the commission to maintain records for any medical necessity disputes. IROs are required by TDI rules to maintain records of review regarding medical necessity disputes for a period of four years. The commission will not require any change to that retention schedule.

COMMENT: Commenter recommended adding the term "appropriateness to necessity" as required by HB-2600.

RESPONSE: The commission disagrees with the recommended language changes. The proposed language is in compliance with the statutory language within HB-2600. The statutory provision cited by the commenter is taken from HB-2600 article 2 that deals with regional networks.

COMMENT: Commenter recommended inclusion of a new paragraph regarding informal resolution conference process when disputing parties file a timely request for a hearing.

RESPONSE: The commission disagrees with commenter's recommendation regarding informal resolution conference (IRC). Given other mandates of HB-2600 the commission does not feel that it can commit resources to the IRC process; however, parties appealing to SOAH can agree to mediate their disputes instead of proceeding to a SOAH hearing.

COMMENT: Commenter recommended that the commission add a rule provision establishing priority for various types of disputes, with preauthorization disputes having the first priority, given that it is likely that sufficient IRO capacity will not exist by January 1, 2002. Commenter recommended that the commission provide in the rules an alternate medical dispute resolution process to be used by agreement of the parties if IRO capacity is insufficient on January 1, 2002. Commenter also recommended the rule provide a similar provision or identical alternative process for low-cost services in dispute, because the $650 IRO fee may cause providers to not dispute or carriers to automatically approve low-cost items.

RESPONSE: The commission agrees in part with commenter's recommendation. The commission by rule has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded. In addition, the rule as adopted allows the commission to assign disputes in accordance with the priorities established in this rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity. The commission encourages all parties to explore all options in resolving their medical disputes prior to requesting medical dispute resolution. The commission disagrees with providing an alternate medical dispute resolution process for low-cost services in dispute, because the statute does not provide for that distinction. The commission will, however, by advisory, provide information regarding possible alternative processes which the parties may voluntarily use to resolve disputes on low-cost items.

COMMENT: The commenter suggested the commission consider interim procedures and provisions to accommodate and reduce the system-wide cost of the potential delays and backlogs while phasing in the IRO process and emphasize those disputes for which time is an element.

RESPONSE: The commission agrees in part. HB-2600 mandates an effective date of January 1, 2002 to utilize IROs for resolving medical necessity issues in workers' compensation medical disputes. The commission understands the concerns, but the legislature has mandated the review process for medical disputes and use of any alternate process will have to be by mutual agreement of the parties. The commission has taken steps in these rules, however, to attempt to reduce the burden on IROs, including changes in the billing process and in the determination of the nonprevailing party, while still complying with statutory intent. In the rules as adopted, the commission has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded. In addition, the rule as adopted allows the commission to assign disputes in accordance with the priorities established in the rule and in a manner other than a

rotating basis if necessary because of insufficient IRO capacity. The commission encourages all parties to explore all options in resolving their medical disputes prior to requesting medical dispute resolution.

COMMENT: Commenter suggested that the commission consider the interaction of compensability and extent of injury disputes with medical necessity disputes, and the interaction of fee and necessity disputes on the same health care.

RESPONSE: The commission has addressed issues of compensability and extent of injury disputes by requiring that a request for an IRO will be held in abeyance until the compensability dispute has been resolved by final decision of the commission.

COMMENT: Commenter recommends that the commission revise the proposed rule to address commission enforcement of IRO standards as they apply to workers' compensation reviews; the rule should include the standards for enforcement of the provisions proposed; an example of language to accomplish this was provided. A Memorandum of Understanding between TDI and the commission should specifically address how various complaints and subsequent actions will be handled. To the extent commission rules govern the IRO process, the commission should handle the complaint and any subsequent actions; if a complaint is based upon a violation of the Insurance Code or TDI rules, TDI would handle the complaint and any subsequent actions. The MOU may also address how each agency notifies the other of any actions taken with regard to IRO's.

RESPONSE: The commission agrees in part and has added language in the rules as adopted to address commission and TDI enforcement of IRO standards as they apply to workers' compensation reviews. The commission and TDI will address in an MOU how complaints, violations and other enforcement-related issues will be handled between the agencies.

COMMENT: Commenter recommended the commission issue the IRO decision and that the decision include an order instructing the carrier to pay within 20 days of receipt of the order in accordance with TLC, rules, and guidelines.

RESPONSE: The commission agrees in part. Language has been added to the rule as adopted to require pre-payment to the IRO in all disputes. The division will determine the prevailing party in the retrospective disputes and if appropriate, will issue an order for the carrier to reimburse the prevailing provider within 20 days of receipt of the order in accordance with the Texas Labor Code rules and guidelines.

COMMENT: Commenter stated that TDI interprets the Insurance Code 21.58A-C to deny jurisdiction over retrospective reviews. Does the rule expand scope of 21.58A-C for retrospective claims for workers' compensation benefits? "In the same manner" probably does refer to jurisdiction. It should be made clear that retrospective reviews are covered by this rule notwithstanding any provision or rule under the Insurance Code.

RESPONSE: The commission disagrees that clarification is necessary. HB-2600 expands the scope of the IRO to include resolving retrospective medical necessity disputes in the workers' compensation system. The purpose of inclusion of references to the TDI rules in subsection (b) is to address the requirement of IROs to review retrospective medical necessity disputes.

COMMENT: Commenter recommended the commission review the IRO decision for accuracy and completeness. Commenter further recommended that additional payment would not be provided for any additional review of issues not addressed in the initial review. Commenter also recommended that the complete file be returned to the division and that the division issue the IRO decision.

RESPONSE: The commission agrees in part. The rule has been amended to include language on monitoring performance and outcomes of IRO decisions. For reasons discussed elsewhere in this preamble, the commission concurs that additional payment should not be provided for additional review of issues not addressed in the initial review. The commission disagrees with the recommendation that the IRO send the file to the division upon completion of an IRO review for reasons also discussed elsewhere in this preamble. By rule, TDI requires the IRO to retain records for four years and this requirement is applicable to IROs performing workers' compensation dispute reviews. For reviews regarding preauthorization, the IRO decision will be forwarded to all parties including the commission.

Proposed §133.308(a) Applicability

COMMENT: Commenter stated that commission staff have proposed the effective date to be January 1, 2001 and recommended that subsection (a) be withdrawn and replace with an amended version of the current rule as supplied by the commenter.

RESPONSE: Commission disagrees that the rule proposal approved by the commissioners should be withdrawn. The effective date of January 1, 2002 is mandated in HB-2600.

COMMENT: Commenter recommended simplified language to applicability subsections (a) in Rule 133.308.

RESPONSE: Commission disagrees. Section (a) contains two subsections, both of which are necessary as proposed to address how this rule shall be applied - to filings before, and filings on or after, the statutorily mandated applicability date of January 1, 2002.

Proposed §133.308(a)(1)

COMMENT: Commenter fails to see why IROs are necessary in the appeal process. The average IRO appeal will cost $650 per case; commenter does not see the cost advantage to any party in a dispute except for the IROs.

RESPONSE: The commission is mandated by HB-2600 to utilize the IRO process in the same manner as HMOs. The commission has adopted the same Tier 1 and Tier 2 fee schedule utilized in the HMO model in order to minimize any differences between workers' compensation reviews and HMO reviews, although this is subject to monitoring and further review and revision.

COMMENT: Commenter recommended that the phrase in the first sentence is lacking information, i.e. does not mention retrospective review.

RESPONSE: Commission agrees. The language for retrospective reviews regarding medical necessity has been included in subsection (a)(1).

Proposed §133.308(a)(2)

COMMENT: Commenter suggested there are very few retrospective disputes where there is clearly only a medical necessity question. Most have issues over their fees. Commenter is concerned that by setting up basically what would be a bifurcated process will place a great burden on all the parties trying to submit what is basically two separate disputes on one actual bill that the parties are disagreeing on.

RESPONSE: The commission agrees in part. The rules are not overly complicated. However, some modifications have been made to the IRO process to combine an IRO retrospective medical necessity decision with a commission decision in order to address the fee component for the same health care. The commission has amended the rules to process disputes on a single track to the extent possible. The commission does not agree that the two-track process as proposed would cause confusion, but the rule has been amended to streamline the process to allow a combined filing of a retrospective medical necessity dispute with a medical fee component dispute. The different statutory processes required for the various types of disputes prevent any more consolidation of process than has been done in the rules as adopted.

Proposed §133.308(b) TDI Rules

COMMENT: Commenter recommended that §133.308 define the Independent Review Officers qualifications and licensing requirements.

RESPONSE: The commission disagrees. The IRO qualifications and licensing requirements are established in the Insurance Code Articles 21.58A and 21.58C.

COMMENT: Commenters stated that confidentially in the IRO process is maintained. The proposed rules of the Commission will compromise the confidentially and independence of the IRO.

RESPONSE: The relevant TDI rules as they were proposed would have required an IRO notice of determination to include a certification by the reviewing physician or provider that no known conflicts exist. The adoption preamble for the TDI IRO rules states that, upon adoption, the TDI rule "was changed to allow the independent review organization to certify that the reviewer has certified his/her independence in lieu of the certification requirement by the reviewer. Since the reviewer is to be independent and will be conducting reviews for various individuals and entities, it is not appropriate that the specific individual be identified to those persons requesting review. Identification of the specific person conducting the review could result in some form of retaliation against the individual and affect their ability to be independent." 22 TexReg 11364.

A commenter on the TDI rules as proposed recommended that TDI restrict the use of the IRO determination in court proceedings. The commenter was concerned that the IRO staff would be continually subpoenaed to testify if that wasn't done and would adversely impact the cost of IRO appeals. In the adoption preamble TDI responded that the TDI rule: "reflects the statutory intent of confidentiality of individual medical records, personal information and any proprietary information provided by payors. The department does not believe that it can provide that the records and determinations of an independent review organization are those of a "medical committee" as suggested by the commenter because the statutory definition of "medical committee" does not include independent review organizations. The department is concerned that this action would exceed the regulatory authority of the agency." 22 TexReg 11365-11366.

TDI rules require that notification of a determination by an IRO must include a description of the qualifications of the reviewing physician or provider, and a certification by the IRO that the reviewer has certified his/her independence and no known conflicts of interest exist. 28 TAC 12.206(d). In addition to the independent review organization confidentiality requirements in TDI rules, the adopted commission rules require that an IRO preserve the confidentiality of claim file information that is confidential pursuant to the Texas Labor Code. If a third party asserts confidentiality of information that has been requested from the commission pursuant to an Open Records request, the commission requests an opinion from the Attorney General. The issue of the confidentiality of the names of IRO reviewers in TDI cases is in dispute and unresolved at this time. When resolved, it is likely that it will be applicable to a similar request that may be made to the commission in the future. There is precedent for sealing SOAH records to protect claim file information that is confidential by law, and this is on possible solution to part of the concerns. A commission rule may not be controlling on this issue and the adopted commission rule does not address confidentiality more specifically than it was in the rule as proposed.

COMMENT: Commenter suggested that implementation of this rule by the commission would constitute an unconstitutional taking of the property of the IROs if the IROs are compelled to perform commission reviews under the proposed rules.

RESPONSE: The commission disagrees. The IRO review is mandated by HB-2600. IRO reviews will be conducted in the same manner as set forth in the Insurance Code Articles 21.58A and 21.58C.

COMMENT: Commenter expressed concerned regarding the lack of quality review after the process.

RESPONSE: The commission disagrees. The commission and TDI will establish a mechanism through an MOU to address complaints, enforcement and quality issues regarding the IRO process for workers' compensation medical dispute resolution. Additional language has been added in the rule to provide for the commission to review, inspect, copy and/or compel production of documentation or other information as necessary to carry out it's duties and responsibilities under this rule, the Act, and other applicable statutes.

COMMENT: Commenter suggested that the commission leave itself an out of the rule regarding the certification of IRO. There is no requirement in the rules that TDI be the certifying agency. The commenter suggested wording that in addition to TDI certification, the commission require a statement of "or other certification procedure approved by the TWCC which is at least at a minimum substantially the same as the TDI".

RESPONSE: The commission disagrees. HB-2600 specifies that medical necessity of health care services requiring preauthorization and reviews for retrospective medical necessity disputes shall be conducted by an IRO under Article 21.58C of the Insurance Code in the same manner as reviews of utilization review decisions by HMOs - by IROs certified by TDI.

COMMENT: Commenter supported the language included that adopts by reference the TDI IRO rules. Commenter stated that the proposed substitute rule provides greater clarity regarding a doctor who has been removed from the Commission's ADL.

RESPONSE: The commission agrees in part. TDI is responsible for the licensing and certification of the IROs and the commission has no authority in the certification process. The adopted rule has clarity; it clearly states that a provider who has been removed from the commission Approved Doctor List is not eligible to direct or conduct independent reviews of workers' compensation cases.

Proposed §133.308(b)(4)

COMMENT: Commenter suggested that §133.308(b)(4) contain the specific Commission rule name and section number.

RESPONSE: The commission agrees in part. The language has been revised in the rule as adopted to include more information: "The Texas Labor Code and commission rules govern the independent review process and related substantive areas, including: requests, filing, notification, time deadlines, parties, billing, payment, appeal from an adverse IRO decision, and other matters addressed in this rule."

Proposed §133.308(b)(5)

COMMENT: Commenters requested clarification regarding removal of an ADL doctor that is conducting IRO reviews.

RESPONSE: The commission will advise system participants as necessary, of any ADL removals.

COMMENT: Commenter stated each IRO as part of its application certification has filed written screening criteria and review procedures with TDI. IROs urge the commission that the filings with TDI are sufficient. IROs agree this material is available on a confidential basis to the commission for purposes of this provision and shall not be retained by commission as public information subject to disclosure or release under the Texas Administrative Code Chapter 552.

RESPONSE: The commission agrees in part. The rule as adopted address the commission's enforcement authority and right to access IRO information and documentation. If a third party asserts confidentiality of information that has been requested from the commission pursuant to an Open Records request, the commission requests an opinion from the Attorney General. The issue of the confidentiality of the names of IRO reviewers in TDI cases is in dispute and unresolved at this time. When resolved, it is likely that it will be applicable to a similar request that may be made to the commission in the future. A commission rule would not be controlling on this issue and the adopted commission rule does not address confidentiality more specifically than it was in the rule as proposed.

Proposed §133.308(b)(9)

COMMENT: Commenter suggested rule be consistent with §133.304(h) regarding the disclosure of name and license number of carrier's peer reviewer. For the sake of consistency and accountability, the identity of the IRO doctor should be available to insurers.

RESPONSE: The commission disagrees. HB-2600 mandates the use of IROs regulated by TDI for medical dispute resolution reviews. The identity of an IRO reviewer remains confidential under the TDI regulations. The issue of the confidentiality of the names of IRO reviewers in TDI cases is in dispute and unresolved at this time. When resolved, it is likely that it will be applicable to a similar request that may be made to the commission in the future. A commission rule would not be controlling on this issue and the adopted commission rule does not address confidentiality more specifically than it was in the rule as proposed.

Proposed §133.308(c) Parties

COMMENT: Commenter suggested that subsection (c) is unnecessary as current language identifies who can be a party in each type of dispute and recommended replacement of substitute rule.

RESPONSE: The commission disagrees with commenter's recommendation. Subsection (c) clearly identifies the relevant parties to retrospective and prospective medical necessity dispute resolution.

COMMENT: Commenter suggested that proposed §133.308(c) and (d) conflict with TDI rule 12.501 relating to requests for IRO review. Commission rules outline the process for requesting an IRO, including necessary documentation; the application of 12.501 may not be necessary and is confusing.

RESPONSE: The commission disagrees. There is no conflict between the rules; subsection (b) of the commission rule identifies the modifications to TDI rule 12.501 that pertain when IROs review workers' compensation disputes.

Proposed §133.308(c)(2) & (c)(3)

COMMENT: Commenter recommended that "necessity" be inserted between "preauthorization" and "dispute" for consistency with Section 133.305.

RESPONSE: The commission disagrees. A prospective necessity case may be a preauthorization dispute or a concurrent review dispute. Because the parties differ in these types of prospective disputes, it is necessary to distinguish between them in paragraphs (2) and (3).

Proposed §133.308(d) Requests

COMMENT: Commenter expressed concern about lack of an initial review, an initial screening of the request when it comes in from the requestor. There are cases where a cure may be medically necessary but payment policies don't allow payment or actually prohibit it. We are not going to see any party get left holding a bill for an IRO when they really shouldn't have had an IRO done.

RESPONSE: The commission agrees in part. The carrier is required to screen a request for relevant compliance with commission billing and reimbursement rules. The commission has added language to the proposed process that includes additional monitoring and screening by the commission.

COMMENT: Commenter recommended that a safeguard be in place to ensure that the carrier receives a copy of the request for independent review. Commenter also stated that the process as proposed would delay and frustrate the review of medical necessity disputes and is setting the process up for failure. Commenter recommended withdrawal and replacement with substitute rule.

RESPONSE: The rule as adopted contains safeguards. The carrier and the commission will receive a copy of the request for IRO review from the requestor. The commission will be able to track the timeframes for responding to a request for IRO review. The commission disagrees that the process will delay and frustrate review, and with withdrawal and substitution of the rule. The Texas Labor Code as amended by HB-2600 mandates the IRO in workers' compensation cases.

Proposed §133.308(e) Timeliness

COMMENT: Commenter asserted that the rule states that if a party fails to timely file a request for medical necessity dispute resolution, it waives its right to independent review or medical dispute resolution. This is appropriate with respect to retrospectively reviewed medical bills, but is unclear with respect to items subject to preauthorization. Does this mean that the claimant is

forever barred from receiving the treatment, or can another request for preauthorization be made upon showing of a change in medical condition similar to the requirement of §133.206(l)?

RESPONSE: The commission clarifies that §133.308(e)(2) addresses prospective necessity dispute resolution. The commission further clarifies that §134.600 (g)(4) provides that a request for preauthorization for the same health care that has been previously denied at the IRO level as not medically necessary, may only be resubmitted when the requestor provides objective documentation of a substantial change in the employee's medical condition.

COMMENT: Commenter supported the 45 day timeframe for submission of a request for prospective medical necessity disputes and recommended that language be changed to not later than 45 days after requestor has received written denial of reconsideration instead of not later than the 45th day after the carrier denies approval of reconsideration request.

RESPONSE: The commission disagrees because the rule as adopted complies with the statutory and rule provisions applicable to carrier payment of medical bills.

Proposed §133.308(e)(1)

COMMENT: Commenter suggested the new guidelines do not allow pharmacies to bundle their claims together because the time-frame in which we would have to submit cases to be heard by an IRO is much shorter.

RESPONSE: The commission agrees. The rule has, however, been amended; the time frame for requesting medical dispute resolution has been retained as one year from the disputed date(s) of service, as in the rule being repealed.

Proposed §133.308(e)(1)(B)

COMMENT: Commenter recommended a definition be provided for "final action" as there is no specification for carriers to use a standard form to let physicians' offices know in a uniform way that the clock is running on the process. Commenter recommended 90 days as a more appropriate timeframe to file a notice after final action. 90 days is more appropriate to allow large, busy and/or small physicians' offices the time needed to assemble documents and other needed information.

RESPONSE: The commission amended the timeframes for requesting medical dispute resolution to date one year from the disputed date(s) of service. The need to identify final action dates no longer exists.

Proposed §133.308(f) Complete Request (General)

COMMENT: Commenter suggested that the commission has proposed costly documentation submission requirements that are totally unnecessary. Commenter recommended that subsection (f) in proposed §133.308 be withdrawn and that a new medical dispute resolution rule based on the current rule be adopted.

RESPONSE: The commission disagrees and has declined to withdraw the proposed rules. This rule incorporates a medical opinion in prospective and retrospective medical necessity disputes as mandated by HB-2600. The costs associated with the IRO review will be assessed to the nonprevailing party in a retrospective medical necessity dispute. The documentation requirements are no greater than they need to be for resolution of a dispute. The commission has, however, amended the process from the rule as proposed, including the time, place, and content for requests and for filing supporting documentation.

COMMENT: Commenter opposed the proposed requirements under subsection (f), which create different documentation requirements for medical necessity and medical fee disputes creating an unnecessary burden on health care providers and injured workers, and will increase cost.

RESPONSE: The commission disagrees. Disputes regarding prospective and retrospective medical necessity disputes will be reviewed by an IRO. Documentation will be required to be submitted to the IRO upon notification of a request of an IRO review. The commission will decide fee disputes. The documentation required for a review of the two types of disputes is different because of the issues involved. In requests submitted by an injured employee for prospective or retrospective medical necessity dispute review by an IRO, the injured employee will not be burdened with the cost of the IRO fee or associated or copy costs.

Proposed §133.308(f)(1)

COMMENT: Commenter stated that by requesting the identified documentation from both parties, the IRO faces the probability of receiving duplicative documentation from the parties.

RESPONSE: Commission agrees that the possibility of receiving duplicate documentation exists. However, in order to perform a thorough review it is essential to obtain the necessary documentation.

COMMENT: Commenter suggested it is unclear if the information collected in this section will be provided to the independent review organization (IRO) by the Commission. It is recommended that this information be provided to the IRO.

RESPONSE: Commission believes that the rule as adopted is clear. The carrier and the commission will review the request form to determine legitimate requests. The parties will be notified of an assignment of an IRO and are required to provide the documentation directly to the IRO. The IRO will request medical documentation from relevant health care providers that have rendered treatment to the injured employee. The documentation will not be provided to the commission except by request or order of the commission.

§133.308(f)(1)(C)

COMMENTS: Commenter recommends the definition of "convincing proof."

RESPONSE: The commission disagrees. The commission does not want to limit convincing evidence to a specific means of verification. The commission will evaluate what is provided, whether it is certified mail, attempts documented in correspondence or log, facsimile transmission or other electronic means that can be verified. Another example of convincing evidence would be when a provider receives a check for partial payment without an explanation of benefits to explain the reduction of the submitted charges. This may be convincing evidence that the carrier received the bill for audit and payment but failed to explain their denial reasons in the required EOB.

Proposed §133.308(f)(1)(E)

COMMENTS: Commenters suggested that any pharmacy or medical equipment/supply provider knows who prescribed the healthcare it provided, but cannot possibly know other facilities that the injured employee might visit. Commenter request this section be deleted.

RESPONSE: Commission agrees in part. This section captures a list of providers that may have examined or provided health care to an injured employee. A requestor should provide the information that is available to them and submit the request to the insurance carrier. The insurance carrier is then required to complete the form and provide any missing information related to any other health care providers that may have treated the injured employee.

Proposed §133.308(f)(1)(D)

COMMENTS: Commenter questioned what the definition for denial codes T, U and V were.

RESPONSE: The definitions of denial codes appropriate in the workers' comp system are found on the commission for TWCC-62. Denial code "T" is used when the treatment provided is not within the treatment guidelines; "U" is applied to unnecessary treatment (without peer review); and "V" is used to deny unnecessary treatment (with peer review).

Proposed §133.308(f)(1)(F)

COMMENTS: Commenter recommends the requestor provide "a list of all providers that participated in the review or determination of the carrier, if known by the requestor. This section would read more easily if the word "of" were replaced by the word "by".

RESPONSE: The commission agrees and has revised the language in the rule as adopted.

Proposed §133.308(g) Carrier Notification to Commission

COMMENT: Commenter recommends that carrier responses regarding denials of preauthorization or concurrent review include various requirements as contained in the current rule.

RESPONSE: Commission disagrees. The Insurance Code and the Texas Labor Code address adverse determinations by carriers, as do TDI and commission rules. HB-2600 has mandated the use of IROs for prospective medical necessity disputes. Upon assignment of an IRO, the IRO will request the medical documentation directly from the health care providers in order to evaluate and make a determination for prospective medical necessity disputes. Denials of preauthorization or concurrent review will be required to be included with the filing of a request for prospective medical dispute resolution.

COMMENT: Commenter recommends the requirements in (g)(2) and in (g)(4) be combined into one as (g)(4) appears redundant of (g)(2).

RESPONSE: The commission disagrees. The information required in paragraph (2) addresses providers who have examined, provided, or rendered health care to the employee; paragraph (4) addresses providers who participated in the review or determination by the carrier, if known by the requestor.

COMMENT: Commenter suggest that this subsection as proposed will create a great burden on insurance carriers as it requires different documentation for responding for medical necessity disputes filed by health care providers as compared to requirements for medical fee disputes. Recommend withdrawal and adoption of substitute rule.

RESPONSE: The commission agrees in part. While the supporting documentation differs for the type of dispute, the commission has revised adopted §133.307 for medical fee disputes and §133.308 to require only one filing of an initial request for both dispute types. The documentation required for a medical necessity dispute is very different from those required for a fee dispute, given the nature of the disputes. The commission declines to withdraw and adopt a substitute rule for reasons discussed in response to comments elsewhere in this document.

COMMENT: Commenter suggested the respondent should be allowed to file a "statement of position" similar to the one required by §133.307(j)(1)(E).

RESPONSE: Commission disagrees. Disputes regarding prospective and retrospective medical necessity disputes will be reviewed by an IRO in order to render a medical opinion. The IROs will request medical documentation from health care providers that have provided care to an injured employee in order to evaluate all of the medical documentation necessary to render the medical opinion; a statement of position from either party is no longer required.

§133.308(g)(4)

COMMENT: Commenter stated the proposed rule required that the carrier provide "a list of all providers that participated in the review or determination of the carrier, if known by the requestor." This section would read more easily if the word "of" were replaced by the work "by".

RESPONSE: The commission agrees and this change has been made in the rule as adopted.

COMMENT: Commenter suggested that this information is already required by §133.308(f)(6). If the intent is to get a complete list of providers, perhaps the language should be "a list of any additional providers that participated in the review of determination of the carrier, known by the respondent."

RESPONSE: Commission disagrees. The requirement in §133.308(f)(6) is for the requestor to submit the required information. The requirement in §133.308(g)(4) is for the respondent to complete the required form with any additional information not provided by the requestor.

§133.308(g)(5)

COMMENT: Commenter suggested that this subsection contains instructions pertinent to the requestor to file proof that a benefit review conference has been requested. However, subsection (g) is in regards to respondent requirements. Further, it is the requestor that is the sub-claimant. Therefore, paragraph (5) of subsection (g) should be under subsection (f).

RESPONSE: Commission agrees. The rule as adopted has been revised by moving paragraph (5) to subsection (f).

COMMENT: Commenter recommends that the Commission should clarify that this section is not intended to apply to a subclaim for medical benefits provided to an injured employee under Tex. Lab. Cd. Sec. 409.009.

RESPONSE: The commission disagrees. A health care provider qualifies as a subclaimant under the Texas Labor Code Sec. 409.009, however, the reference to Chapter 141 relating to Benefit Review Conference describes the process of requesting a BRC as a subclaimant. This paragraph (5) has been moved to subsection (f) as it pertains to a requestor.

Proposed §133.308(h) Filing

COMMENT: Commenters recommended a three- day and 14-day turn around time. Commenters indicate that this time frame is short and places an unnecessary burden on the carrier. The proposed three-day time frame is unrealistic and not possible. The proposed time frame will be burdensome

to the respondent (possibly a healthcare provider in a refund request dispute) and will not result in timely and appropriate adjudication of the disputed issue(s). Commenter recommends the response timeframe be extended to seven (7) working days for prospective medical necessity review and three (3) days for a concurrent review for medical necessity dispute.

RESPONSE: The commission disagrees. This subsection applies to the filing of the request for dispute resolution, not to the time frame for providing supporting documentation. IRO requests under TDI rules require a one-day turnaround on requests for IRO review. The commission is allowing a three-day time frame as opposed to one day. A health care provider in a refund request dispute will not be provided with any more time to respond than will a carrier. The commission has determined that the time frame is realistic and reasonable and will result in timely decisions in prospective and retrospective medical necessity disputes reviewed by IROs.

COMMENT: Commenter recommends the word "request" be changed to "response".

RESPONSE: Commission agrees and revises the language to apply to a "response to the request."

Proposed §133.308(i) TWCC Notification of parties

COMMENT: Commenter recommends that the division notify the parties of an IRO assignment by certified mail or verified facsimile.

RESPONSE: The commission agrees in part. The section has been be amended to include that the parties will be notified via facsimile or regular mail for parties without access to facsimiles. The commission has attempted to model the TDI/IRO/HMO process as in HB-2600; notification by TDI is done by facsimile.

COMMENT: Commenter asks if in §133.308(i), second sentence "accord" be spelled "accordance"?

RESPONSE: Commission agrees and has amended "accord" to read "accordance".

COMMENT: Commenter agreed with proposed assignment of disputes to IROs on a rotating basis. Commenter further supported the Commission notification of parties of the receipt of a dispute and IRO assignment.

RESPONSE: The commission agrees in part with commenter's recommendation. The commission by rule has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded. In addition, the rule as adopted allows the commission to assign disputes in accordance with the priorities established in this rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity.

COMMENT: Commenter suggested that if no IRO is available, or amounts in dispute are less than the IRO fee, the parties are allowed to choose a mutually agreeable doctor from the designated doctor list to review the issues in dispute and issue a decision. Commenter suggested that in medical necessity disputes the Division assign an IRO to review the medical necessity disputes.

RESPONSE: Commission disagrees. No amendments have been made to allow parties to choose a mutually agreeable doctor. However, the commission encourages parties to attempt resolution prior to requesting medical dispute resolution. Although an alternate process is not included in the rule, the commission by rule has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded.

§133.308 (j) IRO Notification of Parties

COMMENT: Commenter requested clarification regarding why a provider should be required to produce another set of documents to the IRO when two sets have already been provided to TWCC; another commenter requested clarification regarding "any" medical records of the injured employee stating that this is too broad and expressed concern that documents would contain resource and reference material along with claimant specific documents.

RESPONSE: Commission disagrees. Under the proposed rules, an IRO will review requests for prospective and retrospective medical necessity disputes. Requests for IRO review will not require the filing of two sets of copies as in the previous process under §133.305. The commission is not specific as to the medical records in possession of the injured worker due to the language in that sentence "relevant to the review". Under §133.308(k), language regarding medical records that may contain claimant specific information requires the IRO to preserve confidentiality of individual medical records as required by law.

COMMENT: Commenter recommended notification of parties and request for documents be submitted on a form and format prescribed by commission, as this would facilitate the process.

RESPONSE: Commission disagrees. HB-2600 mandates the use of IROs for medical dispute resolution in the same manner as reviews performed by IROs in the HMO model. The commission has attempted to mirror this process as much as possible. Therefore, the commission has prescribed that the TWCC form and format is not required because the IROs have processes in place for the notification.

COMMENT: Commenters expressed concern regarding the deadlines, stating that timeframes were unreasonable. Commenter recommended that timeframe imposed on IRO be measured from date of receipt of all necessary documents. Commenter additionally stated that IROs do not have the authority to compel providers to deliver medical records and recommended that the commission compel parties to submit all required documentation to the IRO.

RESPONSE: Commission disagrees. The commission has determined that the time frame is realistic and reasonable and will result in timely decisions in prospective and retrospective medical necessity disputes reviewed by IROs. The rule as adopted, however, has been revised to require pre-payment of the IRO; the revision includes language that starts the IRO timeframe for action from the date the IRO receives the prepaid fee. The IROs are not required to obtain written consent of the injured employee; this should assist the IROs in obtaining records as soon as possible. Parties are required to submit all requested and all relevant documentation to the IRO.

COMMENT: Commenters recommended that the commission serve as the clearinghouse for transfer of documents and maintenance of dispute records. Commenter further stated that proposed rule ends the practice of filing a certified official record with SOAH and the parties to the dispute and will result in significant increase in discovery between the parties and will ultimately result in increased costs associated with medical dispute resolution.

RESPONSE: Commission disagrees. The commission will not facilitate the transfer of documents and the maintenance of dispute records under this rule. The IROs will maintain the medical records utilized in a review for four years as required by TDI rules. It is not within the scope of the proposed rules to address the certified record used in a SOAH hearing.

COMMENT: Commenter expressed concern regarding independent review for prospective and concurrent review and recommended an initial screening process for determining the reason for the IRO request.

RESPONSE: The commission agrees in part. A request for IRO review will be submitted to the carrier for completion of the request. At this time, the carrier has an opportunity to review the request and take action that may result in resolution without an IRO review. The carrier will have three days to complete the form and submit to the commission for assignment. The commission will also review the initial request.

COMMENT: Commenters recommended that the timeframe for the IROs receipt of documentation be changed from not later than 7 days to not later than 14 days for prospective medical necessity disputes, and not later the third working day for concurrent review disputes. Commenter stated that due to unpredictable mail delivery the timeframes proposed are unreasonable and too stringent.

RESPONSE: The commission disagrees. The commission has determined that the timeframes in the rule are realistic and reasonable and will result in timely decisions in prospective and retrospective medical necessity disputes reviewed by IROs; this is based in part on TDI and IRO experience in group health.

Proposed §133.308 (k) Confidentiality

COMMENT: Commenters voiced concerns regarding the release of records to an IRO, stating that the IRO will not be able to get records without a signed release by the injured employee, that this oversight would limit an IRO accessibility to medical records. Further commenters stated that HIPPA requires patient authorization to obtain the release of medical records and IROs representatives recommended that TWCC include the completed release authorization fully executed by the injured employee with the notice of assignment. Commenter recommended changing language to read, "No IRO or provider is required to obtain the written consent..."

RESPONSE: The commission agrees in part. Consent from the employee is not necessary in the workers' compensation system, and the commission has not revised the rule to require that a signed release from the employee be sent with the assignment of an IRO. The commission has, however, revised the subsection to state that no IRO or provider is required to obtain the written consent of the employee. This will give the IRO and providers a method to obtain and release medical records without commission intervention if there is a problem in securing release of the records.

Proposed §133.308 (l) Additional Information

COMMENT: Commenters recommended that for expediency all documentation for an independent review be initially submitted to TWCC and reviewed for completeness prior to submission to IRO and if IRO receives incomplete files, these would be subject to additional IRO fees. Commenters further recommended that the IRO not be allowed to make or keep copies of the documents but return entire file to TWCC for maintenance of the file.

RESPONSE: The commission disagrees. A request for IRO review will be submitted to the carrier for completion of the request. At this time, the carrier has an opportunity to review the request and take action that may result in resolution without an IRO review. Under the rule as proposed, the commission will review the request prior to assigning it to an IRO. If an IRO does not receive sufficient documentation upon which to base a decision, additional information can be requested under this subsection. The IROs under TDI rules are required to maintain files used in a review for four years.

§133.308 (m) Designated Doctor Exam

COMMENT: Commenter supported the IRO designated doctor process. Other commenters recommended that the commission should monitor and limit the IRO's use of designated doctor exams to only preauthorization and concurrent review disputes, or for cases involving spinal surgery, or cases with unusual circumstances requiring the approval of TWCC Medical Advisor. Another commenter recommended clarification that the IRO is not required to request a designated doctor examination in spinal surgery cases.

RESPONSE: Commission disagrees with the recommendation to limit the use of designated doctor exams. HB-2600 did not limit the use of designated doctor exams for a specific dispute type and the commission will not do so for reviews that are being performed by an IRO. The commission will, however, monitor requests for designated doctor exams and the health care in dispute when an exam is requested. The rule is clear that use of a designated doctor exam is at the discretion of the IRO. This maintains the independence of the IRO process and decision.

COMMENT: Commenter recommended a mandated timeframe for the designated doctor exam to be completed after requested. Commenters recommended that the timeframe for requesting the designated doctor exam should be adjusted from 3 days to allow for receipt of the documentation, such as 7 days.

RESPONSE: The commission agrees, but the timeframe for requesting a designated doctor exam has been amended from 3 days to 10 days because the deadlines for IRO decisions have also been amended in the rule as adopted.

COMMENT: Commenter recommended that the commission specify the presumptive weight to be afforded by the IRO to a designated doctor and that doctor's findings. Commenter further requested that consequences be defined for untimely requests by the IRO for the designated doctor exam and recommended a consequence be that no presumptive weight would be given to the IRO determination, or the original request for dispute resolution be dismissed. Commenter stated that the proposed rule does not limit the issues to those specified by the commission and further recommended that TWCC clearly delineate the applicability and appropriate use of the report in pending or future disputes cases of liability, compensability, extent of injury, and/or maximum medical improvement and impairment rating disputes.

RESPONSE: The commission disagrees. Designated doctor exams will not be given presumptive weight if requested by an IRO to perform an exam. This maintains the independence of the IRO process and decision. The commission will monitor timely requests for designed doctor exams, however, the commission will not automatically dismiss IRO reviews due to untimely requests for an exam. The commission will evaluate these situations on a case-by-case basis. HB-2600 was specific in affording an IRO access to a designated doctor exam, however, the commission

does not interpret this to permit use of a designated doctor exam and report for future disputes regarding liability, compensability, extent of injury, and/or maximum medical improvement and impairment rating disputes.

COMMENT: Commenter suggested including language that states that written consent by the injured employee is not required in order to forward medical records to the designated doctor for the requested exam or for the designated doctor to receive the medical records. Commenter further recommended that the treating doctor and the carrier may send the designated doctor an analysis of the employee's medical condition and that the designated doctor may assist in resolution of disputes.

RESPONSE: The commission agrees in part. The language in the rule as adopted has been revised to state: "No IRO or provider is required to obtain the written consent of the injured employee". This will give the IRO and providers a method to obtain medical records without commission intervention if there is a problem in securing release of the records. The commission disagrees with commenter's recommendation for treating doctor and the carrier analysis of the employee's medical condition being submitted to the designated doctor. Section 133.308 (j) delineates what type of documentation is required of the parties. An analysis from the parties is not needed.

COMMENT: Commenter recommended that the designated doctor prepare a narrative report and provide complete rationale for conclusion reached, including specific reference to medical records reviewed and applicable treatment guideline provision. Commenter further suggested that additional language be added to include that neither party may "initiate" communication with the designated doctor.

RESPONSE: The commission disagrees. Subsection (m) provides the requirements related to the designated doctor examination requested by an IRO. The commission will prescribe the form and format of the designated doctor report. The designated doctor will forward the report to the IRO and neither party may communicate with the designated doctor regarding issues not related to the dispute. Section 133.308 (j) delineates what type of documentation is required of the parties. An analysis from the parties is not needed.

COMMENT: Commenter recommended that payment for copies of medical records be made by the carrier for the IRO requested designated doctor exams.

RESPONSE: The commission agrees. The carrier shall pay the designated doctor fee in accordance with subsection (q)(5) of this rule.

§133.308 (n) Time Frame for IRO Decision.

COMMENT: Several commenters expressed support of the inclusion of timeframe provision for issuance of a decision.

RESPONSE: The commission agrees; the timeframes have been revised based on comments discussed elsewhere in this preamble.

COMMENT: Commenter stated that the proposed timeframes are unrealistic and do not allow the IRO ample time to conduct its review activities and requested further clarification. Commenter recommended that the IRO have 20 days from the receipt of all requested documentation to review, render a decision and notify the parties regarding prospective medical necessity disputes and 30 days regarding retrospective necessity disputes.

RESPONSE: The commission agrees, and these recommended timeframes have been included in the rule as adopted.

Proposed §133.308(o) IRO Notification of Decision.

COMMENT: Commenter disagreed that an IRO decision should be deemed to be a commission decision and order and stated a state agency cannot delegate its authority regarding decisions and orders to a private company.

RESPONSE: The commission has amended the rule to require that, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and for all disputes other than preauthorization and employee reimbursement disputes, determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately. There will therefore be no IRO order deemed to be a commission order.

COMMENT: Commenter recommended that commission receive IRO reports and review to determine if all issues were addressed and adjudicate the amount of payment to be made by the insurance carrier.

RESPONSE: The commission agrees. The process in the rule as adopted provides for the commission to receive the IRO decision for commission review and determination of the nonprevailing party. Language has also been added to the rule as adopted stating that the commission will be monitoring IRO quality and performance.

COMMENT: Commenters requested definition of "conflict of interest", and recommended language addition that the reviewing health care providers also certify that no conflicts of interest exist with the carrier or its agents.

RESPONSE: The commission disagrees with providing a definition of "conflict of interest" as it would tend to be either too restrictive or too permissive. The rule requires that the IRO ensure the reviewer assigned to perform an IRO review has signed a statement certifying that no conflicts of interest exist in the review he or she conducts. This is consistent with TDI rules.

COMMENT: Commenter recommended that the format be standardized for IRO decisions, and that all IROs transmit either full reports or summaries. Commenter further recommended that TWCC consider the information needed to determine the prevailing party, post the decision on the TWCC website, monitor IRO decisions and retain the right to access the IROs documentation for the decision.

RESPONSE: The commission agrees in part. The commission agrees that the form and format of an IRO report should be standardized and the rule as adopted requires submission in the form, format, and manner required by the commission. The commission will standardize a format for IRO decisions and reports provided to the commission for posting on the commission's website. The commission is working on similar issues for other commission decisions, and any requirement for a standard format may be addressed simultaneously in the future for several types of decisions.

COMMENT: Commenter recommended expansion of language into an outline format including specific issues and dates of service to be considered by the IRO.

RESPONSE: The commission disagrees. The commission reviewed the suggested language and declines to incorporate recommended format as it is not needed.

COMMENT: Commenter recommended addition of "overnight mail", "certified mail", "via facsimile with transmission verification" be included in language in this subsection to establish a consistent and timely mode of communication.

RESPONSE: The commission disagrees. The rule as adopted requires that the IRO notice to the commission must be sent by mail or otherwise transmitted. This is consistent with IRO notice to TDI in the HMO model for retrospective medical necessity disputes.

COMMENT: Commenter further requested clarification regarding the limitation on the use of the peer review report to the extent that the peer review is inconsistent with the IRO decision. Commenter requested clarification regarding statement "...the review and its rationale shall not be used on subsequent denials in that claim as the IRO has already found it unconvincing", stating language is restrictive and inappropriate.

RESPONSE: The commission believes that the rule is clear as to the limitation on subsequent use of a peer review that has been overturned by IRO decision.

§133.308(p) Commission Posting.

COMMENT: Commenter recommended substitute language, "The Commission shall post a redacted copy of all medical dispute resolution, independent review organization decision, and associated designated doctor reports on its internet website, only after the time the decision becomes final, and after all appeals are finally resolved."

RESPONSE: The commission disagrees to addition of the recommended language. Decisions relating to medical dispute resolution, IRO decision and SOAH decisions will be posted to the website as they are issued. The commission is considering what the posting requirements will be for all commission decisions. Any associated designated doctor reports will not be posted on the commission's website.

COMMENT: Commenter requested clarification of what confidential information will be redacted prior to posting on the commission's website.

RESPONSE: The commission will redact all personal information relating to an injured employee. Other information will be redacted as required by law. Open records issues applicable to the IRO process and decision have not been resolved.

COMMENT: Commenter recommended language to parallel substitute rule offered in place of proposed rule as amendment to current §133.305 with the following addition regarding Commission Posting: Posting of Commission Decisions on the internet. The Commission shall post a redacted copy of all medical dispute resolution, independent review organization decision, and associated designated doctor reports on its internet website, "only after the time the decision becomes final, and after all appeals are finally resolved" to allow system participants to conduct on-line research regarding medical necessity issues. Commenter recommends posting the IRO decisions by the 30th day after the decision has been issued since appeals to decision must be made within 20 days. If the decision has been appealed that should be noted along with the posting.

RESPONSE: The commission disagrees with the language offered in the substitute rule. Decisions relating to medical dispute resolution IRO decisions and SOAH decisions will be posted to the website as they are issued. The commission is considering what the posting requirements will be for all commission decisions. Any associated designated doctor reports will not be posted on the commission's website.

§133.308(q) IRO Billing

COMMENT: Commenter states, "HB-2600 says loser pays and it does not assign billing collection to the IRO." Numerous commenters suggested the commission assume responsibility of the IRO payments and be required to order payment to the IRO. A commenter stated this suggestion would result in greater compliance, and failure to pay would constitute an order violation. Commenter recommended that the most accountable processing for billing of an IRO review to any party other than carriers is that the commission should assume responsibility. The commission's statutory authority allows for a demand for payment that is clear and unambiguous. A commenter expressed concern that the provision of IRO billing and collection will result in accumulated expenses and bad debt that is not currently the case in the TDI IRO program. Commenter suggested that the commission has more "clout" in collecting than the IRO would. Another commenter recommended the commission to review IRO decisions, determine the prevailing party, and send the bill to the paying party in the form of a commission order.

RESPONSE: The commission agrees that the nonprevailing party pays the IRO fee in a retrospective review other than a concurrent review or an employee reimbursement review. In prospective reviews and in concurrent or employee reimbursement retrospective reviews, the carrier pays the IRO fee. The commission has amended the rule to require payment of the IRO fee upon notice of an IRO assignment, in advance of the review. In a prospective dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO at the same time the carrier files the documentation requested by the IRO. In a retrospective dispute, the requestor shall remit payment to the assigned IRO at the same time the requestor files the documentation requested by the IRO. Payment of the IRO fee shall be remitted directly to the assigned IRO. The concerns of these commenters are addressed by this change. In addition, language has been revised to clarify the issuing of commission orders related to IRO decisions.

COMMENT: Commenter suggested the carrier be directed to pay for all reviews as they do for the TDI IRO process, and then be reimbursed by the nonprevailing requestor in a retrospective dispute. Commenter further recommended the commission to develop a guaranty fund to pay IROs when the nonprevailing party defaults.

RESPONSE: The commission disagrees with directing the carrier to pay for all IRO reviews. By statute, the carrier is liable for preauthorization reviews, and otherwise, the nonprevailing party is liable for the review fees. The commission disagrees with a guaranty fund to pay IROs, as there is no statutory provision for this. However, the commission has amended the rule to require the requesting party or the carrier (depending on the type of dispute) to remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately.

COMMENT: Commenter suggested that if the IRO decision finds that the disputed health care is medically necessary, the commission should order the carrier to pay in accordance with the Act and Commission rules. Commenter further stated that upon receipt of the Commission order, the carrier should either appeal the IRO findings or audit the bills for the health care found to be medically necessary. Commenter suggested the proposed rules place unnecessary burdens on the commission as HB-2600 did not envision a bifurcated process that requires simultaneous filing of both a fee dispute and a medical necessity dispute, nor was it envisioned that the commission should assume responsibility for ordering payment following a medical necessity review prior to the carrier first processing the medical invoice upon receipt of the medical necessity finding from the IRO.

RESPONSE: The commission agrees in part. By statute, the carrier is liable for preauthorization reviews, and otherwise, the nonprevailing party is liable for the review fees. The commission has amended the rule to require the requesting party or the carrier (depending on the type of dispute) to remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and for all disputes other than preauthorization and employee reimbursement disputes, determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately.

COMMENT: Commenter recommended the commission should require a fee deposit and block access to dispute resolution by requiring payment of outstanding fees prior to assignment of an IRO for any requestor who has previously failed to pay the IRO fee. Commenter also suggested the commission consider adding a small "bad dept surcharge" of a minimal for retrospective reviews, to be monitored and adjusted as warranted.

RESPONSE: The commission agrees in part. The commission has amended the rule to require that, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. In addition, the rule states that failure to pay or refund the IRO fee may result in enforcement action as allowed by statute and rules, removal from the commission approved doctor list, and/or restriction of future requests for independent review. This should eliminate the concerns of outstanding unpaid fees prior to assignment of an IRO by the commission.

COMMENT: Commenters suggested the proposed rules on billing and collections would jeopardize the ability of the IRO to efficiently perform its medical necessity reviews function, since IROs depend on good working relationships with the medical community. Any collection activity would affect such relationships, would impact the IRO for both the proposed commission reviews and the existing TDI reviews. Commenters suggested that if the IRO were left to decide who pays the fee, that the fee-paying decision would influence the outcome of the medical decision, and impair the "independence" of the process. Commenters stated in some instances, such influence would result in the employee as the party that prevailed since by statute the employee is exempt from liability for payment. One commenter expressed reluctance to pay for an adverse IRO decision that was felt to have been contrary to contents of the medical records that were supportive. Another commenter stated IROs cannot assume the risk of financial impairment of any of the parties involved in a review request. Commenter stated further that if the IRO initiates the review process by delivering the case file to its reviewer, the IRO fee cannot be subject to a refund.

RESPONSE: The commission disagrees with the IRO collection function interfering with an IRO's ability to perform an independent review. The commission also disagrees with implied suggestion that payment will be less forthcoming if the IRO decision is not favorable. However, the commission has amended the rule to require, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. The commission agrees that a requestor may be liable for the IRO fee if the request is withdrawn after the dispute has been delivered to the IRO reviewer and has added language to address these instances.

COMMENT: Commenter recommended that the commission identify at what point the requestor shall be liable for the fee after initiating a request for dispute resolution. Commenter stated that system participants should know when they are locked into the IRO fee. Commenter further suggested that after initiating the request for dispute resolution, if the requestor reverses the desire to pursue this further and has the request withdrawn prior to the commission assigning an IRO, the requestor should not be penalized with an IRO fee.

RESPONSE: The commission agrees that a requestor may be liable for the IRO fee if the request is withdrawn after the dispute has been delivered to the IRO reviewer and has added language to address these instances. The commission has amended the rule to require, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review.

COMMENT: Commenter recommends the commission dismiss medical necessity disputes until compensability issues have been resolved. Commenter states otherwise this could potentially result in the carrier paying an IRO fee on a medical necessity dispute later found non-compensable, and there is no provision for requesting a refund of the IRO fee.

RESPONSE: The commission disagrees with the dismissal of medical necessity when compensability is an issue. The requests for an IRO will be held in abeyance until the compensability dispute has been resolved by final order of the commission. This rule, in subsection (f)(7), directs the requesting party to provide proof that a Benefit Review Conference has been requested. The commission also disagrees that there is no provision for a refund of the IRO fee; this is stated in paragraph (8) of this subsection.

§133.308(q)(1)

COMMENT: Commenters recommended re-wording of §133.308(q)(1). One commenter's suggested language was, "IRO shall be paid by the nonprevailing party for retrospective medical necessity, as well as prospective medical necessity disputes regarding the denial of concurrent review authorization; IRO shall bill the insurance carrier for reviews conducted in injured employee medical reimbursement disputes; commission's decision issued to disputing parties shall include an order directing the responsible party to pay the IRO fee, less the amount deposited by the party with the request and/or response." Another commenter recommended deletion of the words "and in a concurrent review prospective necessity case" because concurrent IRO review should be billed in the same manner as prospective IRO reviews, as proposed. Section 133.305(a)(3) defines concurrent review as a prospective necessity dispute.

RESPONSE: Commission agrees in part. The commission has amended the rule to require, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and for all disputes other than preauthorization and employee reimbursement disputes, determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately. The statutory requirement that the carrier pay, applies to preauthorization disputes only, and the rules as adopted comply with the statute.

§133.308(q)(1)(C)

COMMENT: Commenters made alternative recommendations in the event the IRO cannot make a clear determination as to the prevailing party. A commenter's recommendation was for the commission to dismiss the request of the requesting party and divide the IRO fee equally, or apportion the IRO fee between the requesting and responding parties. Another commenter indicated the IRO might not be able to determine the prevailing party if it is based on proportionate maximum allowable reimbursement costs. A commenter recommended that if the IRO decision fails to clearly determine the nonprevailing party in a medical necessity dispute, or if multiple line items were in dispute and each party prevailed on some of the items, the IRO fee should be apportioned by percentage of dollar amount in the dispute awarded.

RESPONSE: The commission disagrees with the recommended alternative recommendations regarding dividing the fee equally between parties or apportionment in the event an IRO cannot make a clear determination. The statute does not provide for apportioning the fee among the parties, as the statute requires the carrier to pay in preauthorization disputes; otherwise, the nonprevailing party pays. The commission has revised the rule to provide for the commission to determine the nonprevailing party in retrospective necessity disputes. The revision is in (q)(2) of this section.

COMMENT: Commenter encouraged the nonprevailing party, including the injured worker, to be responsible for any associated costs of the IRO process.

RESPONSE: Commission disagrees. By statute, the injured employee may not be held responsible for any portion of the IRO review fee and the carrier must pay the fees in preauthorization disputes. The rule as adopted follows the same statutory requirements for paying associated and copy costs. This has been clarified in (1)(A) and (B) of this subsection.

Proposed §133.308(q)(2)

COMMENT: Commenter asked what was the difference between a prospective treatment requiring preauthorization case, and a concurrent review prospective necessity case? Commenter further stated in a preauthorization prospective necessity dispute, the carrier is required to pay, and asked why stopping ongoing care for a prospective medical service should be any different? Commenter stated concurrent reviews are merely extensions of preauthorizations, and should logically be treated the same as preauthorization. Commenter therefore recommended subsection (q)(2) to read "and for concurrent reviews the IRO shall bill the carrier." Commenter further advised that by rule, the Commission should have the power to extend to any ongoing medical treatment the requirement of 413.014(c) for preauthorization and concurrent review, and noted that HB-2600, Section 413.014(c), mandates preauthorization and concurrent review "of the listed services at a minimum." Commenter recommended deletion of the word "preauthorization" as it would allow all prospective necessity disputes to be billed by the carrier.

RESPONSE: The commission agrees in part. The difference is that in a case where preauthorization has been denied and the health care has not been rendered, then the health care dispute can only be reviewed as a prospective care dispute. In a case where concurrent review has been denied with the denial reason: "not medically necessary", and the health care provider proceeded with performing the care or granting an additional hospital stay, then the health care dispute can only be reviewed for retrospective medical necessity by an IRO.

COMMENT: Commenter suggested that proposed subsection (q)(2) did not accurately state the law. Section 413.031(h) of the Labor Code specifically limits the carrier's liability for the review in the situation where it prevails to disputes that "arise in connection with the request for health care services that require preauthorization under Section 413.014 or commission rules under that section. Section 413.031(i) provides that in all other cases, the "nonprevailing party" is liable for the cost of the review, except that the claimant will never be liable for the cost of the review. Commenter indicated there is no authority for carrier liability in situations regarding employee reimbursement. Such reviews are not governed by section 413.031(h) and therefore are subject to subsection (i). Commenter further determined that although not conceded, to the extent that the commission has the authority to require payment from the carrier, the commission would also have the authority to assess payment against the provider that unlawfully charged the claimant for the cost of services. Commenter also suggested that Section 413.031(j) would appear to put liability on the IRO as a cost of doing business. If the IRO wishes to provide this service then there will be certain situations where they will not be reimbursed.

RESPONSE: Commission disagrees. Payment for IRO fees that are covered by either subsection (h) or (i) are subject to the prohibition of (j) that the injured employee shall not be required to pay the fee. The statute provides discretionary authority to the commission in employee reimbursement disputes. The commission has determined that the cost is best placed upon the carrier. The commission will monitor employee reimbursement disputes to ensure that health care providers do not violate the statute by encouraging or requiring employees to pay the health care provider and seek reimbursement from the carrier. The rule as adopted does not place liability on the IRO as a cost of doing business.

§133.308(q)(3)

COMMENT: Commenter recommended changing subsection (q)(3) to read, "The IRO shall bill copy expenses to the party billed for the independent review." A commenter similarly recommended this section be deleted, or changed to state that copy costs are global to the IRO fee as the IRO fee is sufficient to cover copy costs.

RESPONSE: Commission agrees in part; the rule requires copy costs to be paid by the party liable for the IRO fee, except that the injured employee does not pay for copy or associated costs, and the requestor shall not be paid copy costs by the IRO. If a provider is not party to a dispute and is requested to submit records in an IRO review, then the carrier is liable for copy expenses.

§133.308(q)(4)

COMMENT: Commenter advised that an unintended consequence of this provision would be a deserving employee not requesting a medical review and then not receiving an attendant medical procedure for the monetary considerations of the treating provider rather than the medical reason.

RESPONSE: Commission disagrees. By statute, an injured employee seeking prospective medical necessity dispute resolution is not liable for payment of the IRO fee; a physician seeking preauthorization prospective medical necessity is also not liable for the IRO fee.

§133.308(q)(5)

COMMENT: Commenter recommended that language be included in subsection (q)(5) regarding payment of the designated doctor examination to include, "any additional records copies required."

RESPONSE: Commission disagrees. The treating doctor and the carrier are required to forward a copy of all medical records and diagnostic reports films and other medical documents to the designated doctor. In addition, in subsection (l) of this rule, if a provider is not party to a dispute and is requested to submit records in an IRO review, then the carrier is liable for copy expenses.

§133.308(q)(6)

COMMENT: Commenters advised that subsection (q)(6) was not clearly stated as to what documentation will be required of the IRO to prove it submitted an IRO bill for payment, in order for the IRO to be afforded the protection provided under a "commission order" to pay a fee. Commenter suggested that way the proposed subsection was worded provides that any amount billed is due when received, and that there must be some provision for disputing an amount billed by the IRO.

RESPONSE: The commission has amended the rule to require that, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and for all disputes other than preauthorization and employee reimbursement disputes, determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately. There is no need for the IRO to prove that it billed the fee to a party. There is likewise no need to dispute the amount of the IRO fee, as it is set by TDI rule..

Proposed §133.308(q)(7)

COMMENT: Commenters suggested that anything less than $650 will probably have to be written off by the provider, particularly in an example of a provider disputing a $50 prescription in lieu of risking an IRO fee. Commenter concluded that the injured worker will suffer because the small, cost efficient provider cannot afford to risk the IRO fee and will stop taking worker's compensation cases, or stop treating the patient with the first denial to avoid the whole appeal process. Another commenter noted that pharmacies are indirectly affected due to their uniqueness from other providers, and similarly concluded that carriers would deny every claim below $650, knowing the difficulty it world be for a pharmacy to bring and pay for the IRO dispute. Commenter stated that because of the costliness, procedures that fall below the charge for the IRO would not be dealt with, and carriers would continue hassling the HCP by denying services under $650 knowing that it is too expensive to dispute. Commenter asks if there is some means by which to settle smaller disputes, and suggested allowing the "bunching" of several smaller claims with one carrier? Commenter advised that if this were possible, then the deadline for filing disputes might need to be extended to allow for this option.

RESPONSE: The commission agrees in part. The commission is utilizing the tier 1 and tier 2 fee schedule utilized in the TDI rules. The commission recognizes the issues involving the amount of the fee relative to the cost of the health care provided, including pharmacies and DME providers. The commission does not support the position that the carriers will automatically deny services under $650. The commission will closely monitor carriers for possible violations regarding behavior of this type. The commission also notes that the carriers are at risk of paying the IRO fee in denying any preauthorization request, as the carrier pays the IRO fee for preauthorization disputes. The commission has revised the time frame for requesting medical dispute resolution back to one-year from the date(s) of service in a response to this and other related comments, and this allows providers to group smaller claims.

COMMENT: Commenter suggested that the commission's files for review are larger than those TDI files, and stated they are more complex, are "multi-phasic", "multi-specialty", thicker, and span many years of treatment. Commenter therefore suggested the IRO couldn't expect that the fee under the TDI rule is sufficient to cover the review time in doing a 2-year filing. Another commenter indicated that the TDI tier rates for single specialty physician and chiropractic cases respectively that require up to 45 minutes of reviewer time were adequate. However, from an operational point of view, the commenter suggested that the fee structure provided in HB-2600 and the proposed rules could very well be burdensome and oppressive to the IRO. Commenter suggested that the majority of reviews to be conducted under the TDI IRO program are going to be retrospective, and such reviews typically take more time to review than prospective. Commenter recommended alternative pricing of $300 per hour over the TDI amount for tier one, and $225 per hour over the TDI amount for tier 2 for the time in excess. Commenter expressed that the IRO should be allowed to bill additional fees to cover expenses when physician/medical practitioner review time exceeds one hour on a review. A commenter recommended that IROs be paid on time; and another commenter recommended the rule to state the exact amount of payment in the TDI tier one and tier two model.

RESPONSE: The commission disagrees. The commission has revised the filing timeframe for requesting medical dispute resolution and retained the deadline of one year from the date(s) of service. Due to the one-year deadline in the rule as adopted, a dispute will never span many years of treatment. The comments about the complexity and "multi-phasic", and "multi-specialty", of workers' compensation cases are not borne out by the commission's long-term experience with medical dispute resolution. The commission has adopted the TDI tier 1 and tier 2 schedule for IRO reviews and believes that those fees are reasonable. The commission will, however, closely monitor the fee as the IRO process is implemented and may consider revising the fee amounts in the future. The commission has also revised the rule to require that the requesting party or the carrier (depending on the type of dispute) pay the IRO upon the assignment of the IRO; this will address any collections issues the IRO may have.

COMMENT: Commenter suggested that the commission has the ability to compare the performance of the IROs and could determine any substantial non-uniformity and make adjustments necessary from an analysis of the fees charged by each of the IROs for such case files.

RESPONSE: The commission agrees and has amended the rule to include monitoring of IRO quality of decisions and outcomes; this amendment is located in subsection (b)(8) of this section

COMMENT: Commenter recommended language addition to subsection (q)(7) that reads, "IRO fees will be paid in the same amounts as those set by TDI rules for tier one and tier two fees. All doctors, as defined by the Texas Labor Code, Sec 401.011(17) shall be reimbursed on the same tier equally."

RESPONSE: Commission disagrees. The TDI rules are clear in the qualifications for tier 1 and tier 2 reimbursement and the commission has kept those as they are in the TDI rule, and has provided for chiropractic care to be paid under tier two. The commission will, however, closely monitor the fee as the IRO process is implemented and may consider revising the fee amounts in the future.

§133.308(q)(8)

COMMENT: Commenter suggested a timeframe should be added to identify the length of time between IRO notification to the commission of a non-payment issue and commission action/order to ensure IRO payment by the delinquent party. Another commenter stated that it was unclear as to what the difference is between "order" represented by the original invoice in proposed subsection (q)(6) and the "order" that is to be issued under proposed subsection (q)(8). A commenter indicated that terms of payment for IRO reviews are a net 30 days from the date the invoice from the IRO is received, with interest at prevailing commercial rates for late payment.

RESPONSE: The commission has amended the rule to require that, upon notice of an IRO assignment, the requestor or the carrier (depending on the type of dispute) shall remit payment directly to the assigned IRO in advance of the review. Language has also been added to clarify that the commission will receive the IRO decision and for all disputes other than preauthorization and employee reimbursement disputes, determine the nonprevailing party for retrospective medical necessity disputes and issue orders appropriately. There will therefore be no IRO order deemed to be a commission order.

§133.308(q)(11)

COMMENT: Commenter stated the word "reimbursement", instead of "refund", may better describe this activity in subsection (q)(11). Commenter recommended language in (q)(11) be modified to include that if an IRO decision is subsequently reviewed "or differently decided" at a CCH regarding a proposed spinal surgery, or as a result of a SOAH hearing, the commission should order "proper apportionment" from the nonprevailing party to reimburse the prevailing party the amount paid to the IRO for the independent review. Another commenter recommended that the SOAH Order contain the refund order because the commission has not delineated its mechanism for tracking these orders for refunds, and a time frame for ordering of refunds. Commenter requested clarification as any other scenarios that could require the refund of an IRO fee. Commenter suggested that any re-allocation of the review fee resulting from any appeal process, should be conducted by the commission, or the carrier, and have no effect on the IRO.

RESPONSE: The commission agrees in part. The rule as adopted also addresses the situation in which an IRO decision is differently decided by a CCH order or SOAH decision; this subparagraph is now in (q)(10) of the rule. The commission disagrees with the recommendation to apportion the fee between parties; the statute does not provide for apportioning the fee among the parties. The statute requires the carrier to pay in preauthorization disputes; otherwise, the nonprevailing party pays. The commission has revised the rule to provide for the commission to determine the nonprevailing party in retrospective necessity disputes. The commission acknowledges that it did not delineate a mechanism for tracking the refund orders, however it cannot require that the SOAH contain the refund order language. The commission will address this issue procedurally. Experience with the new processes will reveal what other scenarios would require the refund of an IRO fee. The commission agrees that the IRO has no part in re-allocation of the review fee resulting from any appeal; this is now referenced in (q)(10) of the rule.

Proposed §133.308(q)(12)

COMMENT: Commenter recommended language change from the "the requestor may be liable for the IRO fee" to "the requestor will be liable for the IRO fee."

RESPONSE: The commission disagrees with the language because circumstances will vary among cases, and some experience with this provision is necessary before attempting to delineate consequences for all situations; this paragraph is now (q)(11) of this rule.

Proposed §133.308(s) Unresolved Fee Disputes

COMMENT: Commenter opposed the adoption of this subsection based on the belief that the bifurcated review of medical necessity and payment issues has potential to impact other issues and is unwise. Commenter further recommended that TWCC staff conduct initial review of requests for MDR to determine if a medical necessity dispute exists and impact of payment policies and statutory provisions.

RESPONSE: In the rules as adopted, the commission has revised the process from the proposal. The rule has been amended to streamline the process and allow a combined filing of a medical fee and a medical necessity dispute on the TWCC-60 form. It has also been amended to provide for a combined fee and necessity decision for disputes involving both. The commission believes that the revisions go as far in eliminating a bifurcated system as allowed by the statutory requirements that different types of medical disputes be handled differently.

COMMENT: Commenter recommends removal of this section from the rule, and recommends that Medical Review follow its present procedure of evaluating first the disputed issues. Medical review should only proceed to address medical necessity issues after concluding that Commission Rules, Guidelines, and the Labor Code do not effect the potential payment of medical necessity, if so affirmed by the IRO.

RESPONSE: The process in the rule as adopted incorporates these concepts.

Proposed §133.308(t) Appeal

COMMENT: Commenters state the IRO can only function if its reviewing panel of medical providers can act independently and free from influence. The appeal process provided for under

HB-2600 suggests that the reviewer could be called to testify and thusly be forced to reveal his/her identity. Review physicians would not agree to do reviews for the IRO if there is a possibility of them being dragged into an administrative hearing. If there is a necessity of reviewer testimony in the administrative appeal process, the IRO respectfully demands that the identity of the review witness be shielded through redaction of the identity in written testimony without cross examination or through camera oral testimony to the extent lawfully permitted. The commenter suggests having the IRO itself subpoenable for the SOAH hearing. IRO would speak of the integrity of the process of creating that review opinion.

RESPONSE: Commission disagrees in part. While the commission understands the reason for preferring non-public disclosure of the reviewer names, the appeal process at SOAH and in the courts is not controlled by the commission or its rules. This includes the possibility of subpoena by SOAH or a court. There is precedent for sealing SOAH records to protect claim file information that is confidential by law, and this is on possible solution to part of the concerns. The commission's action in response to an Open Records request for reviewer names has been discussed above.

COMMENT: Commenter describes the IRO as a business entity, separate and distinct, functions and operates independently from any governmental agency, insurance carrier, medical provider, or patient advocate group. Three IROs have been certified by TDI and are authorized and operate under Tex. Insurance. Code Section 21.58C. The three IROs have successfully worked in concert with TDI and the medical community to establish in Texas the first functional and successful independent review program in the United States. Independent Review Organization is independent from influence from: patients, providers, carriers, payors, other reviewers, TDI, other IROs, URAs, courts, and lawyers because of anonymity and confidentiality. The proposed rules of TWCC will compromise the independence of the IRO and cause irreparable harm to the successful independent review process.

RESPONSE: The commission has revised the medical dispute resolution process from the process as proposed. This addresses the concerns raised about independence of the IROs. Again, while the commission understands the reason for preferring non-public disclosure of the reviewer names, the appeal process at SOAH and in the courts is not controlled by the commission or its rules. This includes the possibility of subpoena by SOAH or a court. The commission's action in response to an Open Records request for reviewer names has been discussed above. It is not the intent of the commission to cause harm to the current successful independent review process and modifications have been made to the rule in response to comment to reduce the impact on the current process, including changes in the billing process and in the determination of the nonprevailing party, while still complying with statutory intent. In the rules as adopted, the commission has prioritized the dispute types that will be forwarded to the IROs in the event that IRO capacity is exceeded. In addition, the rule as adopted allows the commission to assign disputes in accordance with the priorities established in the rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity. The commission encourages all parties to explore all options in resolving their medical disputes prior to requesting medical dispute resolution. The commission believes that neither the rules nor the actions of the commission will substantially impact or harm the current successful independent review process.

Proposed §133.308(u) Spinal Surgery Appeal

COMMENT: Commenters expressed concern that subsections (t) and (u) single out spinal surgery cases for special treatment absent any requirement in the statute to do so. A separate, distinct standard should not be imposed by rule unless there is compelling clinical justification for its application.

RESPONSE: The commission disagrees. HB-2600 mandates a separate process for appeal of spinal surgery decisions by IROs and/or designated doctors. This mandate requires specific rule language outlining that process in subsections (t) and (u).

SUBCHAPTER D. DISPUTE AND AUDIT OF BILLS BY INSURANCE CARRIERS

28 TAC §133.305

The repeal is proposed under the Texas Labor Code, §401.011 which contains definitions used in the Texas Workers' Compensation Act; the Texas Labor Code, §401.024, which provides the commission the authority to require use of facsimile or other electronic means to transmit information in the system; the Texas Labor Code, §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form and manner and procedure for transmission of information to the commission; the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §406.010, which authorizes the commission to adopt rules regarding claims service; the Texas Labor Code, §408.004, as amended by the 77th Texas Legislature, which provides for Required Medical Examinations; Texas Labor Code §408.0041, as adopted by the 77th Texas Legislature, which provides for the commission assignment of a designated doctor; the Texas Labor Code §408.023, as amended by the 77th Texas Legislature, which requires the commission to develop a list of approved doctors and lay out the requirements for being on the list; the Texas Labor Code §408.0231, which provides the commission with the responsibility for maintenance of the list, the Texas Labor Code, §408,025, which requires the commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code, §408.102, which provides that temporary income benefits continue until the injured employee reaches maximum medical improvement; the Texas Labor Code, §408.122, as amended by the 77th Texas Legislature, which requires that designated doctors meet specific qualifications; the Texas Labor Code §408.123, which requires a doctor certifying maximum medical improvement to file a report and which requires a certification of MMI and assignment of an impairment rating by a doctor other than the treating doctor be sent to the treating doctor who must indicate either agreement or disagreement with the certification of the evaluation; the Texas Labor Code, §408.124, which provides the commission the authority to by rule adopt the fourth edition of the Guides to the Evaluation of Permanent Impairment " published by the American Medical Association to determine the existence and degree of an injured employee's impairment; the Texas Labor Code, §408.125, as amended by the 77th Texas Legislature, which provides the process for disputing impairment ratings; the Texas Labor Code §408.151, which provides for required medical examinations for supplemental income benefits; and the Texas Labor Code §415.0035, as passed by the 77th Texas Legislature, which establishes administrative violations for repeated administrative violations or for a provider failing to submit required medical reports. No other statutes are affected by the proposed repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

TRD-200107879
Susan Cory
General Counsel
Texas Workers' Compensation Commission
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For further information, please call: (512) 804-4287

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CHAPTER 133. GENERAL RULES FOR REQUIRED REPORTS

SUBCHAPTER D. DISPUTE AND AUDIT OF BILLS BY INSURANCE COMPANY

28 TAC §§133.305, 133.307, 133.308

The new rules are adopted pursuant to the Texas Labor Code §43.024, which provides the Commission authority to require use of facsimile or other electronic means to transmit information in the system; Texas Labor Code §402.042, which authorizes the executive director to enter orders as authorized by the statute as well as to prescribe the form, manner and procedure for transmission of information to the Commission; Texas Labor Code §402.061, which gives the Commission the authority to adopt rules as necessary to implement and enforce the Act; Texas Labor Code §406.010, which authorizes the Commission to adopt rules regarding claims service; Texas Labor Code §408.027, which provides for insurance carrier payment of health care providers; Texas Labor Code §409.009, which allows a person to become a sub-claimant to a workers' compensation claim; Texas Labor Code §413.007, which directs the Medical Review Division to maintain a statewide database of medical billing information; Texas Labor Code §413.015, which directs insurance carrier payments to and audits of health care providers; Texas Labor Code §413.031, which directs medical dispute resolution; Texas Labor Code §413.042, which prohibits private claims; and Texas Civil Practice and Remedies Code, Chapter 146, which directs that health care providers submit bills no later than the 11th month in which the service was provided. The new rules are adopted pursuant to the Texas Labor Code §§401.024, 402.042, 402.061, 406.010, 408.027, 409.009, 413.007, 413.015, 413.031, 413.042, and Texas Civil Practice and Remedies Code, Chapter 146.

§133.305. Medical Dispute Resolution - General.

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

(1) Medical Dispute Resolution - a request for resolution of one or more of the following disputes after reconsideration has been requested as required by commission rules and denied by the carrier:

(A) a medical fee dispute; or

(B) a medical necessity dispute, which may be:

(i) a prospective necessity dispute; or

(ii) a retrospective necessity dispute.

(2) Medical Fee Disputes - Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines). The dispute is resolved by the commission pursuant to commission rules, including §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute). The following types of disputes can be Medical Fee Disputes:

(A) a health care provider dispute of a carrier reduction or denial of a medical bill;

(B) an employee dispute of a carrier reduction or denial of a request for reimbursement of health care charges paid by the employee (employee reimbursement dispute);

(C) a carrier dispute of a health care provider reduction or denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute); and

(D) a health care provider dispute of a commission refund order issued pursuant to a commission audit or review (refund order dispute).

(3) Prospective Necessity Disputes - Prospective Necessity Disputes involve a review of the medical necessity of health care requiring preauthorization or concurrent review. The dispute is reviewed by an independent review organization pursuant to commission rules, including §133.308 of this title (relating to Medical Dispute Resolution by Independent Review Organizations). The following types of disputes may be Prospective Necessity Disputes:

(A) a provider or injured employee dispute of a carrier denial of preauthorization (a denial of the medical necessity of health care listed in §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) made prior to the provision of the health care); or

(B) a provider dispute of a carrier denial of health care pursuant to concurrent review (extension of health care beyond previously approved health care, for health care listed in §134.600 of this title.)

(4) Retrospective Necessity Disputes - Retrospective Necessity Disputes involve a review of the medical necessity of health care provided. The dispute is reviewed by an independent review organization pursuant to commission rules, including §133.308 of this title. The following types of disputes may be Retrospective Necessity Disputes:

(A) a health care provider dispute of a carrier denial of a medical bill based on lack of medical necessity;

(B) an employee dispute of a carrier denial of a request for reimbursement of health care charges paid by the employee (employee reimbursement dispute), based on lack of medical necessity; or

(C) a carrier dispute of a health care provider denial of the carrier request for refund of payment for health care previously paid by the carrier (refund request dispute).

(D) a health care provider dispute of a commission refund order issued pursuant to a commission audit or review based upon lack of medical necessity (refund order dispute).

(5) Requestor - the party that timely files an initial request for medical dispute resolution with the division and the carrier or respondent; the party seeking relief in medical dispute resolution.

(6) Respondent - the party that files a response to all the denial reasons presented to the requestor, prior to the date the request for medical dispute resolution was filed; the party against whom relief is sought.

(7) Initial request - the first request for medical dispute resolution initiated by the requestor identifying unresolved medical fee or medical necessity issues that is filed simultaneously with the respondent and the commission's Division of Medical Review (division).

(b) If there is a medical necessity dispute for which there are medical fee components, the requestor shall file one request for medical dispute resolution to the carrier and simultaneously file a copy with the commission for monitoring of carrier compliance pursuant to §133.308 of this title. The medical necessity dispute will be resolved prior to deciding the medical fee dispute pursuant to §133.307 of this title.

§133.307. Medical Dispute Resolution of Regarding a Medical Fee Dispute.

(a) Applicability. This rule applies to a request for medical fee dispute resolution for which the initial dispute resolution request was filed on or after January 1, 2002. Dispute resolution requests filed prior to January 1, 2002 shall be resolved in accordance with the rules in effect at the time the request was filed. In resolving disputes over the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the commission is to adjudicate the payment, given the relevant statutory provisions and commission rules. Medical necessity is not an issue in a medical fee dispute.

(b) Parties. The following persons may be requestors and respondents in medical fee disputes:

(1) the health care provider (provider) and the insurance carrier (carrier) in a dispute of a medical bill;

(2) the injured employee (employee) and the carrier in a dispute involving an employee's request for reimbursement of medical expenses;

(3) the carrier and the provider in a dispute involving a carrier's refund request;

(4) the provider and the commission in a dispute involving a commission refund order issued pursuant to an audit or review.

(c) Requests. A request for medical dispute resolution of a medical fee dispute must be timely filed simultaneously with the carrier and the commission's Medical Review Division (division).

(d) Timeliness. A person or entity who fails to timely file a request waives the right to medical dispute resolution. The commission shall deem a request to be filed on the date the division receives the initial request, and timeliness shall be determined as follows:

(1) A request for medical dispute resolution on a carrier denial or reduction, of a medical bill pursuant to §133.304 of this title (relating to Medical Payments and Denials, or an employee reimbursement request shall be considered timely if it is filed with the carrier and the division no later than one (1) year after the date(s) of service in dispute.

(2) A request for medical dispute resolution on a provider denial or reduction of a carrier request for refund of payment for health care shall be considered timely if it is filed with the division pursuant to the provisions in §133.304 and no later than one (1) year from the date(s) of service in dispute

(3) A request for medical dispute resolution on a commission refund order issued pursuant to a commission audit or review shall be considered timely if a request for a hearing is filed with the commission Chief Clerk of Proceedings, Hearing Division, not later than 20 days after the date of receipt of the refund order.

(e) Initial Request (General). All provider and carrier requests for medical dispute resolution shall be made in the form, format, and manner prescribed by the commission. (Initial requests for medical dispute resolution on medical fee disputes involving an employee's request for reimbursement of medical expenses are governed by subsection (f) of this section).

(1) Each initial request shall be legible, include only a single copy of each document, and shall include:

(A) a copy of all medical bill(s) as originally submitted to the carrier for reconsideration in accordance with §133.304;

(B) a copy of each explanation of benefits (EOB) or response to the refund request relevant to the fee dispute or, if no EOB was received, convincing evidence of carrier receipt of the provider request for an EOB;

(C) a table listing the specific disputed health care and charges in the form, format, and manner prescribed by the commission; and

(D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission.

(2) Upon receipt of the initial request, the respondent shall:

(A) complete the remaining sections of the request form other than information for an IRO review pursuant to the requirements under §133.308;

(B) provide any missing information required on the form, including absent EOBs not submitted by the requestor with the initial request; and

(C) file the completed request with the division and the requestor within three (3) working days of respondent's receipt of the initial request.

(3) If the respondent did not receive the provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the initial request, or if the dispute has already been resolved, the respondent shall certify this on the form.

(f) Employee Reimbursement Dispute. An employee who has paid for health care may request medical dispute resolution of a denied reimbursement. The employee may only pursue reimbursement up to the amount the employee paid the provider. Reimbursement shall be fair and reasonable in accordance with commission rules, and shall not exceed the Maximum Allowable Reimbursement (MAR) as established in the appropriate fee guideline, or in the absence of a fee guideline, the amount determined to be fair and reasonable for the health care. Health care requiring preauthorization or concurrent review pursuant to §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) must have received the preauthorization or concurrent review approval. The employee's initial request shall be made in the form, format, and manner prescribed by the commission. The initial request must be legible, must contain only a single copy of each document, and must include:

(1) an explanation of the disputed fee issue(s);

(2) proof of employee payment for the health care for which the employee is requesting reimbursement (include receipts of payment made); and

(3) a copy of any EOB relevant to the dispute, or , if no EOB was received, convincing evidence of carrier receipt of employee request for reimbursement.

(g) Commission Notice The respondent shall file the completed request with the requestor and with the division by transmission of facsimile.

(1) The commission shall review the completed request to determine appropriate medical dispute resolution action.

(2) If the request contains unresolved medical necessity issues, the commission shall notify the parties of the review requirements pursuant to §133.308.

(3) If the request contains only medical fee disputes, the commission shall notify the parties and require the requestor to send to the commission, two copies of additional documentation relevant to the fee dispute. The additional documentation shall include:

(A) documentation of the request for and response to reconsideration (when a provider is requesting dispute resolution on a carrier reduction or denial of a medical bill) or, if the carrier failed to respond to the request for reconsideration, convincing evidence of the carrier's receipt of that request;

(B) a copy of any pertinent medical records or other documents relevant to the fee dispute;

(C) a statement of the disputed issue(s) that shall include:

(i) a description of the health care for which payment is in dispute,

(ii) the requestor's reasoning for why the disputed fees should be paid or refunded,

(iii) how the Texas Labor Code and commission rules, and fee guidelines, impact the disputed fee issues, and

(iv) how the submitted documentation supports the requestor position for each disputed fee issue;

(D) if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §133.1 of this title (relating to Definitions) and §134.1 of this title (relating to Use of the Fee Guidelines);

(E) Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute, must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Unredacted information or evidence shall not be considered in resolving the medical fee dispute.

(F) The additional documentation shall be received by the division within 14 days of the requestor's receipt of notice pursuant to this rule.

(4) If the respondent is a carrier, the commission shall forward a copy of the additional documentation to the carrier. The commission shall deem the carrier to have received the documentation on the acknowledgment date as defined in §133.1 of this title. If the division forwards the documentation to the carrier via its Austin representative, the representative shall sign for the request.

(5) If the respondent is a provider, the commission shall forward a copy of the request to the provider by regular U.S. mail service or by transmission of facsimile. The commission shall deem the provider to have received the request on the acknowledgment date as defined in §133.1 of this title.

(h) Response. The respondent shall file the response to the requestor's additional documentation for the medical fee dispute, with the division and the requestor.

(i) Timeliness of Response. A respondent who fails to timely file a response waives the right to respond. The commission shall deem a response to be filed on the date the division receives a response. If the respondent does not respond timely, the commission shall issue a decision based on the request. The response will be considered timely if received by the commission within 14 days after the date the respondent received the copy of the requestor's additional documentation.

(j) Complete Response. All responses to requestor's additional documentation shall be made on the form and in the manner prescribed by the commission.

(1) Each response shall be legible, include only a single copy of each document, and, unless previously provided in the initial request and requestor's additional documentation, shall include:

(A) documentation of carrier response to reconsideration in accordance with commission rules;

(B) a copy of all medical bill(s) relevant to the dispute, if different from that as originally submitted to the carrier for reimbursement;

(C) a copy of all medical audit summaries and/or explanations of benefits (EOBs) relevant to the fee dispute, or a statement certifying that the carrier did not receive the provider's disputed billing prior to the initial request;

(D) a copy of any pertinent medical records or other documents relevant to the fee dispute;

(E) a statement of the disputed fee issue(s), which includes:

(i) a description of the health care in dispute;

(ii) a statement of the reasons that the disputed medical fees should not be paid or refunded;

(iii) a discussion of how the Texas Labor Code and commission rules, including fee guidelines, impact the disputed fee issues; and

(iv) a discussion regarding how the submitted documentation supports the respondent position for each disputed fee issue; and

(F) if the dispute involves health care for which the commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code §413.011 and §§133.1 and 134.1 of this title.

(G) Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute, must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Unredacted information or evidence shall not be considered in resolving the medical fee dispute.

(2) The response shall address only those denial reasons presented to the requestor prior to the date the initial request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an initial request. Any new denial reasons or defenses raised shall not be considered in the review.

(k) Filing of Response. The respondent shall file a copy of the response with the division and the requestor within 14 days of receipt of the requestor's additional documentation.

(l) Additional Information. The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request.

(m) Dismissal. A dismissal does not constitute a decision. The commission may dismiss a request for medical fee dispute resolution if:

(1) the requestor informs the commission, or the commission otherwise determines, that the dispute no longer exists;

(2) the individual or entity requesting medical fee dispute resolution is not a proper party to the dispute per subsection (b) of this section;

(3) the commission determines that the medical bills in the dispute have not been properly submitted to the carrier pursuant to §133.304;

(4) the fee disputes for the date(s) of health care in dispute have been previously adjudicated by the commission; or

(5) the commission determines that good cause exists to dismiss the request.

(n) Decision. The commission shall send the commission decision to the parties to the dispute and post the decision on the commission Internet website after confidential information has been redacted.

(o) Fee. The commission may assess a separate fee in accordance with Texas Labor Code §413.020 of this title (relating to Commission Charges).

(p) Appeal. A party to a medical fee dispute may appeal the commission decision by filing a written request for a State Office of Administrative Hearings (SOAH) hearing with the Chief Clerk of Proceedings, Division of Hearings in accordance with §148.3 of this title (relating to Requesting a Hearing).

(1) the appeal must be filed no later than 20 days from the date the party received the commission decision. The date of receipt of the decision shall be the acknowledgment date as defined in §133.1 of this title. The carrier representative shall sign for the decision.

(2) the party appealing the commission decision shall deliver a copy of its written request for a SOAH hearing to all other parties involved in the dispute.

(3) a party who has exhausted the party's administrative remedies under this subtitle and who is aggrieved by a final decision of the SOAH may seek judicial review of that decision. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(4) the commission shall post the SOAH decision on the commission Internet website after confidential information has been redacted.

§133.308. Medical Dispute Resolution By Independent Review Organizations.

(a) Applicability. This rule is to be applied as follows.

(1) This rule applies to the independent review of prospective or retrospective medical necessity disputes (a review of health care requiring preauthorization or concurrent review, or retrospective review of health care provided) for which the initial dispute resolution request was filed on or after January 1, 2002. Dispute resolution requests filed prior to January 1, 2002 shall be resolved in accordance with the rules in effect at the time the request was filed. All independent review organizations (IRO's) performing reviews of health care under the Texas Workers' Compensation Act (the Act), regardless of where the independent review activities are based, shall comply with this rule.

(2) The review of medical necessity by an IRO will be determined in the following priority:

(A) prospective medical necessity disputes;

(B) employee reimbursement disputes; and

(C) retrospective medical necessity disputes.

(b) TDI Rules. Each IRO performing independent review of health care provided in the workers' compensation system shall be certified by TDI pursuant to Art. 21.58C, of the Texas Administrative Code, and must comply with TDI rules regarding General Provisions and Certification of IROs, Title 28, Part 1, Chapter 12, Subchapters A and B. In addition, TDI rules in Title 28, Part 1, Chapter 12, Subchapters C through F apply to workers' compensation cases except as modified or noted below:

(1) where the word "patient" is used in those TDI rules, it shall mean the injured employee.

(2) where any of the terms "health insurance carrier," "health maintenance organization," or "managed care entity" is used in those TDI rules, it shall mean the carrier or its agent.

(3) the Texas Labor Code and commission rules govern the independent review process and related substantive areas, including: requests, filing, notification, time deadlines, parties, billing, payment, appeal from an adverse IRO decision, and other matters addressed in this rule

(4) a provider who has been removed from the commission Approved Doctor List is not eligible to direct or conduct independent reviews of workers' compensation cases.

(5) the provisions regarding a "life-threatening condition" are not applicable because in the workers' compensation system, emergency health care does not require prospective approval.

(6) in addition to confidentiality requirements in those TDI rules, an IRO shall preserve the confidentiality of claim file information that is confidential pursuant to the Texas Labor Code.

(7) conflicts of interest will not be screened by TDI; the commission shall screen for conflicts of interest to the extent reasonably possible. (Notification of each IRO decision must include a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider and any of the treating providers or any of the providers who reviewed the case for determination prior to referral to the IRO.)

(8) The commission will monitor the activity, quality and outcomes of IRO decisions.

(c) Parties. The following persons are allowed to be requestors and respondents in medical necessity dispute resolution:

(1) in a retrospective necessity dispute - the provider who was denied payment for health care rendered, the employee denied reimbursement for health care for which the employee paid, and the carrier.

(2) in a prospective preauthorization dispute - persons or entities as established in §134.600 of this title (relating to Procedure for Requesting Pre-Authorization of Specific Treatments and Services).

(3) in a prospective concurrent review dispute - the provider and the carrier.

(d) Requests. An initial request for independent review of a medical necessity dispute shall be timely filed simultaneously by the requestor, with the carrier or the respondent and the division.

(e) Timeliness. A person or entity who fails to timely file a request waives the right to independent review or medical dispute resolution. The commission shall deem a request to be filed on the date the division and the carrier receive the initial request, and timeliness shall be determined as follows:

(1) A request for retrospective necessity dispute resolution of a medical bill pursuant to §133.304, of this title (relating to Medical Payments and Denials), shall be considered timely if it is filed with the carrier and the division no later than one (1) year after the date(s) of service in the dispute.:

(2) A request for prospective necessity dispute resolution shall be considered timely if it is filed with the carrier and the division no later than the 45th day after the date the carrier denied approval of the party's request for reconsideration of denial of health care that requires preauthorization or concurrent review pursuant to the provisions of §134.600.

(f) Initial Request (General). A request for independent review must be filed in the form, format, and manner prescribed by the commission. Each request shall be legible, shall include only a single copy of each document, and shall include:

(1) a designation that the request is for review by Independent Review Organization;

(2) written notices of adverse determinations (both initial and reconsideration) of prospective or retrospective necessity disputes, if in the possession of the requestor;

(3) documentation of the request for and response to reconsideration, or, if the respondent failed to respond to a request for reconsideration, convincing evidence of carrier receipt of that request;

(4) for medical necessity disputes:

(A) for retrospective necessity disputes, a table of disputed health care denied for lack of medical necessity, which includes complete details of the dispute issues (denial codes T, U or V) in accordance with §133.304; or

(B) for prospective necessity disputes, a detailed description of the health care requiring preauthorization and/or concurrent review and approval in accordance with §134.600;

(5) a list of any and all providers that have examined or provided health care to the employee during the course of the workers' compensation claim; and

(6) a list of all providers that participated in the review or determination by the carrier, if known by the requestor; and

(7) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission.

(g) Carrier Notification to the Commission. The carrier shall complete the remaining sections of the request form and shall provide any missing information required on the form, which shall include:

(1) the respondent information;

(2) a list of any additional providers that have examined, provided, or rendered health care to the employee at any time during the course of the worker's compensation claim;

(3) notices of adverse determinations of prospective or retrospective medical necessity, not provided by the requestor; and

(4) a list of all providers that participated in the review or determination by the carrier, if known by the requestor.

(h) Filing. The carrier shall file the response to the request with the division and the requestor by facsimile or other electronic means within three working days of receipt of the request for review by the IRO.

(i) TWCC Notification of Parties. The commission shall review the request for IRO review, assign an IRO with which no conflict of interest exists, and notify the parties and the IRO of the assignment, by regular U.S. mail service or by transmission of facsimile. The commission will assign disputes on a rotating basis to the IROs certified by TDI, in accordance with Insurance Code article 21.58C and TDI rules. The commission may assign disputes in accordance with the priorities established in this rule and in a manner other than a rotating basis if necessary because of insufficient IRO capacity.

(j) IRO Notification of Parties. The IRO shall also notify the parties of the assignment and require that documentation be sent directly to the assigned IRO and received not later than the seventh day after the party's receipt of the IRO notice. The documentation shall include:

(1) any medical records of the injured employee relevant to the review;

(2) any documents used by the utilization review agent or carrier in making the decision, to be reviewed by the IRO; and

(3) any supporting documentation submitted to the utilization review agent or carrier.

(k) Confidentiality. No IRO or provider is required to obtain the written consent of the injured employee as a prerequisite to obtaining or releasing medical records relevant to the review in a workers' compensation medical dispute. The IRO shall preserve confidentiality of individual medical records as required by law.

(l) Additional Information. The IRO may request additional relevant information from either party or from other providers whose records are relevant to the dispute, to review the medical issues in a dispute. The party shall deliver the requested information to the IRO as directed. The additional information must be received by the IRO within 14 days of receipt of the request for additional information. If the provider requested to submit records is not a party to the dispute, then copy expenses for the requested records shall be reimbursed by the carrier pursuant to §133.106 of this title (relating to Fair and Reasonable Fees for Required Reports and Records). Reimbursement for copies may not be permitted for a party to the dispute.

(m) Designated Doctor Exam. In performing a review of medical necessity, an IRO may request that the commission order an examination by a designated doctor and order the employee to attend the examination. The IRO request to the commission must be made no later than 10 3 days after the IRO receives notification of assignment of the IRO. The treating doctor and carrier shall forward a copy of all medical records, diagnostic reports, films, and other medical documents to the designated doctor appointed by the commission, to arrive no later than three days prior to the scheduled examination. Communication with the designated doctor is prohibited regarding issues not related to the medical dispute. The designated doctor shall complete a report and file it with the IRO, on the form and in the manner prescribed by the commission, no later than seven working days after completing the examination. The designated doctor report shall address all issues the commission instructed the doctor to address.

(n) Time Frame for IRO Decision. The IRO will review and render a decision on retrospective medical necessity disputes by the 30th day after the IRO receipt of the dispute. The IRO will review and render a decision on prospective necessity disputes by the 20th 8th day after the IRO receipt of the dispute. If a designated doctor examination has been requested by the IRO, the above time frames begin from the date of the IRO receipt of the designated doctor report.

(o) IRO Notification of Decision.

(1) notification of decision by the independent review organization must include:

(A) the specific reasons, including the clinical basis, for decision;

(B) a description and the source of the screening criteria that were utilized;

(C) a description of the qualifications of the reviewing physician or provider; and

(D) a certification by the IRO that the reviewing provider has certified that no known conflicts of interest exist between that provider and any of the treating providers or any of the providers who reviewed the case for decision prior to referral to the IRO.

(2) the notification in a retrospective necessity dispute must be mailed or otherwise transmitted to the commission not later than the 30th day after the IRO receipt of the dispute.

(3) the notification in a prospective necessity dispute must be delivered to the parties not later than the 20th day after the IRO receipt of the dispute.

(4) the notification to the commission shall also include certification of the date and means by which the decision was sent to the parties.

(5) an IRO decision is deemed to be a commission decision and order.

(6) if an IRO decision finds that medical necessity exists for care that the carrier denied, and the carrier utilized the opinion of a peer review or other case review to issue its denial, the review and its rationale shall not be used on subsequent denials in that claim as the IRO has already found it unconvincing for the disputed health care.

(p) Commission Posting. The commission shall post the IRO decision on the commission Internet website after confidential information has been redacted.

(q) IRO Fees. IRO fees shall be paid as follows.

(1) Upon receipt of an IRO assignment:

(A) in a prospective dispute or an employee reimbursement dispute, the carrier shall remit payment to the assigned IRO at the same time the carrier files the documentation requested by the IRO;

(B) in a retrospective dispute, the requestor shall remit payment to the assigned IRO at the same time the requestor files the documentation requested by the IRO;

(2) Upon receipt of an IRO decision in a retrospective necessity dispute other than an employee reimbursement dispute, and in a concurrent review prospective necessity dispute, the commission shall review the decision to determine the prevailing party and, if applicable, will order the nonprevailing party to refund the IRO fee to the party who prevailed by CCH or SOAH decision.

(A) If the IRO decision as to the main issue in dispute is a finding of medical necessity, the requestor is the prevailing party.

(B) If the IRO decision does not find medical necessity with respect to the main issue in dispute, the respondent is the prevailing party.

(C) if the IRO decision does not clearly determine the prevailing party, the commission shall determine the allowable fees for the health care in dispute, and the party who prevailed as to the majority of the fees for the disputed health care is the prevailing party.

(3) The IRO shall bill copy expenses to the party liable for the independent review; provided, however, that no copy costs shall be paid to the requestor.

(4) The injured employee shall not be required to pay any portion of the cost of a review.

(5) Designated doctor examinations ordered by the commission at the request of an IRO, shall be paid by the party who is liable for the IRO fee in accordance with the appropriate fee guideline.

(6) IRO fees will be paid in the same amounts as those set by TDI rules for tier one and tier two fees. In addition to the specialty classifications established as tier two fees in TDI rules, independent review by a doctor of chiropractic shall be paid the tier two fee.

(7) If the fee has not been received by the IRO within 7 days of the party's receipt of notice from the IRO, the IRO shall notify the commission and the commission shall issue an order to pay the IRO fee.

(8) Failure to pay or refund the IRO fee may result in enforcement action as allowable by statute and rules, removal from the commission Approved Doctor List, and/or restriction of future requests for independent review.

(9) A party required to pay or refund the IRO fee to the other party is liable for that fee upon receipt of the order from the commission regardless of whether an appeal of the IRO decision has been or will be filed.

(10) if the IRO decision is subsequently reversed or differently decided at a CCH or by a SOAH decision, the commission shall order a refund of the IRO fee to be paid the party who prevailed by CCH or SOAH decision within 10 days of receipt of the order.

(11) the requestor may be liable for the IRO fee if the request is withdrawn or the review is terminated prior to completion.

(12) The fees provided for IRO review may include a second review of dispute issues if the initial decision is determined by the commission to be incomplete. The amended or corrected decision shall be filed with the division within 5 days of the IRO receipt of such notice from the commission.

(r) Defense. It is a defense for the carrier if the carrier timely complies with the IRO decision with respect to the medical necessity or appropriateness of health care for an injured employee. If a previously timely filed request for fee dispute resolution exists at the time the IRO issues a decision of medical necessity, the carrier is not required to pay for the disputed health care until the commission has resolved the medical fee dispute. If there is no previously pending request for medical fee resolution, the carrier shall immediately comply with the IRO decision.

(s) Unresolved Fee Disputes. If an unresolved fee dispute issue exists at the time the commission receives the IRO decision in a dispute, the commission shall then proceed to resolve the medical fee dispute in accordance with commission rules.

(t) Appeal. Except with respect to a prospective necessity dispute regarding spinal surgery, a party to a prospective or retrospective necessity dispute may appeal the IRO decision by filing a written request for a SOAH hearing with the commission Chief Clerk of Proceedings, Division of Hearings in accordance with §148.3 of this title (relating to Requesting a Hearing).

(1) The appeal must be filed no later than 20 days from the date the party received the IRO decision.

(2) The party appealing the IRO decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

(3) The commission shall file the request for hearing with SOAH.

(4) The hearing shall be conducted by the State Office of Administrative Hearings within 90 days of receipt of a request for a hearing in the manner provided for a contested case under Chapter 2001, Government Code (the administrative procedure law).

(5) The parties to the dispute must represent themselves before SOAH, and the IRO is not required to participate in the SOAH hearing.

(6) A party who has exhausted the party's administrative remedies under this subtitle and who is aggrieved by a final decision of the State Office of Administrative Hearings may seek judicial review of the decision. Judicial review under this subsection shall be conducted in the manner provided for judicial review of contested cases under Subchapter G, Chapter 2001, Government Code.

(7) The commission shall post the SOAH decision on the commission website after confidential information has been redacted.

(u) Spinal Surgery Appeal. A party to a prospective necessity dispute regarding spinal surgery may appeal the IRO decision by requesting a Contested Case Hearing ("CCH").

(1) the written appeal must be filed with the commission Chief Clerk of Proceedings, Division of Hearings, within 10 days after receipt of the IRO decision and must be filed in compliance with §142.5(c) of this title (relating to Sequence of Proceedings to Resolve Benefit Disputes).

(2) the CCH will be scheduled and held within 20 days of commission receipt of the request for a CCH.

(3) the hearing and further appeals shall be conducted in accordance with Chapters 140, 142, and 143 of this title (relating to Dispute Resolution/General Provisions, Benefit Contested Case Hearing, and Review by the Appeals Panel).

(4) the party appealing the IRO decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute; the IRO is not required to participate in the CCH or any appeal.

(v) In all appeals from reviews of prospective or retrospective necessity disputes, the IRO decision has presumptive weight.

(w) The commission is entitled to review, inspect, copy, and/or compel production of documents or other information as necessary to carry out the commission's duties and responsibilities under this rule, the Act, and other applicable statutes.

(x) If the commission believes that any person is in violation of the Act or this rule, the commission may initiate appropriate compliance and enforcement action. If the commission believes that any person is in violation of the Insurance Code or TDI rules, the commission may initiate appropriate action in accordance with any Memorandum of Understanding between the Texas Department of Insurance and the commission. Nothing in this rule modifies or limits the authority of the department or the commission.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER F. PHARMACEUTICAL BENEFITS

28 TAC §§134.500, 134.502 - 134.504, 134.506

The Texas Workers' Compensation Commission (the commission) adopts new §134.500, §§134.502-134.504, and §134.506 with changes to the proposed text published in the August 31, 2001 issue of the *Texas Register* (26 TexReg 6584). In addition, the commission simultaneously withdraws §134.505.

As required by the Government Code §2001.033(1), the commission's reasoned justification for this rule is set out in this order that includes the preamble, which in turn includes the rule. This preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were for or against adoption of the rule, and the reasons why the commission disagrees with some of the comments and proposals.

Changes made to the proposed rule are in response to public comment received in writing and at a public hearing held on October 2, 2001, and are described in the summary of comments and responses section of this preamble. Other changes were

made for consistency or to correct typographical or grammatical errors.

These new rules are adopted to comply with statutory mandates in the Texas Labor Code. Prior to the 77th Legislative Session, 2001, §408.028 required a health care practitioner providing care to an injured employee to prescribe any necessary prescription drugs in accordance with applicable state law. It also stated that an insurance carrier may not require an employee to use pharmaceutical services designated by the carrier.

House Bill 2600 (HB-2600), adopted during the 2001 Texas Legislative Session, amended §408.028. In addition to previous requirements, the revised statute requires that physicians and doctors order over-the-counter alternatives to prescription medications when clinically appropriate and applicable, in accordance with state law. Amended §408.028 requires the commission by rule to develop an open formulary under §413.011 that requires the use of generic pharmaceutical medications as clinically appropriate and over-the-counter alternatives to prescription medications as clinically appropriate and applicable in accordance with state law. Finally, amended §408.028 requires the commission to adopt rules to allow an injured employee to obtain reimbursement for over-the-counter medications prescribed or ordered, and purchased by the employee.

A May, 2000 study by the Research and Oversight Council on Workers' Compensation (the ROC) examined state agency workers' compensation pharmaceutical data and concluded that pharmaceutical costs have risen an average of 50 percent from 1997 to 1999. During the period of 1995 through 1998, the frequency of state employee workers' compensation filings decreased 20 percent. Rising utilization coupled with the fact that injured employees in Texas have a choice between brand name and generic drugs created major cost increases to the system. HB-2600 requires the use of generic medications. This requirement, stated throughout new §134.500, and §§134.502-504, and §134.506, is anticipated to create a system-wide savings.

Before the 77th Session of the Texas Legislature convened in January 2001, the commission identified problems in the delivery of pharmaceutical benefits to injured employees. The problems identified include, but are not limited to, the following:

1. Rapidly increasing cost for prescription medicines;

2. Injured employees who were unable to get prescriptions filled or refilled;

3. Injured employees not being reimbursed for out-of-pocket expenses for medicines related to a compensable injury;

4. Pharmacies not being reimbursed for prescriptions due to a lack of information concerning the medical necessity of a prescription;

5. Inconsistent information from prescribing doctors concerning the medical necessity of prescriptions; and,

6. Doctors prescribing prescription medications in lieu of over-the-counter alternatives to prescription medications in order to prevent out-of-pocket expense by the injured employee.

A commission work group composed of commission staff members and external stakeholders was working toward solutions for pharmacy problems when the Texas Legislature proposed HB-2600. HB-2600 contains two sections concerning the delivery of pharmaceutical benefits to injured employees. HB-2600 identified and addressed some, but not all, of the problems that were being addressed by the commission. HB-2600 gave legislative direction in certain areas. The adopted pharmacy rules contain requirements that are the result of both legislative mandate and commission initiative.

The commission's medical billing database does not contain information concerning outpatient pharmacy benefits. Therefore, data was not readily available to the rule development team. The National Council on Compensation Insurance, Inc. (NCCI) was contacted to assist the team in locating and assessing reliable information. NCCI assisted the commission in locating a recent study conducted by the California Workers' Compensation Institute tilted "Study of the Cost of Pharmaceuticals in Workers' Compensation." Pharmaceutical benefit delivery in the California Workers' Compensation system is similar to the pharmaceutical benefit delivery in the Texas Workers' Compensation System. California is experiencing many of the same problems as Texas. The California study and the data used in the study proved to be a useful and appropriate resource in the development of the pharmacy rules.

NCCI was also requested to analyze the conversion factors originally proposed in §134.503 and to calculate the conversion factor that would achieve cost savings in the Texas Workers' Compensation System and meet the legislative intent of HB-2600. NCCI used data from the recent California study concerning workers' compensation pharmacy cost. The California reimbursement formula is very close to the Texas formula. The NCCI analysis indicated that the proposed reimbursement formula would result in a 0.1% increase in cost because of the increased conversion factor that was proposed for brand name drugs. In addition, NCCI was asked to calculate the conversion factor for both generic and brand name pharmaceuticals that would be cost neutral for Texas utilization with a constant dispensing fee of $4.00, using the dispensing ratio of generics to brand name drugs, and the ratio of the cost of a brand name drug relative to a generic drug derived from the California study. NCCI determined that 1.24 would be cost neutral. This would negate the legislative intent to generate savings from requiring use of generic drugs.

NCCI was also asked to evaluate the impact of the following reimbursement formula for the conversion factor only:

Brand name: AWP x 1.09 = MAR (current)

Generic: AWP x 1.25 = MAR (proposed)

The actuarial assessment by NCCI indicated that with no change in the brand name/generic mix; the savings would be approximately 4.9%. The adopted rules require the use of generic medications unless brand name is medically necessary. If this requirement results in 50% of the current dispensed brand name prescriptions being filled with a generic equivalent in the future, the results would be a cost savings of approximately 5.8%. Changing the dispensing fee from $7.50 to $4.00 for generic medications and retaining the current $4.00 dispensing fee for brand name medicines will result in additional cost savings. The savings generated with the reimbursement formula in the adopted rule meets the legislative intent to create cost savings while ensuring pharmacists will participate in the workers' compensation system and continue to provide access to quality health care.

Adopted new §134.500, §§134.502-504, and §134.506 provide much needed structure and clarification of pharmaceutical benefits. Section 134.501 and §134.505 are reserved for future use. In the absence of pharmacy data, it is difficult to quantify the problems and costs relating to pharmacy issues. However,

based on the anecdotal personal experiences from employees, prescribing doctors, pharmacists, and carriers involved in pharmaceutical delivery, it is believed that the new rules will address many of the problems in the system. The Medical Advisory Committee (MAC) provided advice and input for adopted §134.500, §§134.502-504, and §134.506 through a subcommittee. The commission's Medical Advisor also provided consultation and recommendations for these rules.

§134.500. Definitions.

New §134.500 provides definitions for terms used throughout this subchapter. Adding a section of definitions clarifies the meaning of the rules. The following terms are defined: compounding, statement of medical necessity, nonprescription drug or over-the-counter medication, open formulary, prescribing doctor, prescription, and prescription drug.

Based on comments, changes were made to subsections (a)(1), (a)(2), (a)(3), (a)(4), (a)(6), (a)(7)(B), (a)(7)(C), and (b). The definition of " compounding" was clarified by removing the term " devise" and clarifying that combining drugs by mixing with water does not constitute "compounding". The definition of a "statement of medical necessity" was expanded to include requirements that were in the body of the rule as proposed. The term "device" was removed from subsections (a)(1), (a)(2), (a)(3), (a)(6), (a)(7)(B), and (a)(7)(C). The example of nutritional supplements was removed from subsection (a)(4). Section 134.500(b) was revised to clarify that the new rules are applicable to medications prescribed or filled after the effective date of the rule, and that §134.201 does not apply to prescriptions filled on or after the effective date of this rule.

§134.502. Pharmaceutical Services.

New §134.502 relates to the prescribing, billing and dispensing of medications. This section requires doctors to prescribe generics and over-the-counter alternatives when appropriate and to comply with §134.506, the Outpatient Drug Formulary. Previous rules did not put any limitations on brand name prescriptions and did not address the prescription of over-the-counter medications. Texas Labor Code §408.028 states that the commission must require the use of generic medications and clinically appropriate over-the-counter alternatives to prescription drugs, in accordance with applicable state law, and this rule does both. The rule as adopted does not allow an employee to refuse a generic prescription and opt for a brand name drug by agreeing that the employee will pay additional cost or a co-payment, as allowed in some other health care systems.

This rule also requires a doctor to provide a statement of medical necessity when requested. This tool, already informally used, will assist multiple system participants in the reimbursing of medications. A statement of medical necessity will assist pharmacists in the resolution of medical necessity disputes. The statement will also assist injured employees when seeking reimbursement for out-of-pocket expenses for medications. Section 134.502 formalizes the statement of medical necessity for prescriptions.

Changes were made to §134.502 to clarify instructions and ensure consistency of terminology. Based on comments received, §134.502(c) increases the amount of prescription drugs that can be dispensed at one time from a 30-day supply to a 90-day supply. Section 134.502(e) was changed to require an insurance carrier to request a statement of medical necessity from the prescribing doctor before denying reimbursement for a prescription or over-the-counter medication. The carrier is required to send a copy of the request for a statement of medical necessity to the pharmacist and the injured employee. Subsection (f) allows the employee or the pharmacist to request statement of medical necessity from the prescribing doctor. Section 134.502(h) was added which also requires the carrier to send the prescribing doctor and injured employee a copy of the explanation of benefits when reimbursement is denied. This increases the communication among the system participants regarding prescription reimbursement.

§134.503. Reimbursement Methodology.

New §134.503 provides the reimbursement methodology for pharmaceutical services. The general reimbursement methodology from the 1996 Medical Fee Guideline (MFG) was carried over in part.

The 1996 MFG had a dispensing fee of $7.50 for generic medications and a dispensing fee of $4.00 for brand name medications. The higher fee for generic medications was designed to encourage the dispensing of generic medications and the resultant cost savings. The statute and §134.502 now require the use of generics in most instances; therefore, it is not necessary to provide a financial incentive to dispense generic medications, and the dispensing fee is set at $4.00 for both brand name and generic drugs. The 1996 Medical Fee Guideline required use of two monthly publications of Medispan, while the new rule authorizes use of any nationally recognized pharmaceutical reimbursement system.

New §134.503 instructs the pharmacist to dispense the generic when prescribed or when a prescription does not require the use of a brand name drug. The rule as adopted does not allow an employee to refuse a generic prescription and opt for a brand name drug by agreeing that the employee will pay additional cost or a co-payment, as allowed in some other health care systems.

The new rule sets reimbursement for over-the-counter drug as the price of the lowest package quantity reasonably available that will fill the prescription, and excepts inpatient and parenteral drugs from its requirements.

Based on comments received, separate conversion factors were set for generic drugs and brand name drugs in §134.503 (a)(2). The reimbursement for generic drugs is [(AWP) x (number of units) x 1.25] + $4.00 dispensing fee = MAR. The reimbursement for brand name drugs is [(AWP) x (number of units) x 1.09] + $4.00 dispensing fee = MAR. The compounding fee in §134.503 (a)(2)(B) was reduced to $15.00 per compound. Language was added to §134.503(c) to clarify reimbursement for over-the-counter drugs at the retail price of the lowest package quantity reasonably available that will fill the prescription. The first sentence of §134.503(e) stating: " insurance carriers shall update drug and supply pricing data at least every 30 days" was removed to eliminate confusion with the requirement to use the AWP in effect on the day the prescription is dispensed.

§134.504. Pharmaceutical Expenses Incurred by the Injured Employee.

New §134.504 provides a process for the injured employee to obtain reimbursement for medications that have been purchased out-of-pocket. Previous rules did not address injured employee reimbursement for pharmaceutical expenses, nor did they require a carrier to consider an injured employee's request for reimbursement. Under previous rules, injured employees submitted requests to carriers seeking reimbursement in a variety of ways. New §134.504 establishes a standardized method for employees

to seek and receive reimbursement for monies paid out-of-pocket for prescriptions. Minor language changes were made for accuracy, consistency, and clarity.

§134.505. Chronic Pain Prescriptions.

The Commission recognizes that the issues surrounding chronic pain are important and may need to be addressed by rule; however, after reviewing the comments on proposed §134.505, the Commission has decided to delete this section from the proposal pending further examination of the issues.

§134.506. Outpatient Drug Formulary

New §134.506 adopts the outpatient open drug formulary as required by the statute and defined in §134.500(a)(4).

Based on public comment, §134.506(a)(2), (b), (c), (d), and (e) were removed.

The following groups submitted comments generally supporting §134.500 and §§134.502-134.506: American Insurance Association; Healthwatch, Inc.; Insurance Council of Texas; Liberty Mutual Insurance Group; Pharmaceutical Research and Manufacturers of America, PMSI; State Office of Risk Management; and Texas Association of Businesses and Chambers of Commerce.

The following groups submitted comments generally opposing §134.500 and §§134.502-134.506: Center for Pain Control; Greater North Texas Pain Society; Injured Workers' Assistance Center; Neurocare Network; Patient Advocates of Texas; Pharmacy Management Corporation; Texas Orthopaedic Association; and Texas Pain Society.

The following groups submitted comments making recommendations, and/or supporting portions and opposing portions of §134.500 and §§134.502-134.506: Coalition of Nurses in Advanced Practice; EzRx Pharmacy Services; Flahive, Ogden, and Latson; HEB; Medtronic Neurological; Midwest Employers Casualty Company; National Association of Chain Drug Stores; STAT 2000; Texas Back Institute; Texas Federation of Drug Stores; Texas Medical Association; Texas Mutual Insurance Company; Texas Pharmacy Association; Work Scripts; and Zenith Insurance Company.

Summaries of the comments and commission responses are as follows:

Preamble / General

COMMENT: Commenters generally supported the proposed new rules that, consistent with HB-2600, require that doctors prescribe generic prescription drugs when available and clinically appropriate, and require the doctor to prescribe over the counter medications when appropriate. Commenters believed that the use of generic prescriptions and over-the-counter medications has the potential to result in sizable savings in overall workers' compensation medical costs and commend the commission for its ongoing efforts to improve the Texas workers' compensation system through the effective utilization of the rulemaking process.

RESPONSE: The commission agrees.

COMMENT: Commenters believed that the proposed rules are extremely bad and they must be discarded to avoid the major damage they will produce to the workers' compensation system. Based on Texas Labor Code, HB-2600, the Medical Practice Act, and Texas statutes, commenter objected to the entire proposed preamble.

RESPONSE: The commission disagrees. Sections 408.028 and 413.011 of the Labor Code provide the statutory requirements and authority and direction for the establishment of fee guidelines and a formulary. New §134.500, §§134.502-134.504, and §134.506 meet the statutory requirements and fall within the statutory authority granted to the commission to establish medical policies.

COMMENT: Commenters pointed out that the preamble to §134.500 and §§134.502-506 states: "However, based on the anecdotal personal experiences from employees." The preamble acknowledges an "absence of pharmacy data." Commenters believed that the proposed rules need major revisions to achieve HB-2600's objective regarding standardization and uniformity with other health care delivery systems. Commenter opposed §134.500 and §§134.502-134.506 and expressed the belief that the proposed rules exceed statutory authority and go beyond the intent of HB-2600.

RESPONSE: The Commission database does not contain pharmacy data. In order to have information upon which to base the rules, staff conducted information-gathering sessions in Houston, Dallas, Ft. Worth, San Antonio and El Paso. In addition, assistance and data concerning workers' compensation pharmacy was obtained from the Commission's Medical Advisor, The Texas Mutual Insurance Company (formerly the Texas Workers' Compensation Insurance Fund), the National Council on Compensation Insurance (NCCI), and stakeholder groups concerned with implementing HB-2600. The lack of pharmacy data in the database does not preclude adoption of a pharmacy fee guideline. With assistance and data from the above-mentioned sources and public comment, §134.500, §§134.502-504, and §134.506 have been revised to achieve standardization and uniformity with other health care delivery systems to the extent possible while meeting the requirements of the Texas Workers' Compensation Act and the needs of the workers' compensation system.

COMMENT: Commenters believed that the proposed rules violate patient privacy and require that prescribing doctors violate patient privacy by requiring the disclosure of medical information to pharmacies and to insurance carriers that they are not entitled to under the Texas Labor Code.

RESPONSE: The commission disagrees. Section 408.025 (d) of the Texas Workers Compensation Act states "A health care provider may disclose to the insurance carrier of an affected employer records relating to the diagnosis or treatment of the injured employee without the authorization of the injured employee to determine the amount of payment or the entitlement to payment." The requirements of the proposed rules are consistent with that section of the Texas Workers Compensation Act. The required information is being used to determine the amount of payment or the entitlement to payment. In addition, §562.052 of the Texas Occupations Code prohibits the release of confidential records by a pharmacist except in limited circumstances.

COMMENT: Commenter felt the preamble to the proposed rules misstates the requirement of §408.028 "to require that physicians and doctors order over-the-counter alternatives to prescription medications when clinically appropriate and applicable, in accordance with state law." This is not what Texas Labor Code §408.028 states. This section does not require that the prescribing doctor specify otherwise, i.e., favor a generic or over the counter alternative medication, or otherwise purport to interfere with his diagnosis and treatment of the patient. In other words, the new law is not authority to establish an automatic

presumption against brand name drugs over generic and over the counter alternatives.

RESPONSE: The commission disagrees. Texas Labor Code §408.028 (b) states "The commission by rule shall develop an open formulary under §413.011 that requires the use of generic pharmaceutical medication and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with applicable state law."

COMMENT: Commenter believed that the proposed preamble illegally gives claims adjustors the authority for practicing medicine without a license and whoever wrote the proposed preamble is practicing medicine. Commenter felt that there are many inherent legal issues within the preamble.

RESPONSE: The commission disagrees. It is the role of the insurance carrier to retrospectively review all bills and pay for or deny payment for medical benefits in accordance with the Texas Labor Code, rules, and the appropriate Commission fee and treatment guidelines. This includes evaluating whether or not treatments or services were medically necessary based on supporting documentation submitted by the health care provider. Labor Code §413.011(f) states "The commission by rule shall establish medical policies or treatment guidelines relating to necessary treatments for injuries." Adopted new §134.500, §§134.502-134.504, and §134.506 are within the statutory authority granted to the commission to establish medical policies. In developing the new rules the Commission received input from many medical professionals including medical doctors and pharmacists. The Commission notes that a party, including a health care provider, is entitled to a review of a medical service provided or for which payment has been reduced or denied. Texas Labor Code §413.031(e) requires a review of the medical necessity of a service to be conducted by an independent review organization (IRO), and rule 28 TAC 12.201 of the Texas Department of Insurance requires that the review be conducted by physicians, dentists, or other health care providers, as appropriate.

COMMENT: Commenter suggested that before there can be any justification for challenging the prescription of a licensed, board-certified physician, the carrier must ensure that a true medical peer actually assessed all the medical records provided and compared them to the treatment guideline.

RESPONSE: The Commission disagrees. The statute and Texas Department of Insurance rules address utilization review and require that an adverse decision of a utilization review agent must be made by a physician.

COMMENT: Commenter felt that the proposed rules in general are confusing at best and in many cases seem to be arbitrary in nature. Commenter also stated that the proposed rules are an unduly burdensome addition to an already extremely burdensome system and that this becomes especially true when they are faced with a possible reduction in reimbursement.

RESPONSE: The commission disagrees. The proposed rules will increase communication among the participants in the Texas Workers' Compensation system. It is anticipated that the improved communication will reduce the instances of dispute as to pharmacy bills. The requirement for use of generic drugs and over-the-counter medications is mandated by statute.

COMMENT: Commenter believed that the rules would increase the cost to the injured worker.

RESPONSE: The commission disagrees. The proposed rules provide a method for the injured employee to recover out-of-pocket expenses for prescription medications and over-the-counter alternatives to prescription medications. The recovery of out-of-pocket expenses for these medications was not addressed previously by commission rule. The new rules should help injured employees recover out-of-pocket expenditures.

COMMENT: In general commenters felt that the commission has made too many concessions to the insurance carriers at the expense of the injured workers of Texas and the healthcare providers that treat them.

RESPONSE: The commission disagrees. The requirement for use of generic drugs and over-the-counter medications is mandated by statute. In addition, the commission met with stakeholder groups to ensure the adopted rules balance the interest of all participants in the Texas Workers' Compensation system. Many injured employees provided insight into the issues surrounding pharmaceutical delivery at information-gathering sessions that were conducted in major cities around the state. Injured employees will continue to receive quality health care under these rules, and health care providers will receive fair and reasonable payment.

COMMENT: Commenter recommended that the term "injured employee" be substituted for the term " patient" throughout the proposed pharmaceutical benefit rules.

RESPONSE: The commission agrees. The term "injured employee" is used as appropriate for consistency with the Texas Workers' Compensation Act and the rules of the Texas Workers' Compensation Commission.

COMMENT: Commenter recommended that a carrier should be able to direct the employee to a home pharmacy service if it can be shown there is a cost savings for the identical prescribed drugs or medical supplies throughout such service.

RESPONSE: The commission disagrees. Section 408.028(c) of the Texas Workers' Compensation Act states "Except as otherwise provided by this subtitle, an insurance carrier may not require an employee to use pharmaceutical services designated by the carrier."

COMMENT: Commenter recommended deleting the term "prescribing doctor" and replacing it with "prescribing practitioner." The term prescribing practitioner is descriptive of all health care providers that may legally sign a prescription for an injured employee and does not inadvertently penalize a patient for living in a rural or underserved area where a physician cannot be readily available.

RESPONSE: The commission disagrees. This rule does not prohibit a doctor from delegating prescription-signing authority to persons as permitted by law and license.

§134.500 Definitions

COMMENT: Commenter advocated the deletion of the term "device" from the definition of "compounding" and the inclusion of it as a separate definition. The reasons and/or method of "compounding" a "device" are not common knowledge leading to confusion among system participants and potential disputes. Since the Commission and staff are proposing the adoption of definitions from "Texas Occupations Code, Title III, Health Professions, Subtitle J. Pharmacy and Pharmacists, Chapter

551. General Provisions Section 551.003, Definitions" it is logical to import the corresponding definition of device.

RESPONSE: The Commission agrees in part and has removed the word "device" from the definitions in §134.500. The definition from Chapter 551 of the Pharmacy Act is too broad for the purposes of these rules, as it includes instruments, apparatuses, implements, machines, contrivances, implants, in vitro reagents, or other similar or related articles, including component parts or accessories. A definition of "device" is no longer needed because the term has been deleted from these rules.

COMMENT: Commenters suggested that a list of what should be included in the statement of medical necessity be added to clarify the essential contents of a statement of medical necessity for individual injured employees with individual injuries and diagnoses. Without a clear definition, non-descript, blanket statements and/or form letters or canned language would appear sufficient to establish medical necessity. A commenter inquired as to whether or not a similar definition would be included in durable medical equipment guidelines.

Commenter suggested the following wording:

Statement of Medical Necessity- A written and personally signed statement with supporting documentation from the prescribing doctor to establish medical necessity and relatedness to the compensable injury of a treatment or service, device, or prescription, including the medical necessity for a brand name drug, where applicable, and how the treatment, service, device, or prescription cures, relieves, promotes recovery or enhances the ability of the injured employee to return to or retain employment.

RESPONSE: The Commission agrees and has added language to clarify what information is to be included in a statement of medical necessity; however, the statement of medical necessity is not required to be personally signed, relatedness is not required to be addressed, the statement of medical necessity does not have to be a new or separate document if the required information is part of an existing document. Additionally, "or" was changed to read, " ...written statement AND supporting documentation..." to make clear the need for a clear statement addressing the medical necessity to accompany any documentation. The statement of medical necessity is not currently found in other Commission rules; however, providers may elect to use the statement of medical necessity for communication purposes.

COMMENT: Commenter suggested that implementation of the rules be delayed for as long as possible because the rules will require programming changes in computer systems, procedural changes, and possibly contractual changes. Commenter suggested that perhaps the effective dates of the rules should coincide with rules regarding the seven-day supply limits.

RESPONSE: The Commission disagrees. The legislative intent behind the delayed implementation of Texas Labor Code §413.0141, Initial Pharmaceutical Coverage, was that the business community wanted an opportunity to realize some of the costs savings anticipated from HB-2600 before they had to pick up this additional cost. Generics were a piece of the anticipated savings. The implementation dates were in effect directed by the legislation, which contains different effective dates for different portions of the bill.

COMMENT: Commenter suggested that in order to achieve standardization in payment methodologies for pharmaceuticals on or after March 1, 2002, language should be added that includes refills of medications that are initially prescribed prior to the date of implementation, but refilled thereafter.

RESPONSE: The Commission agrees. Language has been added to §134.500(b) to clarify that prescriptions initiated or refilled on or after March 1, 2002 are subject to these rules and that the Pharmaceutical Fee Guideline contained in the 1996 Medical Fee Guideline (§134.201) does not apply to prescriptions written or filled after March 1, 2002.

COMMENT: Commenter felt proposed §134.500(a)(1) is too broad and pointed out that some medications require mixing with water. Does that qualify for additional reimbursement? All medications require some assembly and all are required to be labeled and packaged. Commenter questioned whether this qualifies for additional reimbursement. Commenter recommended that the wording be changed to read " more than one drug or device that requires a pharmacist to combine said drugs or devices to fill a prescription."

RESPONSE: The Commission agrees clarification is needed and has deleted the word "device" , as explained above, and amended the definition of "compounding" to be more specific. Combining only one drug with water does not constitute compounding or qualify for additional reimbursement. There must be two or more drugs, or one drug combined with a substance other than water.

COMMENT: Commenters recommend adding the words "and vitamins" , "and botanicals," or "and vitamins, herbs, herbal supplements, homeopathic remedies, or other non-commercially available materials" at the end of the definition of the term open formulary. Commenters felt this addition would clarify that nutritional supplements, botanicals, and vitamins are considered to be non-drug items that are not covered under the Commission's open formulary. Leaving it limited to nutritional supplements appears to include these items by default.

RESPONSE: The Commission disagrees that additional language is necessary. It is more appropriate for examples of items that do not fall under the definition of "Open Formulary" to be mentioned in the preamble rather than the rule itself and with this in mind, the Commission has removed the example of nutritional supplements from §134.500(a)(4). Medications that lack FDA approval such as any of the above-mentioned items, including nutritional supplements, do not fall under the definition of "Open Formulary."

§134.502 Pharmaceutical Services

COMMENT: Commenter urges the Commission to implement this proposed rule and bring effective pharmaceutical cost savings and cost containment to the Texas workers' compensation system. Commenter felt that proposed §134.502 accomplishes the objectives of HB-2600, addresses many problems within the system, constrains rising pharmaceutical costs, creates system-wide savings that will benefit all parties, encourages the utilization of less costly generic drugs over higher-priced brand named drugs without interfering with the medical decision making of physician and pharmacist, and restricts the ability of the employee to refuse a generic prescription and opt for a brand name by agreeing to pay the additional cost.

RESPONSE: The Commission agrees.

COMMENT: Commenter suggested adding language to §134.502 that ties requesting a Statement of Medical Necessity

to the time frames for requesting additional documentation found in §133.301 and final action found in §133.304.

RESPONSE: The Commission agrees. Language has been added to §134.502(e) to reflect the suggestion.

COMMENT: Commenters note that throughout this proposed rule there are extensive new duties imposed on physicians. The information required in the statement of medical necessity is quite extensive. Having the rationale within the body of the office notes should be sufficient- not a narrative. The carrier should have all the other information in their files. Shifting the costs of preparing and providing the duplicative documentation involved in these statements of medical necessity to the physician is redundant, ethically reprehensible, and intolerably burdensome. Commenter recommends deleting items 1-8 proposed in subsection (f).

RESPONSE: The Commission has removed items (1)-(8) of proposed §134.502(f); however, the definition of the statement of medical necessity found in §134.500 (2) has been changed to add what the statement must contain in general terms. The statement of medical necessity is an important communication tool and it is important to define and describe its use and contents by rule. If there is a "narrative" contained within an existing document, a separate document is not required to be prepared. However, it is not sufficient to simply provide documentation or product literature that is not clear or case-specific.

COMMENT: Commenters question the purpose of the statement of medical necessity if the carrier is under no obligation to place credence in it. Until more explicit criteria are established regarding the necessary qualifications of the carriers' representatives who will receive and review these statements, commenters felt that this concept has no benefit for the workers' compensation system.

RESPONSE: The Commission disagrees in part. The rule has been changed to place a requirement on the carrier to request the statement of medical necessity before denying a bill and to require the carrier to submit a copy of the request to the sender of the bill (the pharmacist). This, by rule, gives the prescribing doctor the opportunity to explain the prescription's medical necessity. It also notifies the pharmacist that the medical necessity of the prescription is being questioned.

COMMENT: Commenters questioned what happens when a doctor does not comply with the request for a letter of medical necessity. Prescribing practitioners will not always include all the requirements of medical necessity. This could be considered as a potential liability for the dispensing pharmacist. There must be consequences for the doctors who do not follow the rule and a mechanism for the pharmacist to get paid while the carrier and the doctor try to resolve their issues. Perhaps the wording of the rules could read that the doctor will be liable for prescription costs until the statement of medical necessity is submitted and that the carrier pays the pharmacists' bills, with the Doctor reimbursing the carrier for prescriptions that are not medically necessary. This would put the burden on the appropriate party when determining medical necessity.

RESPONSE: The Commission agrees in part. The definition of the statement of medical necessity and requirements related to submitting the statement are found in §134.500, §§134.502-134.504, and §134.506. Any system participant that does not comply with the requirement relating to the statement of medical necessity is subject to administrative penalties. The above recommendation is not feasible; however, the pharmacist has the option of entering into medical dispute resolution.

COMMENT: Commenter noted that carriers obtain "letters of medical necessity" from physicians and still decline payment because information is not sufficient to justify payment. If a physician adheres to the required information in §134.502(f), that should be adequate to assure payment for services. Commenter suggested that this be worded more definitively so that the statement of medical necessity firmly establishes medical necessity (when filled out properly).

RESPONSE: The Commission disagrees. The statement of medical necessity is a communication tool designed to establish the medical necessity of the treatment for the injured employee's condition, and to facilitate payment. Insurance carriers are required to consider a prescribing doctor's statement of medical necessity before denying a bill for prescription or over-the-counter medications. If a doctor does not establish the medical necessity of the medication to the carrier's satisfaction then the carrier may deny payment.

Medical necessity is a fact-specific determination made on a case-by-case basis. The specification of information that should be included in a statement of medical necessity helps the doctor to provide adequate information; however, providing the specified information does not necessarily establish medical necessity for a particular service.

COMMENT: Commenter indicated that there is a need for accountability on the part of the insurance carrier if the carrier denied payment based on medical necessity but has not requested a statement of medical necessity. Commenter asked if a carrier could request a statement of medical necessity from the prescribing doctor and also deny payment for a prescription on the grounds of a lack of medical necessity. Carriers could simply request the physician to provide a statement of medical necessity on every brand name prescription. Commenter felt this would effectively hamper every physician when considering the most appropriate medication for the needs of the injured worker and asked if there would be repercussions for a carrier who routinely requests this information as a way to stall claims processing.

RESPONSE: The Commission agrees in part. Proposed subsection (e) has been modified to require the carrier to request a statement of medical necessity before denying payment for prescription or over the counter medications. The carrier has the right to deny payment if the statement does not establish the medical necessity of the treatment. Subsection (e) now references §133.301(d)-(g) which sets timeframes on requesting the statement of medical necessity and requires payments to be made in accordance with §133.304. Failure to comply with Commission rules may subject a carrier to administrative penalties and/or other sanctions.

COMMENT: Commenter suggested that the carrier should simultaneously notify all providers of the carrier's request for a statement of medical necessity so that the pharmacy provider may be given an opportunity to receive a copy of the doctor's response. This would alert providers that payment might be challenged.

RESPONSE: The Commission agrees. Subsection (e) has been modified to require the carrier to simultaneously notify the sender of the bill and the injured employee when a statement of medical necessity has been requested. In addition, subsection (e) has

been changed to require the carrier to send a copy of the explanation of benefits (EOB) denying payment of a pharmacy bill to both the prescribing doctor and the injured employee. The Pharmacist already receives the EOB per §133.304(c). This provides much needed communication between the carrier, the prescribing doctor, the pharmacy, and the injured employee.

COMMENT: Commenter was of the opinion that the proposed rule improperly places the burden on the carrier to request and obtain statements of medical necessity of the prescription from the prescribing doctor. The commenter felt the burden should be on the doctor to indicate the medical necessity for the prescription and that §134.502(e) should be deleted and §134.502(f) be modified by removing language requiring the doctor to provide documents " no later than the 14th day after receipt of request." This is the current practice and nothing in HB-2600 indicates any legislative intent to vary this process. Commenter suggested that documentation automatically be provided to the carrier without a request being necessary to avoid disputes.

RESPONSE: The Commission disagrees. Currently there is no established practice of prescribing doctors routinely providing information to carriers regarding the medical necessity of prescriptions. It is not necessary to provide documentation of medical necessity for every prescription, only those prescriptions that are in question. A carrier's request for a statement of medical necessity is similar to the carrier's request for additional documentation to justify the treatment or service that was billed.

COMMENT: Commenter requested that the Commission clarify that there is no charge to the carrier for the statement of medical necessity required under §134.502.

RESPONSE: The Commission agrees and has added language to new §134.502(e) to state that a health care provider will not be reimbursed for preparation of, or sending of, a statement of medical necessity.

COMMENT: Commenter suggested that proposed §134.502(b)(2) should use the term "diagnosis" rather than " cause of injury" which is irrelevant to prescribing and dispensing pharmaceuticals.

RESPONSE: The Commission agrees. The list of information to be included in a statement of medical necessity has been deleted from §134.502 and an abbreviated description has been included in the definition of statement of medical necessity in §134.500. The term "cause of injury" is not listed.

COMMENT: The Commission received a number of comments regarding the quantity of a prescription that should be dispensed at one time. Commenters varied in their opinions of dispensing quantity limits. Some commenters supported the 30-day limit in the rule as proposed and advocated that a similar limit be placed on over-the-counter medications. Other commenters advocated that the limit be increased. Commenters suggested: 90-day supply when mail order is used to fill chronic medications; up to a 90-day supply if the prescribing doctor feels it will be more beneficial to the patient; and, no dispensing limit. Commenters advocating an increased dispensing limit indicated that the injured employees most directly affected by this 30-day supply limit were severely injured employees who rely on maintenance medication therapy and home delivery. For these employees, larger supplies provide a level of comfort, convenience, and care and are more beneficial to them. A commenter was of the opinion that a 30-day supply limit would diminish the quality of life and level of care for severely injured employees presently relying on maintenance medication therapy. Commenters felt that dispensing larger supplies provided a cost savings. Other commenters felt that Texas Labor Code §408.028 did not authorize the Commission to impose time limits on the duration of medications.

RESPONSE: The Commission agrees that a limit should be placed on the amount of prescription drugs dispensed at one time. Because some injured employees rely on the convenience of mail-order services for maintenance drugs, and because it appears that there may be some cost savings in dispensing larger quantities, subsection (c) has been changed to allow the dispensing of up to a 90-day supply of a prescription drug. Section 134.502(c) does not impose a limit on the duration of a doctor's prescription. It limits the amount of drugs that may be dispensed at one time to a 90-day supply. The Commission disagrees that a quantity limit for dispensing over-the-counter medications is necessary. Over-the-counter medications are generally less expensive than prescription medications and may be paid for initially by the injured employee. It is not necessary to place a limit on the quantity of over the counter medications. The Commission has revised §134.503(c) to set reimbursement for over-the-counter medications at the retail price of the lowest package quantity reasonably available that will fill the prescription.

COMMENT: Commenters supported language requiring prescribing health care providers to provide documentation that the prescription of a brand name drug is medically necessary. Commenters recommend that the Commission carefully monitor doctors' actual practice in writing prescriptions under the new rules to make sure that the brand name drug exception is not being misused and that the intended medical cost savings are actually achieved.

RESPONSE: The Commission agrees and will monitor all system participants.

COMMENT: Commenter suggested that the Commission should publish a list of reasons for prescribing brand name medications over generic alternatives. Without a list of acceptable reasons any reason becomes medically necessary. Commenter recommended reasons such as "the generic is not an Orange Book equivalent to the brand name medication" or "objective, clinical, peer-reviewed studies demonstrate that the generic alternative for treatment of this (ICD-9 diagnosis) is significantly less therapeutic."

RESPONSE: The Commission disagrees. The doctor's reason for prescribing brand name medications is a clinical decision based on the medical expertise of the doctor and the individual circumstances of the injured employee.

COMMENT: Commenter was of the opinion that §408.028 of the Texas Labor Code directs the commission to impose a requirement on pharmacists and pharmacies when the prescribing doctor does not specify a brand name. Commenter did not believe this section allows the commission to shift this requirement to the physician.

RESPONSE: The Commission disagrees. Section 408.028 requires doctors to prescribe all appropriate prescription and nonprescription medications and when a brand name prescription drug is necessary, to make the appropriate indication on the prescription. Unless it is indicated on the prescription that a brand name drug is necessary, the pharmacist is required to fill the prescription with a generic drug.

COMMENT: Commenter stated that applicable state law requires the physician, when writing a prescription for a brand

name, to simply state "brand name necessary" - nothing more and nothing less. Commenter suggested that the rule should simply reflect the requirements of the statute and applicable state law and that additional requirements are overly broad, unduly burdensome, and exceed the authority granted under the statute. Commenter did not think that workers' compensation patients should be "labeled" as such.

RESPONSE: The Commission disagrees. Texas Labor Code §408.028 requires the Commission to adopt rules requiring the use of generic pharmaceutical medications and over-the-counter alternatives to prescription drugs. The requirement in §134.502(a)(1) is necessary to implement the provisions found in the Texas Labor Code §413.0141. Although rules implementing that statute cannot be adopted before September 1, 2002, the prescription requirements are included in the rule at this time and will also reduce the necessary system changes when additional rules are proposed. In addition, identifying that the prescriptions are related to a workers' compensation claim will prevent the pharmacy from inadvertently billing private insurance companies or injured employees for work related prescriptions.

COMMENT: Commenter stated that a patient often times having first utilized brand names finds the generics not as effective. Commenter suggested that brand name drugs should be considered with documented medical necessity.

RESPONSE: The Commission agrees. If need for a brand name drug exists and is documented, the doctor may prescribe the brand name drug in accordance with proposed §134.502(a)(3), and the pharmacist will fill the prescription with the brand name drug.

COMMENT: Commenter stated that §134.502(a)(3) should be definitively worded so that a physician's specification for " brand name drugs" serves to help in the determination of medical necessity

RESPONSE: The Commission disagrees that §134.502(a)(3) should be changed. An indication of brand name necessary on the prescription is not enough to establish the medical necessity of the brand name prescription. The prescribing doctor must be able to establish medical necessity through documentation.

COMMENT: Commenter felt a doctor should justify his decisions regarding the prescribing of prescription and over-the-counter drugs.

RESPONSE: The Commission agrees. The prescribing doctor should maintain documentation within the employee's clinical file to justify the medical necessity of all prescriptions and must produce a statement of medical necessity when requested.

COMMENT: Commenter predicted that the new requirements for over-the-counter medication might deter physicians in writing prescription for over the counter medications.

RESPONSE: The Commission disagrees. The new requirements for over the counter medications are necessary to facilitate the delivery of required medications to the employee and to facilitate payment to the pharmacist and, when necessary, reimbursement to the injured employee.

COMMENT: Commenter suggested that the doctor's prescription should match the number of doses purchased by the claimant for which reimbursement is sought.

RESPONSE: The Commission disagrees. The number of doses for which the employee seeks reimbursement is not required to exactly match the prescription due to the packaging constraints of over-the-counter medications. The Commission has revised §134.503(c) to set reimbursement for over-the-counter medications at the retail price of the lowest package quantity reasonably available that will fill the prescription. For example, the prescription is for two tablets, four times a day, for eight days, for a total of 64 tablets. The medication is available in bottles of 50 and 100. The prescription calls for 64 to the injured employee must purchase the bottle of 100 in order to follow the doctor's prescription.

COMMENT: Some commenters felt an indication of workers' compensation on the prescription should apply to over-the-counter prescriptions only. This was intended for over-the-counter items in order to have some indication that the item was intended for workers' compensation reimbursement and use.

Another commenter felt that requiring an indication from a prescribing practitioner that the prescription is related to a worker's compensation claim may result in unfilled prescriptions. Because the prescribing practitioner has no responsibility to submit the prescription as a claim, the provider may neglect the proper indication. The pharmacist may be left with an invalid claim for their product and services. Commenter asked if an audit is done of the pharmacy and the pharmacy has filled prescriptions without such wording, if the carrier would be able to request a refund from the pharmacy.

RESPONSE: The Commission disagrees. Requiring a prescribing doctor to indicate on all prescriptions that they relate to a workers' compensation claim assists the pharmacy in knowing how to process the bill for payment. In addition, this notation is needed for the implementation of Texas Labor Code §413.0141. The failure of a prescribing doctor to indicate that the prescription is related to a workers' compensation claim does not mean that the prescription should not be filled, and does not render the pharmacist's bill invalid. The carrier is still responsible for making the appropriate payment.

COMMENT: Commenter notes that a bill was passed in the Texas Legislature this session that requires the " brand necessary" language on all prescriptions, effective in June. Commenters believed that if you create different standards for workers' compensation you would create more confusion among the prescribers and pharmacists. Additionally, commenters noted that not every prescription is written. Some may be called in.

RESPONSE: The Commission disagrees that the new rules create different standards for workers' compensation. Section 562.015, Occupations Code, was amended effective June 1, 2002 to require the use of the phrase "brand necessary" or "brand medically necessary" to prohibit the substitution of a generically equivalent drug. Unless the prescribing doctor uses the "brand necessary" language, the pharmacist shall fill with a generic equivalent. The only difference for prescribers in the workers' compensation system is the requirement that the prescribing doctor indicate that the prescription is related to workers' compensation.

COMMENT: Commenters suggested that §134.502(d)(3) be changed to read: "A pharmacy may contract with a separate person or entity to process bills and payments for a medical service. The pharmacy and the contracted entity are jointly and severally liable for the errors and omissions of the entity. The separate person or entity must bill the carrier at no more

than the price defined in §134.502(d)(1). The provider may not increase its billed price or add any service fee or charge when using the separate person or entity."

Another commenter suggested deletion of the provisions imposing strict liability on pharmacists for the actions of their agents or amendment to reflect current industry practice and agency law. Commenter contended that a pharmacy should be responsible for the actions of the agent only where the agent is acting within the scope of its authority and subject to the discretion of the pharmacy. For those processors that are actually coming in and accepting complete responsibility for the prescription claim under contract, this may not be an appropriate place for regulation.

Commenters opposed permitting pharmacies to contract with a separate entity for billing and payment for medical services without having reasonable restrictions in place to avoid increased costs without benefit to the system participants. Commenters contended that the Commission should regulate billing and payment entities that contract with pharmacies.

RESPONSE: The Commission disagrees that §134.502(d)(3) should be changed. Billing requirements are contained in §134.800 of this title as referenced. The pharmacy is responsible for compliance with the law and Commission rules and cannot transfer that responsibility by contract. Pharmacies can choose whether to contract with a billing entity and with whom they contract. Assurance that the law and Commission rules will be followed should be a major consideration in making that decision. Commission rules place restrictions on other entities submitting bills on behalf of health care providers. Specifically, §134.801(g)(1) requires any entity, including a health care provider that submits a bill to submit the bill for an amount that does not exceed the health care provider's usual and customary charge in accordance with Texas Labor Code §413.011.

COMMENT: Commenter believed that §134.502 forces the pharmacy (health care provider) to bill according to §134.800(d) but does not force the carriers to follow the bill-payment rules, including the rules when additional documentation can be requested. Commenter felt this allows the carrier to wait until the 45th day then request the statement of medical necessity, to which the doctor has 14 days to reply extending the deadline for payment beyond 45 days.

RESPONSE: The Commission disagrees. Carriers are required to abide by the timeframes found in §133.304. Additionally, language has been added to §134.502(e) clarifying that carrier requests for statements of medical necessity shall comply with the requirements found in §133.301(d)-(g). A request for a statement of medical necessity does not extend the time for payment of pharmaceutical bills.

COMMENT: Commenter stated proposed §134.502(d)(1) provides: "Healthcare providers shall bill using national drug codes (NDC) when billing for prescription drugs." The Commission is currently promulgating §134.203(a)(2) that adopts by reference the HCPCS Level II codes. The HCPCS codes are used to bill for medications. The Commission needs to decide which billing system they are going to use.

RESPONSE: The Commission disagrees that there is a conflict in the usage of the billing systems. Section 134.503(d) clearly states that the rule "applies to the dispensing of all drugs except for inpatient drugs and parenteral drugs." Drugs with HCPCS codes are typically administered to patients rather than dispensed. The billing requirement in §134.502(d)(1) has pharmacists and pharmacies in mind rather than physicians administering drugs in an office setting.

COMMENT: Commenter suggested that the following be added: " The provider shall bill the carrier at its lowest posted retail price (store or website) on the date the prescription is filled"

RESPONSE: The commission disagrees. Section 134.801 (g) requires the health care provider to bill their usual and customary charge for the product that was provided. The commission is mandated by Texas Labor Code §413.011 to establish guidelines as follows: "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf." By billing their usual and customary charge for the service or product, health care providers assist the commission in producing meaningful statistics that are correct, consistent, and are of value when monitoring healthcare providers for compliance with law and rules and in the review of healthcare economic trends when establishing future reimbursement guidelines.

COMMENT: Commenter suggested adding the following to §134.502: "where the pharmacy stocks two or more pharmaceutically equivalent over-the-counter alternatives to a prescription drug, the prescription shall be filled with the lowest price product." Commenter also suggested that over-the-counter medications should be reimbursed at the provider's lowest posted retail price (store or web) on the date the prescription is filled.

RESPONSE: The Commission disagrees. The injured employee may select the over-the-counter product that has been prescribed and reimbursement is the retail price of the product chosen. Requiring the injured employee to compare multiple stores or products would be an unreasonable burden on the employee.

COMMENT: Carriers (not claimants) are legally responsible for paying all needed and necessary medical cost related with the compensable injury.

RESPONSE: The Commission agrees. If an injured employee pays for a medically necessary prescription medication, §134.504 provides the procedure for the injured employee to be reimbursed by the carrier.

§134.503 Reimbursement Methodology

COMMENT: Commenter questioned why a compounding fee is warranted and how it will reduce the system costs associated with prescription drugs. Commenter felt a compounding fee conflicts with the expressed intent of the Texas Legislature to reduce costs associated with medical benefits in the Texas workers' compensation system and may encourage fraud and abuse. Commenter recommended that the compounding fee be deleted.
RESPONSE: The Commission disagrees. Because the compounding of drugs requires additional pharmacist time a compound fee is warranted to reimburse the pharmacist for additional time required. However, in reviewing the amount of the compounding fee the Commission has determined that it should be lowered from the $30.00 fee proposed to $15.00 per compound. During the rule-making process the pharmacy work group provided information to the rule development team indicating that generally, compounding fees are approximately $1.00 per minute

and that compounding normally would require up to 30 minutes. An average time needed for compounding is estimated at approximately 15 minutes. Some compounds will require less time, some will require more. Therefore, $15.00 is a reasonable compounding fee.

COMMENT: Commenters felt that "reasonable retail value" of an over-the-counter item is rather vague and seems to allow the carrier to detail what is fair and reasonable. One commenter recommended including language emphasizing that the pharmacy shall bill and be reimbursed it's usual and customary charge that it would normally charge for a walk-in, non workers' compensation customer. Commenters pointed out that there are significant differences in price between brand name products sold in convenience stores vs. privately labeled items sold by chains and mass merchandisers and that the pharmacy's costs of dispensing, storage, inventory, and transportation of over-the-counter drugs are similar to those for prescription drugs. Commenters recommended that the rule establish the same standards for reimbursing over-the-counter drugs as prescription drugs. Commenters suggested that the rule clearly state that if the injured employee buys the item over-the-counter he/she should be paid for their out-of-pocket expense, and if a pharmacy dispenses it, it should be reimbursed at the prescription formula rate drug costs and dispensing fees. A commenter expressed concern that §134.502(a) and §134.503(c) set separate standards for reimbursement for over-the-counter medications.

RESPONSE: The Commission agrees in part and has modified the language to require reimbursement to match the retail price of the lowest package quantity reasonably available that will fill the prescription. As an example, the prescription is for two tablets, four times a day, for eight days, for a total of 64 tablets. The medication is available in bottles of 50 and 100. The prescription calls for 64; therefore, the injured employee must purchase the bottle of 100 in order to follow the doctor's prescription. The language allows the employee to receive the over-the-counter medication in the brand of their choice for the quantity prescribed. "Available" means available at the location where the injured employee goes to fill the prescription. "Reasonable available" means that the product should be purchased at a location that carries medications in appropriate quantities, not a wholesaler that only carries extremely large quantities of medications. The injured employee reimbursement is addressed in adopted §134.504. However, requiring the injured employee to compare multiple stores or products would be an unreasonable burden on the employee. The Commission disagrees that specific language relating to " usual and customary" is necessary because §134.801(g)(1) contains that directive. The Commission also disagrees that there is any conflict between §134.502(a) and §134.503(c) and that over-the-counter medication should be reimbursed under the same methodology as prescription drugs. If a pharmacy dispenses an over-the-counter medication it should be reimbursed at the retail price of the lowest package quantity reasonably available that will fill the prescription just as it is if the injured employee had purchased the medication. There is no added value to the system when an over-the-counter medication is dispensed by a pharmacy.

COMMENT: Commenter questioned whether the term "value" is synonymous with the term "price" as used in §134.503(c). The term "value" implies that the reimbursement would be based on usefulness of the over-the-counter to the compensable injury, where "price" is simply the amount paid.

RESPONSE: The Commission agrees and has changed the word "value" to "price."

COMMENT: The commenter felt that the phrase reasonable retail value has no clear meaning and suggested changing §134.503(c) to read: Reimbursement for over the counter drugs shall be the provider's lowest posted retail price (store or website) during the week and for the county in which the prescription is filled. The suggested language provides an objective standard for determining reimbursement. Another commenter questioned how the injured employee would know what reasonable retail value is.

RESPONSE: The Commission agrees in part and has changed subsection (c) to require reimbursement of "retail price of the lowest package quantity reasonably available that will fill the prescription." Reimbursement should be the actual amount paid whether or not it was the week's lowest price.

COMMENT: Commenter believed that §134.503 should include strict controls on who may dispense and receive reimbursement for over-the-counter medications. Commenter recommended adding language to subsection (c) that over-the-counter drugs are only reimbursable if prescribed by a physician and may not be reimbursed if purchased from or dispensed by the treating doctor, referral doctor, or other non-pharmacy health care provider.

RESPONSE: The Commission disagrees that the suggested language is necessary. The cost of over-the-counter medications is only reimbursable if they were prescribed in accordance with §134.502. The amount of reimbursement is the actual amount paid for the over-the-counter medication as prescribed. There is no restriction on where a medication can be purchased.

COMMENT: Commenter contended that the nationally recognized pharmaceutical data is too broad. Some pharmacists use the daily AWP updates provided by First Data, some use weekly, and some use the monthly publication. Commenters recommend that the Commission specify a specific pharmaceutical reimbursement system that insurers must use to determine the AWP of drugs. Since pricing can differ daily, this will result in uniformity of reimbursed amounts and should prevent many medical disputes.

Some commenters recommend that the Commission adopt by reference First Data Bank's monthly "Price Alert" as modified for the Medicare system, as the reimbursement system publication to be used by insurers and bill review agents since it has recently been adjusted to reflect accurate and lower AWPs.

RESPONSE: The Commission disagrees with the suggestion to select one source for AWP. The Commission wishes to allow flexibility for whichever nationally recognized pharmaceutical reimbursement system the carrier selects and will monitor to determine if future changes are warranted.

COMMENT: Commenters requested clarification regarding whether AWP should be updated weekly or daily. Commenter recommends updating daily.

RESPONSE: The Commission agrees with daily updating, but disagrees that clarification is necessary. Section 134.503(a)(2) states that reimbursement is based on the average wholesale price in effect on the day the prescription drug is dispensed.

COMMENT: Commenter suggested that "lowest" be inserted before "average" in §134.503(a)(2). Average wholesale prices quoted by Redbook or First Data Services differ. The carrier

should be able to utilize the lower of the published AWP from a nationally recognized pharmacy reimbursement service.

RESPONSE: The Commission disagrees that the suggested language is needed. The carrier is required only to use a nationally recognized pharmaceutical reimbursement system. Which system they choose is up to them.

COMMENT: Commenter indicated that Medicaid has a standard for dispensing fees at $5.27 and asked that the Commission look at the justification for that.

RESPONSE: The Commission has found that while the Medicaid dispensing fee is higher than the Commission's, when the entire reimbursement calculation is taken into account, the Medicaid reimbursement rate is lower.

COMMENT: Commenter asked that the Commission reconfigure the reimbursement for prescription drugs so that the prescription of brand name drugs is not incentivized in accordance with the legislative purpose of HB-2600. Instead, incentives to dispense generics are being eliminated while the compensation for the dispensing of brand name drugs is being increased. Commenter observed that the rule as proposed only allows the pharmacy to bill one price regardless of generic or non-generic. It does not allow an injured employee to refuse a generic prescription and opt for a brand name drug by agreeing that the employee will pay additional cost or a co-payment as allowed in some other health care systems. Commenter felt a patient should have the right to pay out of pocket for brand name.

RESPONSE: The Commission agrees in part. The Commission disagrees that the reimbursement structure of §134.503 provides incentives for either brand name or generic drugs, or that the injured employee should be allowed to opt for brand name drugs if a brand name was not prescribed. Texas Labor Code §408.028 requires the Commission to adopt an open formulary that requires the use of generic pharmaceutical medications and over-the-counter medications unless the prescribing doctor specifically indicates otherwise. The decision of whether or not a generic or brand name drug should be dispensed is made by the prescribing doctor not by the pharmacist or the injured employee. Allowing the injured employee to pay the difference between the generic and the brand name drug would allow the injured employee to override the decision of the prescribing doctor and could put the pharmacist in the position of pursuing a private claim against the employee, which is prohibited by Texas Labor Code §413.042. The conversion factor for brand name drugs has been changed from the rule as proposed. See discussion later in this preamble.

COMMENT: Commenters requested clarification on how commission staff arrived at the conversion factor of 1.25 and how the adoption of the 1.25 conversion factor will reduce system costs associated with prescription drugs.

A commenter asked for an explanation of the relationship of the 1.25 conversion factor to Texas Labor Code §413.011 (b)

RESPONSE: Texas Labor Code §413.011(b) gives the Commission authority to develop conversion factors in determining appropriate fees. Currently, the Commission does not collect pharmacy data. Examining the conversion factors previously used by the Commission and discussions with members of the pharmacy community led the Commission to the proposed conversion factor of 1.25 for both brand name and generic drugs. While considering public comment, the Commission worked with the National Council of Compensation Insurance to look at possible savings from several different conversion factor scenarios. In the absence of Texas data, data from California was used. California pharmacy cost percentages are similar to Texas. This analysis revealed that in order to reduce pharmaceutical costs through the use of generic medications, the conversion factor for brand name drugs should not be raised from its current level of 1.09. Therefore, the conversion factor for brand name drugs remains at 1.09. The conversion factors are as follows: Generic drugs: ((AWP) x (number of units) x 1.25) + $4.00 dispensing fee = MAR; Brand name drugs: ((AWP) x (number of units) x 1.09) + $4.00 dispensing fee = MAR. This will provide fair and reasonable fees while effecting the medical cost control mandated by the statute.

COMMENT: Commenter asked if over-the-counter medications are to be filled with generic (store brand). There is a major cost difference between Tylenol brand acetaminophen and store brand acetaminophen. Since the carrier is only responsible for generics, does this apply to over-the-counter medications? Commenter felt over-the-counter medications should be treated the same as a prescription, where the " store brand" is covered the same as a generic and the "name brand" is treated as a brand drug and recommend that subsection (c) be changed to require the use of generic over-the-counter drugs when available. Commenter contended that this would help reduce system costs.

RESPONSE: The Commission disagrees. Requiring generic over-the-counter medications would create much confusion because in many cases the employee will be selecting the medications themselves and may not be aware of the differences between products. Requiring the injured employee to compare multiple stores or products would be an unreasonable burden on the employee. In addition, not all pharmacies or retail stores carry a "store brand." Savings are achieved by the use of the over-the-counter medications in lieu of a prescription medication.

COMMENT: Commenter suggested that the word "Privately" be added between "A" and "negotiated" in §134.503(a)(3) to mirror the Texas Labor Code.

RESPONSE: The Commission disagrees. The language is consistent with commission rule 133.1(a)(8)(C) of this title.

COMMENT: Commenter expressed concern that a provider of pharmaceutical services will be required to join a plan or network. Commenter asked if insurance companies have the right to require a membership before an entity could be a provider.

RESPONSE: Carriers do not have the right to require providers to join a plan or network.

COMMENT: Commenters commented that §134.503 should be clarified to make clear that reimbursement is subject to the requirement that the generic medication is reasonable and necessary and related to the compensable injury.

RESPONSE: The Commission disagrees that clarification is necessary. Reimbursement is always subject to medical necessity and relatedness to the compensable injury. These requirements are found elsewhere in the law and Commission rules.

COMMENT: Commenter contended that carriers insist on paying claims every 45 days. Hence, claims will always be disputed and never be paid.

RESPONSE: The Commission disagrees. Carriers are required to pay medical bills in accordance with Texas Labor Code §408.027 and §413.011.

§134.504 Pharmaceutical Expenses Incurred by the Injured Employee

COMMENT: Commenter recommended changing "or" in proposed §134.504 (c) to "and notify the injured employee of the payment or denial in accordance with §133.304.". This will decrease confusion, questions, and disputes regarding the form and format of notification to the injured employee. Another commenter suggested that "or" be replaced with "and/or."

RESPONSE: The Commission disagrees. "(And" is unnecessary. The injured employee will be paid, or have the payment reduced or denied. If payment is made in full, the carrier is not required to provide an explanation. Only in the event of a reduction or denial would notice and an explanation be needed.

COMMENT: Commenter noted that there are no stipulations as to sanctions against the insurance carrier for delays in reimbursement of the patient for over-the-counter medications.

RESPONSE: The Commission disagrees. Failure of an insurance carrier to take timely action on an employee's request for reimbursement is a violation of Texas Labor Code §415.002 and should be reported to the Division of Compliance and Practices.

COMMENT: Commenter believed that there is a disconnect between the claimant's inability to refuse a brand name at the pharmacy and the claimant being able to pay for brand name and seek reimbursement for the brand drug directly from the carrier. Commenter suggests that wording be included specifying that when claimant is submitting documentation for reimbursement for out-of-pocket expenses, the carrier is only responsible for reimbursing generic medications unless the claimant submits supporting documentation for the brand drug.

RESPONSE: The Commission disagrees. Section 134.502 provides that a doctor shall prescribe generic prescription drugs when available and clinically appropriate. If the doctor believes the brand name is medically necessary the doctor must specify that brand name drugs be dispensed. It is not the option of the injured employee to choose generic or brand name drugs. Therefore, in the event an injured employee seeks reimbursement for a prescription drug, the reimbursement should be for what was specified on the prescription.

COMMENT: Commenter suggested that the Commission establish a limit on the amount of over-the-counter medication that will be reimbursed within a set time period similar to the limitation found in §134.502(c) on prescription drugs.

RESPONSE: The Commission disagrees. Reimbursement for over-the-counter medications is limited by the doctor's prescription. The Commission disagrees that a quantity limit for dispensing over-the-counter medications is necessary. Over-the-counter medications are generally less expensive than prescription medications and may be paid for initially by the injured employee. It is not necessary to place a limit on the quantity of over the counter medications.

COMMENT: The commenter believed that the intent of HB-2600 was to keep reimbursement for injured employees simple. Once the commission gets an injured employee into the medical dispute resolution process, it becomes more complicated than what the average employee should have to go through.

RESPONSE: The Commission disagrees. The law requires the Commission to establish rules for employee reimbursement for out of pocket expenses for medications. In the event a request for reimbursement is denied or reduced, the injured employee is entitled to dispute that action. The rules as adopted do keep the process as simple as possible. The rules do not require the employee to shop around between over-the-counter medications or between brand name and store-name over-the-counter medications. Reimbursement for over-the-counter medications is set at the retail price of the lowest package quantity reasonably available that will fill the prescription.

COMMENT: Commenter suggested that when an injured employee is seeking reimbursement for out-of-pocket expenses, their letter should be personally signed and contain the following items: copy of prescription, number of units or quantity (tablets, capsules, liquid, or suppositories), prescription label, receipt indicating amount paid, employee's name and carrier's claim number, mailing address, date of injury, and social security number.

RESPONSE: The Commission disagrees. The basic information required adopted §134.504 is sufficient. The rule lists information that should be included in the request for the carrier to identify the claim, the amount of reimbursement requested, and the over-the-counter medication prescribed. If more information is needed, the carrier can contact the injured employee or the prescribing doctor.

COMMENT: Commenter questioned why it would become necessary for an injured employee to purchase medications out of pocket. Commenter believed there would be few over the counter prescriptions if the injured employee must bill. If the employee has an account at the pharmacy why can't the pharmacy bill? By the time an injured employee bills, the employee has lost the cost of the drug, if they have it (most don't), interest for over 45 days (when you include mail), maybe some of the cost if denied, and the possible hassle of medical dispute resolution.

RESPONSE: The Commission disagrees. Texas Labor Code §408.028(d) requires the Commission to adopt rules allowing employees to obtain reimbursement for money spent on prescribed over-the-counter medications. Section 134.504 implements the law and extends reimbursement to prescription drugs as well. The rule does not prevent a pharmacist from dispensing an over-the-counter medication and billing the carrier. However, in the event an injured employee has paid out-of-pocket for prescribed medications the rule provides a procedure for recovering that money.

COMMENT: Commenter felt that §134.504 has great potential for cost-shifting of products generally used in the home and unrelated to the injured employee's compensable injury, potentially increasing costs in the workers' compensation system.

RESPONSE: The Commission disagrees. Injured employees must provide a copy of the doctor's prescription along with their request for reimbursement. This prescription will have an indication that it is related to a workers' compensation claim and is required to be medically necessary for treatment of a compensable injury to be reimbursed.

§134.505 Chronic Pain Prescriptions

COMMENT: Some commenters supported the adoption of §134.505. Commenters believed that this rule would address a problematic issue wherein many treating doctors are not

managing the injured employee's use of prescription drugs in a proper manner.

A commenter suggested that the documentation submitted by the treating doctor be produced on a standardized form.

One commenter contended that nothing in §408.028 authorizes the commission to prohibit or label as presumptively unreasonable the use of opioids. Proposed §§134.505-134.506 demonstrate a complete lack of understanding of and compliance with Senate Bill 20, Section 1, Title 71, Article 4495C the Chronic Pain Treatment Act and the amendment, Section 1, Section 6, Article 4495C, Revised Statute Application of Act to Chemically Dependent Persons. The proposed rules also run contrary to the Texas State Board of Medical Examiners, §§170.1-170.3, Authority of a Physician to Prescribe for the Treatment of Pain. Commenter believed that the proposed rules, in particular §134.505; purport to instruct medical doctors to ignore this applicable law and the standard of care and that the rules run contrary to the Drug Addiction Treatment Act of 2000, The National Institute on Drug Abuse Policies and Procedures, The Federation of State Medical Boards of the United States Model Guidelines for the Use of Controlled Substances for the Treatment of Pain, The American Pain Society's Consensus Statement on the Use of Opioids for the Treatment of Chronic Pain, The American Academy of Pain Medicine's Consensus Statement on the Necessity for Early Evaluation and Treatment of the Chronic Pain Patient, and numerous journal reviewed articles on the treatment of chronic pain. Commenter stated that §134.505 ignores and violates the International Narcotic Control Board section 21 of the Code of Federal Regulations and the Intractable Pain Treatment Act of Texas and that State and federal laws have provisions that are more extensive and more clinically appropriate than are the provisions of this proposed rule and that this section should be removed entirely.

Some commenters suggested that §134.505(c)(1) is an illegal invasion of the patient's privacy because it requires a drug screening without cause and it cannot be assumed that every patient taking opioids is likely to become a drug abuser. Commenters believed that drug screening should only be required if a suspicion arises about drug abuse or diversion. One commenter did not think that patients on opioids should be labeled as drug addicts and believed that is essentially what §134.505 and §134.506 do.

Many commenters felt that §134.505 is a treatment guideline and should be deleted since treatment guidelines must be nationally recognized and outcome based. Commenters stated that treatment guidelines should be directed at the physicians, not the suppliers and felt that problems exist when payers seek to enforce treatment guidelines through pharmaceutical benefits as they are dispensed.

One commenter pointed out that this does not alleviate the problem that exists now- the supplier is in the middle and unable to comply. Commenter felt that §134.505 result in operational and clinical procedural problems since it is impossible for someone other than the physician to follow this guideline. Commenter asked how a pharmacist could comply with the opioid guidelines when they are written for the doctor and the pharmacy has no access to any of the records.

Some commenters pointed out that §134.505 was based on a single payer on-line pharmacy system that Texas does not have.

Many commenters pointed out that §134.505 states that payment for the medications "shall" be denied for inadequate documentation, non-compliance, misuse, or very subjective reasons-not for reasons based on the medical necessity of the treatment and that the rule ties payment to " documentation of substantial reduction of the patient's pain intensity and continuing substantial improvement in the patient's function." Commenters felt that in many cases there may be substantial relief of pain but the patient's function may not improve and the rule creates a presumption that without documentation of substantial improvement, the treatment is not reasonable or medically necessary. Commenters believed that there is no statutory authority or factual authority for creating this presumption, nor the standards for continuing or denying payments.

Another commenter contended that the burden of proof needs to lie with the carrier and the carrier needs to justify any denials of payment for these prescriptions by presenting documentation of their beliefs that the prescribing patterned deviate from those practice guidelines and the current Commission treatment guidelines.

One commenter requested clarification that all approvals of treatment plans for chronic pain medications be undertaken and completed on-line, in a timely manner, before the prescription is presented to the pharmacist. Commenter believed that otherwise, the pharmacist will be unaware of the terms or state of approval of any treatment plan and a pharmacist should not be required to ascertain or document medical necessity.

A commenter was very concerned that the regulations proposed are an attempt by insurance carriers to impose regulations on treating doctors that make "chronic" pain in a brief period of time and that the wording of the pharmaceutical benefits section opens the door to define any treatment lasting over three months as "not reasonable and medically necessary" .

Commenter suggested that when a patient has achieved the level of chronic care, it is appropriate to achieve a maintenance level of opiates simply to achieve a continued therapeutic affect and the provision that patients show improvement over the first three months of opioid therapy is of some concern. It may take more time to achieve an appropriate medication level for the patient to become active and for an arbitrary time of three months to be stipulated is unreasonable. A statement of why prior measures may have failed is an exercise in speculation and serves no useful purpose. A statement that the treating doctor has conducted appropriate screening is part of the regular record of the patient kept by the treating physician. A six-month treatment plan cannot be done with any degree of accuracy because treatment conditions are frequently fluid and have to be adjusted to fit the changing situation.

Commenters contended that wording in the proposed rule adds extensive reporting to an already cumbersome system. Commenters felt that the reporting requirements discouraged the use of opiates and it would be too much work to prescribe these drugs. One commenter stated that physicians go to school and should risk being questioned by their boards not the Commission or a carrier when treating an injured employee. Many commenters pointed out that this information could be obtained from provider progress notes that are already available to the carrier as part of the office record and specific narratives are unnecessary.

Commenters believed that the proposed rule will require a substantial increase in the number of visits per claim, not just for

the initial "drug screening, consultations, and all other treatment trials" required, but to comply with "at least every 60 days" updates and contended that after the establishment of an appropriate medication regimen, it is often not necessary to see a patient every 60 days and such a requirement would create an unnecessary inconvenience on the patient. However, the commenter noted that if the patient's pain control is not improving then this time framework might be too long. Commenter also stated that increasing the number of visits is contrary to the Paper Reduction Act.

One commenter suggested that there should be evidence that a prescribing doctor has seen the patient within 10 days of continuing a chronic pain medication and that too many times medications are continued without examination of the patient.

A commenter suggested that the prescribing doctor outline lab tests if a patient is to remain on chronic pain medications.

It was recommended that all references to treating doctor be changed to read treating/referral doctor and the commenter pointed out that as currently written, §134.505 only applies to treating doctors. The commenter stated that referral doctors often prescribe drugs to injured employees and should be subject to the requirements set forth in this rule and suggested that no later than 10 days after a referral doctor begins treating the injured employee with opioids for treatment of chronic, non-cancer pain, the referral doctor shall submit a written report to the treating doctor and carrier in order for the carrier to pay for such treatment. Commenter believed that the written report must include the information set forth in subsection (b) of this section and a referral doctor must submit to the treating doctor and carrier the information set forth in subsection (c) of this section at least every 60 days when treating with opioids.

Some commenters felt that §134.505 is a blatant and unauthorized attempt to limit the treatment for chronic conditions that conflicts with the entitlement given in Texas Labor Code §408.021. Commenter felt that §134.505 is unusually strict and noted that the proposed rule was based on anecdotal experience and those who are board certified in pain medicine and/or board certified in addiction medicine were not consulted. Commenter stated that there is no scientific evidence to support the Commission's position on restricting pain relief and that the Commission failed to state a reasoned justification for the proposed rule.

Commenters believed that health care providers will face arbitrary decisions by carriers to deny payment based upon their determinations of what constitutes adequate compensation, substantial reduction in the patient's pain, substantial improvement in the patient's function, noncompliance, misuse or abuse and that determination of reasonable and necessary usually falls to an economic consideration. One commenter contended that an arbitrary decision to presume that " such treatment (opioids) without documentation of substantial improvement is presumed to be not reasonable or medically necessary" is inhumane and several commenters felt that continued treatment for as long as the pain persists is essential. One commenter felt that such determinations need to be made by a specialist in the management of chronic pain and that the effect of §134.505 will be to substantially reduce the ability of the injured employees to receive appropriate treatment for chronic pain. Another commenter contended that disputes over payment for medication will be numerous and the dispute resolution system will be overwhelmed. A commenter believed that although addiction does exist, the percentage is not high particularly on the pain medications and commenter didn't believe that it would run into a high cost because the percentage is so low.

Commenter inquired as to who determines ambiguous inadequate documentation and ambiguous non-compliance. Commenter believed that claims adjusters are making medical decisions attempting practicing medicine without a Texas license for the purpose for denying paying claims.

One commenter recommended adding psychotropic drugs to the list since many patients who experience chronic pain are on these drugs. Another questioned the source of the definition of chronic pain given in §134.505(a). A commenter contended that the Commission has made Vicodin sound like Percodan.

Commenter recommended including the example in §134.505(f) should be contained in the preamble to the rule rather than the rule itself.

Commenters went on to point out that the origin of the proposed rules is described as being based on faulty sources and concepts devoid of knowledge and awareness of the many modern scientific studies, laws, and treatment guidelines that are followed by pain specialists throughout the state and asked where the clinical studies were to support these rules. Commenters believed that without the participation and contribution of a pain specialist physician, the rule-making process was fatally flawed from its onset and suggested pulling the proposed rules until the commission has accurate data upon which to base its regulations and noted that opioids are not evil when used appropriately. One commenter noted that a good resource for the Commission would be the work group that is being formed by the Board of Pharmacy that includes the prescribing organizations and regulatory organizations. Commenter noted that there are frantic, desperate, suicidal calls when people get abruptly taken off their medication.

RESPONSE: The Commission recognizes that the issues surrounding chronic pain are important and may need to be addressed by rule; however, after reviewing the comments on proposed §134.505, the Commission has decided not to adopt this section pending further examination of the issues.

§134.506 Outpatient Drug Formulary

COMMENT: Commenter recommended that the following language be substituted for the language currently proposed for adoption: Over-the-counter medications with a prescription from a physician shall be reimbursed in the manner set forth in §134.503(c).

RESPONSE: The Commission agrees and has inserted language in §134.506 referencing §134.503.

COMMENT: There were a number of comments regarding the "off-label" use of prescription drugs. A commenter was pleased that under proposed §134.506 Outpatient Drug Formulary, the Commission adopts an open formulary as defined in §134.500(a)(4) and urged the Commission to allow for public notice and comment at any time the commission considers limiting access to drugs or otherwise considers a limited outpatient drug formulary.

One commenter suggested that a better wording would of §134.506 (a) would be: "The insurance carrier shall pay for prescriptions for off label indications when used in accordance with current medical standards and established major medical

organizations and prescribed in compliance with clinical indications, contradictions, precautions, and warning as presented in medical books, journals, seminars, and/or conferences."

Another commenter was of the opinion that off-label drugs are used appropriately in a significant percentage of cases in accordance with current medical standards. Oftentimes once a drug is FDA approved for one purpose, even though subsequently it is found to be appropriate for another purpose, the manufacturer will not go back through the expensive approval process for that purpose. Commenter felt that §134.506 needs a clear and explicit statement that this subsequent finding of additional benefits of medications for other symptoms that are different from those symptoms and benefits of medications for other FDA approval process is a widespread phenomenon throughout the many fields of medicine.

Commenter suggested that the rule specify the Physician's Desk Reference (PDR) alone and/or references derived solely from it are insufficient as tools to render a proper decision about the medical appropriateness of a prescription of a medication to relieve pain. The medical literature published after the initial PDR-approved investigations must also be considered.

RESPONSE: The Commission disagrees that the suggested additions to the wording in §134.506 are necessary; however, subsection (a) has been re-worded to clarify that off-label uses of prescription drugs are sometimes appropriate. The prescribing doctor may cite medical findings and publications in support of an off-label use of a prescription medication. Not all books, seminars, and journals may be authoritative sources. The carrier must review the documentation provided to make its decision and should consider the reputation of the resource provided in support, as well as the conclusion of the resource.

COMMENT: Commenter suggested the removal of §134.506(b) stating it is a poor attempt to establish an open formulary and it reads more like an outpatient drug rehab treatment guideline. Commenter felt that this is a violation of both the intent and wording of HB-2600. Much language in this section is word for word from the State of Washington workers' compensation rules, which are of little use in Texas. Because Washington is a single payer state, they utilize an on-line automated paperless system to process pharmacy claims. Very few workers' compensation carriers are set up to handle claims in this manner. Because of this, most of these proposed rules in this section will cause more problems than they will solve. Commenter felt many of the areas addressed in this section have operational concerns. Additionally, many of the items addressed in this section are already addressed in other areas, especially §134.506(a)(2), (c), which flagrantly violates the Texas Labor Code, and (d) of §134.506. Commenter contended that proposed §134.506 is nothing more than additional hoops for pharmacists to jump through to get paid. There is no two-way mechanism for when the carrier has concerns, just one-way. This will result in decreased pharmacists accepting workers' compensation.

RESPONSE: The Commission agrees that §134.506(b) should be removed because they would be somewhat misplaced in this rule. In addition, §134.506(a)(2) has been deleted as unnecessary.

COMMENT: Commenter requested clarification that §134.506(c)(B) applies only to "claimants with a compensable accepted psychiatric disorder"

Commenter suggested that to achieve greater clarity and specificity, this section should incorporate the language in the Mental Health Treatment Guideline. For example, "dependent or toxic" should be modified to be consistent with the language and diagnoses of the Mental Health Treatment Guideline.

Commenter felt that §134.506(c)(5) should be deleted and that it is far too prescriptive and its restrictive concepts cannot even begin to apply appropriately to the extraordinary complicated and numerous variations which occur in the listed clinical circumstances. The list of patient types do not include the many other several circumstances which can or must rely on the use of benzodiazapines to treat IEs.

Commenter suggested that the Commission add SSRI's and MOAI's to the list of drug classifications that are limited to 30 days or remove the restriction altogether. This is too burdensome to track for carriers, doctors and pharmacists to be effective. Benzodiazepines are just one type of psychotropic medication that can be used to treat the same illness as SSRI's and MOAI's.

Commenter contended that the wording on this section does not comply with certain aspects of pain management prescribing practices as established by the standards described previously. For example, some prescriptions are available only in an injectable form but they are used non-injectable routes of administration. Nothing in §408.028 authorized the Commission to prohibit or label as presumptively unreasonable the use of injectable over non-injectable medications or opioids. Limitations as set out in the proposed rules may limit appropriate use of medications.

RESPONSE: The Commission agrees that subsection (c) should be reviewed further to determine whether such reimbursement directions should be included in Commission rules. Therefore it has been removed.

COMMENT: Some commenters believed that §134.506 encourages the payment of prescriptions for conditions not related to the compensable injury and an insurance company should never pay for prescriptions for conditions not related to the compensable injury. The payment of prescriptions for conditions not related to the compensable injury and §134.506 would result in payment of health care benefits not provided for by Texas Labor Code §408.021 and is not in keeping with the intent of the Texas Legislature as expressed in HB-2600. Commenters noted that §134.506(b)(2) and (3) would require the carrier to pay for chemical dependency treatment and detoxification treatment even when the condition did not arise from the compensable injury. Commenters contended that the proposed rule violates the intent of HB-2600 to promote the reduction of pharmaceutical costs and that §134.506 would dramatically increase costs to the system because of the high cost of treatment and any dependency or toxicity due to medications for an unrelated condition will retard recovery of any injury. Commenters point out that the workers' compensation system is not the appropriate mechanism for addressing drug addiction, abuse, or health issues which are not related to the compensable injury and that prescriptions of non-compensable conditions should be paid for by the injured employee's private health care insurance. Commenters recommended that subsection (a)(2) of §134.506 be deleted entirely or that payment for such treatments be voluntary within the sole discretion of the carrier.

Some commenters requested clarification as to how the carrier may grant and terminate "temporary authorization for treatment of unrelated psychiatric disorders" as permitted under subsection (c) of §134.506 without that condition becoming a part of the accepted injury. Commenters recommended specifying that the "temporary" period will end when the non-work injury related

condition is no longer a risk to block recovery or a risk to cause relapse of symptoms directly caused by the work injury.

Other commenters stated that unless something is to be mandated, regulations giving discretionary power to carriers should not be included. Commenters believed that the use of the term "authorize" implies preauthorization, and may produce confusion. Carriers already have the ability to do what §134.506 states. Commenter requested an explanation of the relationship between the proposed rule and §124.3 of this title.

Some commenters suggested that "may" should be changed to "shall" throughout §134.506. A commenter believed that the circumstance and the seriousness of the cancer pain is so severe that the carrier having only discretionary obligations to pay for pain medications is ethically untenable. If any medication is found to be medically necessary for the patient to recover from the compensable injury, it should be reimbursed regardless of setting. The language seems to suggest that the carrier has the option of not paying even though it is medically indicated and there is no mode for preauthorization or pre-certification by the pharmacist. Adoption of such a section might result in unnecessary confusion. One commenter recommended changing the language in subsection (c)(1) to require the payment of anti-spasticity medications if medically indicated. A commenter questioned whether the Commission would rather an injured employee injured employee in the emergency room with intractable pain be admitted to the hospital in order to get an injection of opioid or analgesic rather than be given an injection and sent home at a physician's discretion.

Commenter expressed the belief that "temporary coverage" for prescription medications can be stopped at any time as a strategy for ending paying for a claimant's prescription medications.

Some commenters felt that new requirements in §134.506(d) were unduly burdensome and would add unnecessary expense to the system. A commenter recommended deletion of subsection (d)(2) since other provisions of this section allow contact between the carrier and the provider.

Another commenter recommends removing subsection (d)(5) of §134.506 since patients should not be limited to one doctor. That goes against multiple other rules and law allowing the patient the freedom to choose their health care provider.

A commenter pointed out that there might be situations where the treating and referral doctor may each be treating conditions that would require the writing of a prescription or situations where more than one doctor is taking care of the patient. Commenters stated that there is no statutory authority for limiting an injured employee to one doctor.

Commenter recommended that the following new subsection (d)(6) be added to subsection (d) of §134.506: " Reduce or deny reimbursement of the drugs the injured employee is receiving." Recommend that the word " or" be deleted from subsection (d)(4) and added to the end of subsection (d)(5).

Commenters felt that a specialist of similar training should conduct a required medical exam (RME) if the carrier has not used up their ability to request a RME and have exhausted the other remedies listed here. Unless a specialist performs the examination, the assessment is usually meaningless and simply adds days or weeks to a request for specific intervention usually resulting in a worsening clinical situation. The RME request should come from a carrier doctor so the prescribing physician can call and discuss.

Commenters felt that proposed §134.506 (e) is unnecessary and unwarranted given the fact that Texas Labor Code §408.027 sets out a reasonable time frame for review and payment of a medical bill. The Texas Labor Code does not provide the commission with the authority to adopt a rule that adds an additional and very burdensome duty to an insurance company. The requirement to notify the injured employee, pharmacy, and doctor of the insurer's intent to dispute payment of medical bills associated with a specific prescription drug will add unnecessary costs to the Texas workers' compensation system at a time when the Texas Legislature has directed the commission to reduce costs in the system. Commenter suggested deletion of subsection (e) of §134.506. A commenter asked for clarification as to whether or not a carrier's discontinuation of payment for " one or more drugs" in the regimen after adequate prior notification of 15 days indicated that carriers have authority for denying payment for all prescription medications.

Some commenters supported the language requiring carriers to provide a 15-day notice prior to discontinuing reimbursement for one or more drugs. Commenter felt the establishment of a 15-day notice prior to discontinuing is recognition of the critical requirement that medications must be discontinued or tapered in such extreme conditions in a fashion that will not put the patient's health and life in jeopardy. Unfortunately, the 15-day time period is too short for discontinuation of several medications used to treat chronic pain.

A commenter pointed out that there is no language protecting the patient's rights to confidentiality by communications with various parties.

RESPONSE: The Commission has removed §134.506(a)(2), (b), (c), (d), and (e). The Commission agrees that insurance carriers are only responsible for the payment of medications that are reasonable and medically necessary and related to the compensable injury and has removed discretionary language allowing carriers to pay for medications for unrelated conditions. The Commission disagrees that the wording should be changed to "shall" throughout §134.506 for the reasons stated above. The Commission has elected to remove §134.506(d) and agrees with commenters who stated that many of the options outlined in the subsection were already available or required by other rules. The Commission also agreed with commenters who pointed out that limiting the injured employee to one prescribing doctor may create problems. The Commission agreed with commenters that suggested removal of subsection (e); however, the Commission has elected to place a requirement in §134.502(e) that would notify all parties of a possible denial.

The Commission received some comments that were beyond the scope of the proposed rule changes and could not be tied to specific portions of the proposed rules. In some cases the comments contained criticism of the Commission and other system participants. The Commission has answered all comments that the Commission was able to tie to a specific rule or Commission function.

The new rules are adopted pursuant to the Texas Labor Code §402.042, that authorizes the Executive Director to enter orders as authorized by the statute as well as to prescribe the form and manner and procedure for transmission of information to the commission; the Texas Labor Code §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §406.010, that authorizes the commission to adopt rules necessary to specify the requirements for carriers

to provide claims service and establishes that a person commits a violation if the person violates a rule adopted under this section; the Texas Labor Code §408.021(a), that states an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed; the Texas Labor Code §408.025, that requires the commission to specify by rule what reports a health care provider is required to file; the Texas Labor Code §408.028, as passed by the 77th Texas Legislature, that requires health care practitioners providing care to an employee to prescribe any necessary prescription drugs in accordance with applicable state law; the Texas Labor Code §413.002, that requires the commission to monitor health care providers and insurance carriers to ensure compliance with commission rules relating to health care including medical policies and fee guidelines; the Texas Labor Code §413.011, as passed by the 77th Texas Legislature, that requires the commission by rule to establish medical policies and guidelines relating to necessary treatments for injuries, and fees, designed to ensure the quality of medical care and to achieve effective medical cost control; the Texas Labor Code §413.012, that requires the commission to review and revise medical policies and fee guidelines at least every two years to reflect current medical treatment and fees that are reasonable and necessary; the Texas Labor Code §413.013 (1) (2) and (3), that require the commission by rule to establish a program for prospective, concurrent, and retrospective review and resolution of a dispute regarding health care treatments and services; a program for the systematic monitoring of the necessity of the treatments administered and fees charged and paid for medical treatments or services including the authorization of prospective, concurrent or retrospective review under the medical policies of the commission to ensure the medical policies and guidelines are not exceeded; and a program to detect practices and patterns by insurance carriers in unreasonably denying authorization of payment for medical services requested or performed if authorization is required by the medical policies of the commission; the Texas Labor Code §413.0141, as passed by the 77th Texas Legislature, regarding initial pharmaceutical coverage; the Texas Labor Code §413.017, that establishes presumption of reasonableness of medical services; the Texas Labor Code §413.031, as passed by the 77th Texas Legislature, that entitles a party, including a health care provider, to a review of a medical service for which authorization for payment has been denied or reduced; the Texas Labor Code §415.002, that establishes an administrative violation for an insurance carrier to: unreasonably dispute the reasonableness and necessity of health care, to violate a commission rule or to fail to comply with the Act; the Texas Labor Code §415.003, as passed by the 77th Texas Legislature, that establishes an administrative violation for a health care provider to: administer improper, unreasonable, or medically unnecessary treatment or services, to violate a commission rule, or to fail to comply with the act; and the Texas Labor Code §415.0035, that establishes an administrative violation for an insurance carrier to deny preauthorization in a manner that is not in accordance with commission rules.

The new rules are adopted pursuant to the Texas Labor Code §402.042, §402.061, §406.010, §408.021(a), §408.025, §408.028, §413.002, §§413.011-413.013 (1) (2) and (3), §413.0141, §413.017, §413.031, §415.002, §415.003, and §415.0035.

§134.500. Definitions.

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

(1) Compounding--The combining of a drug with one or more drugs or substances (other than water) as a result of a prescription.

(2) Statement of Medical Necessity--A written statement and supporting documentation from the prescribing doctor to establish the need for treatments or services, or prescriptions, including the need for a brand name drug where applicable. A statement of medical necessity includes the employee's full name, date of injury, social security number or TWCC claim number, and how the services, or prescriptions treat the diagnosis, promote recovery, or enhance the ability of the employee to return to or retain employment.

(3) Nonprescription drug or over-the-counter medication--A non-narcotic drug that may be sold without a prescription and that is labeled and packaged in compliance with state or federal law.

(4) Open formulary--Includes all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs, but does not include drugs that lack FDA approval, or non-drug items.

(5) Prescribing doctor--a doctor who prescribes prescription drugs or over the counter medications in accordance with the doctor's license and state and federal laws and rules.

(6) Prescription--An order from a doctor for a prescription or nonprescription drug to be dispensed.

(7) Prescription drug--

(A) A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public;

(B) A drug that under federal law is required, before being dispensed or delivered, to be labeled with the statement, " Caution: federal law prohibits dispensing without prescription"; or,

(C) A drug that is required by federal or state statute or regulation to be dispensed on prescription or that is restricted to use by a prescribing doctor only.

(b) Section 134, Subchapter F applies to all prescriptions that are prescribed or filled on or after March 1, 2002. For prescriptions filled before March 1, 2002 §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) shall be applicable.

§134.502. Pharmaceutical Services.

(a) A doctor providing care to an injured employee shall prescribe for the employee medically necessary prescription drugs and over-the-counter medication (OTC) alternatives as clinically appropriate and applicable in accordance with applicable state law and as provided by this section.

(1) It shall be indicated on the prescription that the prescription is related to a workers' compensation claim.

(2) When prescribing an OTC medication alternative to a prescription drug, the doctor shall indicate on the prescription the appropriate strength of the medication and the approximate quantity of the OTC medication that is reasonably required by the nature of the compensable injury.

(3) The doctor shall prescribe generic prescription drugs when available and clinically appropriate. If in the medical judgment of the prescribing doctor a brand-name drug is necessary, the doctor must specify on the prescription that brand-name drugs be dispensed

in accordance with applicable state and federal law, and must maintain documentation justifying the use of the brand-name drug, in the patient's medical record.

(4) The doctor shall prescribe OTC medications in lieu of a prescription drug when clinically appropriate.

(b) When prescribing, the doctor shall choose medications and drugs from the formulary adopted by the commission.

(c) The pharmacist shall dispense no more than a 90-day supply of a prescription drug.

(d) Pharmacists shall submit bills for pharmacy services in accordance with §134.800(d) of this title (relating to Required Billing Forms and Information).

(1) Health care providers shall bill using national drug codes (NDC) when billing for prescription drugs.

(2) Compound drugs shall be billed by listing each drug included in the compound and calculating the charge for each drug separately.

(3) A pharmacy may contract with a separate person or entity to process bills and payments for a medical service; however, these entities are subject to the direction of the pharmacy and the pharmacy is responsible for the acts and omissions of the person or entity. Except as allowed by Texas Labor Code § 413.042, the injured employee shall not be billed for pharmacy services.

(e) An insurance carrier shall request a statement of medical necessity from the prescribing doctor before denying reimbursement for prescription or over the counter medications. This request shall be made in accordance with §133.301(d)-(g) of this title (relating to Retrospective Review of Medical Bills). At the time an insurance carrier sends the request for a statement of medical necessity, the carrier shall send the provider of the pharmaceutical services and the employee a copy of the request. The prescribing doctor shall not bill for nor shall the carrier reimburse for the statement of medical necessity.

(f) The employee or pharmacist may request a statement of medical necessity from the prescribing doctor.

(g) The prescribing doctor shall provide a statement of medical necessity to the requesting party no later than the 14th working day after receipt of request.

(h) At the time an insurance carrier reduces or denies payment for medications, the carrier shall send the explanation of benefits to the pharmacist, the employee, and the prescribing doctor.

§134.503. Reimbursement Methodology

(a) The maximum allowable reimbursement (MAR) for prescription drugs shall be the lesser of:

(1) The provider's usual and customary charge for the same or similar service;

(2) The fees established by the following formulas based on the average wholesale price (AWP) determined by utilizing a nationally recognized pharmaceutical reimbursement system (e.g. Redbook, First Data Bank Services) in effect on the day the prescription drug is dispensed.

(A) Generic drugs: ((AWP per unit) x (number of units) x 1.25) + $4.00 dispensing fee = MAR;

(B) Brand name drugs: ((AWP per unit) x (number of units) x 1.09) + $4.00 dispensing fee = MAR;

(C) A compounding fee of $15 per compound shall be added for compound drugs; or

(3) A negotiated or contract amount.

(b) When the doctor has written a prescription for a generic prescription drug or a prescription that does not require the use of a brand-name drug, in accordance with §134.502(a)(3), the pharmacist shall dispense and be reimbursed for the generic pharmaceutical medication.

(c) Reimbursement for over-the-counter medications shall be the retail price of the lowest package quantity reasonably available that will fill the prescription.

(d) This section applies to the dispensing of all drugs except inpatient drugs and parenteral drugs.

(e) Upon request by the provider, the insurance carrier shall disclose the source of the AWP used.

§134.504. Pharmaceutical Expenses Incurred by the Injured Employee

(a) It may become necessary for an injured employee to purchase prescription drugs or over-the-counter alternatives to prescription drugs prescribed or ordered by the treating doctor or referral health care provider. In such instances the injured employee may request reimbursement from the insurance carrier by submitting a request to the carrier.

(b) The injured employee shall submit to the insurance carrier a letter requesting reimbursement along with a receipt indicating the amount paid and a copy of the prescription. The letter should include information to clearly identify the claimant such as the claimant's name, address, date of injury, and social security number.

(c) The insurance carrier shall make appropriate payment to the injured employee in accordance with §134.503, or notify the injured employee of a reduction or denial of the payment within 45 days of receipt of the request for reimbursement from the injured employee. If the insurance carrier does not reimburse the full amount requested, or denies payment the carrier shall include a full and complete explanation of the reason(s) the insurance carrier reduced or denied the payment and shall inform the injured employee of his or her right to request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution). The statement shall include sufficient claim-specific substantive information to enable the employee to understand the insurance carrier's position and/or action on the claim. A general statement that simply states the carrier's position with a phrase such as "not entitled to reimbursement" or a similar phrase with no further description of the factual basis does not satisfy the requirements of this section.

§134.506. Outpatient Drug Formulary

The commission hereby adopts an open formulary as defined in §134.500(a)(4). The carrier shall pay for drugs that are reasonable and medically necessary to treat the compensable injury or occupational disease including prescriptions for off label indications when used in accordance with current medical standards and prescribed in compliance with published contradictions, precautions, and warnings. Over-the-counter medications with a prescription shall be reimbursed in accordance with §134.503 (relating to Reimbursement Methodology).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107938

Susan Cory
General Counsel
Texas Workers' Compensation Commission
Effective date: January 3, 2002
Proposal publication date: August 31, 2001
For further information, please call: (512) 804-4287

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS NATURAL RESOURCE CONSERVATION COMMISSION

CHAPTER 39. PUBLIC NOTICE

The Texas Natural Resource Conservation Commission (TNRCC or commission) adopts amendments to §39.105, Application for a Class 1 Modification of an Industrial Solid Waste, Hazardous Waste, or Municipal Solid Waste Permit and §39.403, Applicability. The commission also adopts new §39.106, Application for Modification of a Municipal Solid Waste Permit or Registration. Sections 39.105, 39.106, and 39.403 are adopted *with changes* to the proposed text as published in the June 8, 2001 issue of the *Texas Register* (26 TexReg 4019). The effective date of the proposed changes in these rules is delayed to effect an orderly transition and implementation of these new requirements.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULES

In 1993, the commission adopted 30 TAC §305.70 concerning Municipal Solid Waste Class I Modifications, which established a process to allow administrative approval of certain changes to municipal solid waste (MSW) permits. The section identified the changes to an MSW facility or operation that qualified for this administrative approval and defined eligible changes as those that are minor, routine in nature, do not substantially alter permit conditions, and maintain or improve environmental protection standards. In addition, the new section was considered a mechanism whereby many facilities would be able to begin compliance with the recently promulgated federal regulations (40 Code of Federal Regulations Part 258 concerning Criteria for Municipal Solid Waste Landfills), commonly referred to as "Subtitle D upgrades," which called for stricter operation, design, and management standards for all MSW landfill facilities. Until the modification rule was adopted, changes to permits to incorporate the new standards could only have been made through the more formal and lengthy amendment process. Under the modification rule, the stricter federal standards were able to be implemented more expeditiously.

The rule required mailed notice in accordance with then-existing §305.103(b) concerning Notice by Mail to certain persons if the permit modification sought was one that was marked with a superscript "1." Although the superscript notation was discussed in the preambles to the proposed and adopted versions of the rule, the superscript did not appear in the published adopted version of the rule. Therefore, an applicant could not be required to provide the mailed notice described in the rule, and the mailed notice provisions once found in §305.103(b) had been relocated to other commission rules.

Since the urgency of implementing Subtitle D upgrades has long since subsided, the commission on May 19, 2000 decided that the use of the §305.70 permit modification process for Subtitle D upgrades would not continue beyond May 19, 2003, and that such a change to a permit can only be accomplished through a major amendment. The commission proposed the repeal of the existing §305.70 and its replacement with a new and expanded §305.70 to implement the May 19 decision and other changes considered necessary. In this rulemaking, the commission has replaced previously-existing §305.70 with a new §305.70 that rectifies the superscript defect, excludes references to obsolete sections, establishes a clearer set of mailed notice requirements, identifies more specifically the changes which can be made to permits through the modification process, expands the modification process to include changes to MSW facility registrations, and reflects the recent commission and legislative decisions regarding Subtitle D upgrades. As part of this rulemaking, §39.105 is amended by transferring and expanding the public notice procedures pertaining to MSW permits into new §39.106, to supplement the public notice requirements of new §305.70. Concurrently, §39.403 is being amended to reflect the change in the title of §39.105 and to reflect the relocation of notice requirements pertaining to MSW facility modifications to the new §39.106.

SECTION BY SECTION DISCUSSION

Section 39.105 has been amended by removing all references to modifications of MSW permits, leaving this section to apply only to Class 1 modifications of an industrial solid waste or hazardous waste permits. Language has been added in new subsection (d) to address the delayed implementation of the section.

New §39.106 will apply only to applications for modification of an MSW permit or registration. Subsection (a) specifies what information shall be included in the text of a modification notice, and states that the mailed notice shall be provided by the person holding the permit or registration. Subsection (b) specifies that when a mailed notice is required by §305.70, such notice shall be mailed to the persons listed in §39.413 concerning Mailed Notice. Subsection (c) had been proposed to specify that notice by publication was required to be provided by a permittee applying for a modification under §305.70(k)(8) (now renumbered as §305.70 (k)(4) concerning Subtitle D upgrades for landfills). However, the requirement to provide published notice for that modification was deleted, so the need for subsection (c) no longer exists and the subsection has been deleted. A new subsection (c) has been added to address the delayed implementation of the section.

Section 39.403(c)(9) has been amended to reflect the change in title of §39.105 which will indicate that notice requirements for applications for modification of MSW permits will no longer be covered under §39.105.

Section 39.403(c)(10) has been amended to indicate that notice requirements for applications for modification of MSW permits and registrations will now be covered under new §39.106.

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission has reviewed the rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute and it does not meet any of the four applicability requirements listed in §2001.0225(a). Major environmental rule means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of

the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. As for the four applicability requirements, the adoption does not exceed a standard set by federal law, exceed an express requirement of state law, exceed a requirement of any delegation agreement or contract between the state, the commission, and an agency or representative of the federal government, nor is the rulemaking performed solely under the general powers of the agency. Additionally, the rulemaking is not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the purpose of the adopted rules is to clarify the requirements for providing notice when making changes to permits and registrations for MSW facilities. Comments on the draft regulatory impact analysis were solicited, and no comments were received.

TAKINGS IMPACT ASSESSMENT

The commission has prepared a takings impact assessment for the rulemaking under Texas Government Code, §2007.043. The following is a summary of that assessment. The specific purpose of the rulemaking is to revise the commission rules to clarify procedures for public participation in the processing of applications for modifications of MSW permits and registrations. The rules relate to procedures for providing public notice and providing opportunity for public comment. The rules will substantially advance these stated purposes by clarifying and providing specific provisions on the aforementioned matters. Promulgation and enforcement of these rules will not affect private real property which is the subject of the rules because the rulemaking consists of amendments and a new section relating to the commission's procedural rules.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission has reviewed the rulemaking and found that the adopted rules are neither identified in Texas Coastal Coordination Act Implementation Rules, 31 TAC §505.11, relating to Actions and Rules Subject to the Coastal Management Program, nor will they affect any action or authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11. Therefore, the rulemaking is not subject to the Texas Coastal Management Program (CMP).

HEARING AND COMMENTERS

The commission held a public hearing on the proposal in Austin on August 17, 2001. The original comment period did not provide for a public hearing; however, Clean Water Action requested that a public hearing be held on the proposal. Therefore, a public hearing was scheduled and the close of the comment period was extended to August 17, 2001.

Clean Water Action and Henry, Lowerre and Frederick (CWAT/HLF) submitted joint comments. Other commenters were the Texas Chapter of the National Solid Wastes Management Association (NSWMA); Republic Services, Inc. (RSI); Waste Management of Texas, Inc. (WMT); and TNRCC Public Interest Counsel (PIC). Comments provided by NSWMA also were endorsed by El Paso Disposal (EPD); G. O. Weiss, Inc. (GOW); Olympic Waste Services (OWS); Texas Disposal Systems Landfill, Inc. (TDSL); and Trinity Waste Services (TWS). NSWMA, RSI, and WMT recommended withdrawal of the proposed rules which included changes to Chapter 39 and Chapter 305. Texas Department of Transportation conducted a review of the proposed changes to Chapter 39 as they relate to the CMP but offered no comment or suggestion. The Municipal Solid Waste Management and Resource Recovery Advisory Council (Council) recommended withdrawal of the proposed rules but subsequently indicated its support of the rule proposal in general as further described herein.

The Council discussed these rules at meetings conducted by the Council on June 8, 2001, September 7, 2001, and November 19, 2001. At these meetings, the Council elaborated on and modified its written comments submitted during the formal comment period. Although the Council had originally recommended to withdraw the proposed rules, it later indicated that it supported the majority of the proposed rules as modified in response to comments.

RESPONSE TO COMMENTS

NSWMA, RSI, and WMT commented that the proposed rules should be withdrawn, due to the negative impact on the waste industry.

Although only WMT specifically addressed the proposed changes to Chapter 39, they are part of the overall proposed rulemaking which the other commenters recommended for withdrawal. The commission considers that the changes to Chapter 39 are an integral part of the modification process and are necessary to bring the public notification procedures for MSW modifications in line with the procedures in use by other agency programs. Therefore, the commission does not agree that the rules should be withdrawn, and has adopted the rule amendments with only a minor change.

HLF/CWAT and PIC commented that public notice text requirements in §39.106(a) should include a description of the public comment procedures, the location where the public may obtain access to the application, and the procedures on how to be placed on a mailing list. PIC commented that the rules should include a 30-day period for the public to submit written comments prior to TNRCC approval of the application, and provide for a TNRCC response to those comments. PIC also commented that the text of the notice should provide information on the right to file a Motion to Overturn the Executive Director's Action, and that notice should be delivered by certified mail.

The commission does not agree that a requirement for TNRCC response is appropriate for the type of changes being made through the modification process, and has not revised the rule based on these comments. A response to comments, in accordance with 30 TAC §55.101, is mandatory only for applications filed under Texas Health and Safety Code (THSC), Chapter 361 and does not apply to the modification procedures. The commission agrees that procedures for being placed on a mailing list and on the availability of the application at the TNRCC regional office or other local location are appropriate and has revised §39.106(a) to include these information requirements. The commission also agrees that a public comment period should be provided and has incorporated an opportunity for comment into these rules. Information on filing a Motion to Overturn the Executive Director's Action will be provided by the chief clerk with notice of issuance. Delivery of the notice by other than first-class mail is inconsistent with other TNRCC modification notice procedures and the commission has not revised §39.106(a) based on this comment.

NSWMA and WMT commented that expanded mail notice goes far beyond notification requirements in the former permit modification rules. NSWMA commented that changes to a facility

would be of interest only to adjacent property owners, and that notification of governmental agencies and public officials as required in §39.106(b) is unnecessary, burdensome for facilities with a large number of neighboring property owners, and will discourage change and improvement. RSI commented that the notice requirements may fuel controversy or opposition, and adversely affect relations between the facility and the surrounding community. WMT commented that the rules will afford no additional environmental protection, and that compliance will be virtually impossible and inordinately costly, while creating less flexibility for efficient operation.

The commission acknowledges that the public notice requirements in §39.106 are more extensive than were intended for the former permit modification rules. However, the requirements in §39.106(b) are identical to notice requirements for other TNRCC programs and are in response to legislative direction for expanded public notice relating to permit actions. The commission believes that the large majority of permit modifications will not require public notice and that the estimated cost of notice, at $.45 per notice, will not be overly burdensome even to sites with large numbers of property owners within 500 feet. The commission does not agree that notifying neighboring landowners and public officials of proposed permit revisions will hinder improvements, reduce flexibility or operational efficiency, or that concern over controversy adequately justifies eliminating notice, and has not changed the rules based on these comments.

SUBCHAPTER B. PUBLIC NOTICE OF SOLID WASTE APPLICATIONS

30 TAC §39.105, §39.106

STATUTORY AUTHORITY

The amendment and new section are adopted under Texas Water Code, §5.103, which provides the commission the authority to adopt and enforce rules necessary to carry out its powers and duties under the laws of this state; THSC, §361.011, which provides the commission all powers necessary and convenient to carry out its responsibilities concerning the regulation and management of MSW; §361.024, which provides the commission authority to adopt and promulgate rules consistent with the general intent and purposes of THSC; §361.061, which provides the commission the authority to require and issue permits authorizing and governing the construction, operation, and maintenance of the solid waste facilities used to store, process, or dispose of solid waste under THSC, Chapter 361; and §361.064, which authorizes the commission to prescribe the form of and reasonable requirements for the permit application; and the procedures for processing the application.

§39.105. Application for a Class 1 Modification of an Industrial Solid Waste or Hazardous Waste Permit.

(a) Notice requirements for Class 1 modifications are in §305.69 of this title (relating to Solid Waste Permit Modification at the Request of the Permittee) for industrial solid waste or hazardous waste permits.

(b) The text of required notice shall follow the requirements of §39.11 of this title (relating to Text of Public Notice) and the additional requirements in §305.69 of this title.

(c) When mailed notice is required, the applicant shall mail notice to the persons listed in §39.13 of this title (relating to Mailed Notice).

(d) The effective date of the amendment of existing §39.105 of this title (relating to Application for a Class 1 Modification of an Industrial Solid Waste, Hazardous Waste, or Municipal Solid Waste Permit) and this new §39.106 of this title (relating to Application for Modification of a Municipal Solid Waste Permit or Registration) is June 3, 2002. Applications for modifications filed before this amended section and new §39.106 of this title become effective, will be subject to this section as it existed prior to June 3, 2002.

§39.106. Application for Modification of a Municipal Solid Waste Permit or Registration.

(a) When mailed notice is required under §305.70 of this title (relating to Municipal Solid Waste Permit and Registration Modifications), the mailed notice shall be mailed by the permit or registration holder and the text of the notice shall comply with §39.411(b)(1) - (3), (6), (7), (9), and (12) of this title (relating to Text of Public Notice), and shall provide the location and phone number of the appropriate regional office of the commission to be contacted for information on the location where a copy of the application is available for review and copying.

(b) When mailed notice is required by §305.70 of this title (relating to Municipal Solid Waste Permit and Registration Modifications), notice shall be mailed by the permit or registration holder to the persons listed in §39.413 of this title (relating to Mailed Notice).

(c) The effective date of the amendment of existing §39.105 of this title (relating to Application for a Class 1 Modification of an Industrial Solid Waste, Hazardous Waste, or Municipal Solid Waste Permit) and this new §39.106 is June 3, 2002. Applications for modifications filed before amended §39.105 of this title and this new §39.106 become effective, will be subject to §39.105 of this title as it existed prior to June 3, 2002.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 10, 2001.

TRD-200107715
Stephanie Bergeron
Division Director, Environmental Law Division
Texas Natural Resource Conservation Commission
Effective date: December 30, 2001
Proposal publication date: June 8, 2001
For further information, please call: (512) 239-5017

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SUBCHAPTER H. APPLICABILITY AND GENERAL PROVISIONS

30 TAC §39.403

STATUTORY AUTHORITY

The amendment is adopted under Texas Water Code, §5.103, which provides the commission the authority to adopt and enforce rules necessary to carry out its powers and duties under the laws of this state; THSC, §361.011, which provides the commission all powers necessary and convenient to carry out its responsibilities concerning the regulation and management of MSW; and §361.024, which provides the commission authority to adopt and promulgate rules consistent with the general intent

and purposes of the THSC; §361.061, which provides the commission the authority to require and issue permits authorizing and governing the construction, operation, and maintenance of the solid waste facilities used to store, process, or dispose of solid waste under THSC, Chapter 361; and §361.064 which authorizes the commission to prescribe the form of and reasonable requirements for the permit application; and the procedures for processing the application.

§39.403. Applicability.

(a) Permit applications that are declared administratively complete on or after September 1, 1999 are subject to Subchapters H - M of this chapter (relating to Applicability and General Provisions; Public Notice of Solid Waste Applications; Public Notice of Water Quality Applications; Public Notice of Air Quality Applications; Public Notice of Injection Well and Other Specific Applications; and Public Notice for Radioactive Material Licenses). Permit applications that are declared administratively complete before September 1, 1999 are subject to Subchapters A - F of this chapter (relating to Applicability and General Provisions; Public Notice of Solid Waste Applications; Public Notice of Water Quality Applications and Water Quality Management Plans; Public Notice of Air Quality Applications; Public Notice of Other Specific Applications; and Public Notice for Radioactive Material Licenses). All consolidated permit applications are subject to Subchapter G of this chapter (relating to Public Notice for Applications for Consolidated Permits). The effective date of the amendment of existing §39.403, specifically with respect to subsections (c)(9) and (10), is June 3, 2002. Applications for modifications filed before this amended section becomes effective will be subject to this section as it existed prior to June 3, 2002.

(1) Explanation of applicability. Subsection (b) of this section lists all the types of applications to which Subchapters H - M of this chapter apply. Subsection (c) of this section lists certain types of applications that would be included in the applications listed in subsection (b) of this section, but that are specifically excluded. Subsections (d) and (e) of this section specify that only certain sections apply to applications for radioactive materials licenses or voluntary emission reduction permits.

(2) Explanation of organization. Subchapter H of this chapter contains general provisions that may apply to all applications under Subchapters H - M of this chapter. Additionally, in Subchapters I - M of this chapter, there is a specific subchapter for each type of application. Those subchapters contain additional requirements for each type of application, as well as indicating which parts of Subchapter H of this chapter must be followed.

(3) Types of applications. Unless otherwise provided in Subchapters H - M of this chapter or Subchapter G of this chapter, public notice requirements apply to applications for new permits, concrete batch plant air quality exemptions from permitting or permits by rule, and applications to amend, modify, or renew permits.

(b) As specified in those subchapters, Subchapters H - M of this chapter apply to notices for:

(1) applications for municipal solid waste, industrial solid waste, or hazardous waste permits under the Texas Solid Waste Disposal Act, Texas Health and Safety Code, Chapter 361;

(2) applications for wastewater discharge permits under Texas Water Code, Chapter 26, including:

(A) applications for the disposal of sewage sludge or water treatment sludge under Chapter 312 of this title (relating to Sludge Use, Disposal, and Transportation); and

(B) applications for individual permits under Chapter 321, Subchapter B of this title (relating to Concentrated Animal Feeding Operations).

(3) applications for underground injection well permits under Texas Water Code, Chapter 27, or under the Texas Solid Waste Disposal Act, Texas Health and Safety Code, Chapter 361;

(4) applications for production area authorizations under Chapter 331 of this title (relating to Underground Injection Control);

(5) contested case hearings for permit applications or contested enforcement case hearings under Chapter 80 of this title (relating to Contested Case Hearings);

(6) applications for radioactive material licenses under Chapter 336 of this title (relating to Radioactive Substance Rules), except as provided in subsection (e) of this section;

(7) applications for consolidated permit processing and consolidated permits processed under Texas Water Code, Chapter 5, Subchapter J, and Chapter 33 of this title (relating to Consolidated Permit Processing);

(8) applications for air quality permits under Texas Health and Safety Code, §382.0518 and §382.055. In addition, applications for permit amendments under §116.116(b) of this title (relating to Changes to Facilities), initial issuance of flexible permits under Chapter 116, Subchapter G of this title (relating to Flexible Permits), amendments to flexible permits under §116.710(a)(2) and (3) of this title (relating to Applicability) when an action involves:

(A) construction of any new facility as defined in §116.10(4) and (10) of this title (relating to General Definitions);

(B) modification of an existing facility as defined in §116.10(9) of this title which result in an increase in allowable emissions of any air contaminant emitted equal to or greater than the emission quantities defined in §106.4(a)(1) of this title (relating to Requirements for Exemptions from Permitting) and of sources defined in §106.4(a)(2) and (3) of this title; or

(C) other changes when the executive director determines that:

(i) there is a reasonable likelihood for emissions to impact a nearby sensitive receptor;

(ii) there is a reasonable likelihood of high nuisance potential from the operation of the facilities;

(iii) the application involves a facility or site for which the compliance history contains violations which are unresolved or constitute a recurring pattern of conduct that demonstrates a consistent disregard for the regulatory process;

(iv) there is a reasonable likelihood of significant public interest in a proposed activity; or

(9) applications subject to the requirements of Chapter 116, Subchapter C of this title (relating to Hazardous Air Pollutants: Regulations Governing Constructed or Reconstructed Major Sources (FCAA, §112(g), 40 Code of Federal Regulations Part 63)), whether for construction or reconstruction;

(10) concrete batch plants registered under Chapter 106 of this title (relating to Exemptions from Permitting) unless the facility is to be temporarily located in or contiguous to the right-of-way of a public works project;

(11) applications for voluntary emission reduction permits under Texas Health and Safety Code, §382.0519;

(12) applications for permits for electric generating facilities under Utilities Code, §39.264;

(13) Water Quality Management Plan (WQMP) updates processed under Texas Water Code, Chapter 26, Subchapter B.

(c) Notwithstanding subsection (b) of this section, Subchapters H - M of this chapter do not apply to the following actions and other applications where notice or opportunity for contested case hearings are otherwise not required by law:

(1) applications for authorizations under Chapter 321 of this title (relating to Control of Certain Activities by Rule), except for applications for individual permits under Subchapter B of that chapter;

(2) applications for registrations and notifications under Chapter 312 of this title;

(3) applications under Chapter 332 of this title (relating to Composting);

(4) applications under Chapter 122 of this title (relating to Federal Operating Permits);

(5) applications under Chapter 116, Subchapter F of this title (relating to Standard Permits);

(6) applications under Chapter 106 of this title, except for concrete batch plants specified in subsection (b) (10) of this section.

(7) applications under §39.15 of this title (relating to Public Notice Not Required for Certain Types of Applications) without regard to the date of administrative completeness;

(8) applications for minor amendments under §305.62(c)(2) of this title (relating to Amendment). Notice for minor amendments shall comply with the requirements of §39.17 of this title (relating to Notice of Minor Amendment) without regard to the date of administrative completeness;

(9) applications for Class 1 modifications of industrial or hazardous waste permits under §305.69(b) of this title (relating to Solid Waste Permit Modification at the Request of the Permittee). Notice for Class 1 modifications shall comply with the requirements of §39.105 of this title (relating to Application for a Class 1 Modification of an Industrial Solid Waste or Hazardous Waste Permit), without regard to the date of administrative completeness, except that text of notice shall comply with §39.411 of this title (relating to Text of Public Notice) and §305.69(b) of this title;

(10) applications for modifications of municipal solid waste permits and registrations under §305.70 of this title (relating to Municipal Solid Waste Permit and Registration Modifications). Notice for modifications shall comply with the requirements of §39.106 of this title (relating to Application for Modification of a Municipal Solid Waste Permit or Registration), without regard to the date of administrative completeness;

(11) applications for Class 2 modifications of industrial or hazardous waste permits under §305.69(c) of this title. Notice for Class 2 modifications shall comply with the requirements of §39.107 of this title (relating to Application for a Class 2 Modification of an Industrial or Hazardous Waste Permit), without regard to the date of administrative completeness, except that text of notice shall comply with §39.411 of this title and §305.69(c) of this title;

(12) applications for minor modifications of underground injection control permits under §305.72 of this title (relating to Underground Injection Control (UIC) Permit Modifications at the Request of the Permittee);

(13) applications for minor modifications of Texas Pollutant Discharge Elimination System (TPDES) permits under §305.62(c)(3) of this title; or

(14) applications for registration and notification of sludge disposal under §312.13 of this title (relating to Actions and Notice).

(d) Applications for initial issuance of voluntary emission reduction permits under Texas Health and Safety Code, §382.0519 and initial issuance of electric generating facility permits under Texas Utilities Code, §39.264 are subject only to §39.405 of this title (relating to General Notice Provisions), §39.409 of this title (relating to Deadline for Public Comment, and for Requests for Reconsideration, Contested Case Hearing, or Notice and Comment Hearing), §39.411 of this title, §39.418 of this title (relating to Notice of Receipt of Application and Intent to Obtain Permit), §39.602 of this title (relating to Mailed Notice), §39.603 of this title (relating to Newspaper Notice), §39.604 of this title (relating to Sign-Posting), §39.605 of this title (relating to Notice to Affected Agencies), and §39.606 of this title (relating to Alternative Means of Notice for Voluntary Emission Reduction Permits), except that any reference to requests for reconsideration or contested case hearings in §39.409 of this title or §39.411 of this title shall not apply.

(e) Applications for Radioactive Materials Licenses under Chapter 336 of this title are not subject to §§39.405(c) and (e), 39.418, 39.419, 39.420, and certain portions of §39.413 of this title (relating to Mailed Notice).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 305. CONSOLIDATED PERMITS
SUBCHAPTER D. AMENDMENTS, RENEWALS, TRANSFERS, CORRECTIONS, REVOCATION, AND SUSPENSION OF PERMITS

The Texas Natural Resource Conservation Commission (commission) adopts the repeal of §305.70, Municipal Solid Waste Class I Modifications. The commission also adopts new §305.70, Municipal Solid Waste Permit and Registration Modifications. New §305.70 is adopted *with changes* to the proposed text as published in the June 8, 2001 issue of the *Texas Register* (26 TexReg 4042). The repeal is adopted *without changes* and will not be republished.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE ADOPTED RULE

In 1993, the commission adopted §305.70, Municipal Solid Waste Class I Modifications, which established a process to

allow administrative approval of certain changes to municipal solid waste (MSW) permits. The section identified the changes to an MSW facility or operation that qualified for this administrative approval and defined eligible changes as those that are minor, routine in nature, do not substantially alter permit conditions, and maintain or improve environmental protection standards. In addition, the new section was considered a mechanism whereby many facilities would be able to begin compliance with the recently promulgated federal regulations (40 Code of Federal Regulations (CFR) Part 258 concerning Criteria for Municipal Solid Waste Landfills), commonly referred to as "Subtitle D upgrades," which called for stricter operation, design, and management standards for all MSW landfill facilities. Until the modification rule was adopted, changes to permits to incorporate the new standards could only have been made through the more formal amendment process. Under the modification rule, the stricter federal standards were able to be implemented more expeditiously.

The rule required mailed notice in accordance with then-existing §305.103(b) concerning Notice by Mail to certain persons if the permit modification sought was one that was marked with a superscript "1." Although the superscript notation was discussed in the preambles to the proposed and adopted versions of the rule, the superscript did not appear in the published adopted version of the rule. Therefore, an applicant could not be required to provide the mailed notice described in the rule, and the mailed notice provisions once found in §305.103(b) had been relocated to other commission rules.

Although §305.70 only specifically addressed changes to MSW permits, the executive director utilized the rule to process minor changes to permitted and registered MSW facilities since adoption of the rule in 1993. The rule was used to process minor changes to registered facilities as there was otherwise no authorization process, other than that required for a new registration, to make minor changes to an existing registered facility.

Over the years, the executive director identified other permit and registration changes that were more appropriately handled through the modification process and generally processed those applications under §305.70(i). The language in this "catch all" provision was subject to a continuing debate over what permit changes §305.70(i) could or should cover. The effective date of the changes in this rule is delayed to effect an orderly transition and implementation of these new requirements.

SECTION BY SECTION DISCUSSION

Since the urgency of implementing Subtitle D upgrades has long since subsided, the commission on May 19, 2000 decided that the use of the §305.70 permit modification process for Subtitle D upgrades would not continue beyond May 19, 2003, and that such a change to a permit can only be accomplished through a major amendment. The commission proposed the repeal of the existing §305.70 and its replacement with a new and expanded §305.70 to implement the May 19 decision and other changes considered necessary. Subsequently, House Bill (HB) 2912, 77th Legislature, 2001, amended Chapter 361, Texas Health and Safety Code (THSC), to add §361.120, which requires a major permit amendment to implement a Subtitle D upgrade for landfills which have stopped accepting waste for a period of five years or longer. The governor signed HB 2912 on June 15, 2001 with an effective date of September 1, 2001 for §361.120. Therefore, the provisions of §361.120 have been incorporated in this rule under §305.70(k)(4). The May 19, 2003 deadline for the Subtitle D upgrade remains in effect for any facilities not subject to THSC, §361.120.

This rule rectifies the superscript defect, excludes references to obsolete sections, establishes a clearer set of mailed notice requirements, clarifies that the rule applies to both permitted and registered MSW facilities, identifies more specifically the changes which can be made to registrations and permits through the modification process, and reflects recent legislation and the commission decision regarding Subtitle D upgrades.

The adopted rule reflects a change in philosophy to allow owners and operators the flexibility to implement those changes that are necessary to improve day-to-day operations or to prevent nuisance problems without a long wait for agency approval, provided they meet expected performance standards and do not result in a decrease in protection of the environment or public health and safety. Examples of changes which will not require a modification are changes to eliminate interim fill sectors or cells, improvements to a safety or fire protection plan, changes in interior road design or construction materials, use of alternative windblown control measures, and addition of visual screening devices. Facilities exempt from permitting or registration will not be regulated under a permit or registration if they are located in non-waste management areas, as long as they do not affect drainage. Instead of requiring approval by modification, temporary use of alternative daily cover, and temporary changes in operating hours may be approved by the executive director under §305.70(m).

FINAL REGULATORY IMPACT ANALYSIS DETERMINATION

The commission has reviewed the rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in that statute and it does not meet any of the four applicability requirements listed in §2001.0225(a). Major environmental rule means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. As for the four applicability requirements, the rulemaking does not exceed a standard set by federal law; exceed an express requirement of state law; exceed a requirement of any delegation agreement or contract between the state, the commission, and an agency or representative of the federal government; nor are the repeal and new rule adopted solely under the general powers of the agency. Additionally, the rulemaking is not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the purpose of the rulemaking is to clarify and simplify the process for making changes to permits and registrations for MSW facilities. The commission solicited public comment on the draft regulatory impact analysis determination, and comments received are addressed in the RESPONSE TO COMMENTS section of this preamble.

TAKINGS IMPACT ASSESSMENT

The commission has prepared a takings impact assessment for this rulemaking under Texas Government Code, §2007.043. The following is a summary of that assessment. The specific purpose of the rulemaking is to repeal the existing rule and replace

it with a new rule which will specifically identify those modifications for which public notice must be given, remove references to obsolete sections, establish a clearer set of mailed notice requirements, clarify that the section applies to both permitted and registered MSW facilities, identify more specifically the changes which can be made to registrations and permits through the modification process, and reflect the recent commission decision that Subtitle D upgrades may be implemented only through a major permit amendment after May 19, 2003. The rulemaking will substantially advance the stated purpose by clarifying and providing specific provisions on the aforementioned matters. Promulgation and enforcement of this rule will not burden or affect private real property which is the subject of the rule because the new rule is only an update of the repealed rule, providing current references, clarification of procedures, and more specific information on the type of modifications that can be made to permitted and registered MSW facilities. The rule is applicable only to entities which have permits or registrations for MSW facilities. Therefore, this rulemaking will not constitute a takings under Texas Government Code, Chapter 2007.

CONSISTENCY WITH THE COASTAL MANAGEMENT PROGRAM

The commission has reviewed this rulemaking and found that the rulemaking is subject to the Texas Coastal Management Program (CMP) and must be consistent with all applicable goals and policies of the CMP. The commission has prepared a consistency determination for this rulemaking under 31 TAC §505.22 and has found that the rulemaking is consistent with the applicable CMP goals and policies. The following is a summary of that determination. The CMP goals applicable to the rulemaking are the goals to protect, preserve, restore, and enhance the diversity, quality, quantity, functions, and values of coastal natural resource areas (CNRAs). Applicable policies are those related to the regulation of solid waste facilities in 31 TAC §501.14(d)(1)(I) and (d)(2). These policies require that solid waste facilities be sited, designed, constructed, and operated to prevent releases of pollutants that may adversely affect CNRAs and, at a minimum, comply with standards established under the federal Solid Waste Disposal Act, and that the commission shall comply with the policies in 31 TAC §501.14(d) when issuing permits and adopting rules under THSC, Chapter 361. The specific purpose of the rulemaking is to repeal an existing rule and replace it with a new rule which will specifically identify those modifications for which public notice must be given, remove references to obsolete rules, establish a clearer set of mailed notice requirements, clarify that the rule applies to both permitted and registered MSW facilities, identify more specifically the changes which can be made to registrations and permits through the modification process, and reflect the recent commission decision that landfill permit upgrades to meet standards under Subtitle D of the federal Solid Waste Disposal Act may be implemented only through a major permit amendment after May 19, 2003. Promulgation and enforcement of the adopted rule will be consistent with the applicable CMP goals and policies, and the rule will not reduce the capability of a facility to protect human health and the environment. The commission solicited public comment on the applicability of the CMP and on the consistency determination of the proposed rule, and the only responder was the Texas Department of Transportation, who stated that it had reviewed the proposed amendments for consistency with state law and had no comments or suggestions to offer.

HEARING AND COMMENTERS

The commission held a public hearing on the proposal in Austin on August 17, 2001. The original comment period did not provide for a public hearing; however, Clean Water Action requested that a public hearing be held on the proposal. Therefore, a public hearing was scheduled and the close of the comment period was extended to August 17, 2001. Fifteen commenters submitted comments during the public comment period. Five of the six commenters who provided oral comments at the public hearing also had submitted written comments.

The rulemaking was generally opposed by the Texas Chapter of the National Solid Wastes Management Association (NSWMA); Republic Services, Inc. (RSI); the Lone Star Chapter of the Solid Waste Association of North America (TxSWANA); Texas Disposal Systems Landfill, Inc. (TDSL); and Waste Management of Texas, Inc. (WMT). Comments provided by NSWMA were also endorsed by El Paso Disposal (EPD); G. O. Weiss, Inc. (GOW); Olympic Waste Services (OWS); TDSL; and Trinity Waste Services (TWS). TWS, NSWMA, RSI, and WMT recommended withdrawal of the proposed rule. The Municipal Solid Waste Management and Resource Recovery Advisory Council (Council) recommended withdrawal of the proposed rule but subsequently indicated its support of the rule proposal in general as further described herein.

Clean Water Action Texas and Henry, Lowerre and Frederick (CWAT/HLF) submitted joint comments, the commission's Public Interest Counsel (PIC), and one individual recommended changes to the rule package. The Texas Department of Transportation conducted a review of the proposed rule as it relates to the CMP but offered no comment or suggestion.

The Council discussed this rule at meetings conducted by the Council on June 8, 2001, September 7, 2001, and November 19, 2001. At these meetings, the Council elaborated on and modified its written comments submitted during the formal comment period. Although the Council had originally recommended to withdraw the proposed rule, it later indicated that it supported the majority of the proposed rule as modified in response to comments.

RESPONSE TO COMMENTS

NSWMA, RSI, and WMT commented that the proposed rule should be withdrawn, due to the negative impact on the waste industry.

The commission believes that the proposed rule required revisions in response to comments, but does not agree that the rule should be withdrawn. The commission believes that this rule is necessary to provide a process for allowing minor changes to registered facilities, for establishing mailed notice requirements for appropriate permit and registration changes, for more specifically identifying changes which can be made to registrations and permits through the modification process, and for reflecting recent legislation and commission decisions regarding Subtitle D upgrades. The commission believes that the modification process has shown to be useful for implementing minor changes necessary for day-to-day operations in lieu of requiring a new registration or a permit amendment, and that this rule will facilitate the process for making those changes for MSW facilities.

CWAT/HLF commented that proposed §305.70 expands the limitations on modifications, allows substantive changes that will not maintain or improve protection of human health and the environment, and that the changes represent a major environmental rule, subject to Texas Government Code, §2001.0225.

The commission does not agree that §305.70 expands the limits on conditions that can be revised through the modification process or that it will allow substantive changes to permit or registration conditions, and has not revised the rule based on these comments. The expansion is the result of adding to the list of specifically listed modifications, those modifications which were more commonly requested under a "catch-all" provision of previously existing §305.70(i). The commission believes that adding the more commonly requested "catch-all" modifications to the specific list of allowable modifications will provide a ready aid to the regulated community and staff for identifying what changes can be processed as modifications without having to evaluate each non-listed modification request through a screening committee to determine if it qualifies as a modification. The rule provides that modifications apply to minor changes to an MSW facility or its operation that do not substantially alter the permit or registration conditions and do not reduce the capability of the facility to protect human health and the environment. An application for a substantive change to a permit or registration condition would not meet these criteria and could not be processed using the modification procedures. The commission does not agree that §305.70 is a major environmental rule as defined in the Texas Government Code, or that it meets any of the four applicability requirements listed in §2001.0225(a), that is, that it exceeds a standard set by federal law; exceeds an express requirement of state law; exceeds a requirement of any delegation agreement or contract between the state, the commission, and an agency or representative of the federal government; or that the rule is adopted solely under the general powers of the agency.

CWAT/HLF commented that the changes will adversely affect public health, environment, land values, and other property interests, and that the fiscal notes and cost/benefit analysis ignored the public impact from the rule. One individual commented that the commission failed to perform an extensive impact statement on affected parties such as landfill owners/operators.

The commission has not changed the rule based on these comments. The commission performed an evaluation of the rulemaking impact and believes the rule will not adversely affect in a material way the economy, a sector of the economy (including landfill owners/operators), productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the purpose of the rule is to clarify and simplify the process for making changes to permits and registrations for MSW facilities.

CWAT/HLF commented that the rule will result in additional costs and burden to the state as operators attempt to achieve large changes to the permit through a piecemeal approach, and recommended that the commission impose a limit of two modifications in a 12-month period.

The commission anticipates that operators may utilize this rule to update facility permits or registrations; however, the criteria in §305.70(d), which provides that modifications apply to minor changes to an MSW facility or its operation that do not substantially alter the permit or registration conditions and do not reduce the capability of the facility to protect human health and the environment, will prevent an influx of applications from operators attempting a piecemeal approach to major changes. The commission believes that eliminating the ability to accommodate unanticipated changes at a facility through a maximum allowable number of modifications is not justifiable and has not changed the rule in response to these comments.

CWAT/HLF and NSWMA commented that the need for the rule has not been adequately explained, and CWAT/HLF commented that a record of factual support for the changes must be created. NSWMA, RSI, TxSWANA, and WMT commented that the rule is unnecessary, will discourage innovation and environmental improvement at facilities, and that the rule attempts to include excessive detail into permits, requiring an increased need for permit modifications that will burden both the regulated community and the commission. NSWMA, TxSWANA, and WMT commented that the rule attempts to regulate previously unregulated and non-MSW activities is contrary to the commission's stated performance-based regulatory approach, and will result in an increased number of violations with far-reaching impacts due to an increased emphasis on compliance history.

The commission believes that owners/operators of public and private sector facilities clearly and repeatedly have demonstrated a need to make minor changes to their permits/registrations to meet changing industry conditions or as a means to resolve notices of violation from the commission. During the four-year period 1997 - 2000, the commission processed approximately 450 - 650 modification requests annually, with approximately 50% of the modifications processed under the "catch-all" provision, former §305.70(i). The commission believes that adding the more-commonly requested "catch-all" modifications to the specific list of allowable modifications in this rule will provide a ready aid to the regulated community and staff for identifying what changes can be processed as a modification without having to evaluate each non-listed modification request through a screening committee to determine if it qualifies as a modification. The commission does not agree that §305.70 will discourage innovations in the MSW industry, or that it regulates previously unregulated or non-MSW activities, or that it will result in an increased need for permit modifications. The modification was a previously existing requirement for making minor changes to a permit, including conditions in the Site Development Plan and Site Operating Plan. Many permits and registrations were written with very specific requirements or conditions that have resulted in notices of violation from normal operational changes. The commission encourages applicants to include language in the permit/registration applications that meets regulatory requirements and allows flexibility and innovation in daily operational needs; however, a modification has been and is necessary to replace existing language with performance-based measures. When used for this purpose, the commission believes that the modifications will result in a reduced potential for notices of violation.

TxSWANA commented that emphasis should be on identifying the basis for amendments or general categories of changes that would be processed as an amendment or a modification, and that a list of changes requiring only notification should be created. TxSWANA commented that a list of modifications can never be comprehensive and that the commission should clarify that the purpose of this rule is not to create a new basis upon which operators can be found liable, but to codify listed changes that have been considered modifications in the past.

The commission has not changed the rule based on these comments. The commission agrees that a list of major changes requiring a permit amendment or a list of minor activities which require no review or approval would be useful. However, the commission believes it has been demonstrated that both lists would be far less utilized than the modification process. The commission acknowledges that the modifications in §305.70 do not represent new modifications, nor are they intended to comprise a

comprehensive list. The modifications listed in §305.70(j) include many of the more commonly requested modifications processed for MSW owners/operators under the "catch-all" provision of the former §305.70(i), and serve as examples of the types of activities that may be processed as a modification. A provision remains under §305.70(l) for accommodating non-listed changes that may qualify as modifications.

CWAT/HLF commented that the use of the term "special conditions" in §305.70(a) is not clear, leaving both the term and rule subject to interpretation.

The commission agrees that the term is not defined and has removed the word "special" from the rule, clarifying applicability to regulated MSW activities and any conditions specifically ordered by the commission or included by the executive director as a result of negotiations between the applicant and interested persons.

One individual commented that §305.70(b) should be revised to indicate that the terms "permit" and "registration" include only the documents and attachments defined in 30 TAC Chapter 330, Subchapter E.

The commission has not changed the rule based on this comment. The documents pertaining to the permit or registration are defined in MSW regulations and the commission believes this definition will not be clarified further by the suggested language.

NSWMA and TxSWANA commented that §305.70(c) should be revised to read "maximum limit of waste acceptance." PIC commented that the reference to Type V facilities should be deleted to indicate applicability to all types of facilities.

The commission agrees with the commenters that the suggested revisions clarify restriction to a previously established maximum volume and that the restriction may apply to other than Type V facilities. Section 305.70(c) has been revised to include these changes.

PIC commented that §305.70(d) should be revised to state "except as provided in subsection (k)," to clarify that no changes other than those listed in §305.70(k) would be considered.

The commission believes that modifications other than those specifically listed in subsection (k) may be appropriate when accompanied by public notice, and the ability to request those modifications should not be limited. However, the commission has revised §305.70(d) to clarify that modifications processed under §305.70(k) still must be changes that are minor in nature, and which do not substantially alter the permit or registration conditions, do not reduce the capability of the facility to protect human health and the environment, but which may have a greater potential to affect neighboring landowners.

One individual commented that §305.70(e) should allow that a permittee or registrant who has filed a modification request would not be subject to a notice of violation (NOV) in the related area if commission review of the request is pending.

The commission has not changed the rule based on this comment. Owners/operators currently have the ability to refute NOVs and the commission believes the suggested revision would not be of benefit to either the inspection or modification procedures.

NSWMA and TxSWANA commented that language in §305.70(f) should be revised from "shall result in the application being returned" to "may result in the application..." to allow discretion in returning an application.

The commission agrees that the rule should allow discretion in the return of an application and has revised §305.70(f) to allow this flexibility. Section 305.70(f) specifies administrative and signatory requirements for submitting an application.

One individual, CWAT/HLF, and PIC commented that the rule should require that one copy be sent directly to the commission's regional office. PIC also recommended that one copy be submitted directly to the commission's Central Records.

The commission agrees that the application should be more easily available to potentially affected parties and has included requirements for delivery to the appropriate commission regional office. Routing to Central Records from the MSW Permits Section ensures proper identification of the submittal prior to insertion in the public record, and the commission has not included a requirement for delivery to Central Records in the rule.

CWAT/HLF commented that §305.70(f) appeared to eliminate the use of a notice of deficiency (NOD) to require additional information in conflict with §305.70(g), and that applicants should provide a sworn statement of justification.

Section 305.70(f) relates to additional administrative requirements and the commission does not agree that this subsection conflicts with actions provided for in §305.70(g), which is related to response resulting from technical review. The commission believes that the documentation of accuracy provided by the signatory certification required in §305.44 is adequate and has not revised the rule based on these comments.

One individual commented that §305.70(f) should describe in detail what constitutes an engineering document rather than referring to a regulatory citation.

The reference in §305.70(f) to engineering seal and signatory requirements in §330.51(d), does not pertain to document definition, and the rule has not been changed based on this comment.

One individual commented that a specific review time should be identified in §305.70(g) rather than requiring an action within a 60-day period. NSWMA commented that the rule may allow staff to delay action on the application until after the public notice period has expired or until near the completion of the 60-day review period. NSWMA, RSI, WMT, and one individual commented that the option in §305.70(g)(4) to extend the commission review period will result in an unpredictable response time, placing an unnecessary burden on the permittee. CWAT/HLF commented that the 60- day deadline for commission action is inadequate for public participation, and does not provide the commission adequate time to respond to public comment.

The commission agrees that §305.70(g) provides adequate response options without §305.70(g)(4), and has removed this provision and the requirement in §305.70(g)(3) for resubmitting an application in response to an agency request for information. The commission believes the schedule for commission action must provide staff adequate time to review application materials and the flexibility to accommodate varying workloads, without being overly burdensome to the regulated community. The commission believes this can be accomplished through the 60-day review period and has retained it in §305.70(g). The rule has been revised to more clearly identify time frames for the comment and response periods, and the commission has deleted reference to a major amendment in §305.70(g)(5). Municipal solid waste permits may be revised under the procedures for minor amendments, as defined in §305.62(c), and §305.70(g)(5) has been revised to not exclude these procedures. The commission

acknowledges that response to public comment may not be accommodated by the 60-day time frame but a response to comments, in accordance with 30 TAC §55.101, is mandatory only for applications filed under THSC, Chapter 361 and does not apply to the modification procedures.

One individual stated that §305.70(h) should be revised to include an option for the permittee to request a meeting to discuss an application prior to completion of the commission review.

The commission has not changed the rule based on this comment. Owners/operators may request a meeting with the commission at any time to discuss permit issues, and the commission does not believe provisions to request a meeting are necessary in the rule.

NSWMA and WMT commented that mailed notice requirements in §305.70(i) are excessive, unprecedented, and will be burdensome to operators and commission staff. NSWMA commented that notice should be eliminated or required of only a few activities, and TxSWANA stated that mailed notice should be limited to a post-approval procedure. RSI and WMT commented that the required notice may fuel controversy over landfill operations, and adversely impact community relations. CWAT/HLF commented that all modifications should have some form of notice as do the industrial and hazardous waste rules, and that notice for only some activities has not been justified. One individual commented that the public notice requirements are unfairly burdensome to the operators when activities improve facility operations and that notice should be removed from the rule because it is not required for permit modifications by the Administrative Procedure Act. The commenter also stated that notice may be misinterpreted by a potentially affected party, and expressed concern that a modification might be denied solely on community opposition to an application.

The commission believes that a pre-approval notice is appropriate to allow affected parties an opportunity to review the application and to provide the executive director with information they believe necessary for proper evaluation, and has revised the rule to provide a Notice of Application and Preliminary Decision after technical review is complete but before action is taken on the application. Only a limited list of modifications require notice in this rule. Although the ability to require notice for unspecified modifications has been retained in §305.70(l), the commission anticipates that the majority of future §305.70 applications will not require public notice. The commission does not agree that public concern is equal for MSW and hazardous waste facilities, or that mailed notice is necessary for every operational change at an MSW site. However, the commission believes that public notice should be required when an activity has a potential to affect neighboring landowners or the community even if those activities may improve facility operations (e.g., alternate daily cover), and that a pre-approval notice is necessary to allow those parties an opportunity to review the application. Public comment will be considered if provided during the evaluation period; however, opposition to an application does not in itself constitute adequate justification for denial by the commission.

NSWMA commented that the phrase "in order to qualify" should be deleted from §305.70(j) because it creates uncertainty that the listed items will be processed as modifications.

The commission has deleted the phrase "in order to qualify" from §305.70(j) and clarified that the listed items may be processed as a modification when meeting the requirements in §305.70(d).

CWAT/HLF commented there is an apparent conflict between §305.70(j)(2)(B) and (5).

The commission agrees that §305.70(j)(2)(B) appears to conflict with §305.70(j)(5) and has removed §305.70(j)(2)(B) from the rule.

NSWMA commented that authorization under §305.70(j)(7) will discourage activities necessary to facility operation and should be required only if not specified by the permit. CWAT/HLF commented that language and the difference in language of §305.70(j)(7) and (k)(10) are very unclear.

The commission does not believe that the location of an MSW management activity as described in §305.70(j)(7) is inconsequential or that it need not be reflected on the site plan. The commission also disagrees that requiring that it be shown on the site plan will discourage new facility operations. Activities under §305.70(j)(7), other than registrations, may be evaluated for impact to drainage but otherwise have only general regulatory requirements. Section 305.70(k)(6) includes activities subject to an approval process other than registration. The commission has revised §305.70(j)(7) and (k)(6) to clarify applicability to MSW facilities and activities.

NSWMA commented that language in §305.70(j)(8) regarding the addition of a wash pad should be deleted. PIC commented that §305.70(j)(8) should exclude changes to all gate locations and suggested clarification regarding the addition of a wash pad.

The commission intends that the reference to the entry gate in §305.70(j)(8) refers only to changes at the site entrance and does not include changes to other on-site gates. The commission believes if a wash pad is constructed on-site, it should be shown on the site plan, but acknowledges that this activity does not fit the category of a frequently submitted modification and has adopted the suggested revision.

NSWMA, RSI, and WMT commented that §305.70(j)(10) seeks too much detail, impairing the ability to conduct normal operations. PIC commented that reference to equipment changes should be deleted from §305.70(j)(10) to allow evaluation of changes on a case-by-case basis for the necessity of public notice.

The commission agrees that the language in §305.70(j)(10) allows an overly-broad interpretation of changes necessitating revision to permit documents and has revised this provision to encourage operators to incorporate performance-based requirements for existing operational needs. The commission does not agree that public notice should be required for equipment changes which comply with criteria in §305.70(d).

WMT commented that §305.70(j)(7), (10) - (12), (14), and (17) represent needless control over daily operations, and are contrary to the stated goal of flexibility.

The commission acknowledges that some revision of the proposed rule in response to the comment was appropriate for §305.70(j)(10) and has revised it deleting §305.70(j)(12) and (14). However, the commission disagrees that the modifications listed in this rule will impede the goal of flexibility and believes the modification process is necessary to reflect changes in minor permit conditions and essential for the replacement of overly-specific or outdated operational requirements.

NSWMA commented that §305.70(j)(11) should be revised to clarify that only improvements can be made to internal drainage.

The commission does not agree that §305.70(j)(11) should exclude changes which produce equivalent internal stormwater run-on/run-off controls and has revised §305.70(j)(11) to allow minor changes to internal drainage features that result in no impact to offsite drainage, to provide additional flexibility in operations.

NSWMA commented that changes referenced in §305.70(j)(12) are unclear and should be deleted.

The commission agrees that changes to perimeter roads, berms, or the buffer resulting from alteration of the drainage system would be accommodated in an application for drainage system revisions and has deleted the proposed §305.70(j)(12) and replaced it with the formerly- proposed §305.70(k)(1)(B).

NSWMA, TxSWANA, and WMT commented that §305.70(j)(14) relates to non-MSW activities and should be removed.

The commission does not agree that access to a borrow area to acquire daily cover material for the landfill, as referenced in §305.70(j)(14), is an activity unrelated to the management of solid waste. However, the commission agrees that §305.70(j)(14) is too narrowly worded and has deleted it from the rule and replaced it with the formerly-proposed §305.70(k)(2).

NSWMA commented that §305.70(j)(17) should include a maximum distance for monitor well replacement.

The commission believes that a monitor well replacement must be based on equivalent or improved performance and has not added a specific distance within which a well can be relocated in §305.70(j)(17). The commission made a minor revision to §305.70(j)(17) for consistency in use of the term "monitoring well."

PIC recommended that language be added to §305.70(j)(4) - (6), (9), (18) - (21), and (23) to explicitly state that these changes will maintain or provide for increased protection.

The commission believes that requiring applications submitted under §305.70(j)(4) - (6), (9), (18) - (21), and (23) to maintain or provide for increased protection is unnecessary inasmuch as §305.70(d) already requires that modifications not reduce the capability of a facility to provide protection, thereby also providing the option to maintain or increase protection. However, the commission has determined that some changes to a landfill gas collection system may be necessary to comply with air emission requirements and that a delay for an MSW permit modification could result in a violation of other (not MSW) permit requirements. Section 305.70(j)(21) has been revised to ensure that operators are not inadvertently placed in violation of other permit requirements.

PIC commented that language should be deleted from §305.70(j)(23) to limit changes to the Groundwater Sampling and Analysis Plan.

The Groundwater Sampling and Analysis Plan contains information relating to many aspects of the sampling program and the commission does not agree that revisions to the plan should be limited to only those specified in §305.70(j)(23). The commission has not changed the rule based on this comment, but has revised §305.70(j)(23) to clarify this flexibility.

CWAT/HLF commented that §305.70(j)(26) is an activity that should require a major amendment.

The commission agrees that except as allowed for sites performing an upgrade to meet the requirements of 40 CFR Part 258 in accordance with §305.70(k)(4), the installation of a groundwater monitoring system where one had not previously existed requires a permit amendment, and has removed §305.70(j)(26) from the rule. The succeeding subsections have been renumbered accordingly.

NSWMA commented that financial assurance updates are required by rule and §305.70(j)(30) - (32) should not be processed as modifications.

The commission agrees that financial assurance updates for inflation should not be permit modifications, but believes that other revisions to closure cost estimates which affect financial assurance or financial assurance for corrective action as referenced in §305.70(j)(30) - (32), should be reflected as requirements of the site permit. Reference to §330.281 and §330.283 concerning Closure for Landfills; and Post-Closure Care for Landfills has been included in §305.70(j)(30) for clarification. The commission has combined §305.70(j)(30) and (31) and has removed reference to registered and exempted facilities to eliminate repetitive language and redundant financial assurance requirements.

PIC recommended minor revisions to clarify the subparagraphs under §305.70(k)(1). NSWMA, RSI, and TxSWANA commented that §305.70(k)(1)(B) should not require notice if an activity is already authorized in the permit.

The commission agrees that a previously authorized activity, as described under §305.70(k)(1)(B), should not require public notice and has moved this activity to §305.70(j)(12). The commission also believes that many changes to the sequence of landfill development have no impact on adjoining property owners and has relocated this activity to §305.70(j)(32) with a provision that changes which would potentially affect the adjacent property owners or community will require notice. If evaluation indicates that the sequence change will result in the development of an area where landfilling could have been reasonably expected not to have occurred for several years and which may adversely affect an adjoining landowner as a result, public notice will be required in accordance with §305.70(i). The commission believes §305.70(k)(4) (relating to changes to entry gate location that do not alter access traffic patterns) represents an activity of dissimilar impact compared to the remaining modifications in §305.70(k), and has relocated this activity to §305.70(j)(33). The succeeding paragraphs have been renumbered accordingly.

NSWMA and TxSWANA commented that metes and bounds changes described under §305.70(k)(2) should require a permit amendment.

The commission agrees that substantial changes to metes and bounds descriptions require a permit amendment, and has revised §305.70(k)(2) to allow minor changes to boundary description and has moved this activity to §305.70(j)(14). The succeeding paragraphs have been renumbered accordingly.

NSWMA commented that authorization to use alternate daily cover under §305.70(k)(3) should be subject to revocation if site conditions deteriorate.

The commission agrees that authorization of alternate daily cover under §305.70(k)(3) can be revoked if site conditions deteriorate; however, this is true of any modification and the commission has not changed the rule based on this comment.

PIC recommended a minor revision to clarify §305.70(k)(5)(F).

The commission has made the recommended revision to §305.70(k)(5)(F) by inserting "or" between the two clauses.

NSWMA and TxSWANA commented that post-closure use under §305.70(k)(7) should not require notice for non-MSW activities or changes in compatible use, as long as landfill integrity is maintained. WMT commented that the intent of §305.70(k)(7) is unclear.

The commission agrees that notice may not be justified for all changes in post-closure use under §305.70(k)(7) and has included reference to §330.255 concerning Post-Closure Land Use, which requires executive director approval for activities that may disturb the final cover and relocated this modification to §305.70(j)(28) with a provision that changes which would potentially affect the adjacent property owners or community will require notice. The succeeding paragraphs have been renumbered accordingly.

NSWMA and TxSWANA commented that §305.70(k)(8) should be revised to maintain consistency with HB 2912, and NSWMA noted that revisions also will be necessary for §330.1(a). CWAT/HLF commented that §305.70(k)(8) should require a permit amendment, and NSWMA commented that the provision limiting the applicant to three NODs should be deleted. PIC recommended a minor revision to clarify §305.70(k)(8).

Section 305.70(k)(8) has been renumbered to §305.70(k)(4) and has been revised to incorporate the applicable provisions of HB 2912. The commission agrees that the Subtitle D upgrade should require a major amendment and established a deadline of May 19, 2003 for completion of the upgrade as a modification. The commission agrees that a maximum allowance of three NODs should not be in the rule and has deleted it from §305.70(k)(4), with revisions for clarification. The commission does not believe it is necessary to revise §330.1(a) concerning Declaration and Intent and does not intend to open that section for revision at this time. The provisions of §330.1(a) and §305.1(a) provide overlapping authorities to assure that the provisions of THSC, §361.120, as adopted under HB 2912 are enforced, including the requirement that an owner or operator of an MSW landfill facility comply with any other applicable federal rules, laws, regulations, or other requirements.

NSWMA, RSI, TxSWANA, and WMT commented that §305.70(k)(9) could discourage or delay the installation of upgraded gas collection systems, and NSWMA and TxSWANA commented that notice should not be applied to gas system additions or well replacements. CWAT/HLF commented that gas system revisions performed under §305.70(k)(9) might be less protective to public health.

The commission agrees that voluntary improvements to a landfill gas collection system should not require notice and has revised §305.70(k)(9), now renumbered as §305.70(k)(5), to indicate that notice will be provided when remedial action is required by MSW regulation. Changes less protective of the environment do not meet the criteria in §305.70(d) and cannot be processed as a modification.

NSWMA and TxSWANA commented that §305.70(k)(10) should not require notice if an activity is allowed by the permit but not identified for a specific location and, with RSI and WMT commented that the rule is subject to interpretation and should not require notice for unspecified "changes" or "activities." TxSWANA commented that §305.70(k)(10) should not require notice for the deletion of an activity.

The commission does not agree that notice should be eliminated for an activity of the type in §305.70(k)(10), now renumbered as §305.70(k)(6), if it has been authorized for an unspecified location. However, the commission has revised §305.70(k)(6) to include only the more commonly-requested activities. The commission believes that these activities may potentially impact adjacent landowners and notice is an appropriate action. The commission also does not agree that "changes" is subject to interpretation other than might occur in everyday usage, and believes the examples under §305.70(k)(6) illustrate the types of activities being referenced. The commission agrees that the deletion of an activity should not require public notice and has deleted it from §305.70(k)(6).

NSWMA commented that the provision for public notice at the executive director's discretion in §305.70(l) should be eliminated and that notice should apply only to specific modifications. TxSWANA commented that the "catch-all" provision for processing modifications not identified under §305.70(j) and (k) produces uncertainty as to what may qualify as a modification, thereby inhibiting effective planning.

The rule has been revised to clarify that modification applications which require public notice must be of similar impact as modifications listed in subsection (k). The commission believes it requires discretion in determining if an application meets the criteria for a modification under §305.70(d) and §305.70(e), and if mailed notice is appropriate for an application. The commission has retained flexibility in determining application eligibility and the necessity for mailed notice, in lieu of requiring a permit amendment. A reference to §305.70(i) has been added to highlight notification requirements.

NSWMA expressed concern that staff may attempt to apply the temporary authorizations under §305.70(m) to non-MSW or other on-site activities not included in the permit activities, noting that activities conducted in an emergency situation might be considered a violation of the permit. NSWMA and TxSWANA commented that language regarding temporary authorizations in former §305.70 should be retained. PIC commented that public notice should be provided if an applicant seeks a temporary authorization, and recommended that the six-month extension for use of alternate daily cover be deleted.

The commission does not agree that a request for authorization, which is initiated by the owner/operator, can be used by staff to impose operational requirements in lieu of a permit modification, and has retained subsection (m). The temporary authorization is intended to allow permittees additional flexibility in addressing changes in daily operations, including unexpected conditions or emergency situations. To meet these goals, the rule has been revised to include a verbal authorization process for emergency situations, and authorization of activities necessary to prevent the disruption of waste management activities. The commission does not believe public notice is consistent with this objective and has not included it in the rule. The commission agrees with PIC that a six-month period is adequate to evaluate alternate daily cover, but believes that additional time may be necessary to evaluate cover effectiveness for odor and vector control as a result of varying seasonal or climatic conditions. The possible extension under §305.70(m) has been revised to include that condition.

NSWMA and TxSWANA commented that the timing of the motion to overturn under §305.70(n) should be adjusted to fit a post-approval public notice procedure.

The commission has not changed the rule based on these comments. The commission believes the pre-approval public notice

is necessary to provide an adequate amount of time for public review of an application and related materials.

30 TAC §305.70

STATUTORY AUTHORITY

The repeal is adopted under Texas Water Code, §5.103, which provides the commission the authority to adopt and enforce rules necessary to carry out its powers and duties under the laws of this state; THSC, §361.011, which provides the commission all powers necessary and convenient to carry out its responsibilities concerning the regulation and management of MSW; §361.024, which provides the commission authority to adopt and promulgate rules consistent with the general intent and purposes of THSC; §361.061, which provides the commission the authority to require and issue permits authorizing and governing the construction, operation, and maintenance of the solid waste facilities used to store, process, or dispose of solid waste under THSC, Chapter 361; and §361.064, which authorizes the commission to prescribe the form of and reasonable requirements for the permit application; and the procedures for processing the application.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 10, 2001.

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Texas Natural Resource Conservation Commission
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For further information, please call: (512) 239-5017

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30 TAC §305.70

STATUTORY AUTHORITY

The new section is adopted under Texas Water Code, §5.103, which provides the commission the authority to adopt and enforce rules necessary to carry out its powers and duties under the laws of this state; THSC, §361.011, which provides the commission all powers necessary and convenient to carry out its responsibilities concerning the regulation and management of MSW; §361.024, which provides the commission authority to adopt and promulgate rules consistent with the general intent and purposes of THSC; §361.061, which provides the commission the authority to require and issue permits authorizing and governing the construction, operation, and maintenance of the solid waste facilities used to store, process, or dispose of solid waste under THSC, Chapter 361; and §361.064, which authorizes the commission to prescribe the form of and reasonable requirements for the permit application; and the procedures for processing the application.

§305.70. Municipal Solid Waste Permit and Registration Modifications.

(a) This section applies only to modifications to municipal solid waste (MSW) permits and registrations related to regulated MSW activities. Modifications to industrial and hazardous solid waste permits are covered in §305.69 of this title (relating to Solid Waste Permit Modification at the Request of the Permittee). Changes to conditions in an MSW permit or registration which were specifically ordered by the commission following the contested hearing process or included by the executive director as a result of negotiations between the applicant and interested persons during the permitting/registration process are not eligible for modification under this section. The effective date of the repeal of existing §305.70 of this title (relating to Municipal Solid Waste Class I Modifications) and replacement with this new §305.70 of this title (relating to Municipal Solid Waste Permit and Registration Modifications) is June 3, 2002. Applications for modifications filed before this new section becomes effective, will be subject to the section as it existed prior to June 3, 2002.

(b) References to the term "permit" in this section include the permit document and all of the attachments thereto as further defined in 30 TAC Chapter 330, Subchapter E, §§330.50 - 330.64 of this title (relating to Permit Procedures). References to the term "registration" in this section include the registration document and all of the attachments thereto as further defined in Chapter 330, Subchapter E of this title.

(c) Except as provided in subsection (k) of this section, any increase in the landfill capacity authorized for waste disposal or any increase in the permitted or registered daily maximum limit of waste acceptance shall be subject either to the requirements of §305.62(c)(1) of this title (relating to Amendment) in the case of a permitted facility, or to the requirements of a new registration in the case of a registered facility.

(d) Permit and registration modifications apply to minor changes to an MSW facility or its operation that do not substantially alter the permit or registration conditions and do not reduce the capability of the facility to protect human health and the environment.

(e) A permittee or registrant may implement a modification to an MSW permit or registration provided that the permittee or registrant has received prior written authorization for the modification from the executive director. In order to receive prior written authorization, the permittee or registrant must submit a modification application to the executive director which includes, at a minimum, the following information:

(1) a description of the proposed change;

(2) an explanation detailing why the change is necessary;

(3) appropriate revisions to all applicable narrative pages and drawings of Attachment A of a permit or a registration (i.e., a site development plan, site operating plan, engineering report, or any other approved plan attached to a permit or a registration document). These revisions shall be marked and include revision dates and notes as necessary in accordance with §330.51(e)(4) of this title (relating to Permit Application for Municipal Solid Waste Facilities) and §330.64(b) and (c) of this title (relating to Additional Standard Permit Conditions for Municipal Solid Waste Facilities);

(4) a reference to the specific provision under which the modification application is being made; and

(5) for those modifications submitted in accordance with subsection (l) that the executive director determines that notice is required and for those listed in subsection (k) of this section, an updated landowners map and an updated landowners list as required under §330.52(b)(4)(D) and (b)(5) of this title (relating to Technical Requirements of Part I of the Application).

(f) The permittee or registrant must submit one original and two copies of the modification application in accordance with §305.44 of this title (relating to Signatories to Applications). The applicant shall provide one of the two copies to the appropriate commission regional office. Failure to submit the modification application with complete

information may result in the application being returned to the permittee or registrant without further action. Engineering documents must be signed and sealed by the responsible licensed professional engineer as required by §330.51(d) of this title.

(g) The following shall guide the processing of applications for modification of permits and registrations:

(1) For an application for a modification that does not require notice, if at the end of 60 calendar days after receipt of the permit or registration modification application the executive director has not taken one of the following five steps, the application shall be automatically approved:

(A) approve the application, with or without changes, and modify the permit or registration accordingly;

(B) deny the application;

(C) provide a notice-of-deficiency letter requiring additional or clarified information regarding the proposed change;

(D) determine that the application does not qualify as a registration modification, and that the requested change requires a new application for registration; or

(E) determine that the application does not qualify as a permit modification and that the requested change requires an amendment to the permit in accordance with §305.62(c) of this title.

(2) For an application for a modification that requires notice, technical review shall be completed within 60 calendar days of receipt of the permit or registration modification application, unless the review period is extended by the executive director in writing if needed to resolve outstanding notice of deficiencies. Upon completion of the comment period, the executive director may do one of the following.

(A) If no comments are received, the executive director may grant the application on the 28th calendar day (unless extended by the executive director) after the notice requirements have been met as evidenced by the certification of notice filed with the chief clerk. The application is automatically approved if not acted on by the 28th calendar day (unless extended by the executive director) after the notice requirements have been met as evidenced by the certification of notice filed with the chief clerk.

(B) If comments are received, the executive director may take one of the steps listed in paragraph (1) of this subsection on or before the 45th calendar day (unless extended by the executive director) after the notice requirements have been met as evidenced by the certification of notice filed with the chief clerk. The application is automatically approved if not acted on by the 45th calendar day (unless extended by the executive director) after the notice requirements have been met as evidenced by the certification of notice filed with the chief clerk.

(h) If an application for a permit or registration modification is denied by the executive director, the permittee or registrant must comply with the original permit or registration conditions.

(i) If a permit or registration modification is listed in subsection (k) of this section or if a permit or registration modification application is made under subsection (l) of this section and the executive director determines that notice is required, the permittee or registrant must prepare and provide Notice of Application and Preliminary Decision after technical review is complete in accordance with 30 TAC §39.106 of this title (relating to Application for Modification of a Municipal Solid Waste Permit or Registration). If notice is required, the applicant must file a current landowner list under §305.70(e)(5) of this title and §39.413(1) of this title (relating to Mailed Notice). The notice shall state that a person may provide the commission with written comments on the application within 23 days after the date the applicant mails notice. Before acting on an application, the executive director shall review and consider any timely written comments. The executive director is not required to file a response to comments. Prior to approval of a modification application, the permittee or registrant must file certification, on a form prescribed by the executive director, that notice was provided as required by §39.106 of this title. The chief clerk shall mail notice of issuance of a modification in accordance with 30 TAC §50.133(b) of this title (relating to Executive Director Action on Application or WQMP Update). Section 50.133(b) of this title does not apply to modifications which do not require notice under subsection (j) or (l) of this section.

(j) Paragraphs (1) - (33) of this subsection are allowable permit and registration modifications if they meet the criteria in subsection (d) of this section (i.e., they must apply to minor changes to an MSW facility or its operation that do not substantially alter the permit or registration conditions and do not reduce the capability of the facility to protect human health and the environment):

(1) the establishment of a trench or area that will accept brush and construction demolition waste and rubbish only (also known as a Type IV area) if the trench or area is located within the disposal footprint specified in the site development plan or municipal solid waste landfill (MSWLF) permit;

(2) changes in excavation details for landfills, except for changes that would:

(A) increase the depth or lateral extent of the disposal footprint as described in the site development plan or permit; or

(B) increase the disposal capacity of the landfill facility;

(3) changes to the landfill marker systems (e.g., from a grid based upon geographic coordinates to a grid based upon survey coordinates);

(4) changes in sampling frequency (e.g., for groundwater and landfill gas monitoring systems);

(5) submittal of a new Soils and Liner Quality Control Plan (SLQCP) or changes to an existing SLQCP;

(6) changes in closure or post-closure care plans;

(7) changes to the site layout plan that add or delete a properly registered or exempted MSW facility/activity, provided that the facility/activity either requires a registration or would be exempt were it located offsite (e.g., a used or scrap tire collection area, a compost operation, a recycling collection area, a liquid waste processing facility, a registered transfer station, a citizens' collection area used for collection of non-putrescible recyclable materials either stockpiled or collected in bins, a citizens' collection station, a beneficial landfill gas recovery plant, a brush collection/chipping/mulching area, stockpiles of non-putrescible recyclable materials, etc.);

(8) changes in the site layout, other than entry gate location, that relocate the gatehouse, office or maintenance building locations, or that add scales to the facility;

(9) changes in the design details for a solidification basin;

(10) changes to existing provisions in the site development plan, site operating plan, engineering report, the Part A application form of a permit or registration, or of any other approved plan regarding minimum equivalent performance-based requirements for operating personnel or operating equipment needs;

(11) changes in the drainage control plan that significantly alter internal stormwater run-on/run-off control without impacting offsite drainage or increasing landfill disposal capacity. Changes may include revisions to topslopes and sideslopes of landfills which may cause adjustment to approved final contours;

(12) the addition of design and operational requirements in accordance with §330.137 of this title (relating to the Disposal of Industrial Wastes) for the opening of a dedicated trench or area that will accept Class 1 nonhazardous industrial waste, provided that the landfill permit authorizes the acceptance of that waste and that the dedicated trench or area is located within the disposal footprint specified in the site development plan or MSWLF permit;

(13) changes to the approved final contours and approved final slopes with no height or capacity increase over the maximum permitted height or capacity, due to sequence of development changes that reduce the waste disposal area;

(14) corrections in the metes and bounds description of the permit or registration boundary that reduce the size of the facility and that do not result in permit or registration acreage beyond the original permit or registration boundary;

(15) a change in the facility records storage area from an onsite to an offsite location;

(16) the addition of a compost plan (a plan containing instructions and procedures to ensure collection of the composting refund, as cited in Texas Health and Safety Code, §361.0135) to the site operating plan of an MSWLF;

(17) new monitoring wells that replace existing monitoring wells (e.g., landfill gas or groundwater monitoring wells) that have been damaged or rendered inoperable, with no change to the design or depth of the wells or to the monitoring system design;

(18) changes to an existing leachate collection system design or installation of a new leachate collection system;

(19) installation of a landfill gas monitoring system;

(20) changes to an existing landfill gas monitoring system design;

(21) changes to an existing landfill gas collection system design, unless the changes are made for the purpose of complying with other permits in which case the changes do not require prior approval under this section before implementation. Notification of changes made to a landfill gas collection system in order to comply with other permits shall be sent within 30 days to the executive director and the appropriate commission regional office;

(22) changes to comply with the provisions of §330.203 of this title (relating to Special Conditions (Liner Design Constraints));

(23) submittal of a new Groundwater Sampling and Analysis Plan (GWSAP) or changes to an existing GWSAP;

(24) submittal of a new waste acceptance plan or the addition of detailed narrative or design drawings which provide details for the acceptance of waste streams authorized within the permit or registration (e.g., Class 1 nonhazardous industrial waste);

(25) revisions to an existing waste acceptance plan to include waste streams authorized by the permit or registration;

(26) upgrade of an existing landfill groundwater monitoring system so long as there is no increase in depth or design of wells or well system or change in groundwater characterization as defined in Chapter 330, Subchapter I of this title (relating to Groundwater Monitoring and Corrective Action), in which case the changes would have to be requested as an amendment under §305.62 of this title;

(27) the plugging of groundwater monitoring wells when the executive director has determined that the plugging of groundwater monitoring wells is appropriate in various situations including, but not limited to, when a facility has completed the post-closure maintenance period, when an obsolete groundwater monitoring system is being replaced with a new groundwater monitoring system, or when a damaged groundwater monitoring well is being replaced;

(28) changes to post-closure use of a landfill in accordance with §330.255 of this title (relating to Post-Closure Land Use) during the post-closure care period unless the changes would potentially affect the adjacent property owners or community in which case notice in accordance with §39.106 of this title would be required;

(29) substitution of an equivalent financial assurance mechanism;

(30) changes to a closure or post-closure care cost estimate required under §330.281 and §330.283 of this title (relating to Closure for Landfills; and Post-Closure Care for Landfills) that result in an increase/decrease in the amount of financial assurance required if the increase/decrease in the cost estimate is due to an increase/decrease in the maximum area requiring closure;

(31) changes in the amount of financial assurance required as the result of corrective action;

(32) changes in the sequence of landfill development unless the changes would potentially affect the adjacent property owners or community in which case notice in accordance with §39.106 of this title would be required; and

(33) changes to the entry gate location that do not alter access traffic patterns delineated in the permit or registration;

(k) Paragraphs (1) - (6) of this subsection are modifications which require notice. For those modifications requiring notice, the permittee or registrant must send notice of the modification application by first-class mail in accordance with §39.106 of this title and to all persons listed in §39.413 of this title:

(1) the use of an alternate daily cover material on a permanent basis in accordance with §330.133(c) of this title (relating to Landfill Cover);

(2) an increase in the height of a landfill over the maximum permitted height of the landfill in accordance with the following criteria:

(A) Authorization to increase the height of a landfill may only be granted as a modification one time per facility. Subsequent applications for an increase in height require a major permit amendment in accordance with §305.62 of this title.

(B) A height increase shall be limited to ten feet at any one or several points above the originally permitted final contour elevations for the purpose of improving drainage.

(C) A revised final contour plan shall be prepared and submitted with the application. The plan must detail the revised final contours and include design calculations demonstrating that the proposed design provides the necessary runoff capability and controls, including erosion controls.

(D) The waste disposal area may not be expanded beyond the disposal footprint specified in the landfill permit.

(E) A height increase cannot result in a rate of waste disposal greater than noted in the landfill permit.

(F) A height increase can only be granted for one of the following situations:

(i) the entire facility will cease the receipt of solid waste within 365 days of the approval of the height increase (including the additional fill authorized by the height increase) and initiate formal closure of the entire facility; or

(ii) the height increase is requested solely for the purpose of improving the surface water drainage from the fill area;

(3) a modification in the operation of a landfill that will change the incoming waste stream to a more restrictive waste stream (i.e., a change from a Type I, II, or III landfill operation to a Type IV landfill operation). The modification may be granted if the receipt of waste under the present operation ceases once the modification is approved; the filled portion of the landfill will be closed in accordance with Chapter 330, Subchapter J of this title (relating to Closure and Post-Closure); and the modification application details changes to the site development plan and site operating plan as appropriate to reflect the proposed change in operation;

(4) upgrade of a permitted landfill facility to meet the requirements of 40 Code of Federal Regulations Part 258 (relating to Criteria for Municipal Solid Waste Landfills). An upgrade may be approved as a modification until May 19, 2003 except as prohibited by Texas Health and Safety Code, §361.120;

(5) installation of a landfill gas collection system for a landfill gas remediation plan in accordance with §330.56(n) of this title (relating to Attachments to the Site Development Plan); and

(6) changes to a site layout plan that add or relocate a liquid waste solidification facility or a petroleum-contaminated soil stabilization area.

(l) In case of an application for a permit or registration modification for a change not listed in subsection (j) or (k) of this section, the executive director shall make a determination as to whether the change is eligible to be processed as a permit or registration modification and if the change requires public notice in accordance with subsection (i) of this section. In making this determination, the executive director shall consider if the requested change meets the criteria in subsections (d) and (e) of this section. Public notice shall be reserved for modification applications of similar impact as modifications listed in subsection (k) of this section.

(m) In order to obtain a temporary authorization, a permittee or registrant shall request a temporary authorization and include in the application a specific description of the activities to be conducted, an explanation of why the authorization is necessary, and how long the authorization is needed. The executive director may approve a temporary authorization for a term of not more than 180 days, and may reissue the temporary authorization once for an additional 180 days, if circumstances warrant the extension. The executive director may provide verbal authorization for activities related to natural disasters as described in paragraph (3) of this subsection. The permittee or registrant shall document the request and the verbal approval in a letter to the executive director within three days. Temporary authorizations must otherwise be in accordance with subsections (d) and (e)(1) and (2) of this section (i.e., they must apply to minor changes to an MSW facility or its operation that do not substantially alter the permit or registration conditions; do not reduce the capability of the facility to protect human health and the environment; etc.). Examples of temporary authorizations include:

(1) the use of an alternate daily cover material on a trial basis not to exceed six months; however, one extension of up to six months may be granted to properly evaluate cover effectiveness for odor and vector control as a result of varying seasonal or climatic conditions;

(2) temporary changes in operating hours to accommodate special community events, or prevent disruption of waste services due to holidays;

(3) temporary changes necessary to address natural disaster situations; and

(4) temporary changes necessary to prevent the disruption of solid waste management activities.

(n) The applicant, public interest counsel, or other person may file with the chief clerk a motion to overturn the executive director's action on a modification application in accordance with §50.139 of this title (relating to Motion to Overturn Executive Director's Decision).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 10, 2001.

TRD-200107714
Stephanie Bergeron
Division Director, Environmental Law Division
Texas Natural Resource Conservation Commission
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For further information, please call: (512) 239-5017

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 58. OYSTERS AND SHRIMP

SUBCHAPTER B. STATEWIDE SHRIMP FISHERY PROCLAMATION

31 TAC §§58.102, 58.160 - 58.163, 58.165

The Texas Parks and Wildlife Commission adopts amendments to §§58.102, 58.160-58.163 and 58.165, concerning Statewide Shrimp Fishery Proclamation, without changes to the proposed text as published in the October 5, 2001, issue of the *Texas Register* (26 TexReg 7803). The Legislature granted management authority over shrimp to the Texas Parks and Wildlife Commission in 1985 contingent upon development of a shrimp management plan. Adopted in November 1989, the Texas Shrimp Fishery Management Plan (FMP) resulted in Commission authority over regulation of traditional management measures, including means, methods, times, places, quantity, and size of harvest.

Since August 2000, when the shrimp regulations were most recently revised, members of the shrimping industry have requested clarification of some rule provisions and requested that certain rules be made more flexible or be made consistent

with federal regulations. The amendment to §58.102 (3)(B) is necessary to revise the bait bay boundary in West Bay in the Galveston Bay system in order to create a larger bait bay area on the Texas coast. The amendment to §58.160 (d)(6) is necessary to allow currently acceptable federal Turtle Excluder Devices (TEDs) to be used without alteration. The amendment to §58.160 (e)(4) is necessary to expand the range of distance within which a fisheye-like Bycatch Reduction Device (BRD) may be inserted in a trawl. The amendments to §58.160 (e)(2) and (f)(2) is necessary to exempt shrimp boats from the use of BRDs and TEDs in areas where TEDs are exempted by the National Marine Fisheries Service due to special environmental conditions. The amendments to §58.161 (a)(5)(C)-(D) is necessary to allow the use of a try net while shrimping for seabobs. The amendments to §58.102 (3)(A)-(B), (16)(A)-(B); §58.161 (a)(3)(A)-(B), (a)(4), (a)(4)(B), and (a)(5); §58.161 (d)(1)-(2) and (4); §58.163 (c)(4)(B) and (c)(5)(C); and §58.165 (b)(1)(A)-(D) and (c)(3)(D)(ii) are necessary to eliminate unnecessary language and correct clerical errors.

The amendment to §58.160 (d)(6) will function by revising the Turtle Excluder Device (TED) sleeve measurement to allow currently acceptable federal TEDs to be used without alteration. The amendment to §58.160 (e)(4) will function by expanding by one foot the range of distance within which a fisheye-like Bycatch Reduction Device (BRD) may be inserted in a trawl. The amendments to §58.160 (e)(2) and (f)(2) will function by exempting shrimp boats from the use of BRDs and TEDs in areas where TEDs are exempted by the National Marine Fisheries Service due to special environmental conditions. The amendments to §58.161 (a)(5)(C)-(D) will function by allowing the use of a try net while shrimping for seabobs. The amendments to §58.102 (3)(A)-(B), (16)(A)-(B); §58.161 (a)(3)(A)-(B), (a)(4), (a)(4)(B), and (a)(5); §58.161 (d)(1)-(2) and (4); §58.163 (c)(4)(B) and (c)(5)(C); and §58.165 (b)(1)(A)-(D) and (c)(3)(D)(ii) will function by eliminating unnecessary language and correcting nonsubstantive clerical errors.

The department received six comments regarding adoption of the proposed amendments. Two individuals supported the amendments. Four individuals requested additional liberalizations. The additional liberalizations that were requested included allowing nets greater than 65 feet in head rope length in the near shore Gulf, and standardization of inshore try net sizes to the larger size try net used at this time during inshore shrimping seasons. The department disagrees with the comments. The department is concerned that the changes proposed may not contribute to the achievement of optimum yield and the prevention of overfishing. More public input and further study of these proposals are necessary. No changes were made as a result of the comment.

The amendments are adopted under Parks and Wildlife Code, Chapter 61, Uniform Wildlife Regulatory Act (Wildlife Conservation Act of 1983), which provides the Commission with authority to establish wildlife resource regulations for this state; Chapter 67, which gives the Commission the authority to establish any limitations on the take, possession, propagation, transportation, importation, exportation, sale, and offering for sale of nongame fish and wildlife necessary to manage those species; Chapter 68, which provides the Commission with the authority to establish regulations governing the capture, trap, take, kill, possession, transportation, exportation, sale, and offering for sale of endangered fish and wildlife; and Chapter 77, Shrimp, which provides the Commission with authority to regulate the catching, possession, purchase, and sale of shrimp.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

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Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
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For further information, please call: (512) 389-4775

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CHAPTER 65. WILDLIFE
SUBCHAPTER A. STATEWIDE HUNTING AND FISHING PROCLAMATION

The Texas Parks and Wildlife Commission adopts amendments to §65.3 and §65.78, concerning Statewide Hunting and Fishing Proclamation. Section 65.78, concerning Crabs and Ghost Shrimp, is adopted with changes to the proposed text as published in the October 5, 2001, issue of the *Texas Register* (26 TexReg 7806). Section 65.3, concerning Definitions, is adopted without changes and will not be republished. The change to §65.78 adds clarifying language to provide that crab traps, whether they are in use or not, are subject to the closure if left in coastal waters. The crab fishery in Texas is managed using guidelines in the Crab Fishery Management Plan (FMP) adopted by the Parks and Wildlife Commission in 1992, which noted concerns about abandoned crab traps. Senate Bill 1410, enacted by the 77th Texas Legislature, provided the commission with the authority to establish a closed crabbing season for the purpose of removing abandoned crab traps. It is currently estimated that tens of thousands of crab traps are abandoned in coastal waters, resulting in navigation hazards and resource depletion.

The amendment to §65.3, concerning Definitions, is necessary to alter the language in the definition of 'gear tag' so as to exempt crab traps from requirements stipulated elsewhere in the rules. This change will increase the efficiency of crabbers while having little or no impact on the blue crab resources in Texas. The original intent of the date requirement for gear tags was to create an enforcement mechanism to encourage fishermen to check their traps regularly. Regular checking of crab traps minimizes crab mortalities typically caused by ignored, lost, or abandoned traps. TPWD believes it is no longer necessary that the gear tag be dated. Commission rules now require a trap marking system, as well as escape rings and degradable panels, accordingly the need to have a date marked gear tag has been significantly reduced.

The amendment to §65.78, concerning Crabs and Ghost Shrimp, is necessary for the department to implement the provisions of Senate Bill 1410 as enacted by the 77th Texas Legislature. In order for the department to identify and remove abandoned crab traps, the commission must establish a closed season. Under the terms of S.B. 1410, all crab traps in coastal waters during a closed season become litter and may be removed.

The amendment to §65.3 will function by eliminating the applicability of certain gear tag requirements to crab traps in coastal waters.

The amendment to §65.78 will function by establishing a closed season during which the placement and/or use of crab traps in coastal waters is prohibited. By statute, all crab traps in coastal waters during a closed season become litter and may be removed.

The department received 23 comments during the public comment period regarding adoption of the proposed amendments. Seven individuals supported the 16-day closure while 16 individuals spoke against this length of closure, preferring a 10-day closure instead, noting the possible loss of product for the crab market, and loss of fishing time for the crabbers. The department disagrees with the comment and responds that the rule will have minimal impact on the crab market and the fishermen since crab production is at its lowest during February and March. In addition, the 16-day closure allows for a long enough period to create a bona fide crab trap removal program, and provides additional time to compensate for possible inclement weather during the first weekend. No changes were made as a result of the comments. A total of 22 individuals supported the amendment to remove the gear tag dating requirement. One individual spoke against the amendment noting that the dating requirement was a successful deterrent to willful abandonment of crab traps. The department disagrees with the comment and responds that the current crab license management system mandates each fisherman clearly mark each crab trap in use with his/her individual crab license number, and that the marking system in concert with the clean up program will allow for continued clean up of abandoned crab traps. No changes were made as a result of the comment.

DIVISION 1. GENERAL PROVISIONS

31 TAC §65.3

The amendments are adopted under authority of Parks and Wildlife Code, §78.115, which authorizes the commission to establish a closed season for the use of crab traps in the public water of Texas, and requires that the closed season be not less than ten days or more than 30 days between January 31 and April 1 in years designated by the commission; and Chapter 61, Uniform Wildlife Regulatory Act, which authorizes the commission to regulate periods of time, means, methods, and places where it is lawful to hunt, take, or possess aquatic animal life, including crabs.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
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DIVISION 3. SEASONS AND BAG LIMITS--FISHING PROVISIONS

31 TAC §65.78

The amendments are adopted under authority of Parks and Wildlife Code, §78.115, which authorizes the commission to establish a closed season for the use of crab traps in the public water of Texas, and requires that the closed season be not less than ten days or more than 30 days between January 31 and April 1 in years designated by the commission; and Chapter 61, Uniform Wildlife Regulatory Act, which authorizes the commission to regulate periods of time, means, methods, and places where it is lawful to hunt, take, or possess aquatic animal life, including crabs.

§65.78. Crabs and Ghost Shrimp.

(a) Bag, possession and size limits.

(1) It is unlawful while fishing on public waters to have in possession crabs or ghost shrimp in excess of the daily bag limit as established for those waters.

(2) There are no bag, possession, or size limits on crabs or ghost shrimp except as provided in these rules.

(3) It is unlawful to:

(A) possess egg-bearing (sponge) crabs or stone crabs;

(B) possess blue crabs less than five inches in width (measured across the widest point of the body from tip of spine to tip of spine) except that not more than 5.0%, by number, of undersized crabs may be possessed for bait purposes only, if placed in a separate container at the time of taking;

(C) remove or possess the left claw from a stone crab (each retained claw must be at least 2-1/2 inches long as measured from the tip of the immovable claw to the first joint behind the claw);

(D) fail to return immediately a stone crab to the waters where caught;

(E) buy or sell a female crab that has its abdominal apron detached; or

(F) possess more than 20 ghost shrimp (Callichiris islagrande, formerly Callianassa islagrande) per person.

(b) Seasons. There are no closed seasons for the taking of crabs, except as listed within this section.

(c) Closed crab trap season: It is unlawful to place or fish a crab trap in the coastal waters of the state from 12:01 a.m. Saturday, February 16, 2002 through 12:00 midnight Sunday, March 3, 2002. No crab or crab trap component may be left in the coastal waters of this state from 12:01 a.m. Saturday, February 16, 2002 through 12:00 midnight Sunday, March 3, 2002.

(d) Places. There are no places closed for the taking of crabs, except as listed within this section.

(e) Devices, means and methods.

(1) It is unlawful to take, attempt to take, or possess crabs caught by devices, means, or methods other than as authorized in this subchapter.

(2) Only the following means and methods may be used for taking crabs:

(A) Crab line. It is unlawful to fish a crab line for commercial purposes that is not marked with a floating white buoy not less

than six inches in height, six inches in length and six inches in width bearing the commercial crab fisherman's license plate number in letters of a contrasting color at least two inches high attached to the end fixtures.

(B) Crab trap. It is unlawful to:

(i) fish for commercial purposes under authority of a commercial crab fisherman's license with more than 200 crab traps at one time;

(ii) fish for commercial purposes under authority of a commercial finfish fisherman's license with more than 20 crab traps at one time;

(iii) fish for non-commercial purposes with more than six crab traps at one time;

(iv) fish a crab trap in the fresh waters of this state;

(v) fish a crab trap that:

(I) exceeds 18 cubic feet in volume;

(II) is not equipped with at least two escape vents (minimum 2-3/8 inches inside diameter) in each crab-retaining chamber, and located on the outside trap walls of each chamber; and

(III) is not equipped with a degradable panel. A trap shall be considered to have a degradable panel if one of the following methods is used in construction of the trap:

(-a-) the trap lid tie-down strap is secured to the trap by a loop of untreated jute twine (comparable to Lehigh brand # 530) or sisal twine (comparable to Lehigh brand # 390). The trap lid must be secured so that when the twine degrades, the lid will no longer be securely closed; or

(-b-) the trap lid tie-down strap is secured to the trap by a loop of untreated steel wire with a diameter of no larger than 20 gauge. The trap lid must be secured so that when the wire degrades, the lid will no longer be securely closed; or

(-c-) the trap contains at least one sidewall, not including the bottom panel, with a rectangular opening no smaller than 3 inches by 6 inches. Any obstruction placed in this opening may not be secured in any manner except:

(-1-) it may be laced, sewn, or otherwise obstructed by a single length of untreated jute twine (comparable to Lehigh brand # 530) or sisal twine (comparable to Lehigh brand # 390) knotted only at each end and not tied or looped more than once around a single mesh bar. When the twine degrades, the opening in the sidewall of the trap will no longer be obstructed; or

(-2-) it may be laced, sewn, or otherwise obstructed by a single length of untreated steel wire with a diameter of no larger than 20 gauge. When the wire degrades, the opening in the sidewall of the trap will no longer be obstructed; or

(-3-) the obstruction may be loosely hinged at the bottom of the opening by no more than two untreated steel hog rings and secured at the top of the obstruction in no more than one place by a single length of untreated jute twine (comparable to Lehigh brand # 530), sisal twine (comparable to Lehigh brand # 390), or by a single length of untreated steel wire with a diameter of no larger than 20 gauge. When the twine or wire degrades, the obstruction will hinge downward and the opening in the sidewall of the trap will no longer be obstructed.

(vi) fish a crab trap for commercial purposes under authority of a commercial crab fisherman's license:

(I) that is not marked with a floating white buoy not less than six inches in height, six inches in length, and six inches in width attached to the crab trap;

(II) that is not marked with a white buoy bearing the commercial crab fisherman's license plate number in letters of a contrasting color at least two inches high attached to the crab trap;

(III) that is marked with a buoy bearing a commercial crab fisherman's license plate number other than the commercial crab fisherman's license plate number displayed on the crab fishing boat;

(vii) fish a crab trap for commercial purposes under authority of a commercial finfish fisherman's license:

(I) that is not marked with a floating white buoy not less than six inches in height, six inches in length, and six inches in width attached to the crab trap;

(II) that is not marked with a white buoy bearing the letter 'F' and the commercial finfish fisherman's license plate number in letters of a contrasting color at least two inches high attached to the crab trap;

(III) that is marked with a buoy bearing a commercial finfish fisherman's license plate number other than the commercial finfish fisherman's license plate number displayed on the finfish fishing boat;

(viii) fish a crab trap for non-commercial purposes without a floating white buoy not less than six inches in height, six inches in length, and six inches in width, bearing a two-inch wide center stripe of contrasting color, attached to the crab trap;

(ix) fish a crab trap in public salt waters without a valid gear tag. Gear tags must be attached within 6 inches of the buoy and are valid for 30 days after date set out.

(x) fish a crab trap within 200 feet of a marked navigable channel in Aransas County; and in the water area of Aransas Bay within one-half mile of a line from Hail Point on the Lamar Peninsula, then direct to the eastern end of Goose Island, then along the southern shore of Goose Island, then along the eastern shoreline of the Live Oak Peninsula past the town of Fulton, past Nine Mile Point, past the town of Rockport to a point at the east end of Talley Island including that part of Copano Bay within 1,000 feet of the causeway between Lamar Peninsula and Live Oak Peninsula or possess, use or place more than three crab traps in waters north and west of Highway 146 where it crosses the Houston Ship Channel in Harris County;

(xi) remove crab traps from the water or remove crabs from crab traps during the period from 30 minutes after sunset to 30 minutes before sunrise;

(xii) place a crab trap or portion thereof closer than 100 feet from any other crab trap, except when traps are secured to a pier or dock;

(xiii) fish a crab trap in public waters that is marked with a buoy made of a plastic bottle(s) of any color or size; or

(xiv) use or place more than three crab traps in public waters of the San Bernard River north of a line marked by the boat access channel at Bernard Acres.

(C) Sand pump. It is unlawful for any person to use a sand pump:

(i) that is not manually operated; or

(ii) for commercial purposes.

(D) Other devices. Devices legally used for taking fresh or salt water fish or shrimp may be used to take crab if operated in places and at times authorized by a proclamation of the Parks and Wildlife Commission or the Parks and Wildlife Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
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PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 356. GROUNDWATER MANAGEMENT

SUBCHAPTER A. GROUNDWATER MANAGEMENT PLAN CERTIFICATION

31 TAC §§356.1 - 356.6, 356.10

The Texas Water Development Board (board) adopts amendments to 31 TAC §§356.1 through 356.6 and new §356.10 concerning Groundwater Management Plan Certification. Sections 356.2, 356.4, 356.5, and 356.10 are adopted with changes to the proposed text as published in the November 2, 2001 issue of the *Texas Register* (26 TexReg 8733). Sections 356.1, 356.3, and 356.6 are adopted without changes and will not be republished. These amendments and the new section are adopted in response to Senate Bill 2, 77th Texas Legislature, Regular Session, 2001 and pursuant to the four-year rule review requirement of Texas Government Code §2001.039.

The chapter will be renamed to Groundwater Management due to the fact that the board's responsibilities have been expanded by Senate Bill 2. The current title of Groundwater Management Plan Certification is too narrow and misleading given the board's new duties. The board will restructure the chapter into subchapter A, Groundwater Management Plan Certification, composed of §§356.1-356.10, and subchapter B, Designation of Groundwater Management Areas, composed of new sections not yet developed.

The board adopts changes to §356.1 to correct for the creation of the new subchapters. Section 356.1 currently states that it governs all of chapter 356 but, after the expansion of the chapter, it will only govern subchapter A. This revision will provide accuracy and avoid confusion.

Amendments will remove the definition for "management objectives," at §356.2(10), and move it to §356.5(a)(2) relating to Required Content of Management Plan. This change does not have a material impact on the rules and is merely done for clarification. Using the definition in the section where management objectives are required will make it easier to understand what is required. This change is based on comments received from groundwater conservation districts that have gone through the management plan certification process.

Amendments will remove the definition of "performance standards," at §356.2(14), and move it to §356.5(a)(3) relating to Required Content of Management Plan. This change does not have a material impact on the rules and is merely done for clarification. Using the definition in the section where performance standards are required will make it easier to understand what is required. This change is based on comments received from groundwater conservation districts that have gone through the management plan certification process.

The board adopts amendment to the definition of "projected water supply," at §356.2(14), to clarify that usable groundwater must be of an acceptable quality. Further, the board will require the groundwater conservation districts to determine the usable amount of groundwater based on the best available data, as required by Senate Bill 2. This will provide consistency and predictability to the determinations. Lastly, the board amends the definition as it pertains to surface water to be the quantity based on full implementation of any applicable, approved regional water plan. Now that the first round of regional water planning is complete and all regional water plans have been approved, this provides the groundwater conservation districts with an accurate determination of surface water availability that can be used for their planning efforts. Not only will this make it easier for groundwater conservation districts to plan for the impact of surface water use in their districts, it will provide consistency between the management plan and regional water plans as they pertain to surface water.

Amendments will remove the definition of "regional water plan," at §356.2(18), because the term "approved regional water plan" is already defined. This definition is duplicative and may cause confusion. For clarification, this second definition is removed. There will be no material impact from this change.

The board adopts amendment to remove the definition of "useable amount of groundwater," at §356.2(20), because the pertinent terms have been included in the definition of the term "projected water supply." This definition is duplicative and may cause confusion. For clarification, this definition is removed. There will be no material impact from this proposed change.

The amendments to §356.3 are intended to remove expired language that no longer is necessary to the section. The deadline of September 1, 1998 for filing management plans with the board has past and is no longer applicable. There will be no material impact from this change.

The amendments to §356.4 are intended to comply with Texas Water Code §36.1071(b), which was amended by Senate Bill 2. Section 36.1071(b) now requires groundwater conservation districts to forward their management plans to the appropriate regional water planning group for consideration in their planning process. The requirement for the management plan to be consistent with the approved regional water plan has been removed. Therefore, it is necessary to revise §356.4 to reflect these changes. The board's amendments remove the requirement for consistency with the approved regional water plans and instead require the groundwater conservation districts to forward their management plans for consideration. This section was further revised due to public comment. It was revised to clarify that the groundwater conservation district is to forward a copy

of its certified management plan to the chair of the appropriate regional water planning group for that group's consideration in its planning efforts.

The amendments to §356.5 are intended to add clarity and to comply with Senate Bill 2. The revisions to §356.5(a)(1) are intended to comply with Texas Water Code §36.1071(a)(6) and (7), which were added by Senate Bill 2. These statutory provisions add requirements that groundwater conservation district management plans address drought conditions and conservation. These requirements are added at §356.5(a)(1)(F) and (G). The revisions to §356.5(a)(2) are intended to clarify the paragraph. The revisions add the definition of "management objectives" that has been proposed for removal from §356.2 (relating to Definitions of Terms). This change is based on comments received from groundwater conservation districts that have gone through the management plan certification process. Further, the board adds to §356.5(a)(2) that the desired future accomplishments and outcomes of the district must be the result of actions that can be taken by district staff or assigns. This is necessary because the board has received management plans that had objectives that depended on parties outside of the groundwater conservation district's control. Because management objectives should be achievable by the district, it is appropriate to add this limitation to the rule provision. The amendments to §356.5(a)(3) move the definition of "performance standards" from the definitions of §356.2 to the substantive rule for clarification. It also splits the current §356.5(a)(2) into separate paragraphs to avoid confusion between management objectives and performance standards. There is no material impact from this change. The amendments to §356.5(a)(5) are intended for clarification. The language in §356.5(a)(5)(C) is adopted to mirror the language of Texas Water Code §36.1071(e)(3)(C). This will avoid confusion that has been caused by the language differences between these two provisions and will provide consistency for groundwater conservation districts. There is no material impact to the rules from this change.

Due to public comment, the proposed amendments have been further revised to provide consistency with §356.5(a) and compliance with Senate Bill 2. The board revised §356.5(b) to clarify that the groundwater conservation districts must use the best information available to them in preparing their management plans, as required by Texas Water Code §36.1071(b). The section was further revised to require the districts to use the groundwater availability modeling information provided by the executive administrator in conjunction with any available site-specific information provided by the district and acceptable to the executive administrator when developing estimates required in §356.5(a)(4), as required by Texas Water Code §36.1071(h). All language concerning the district's ability to use any information available has been removed pursuant to the new requirements of Senate Bill 2.

The amendments to §356.6(a)(5) are intended to comply with Texas Water Code §36.1071(b). As stated above, this statute has been amended to remove the requirement that groundwater conservation district management plans be consistent with approved regional water plans. Section 356.6(a)(5) currently contains the requirement that the plans be consistent. The board removes this language to be consistent with the revised law. However, Texas Water Code §36.1071(e)(4) continues to require that groundwater conservation district management plans address water supply needs in a manner not in conflict with the approved regional water plan. The board, therefore, will continue to require, in §356.6(a)(5), that groundwater conservation districts identify any potential conflict between their management plans and approved regional water plans at the time the management plan is submitted to the board for certification.

The board adopts new §356.10 to comply with Texas Water Code §36.1072(g). This statutory provision was added by Senate Bill 2 to require the board to resolve conflicts that exist between a groundwater conservation district's management plan and the state water plan. Pursuant to this law, the board adopts §356.10 to provide a mechanism for groundwater conservation districts and persons with a legally defined interest in groundwater in a district or regional water planning group to petition the board to resolve a potential conflict between the district's certified management plan and the state water plan. Due to public comment, the board has defined the phrase "person with a legally defined interest in groundwater" to include, but not be limited to, a person who owns land or groundwater rights in the district, has a legal interest in a well in the district, or has an authorization from or an application pending with the district to produce groundwater. This will clarify the intent and scope of the section. The petition must be in writing and must state the specific nature of the conflict, the specific sections and provisions of the management plan and the state water plan that are in conflict, and resolution to the conflict. Due to public comment, the board has amended the proposed rule to include a requirement to send a copy of the petition to the chairperson of any involved regional water planning group. This information will assist the board in isolating the conflict and working more efficiently to resolve it. Within 30 days of receiving the petition, the executive administrator will determine if a conflict exists and, if so, coordinate a resolution between the affected parties. Coordination may include requiring the affected parties to respond in writing to the petition, meeting with the affected parties for informal mediation, or arranging formal mediation. If the affected parties cannot resolve the conflict within 150 days from receipt of the groundwater conservation district's petition, then the executive administrator will bring the issue to the board at a public meeting for the board to adopt a resolution to the conflict. The board may require the groundwater conservation district to amend its management plan to resolve the conflict. If the groundwater conservation district is required to amend its management plan, then the board's certification of the plan will be suspended until the groundwater conservation district made the revision, following a public hearing. Either the groundwater conservation district or the regional water planning group may request that the board include in the state water plan a discussion of the conflict and its resolution.

The board conducted a hearing on the proposed rules on November 28, 2001 in Room 118, Stephen F. Austin Building, 1700 N. Congress Ave., Austin, Texas. No comments were received at this hearing. The following made comments in writing within the prescribed period following the publication of the proposed rules: Freese and Nichols, Inc., Brazos River Authority, and the East Texas Regional Water Planning Group.

Brazos River Authority commented that §356.2(4) should state that the site-specific information can be provided by groundwater conservation districts and others. *The board makes no changes based on this comment. The language used in proposed §356.2(4) is directly from the amendment to Texas Water Code §36.1071(h), as added by Senate Bill 2. To do as Brazos River Authority proposes would go beyond the scope of the law. However, the proposed addition of §356.2(4) was removed as a result of another comment received by the board.*

Freese and Nichols comments that the use of the phrase "acceptable to the executive administrator" in §356.2(4) is unusual. They state that "approved by the executive administrator" would be better and would indicate there is a process for using site-specific data. *The board makes no changes based on this comment. The phrase used in the proposed amendments is directly from Texas Water Code §36.1071(h), as amended by Senate Bill 2. Use of a different term may cause confusion and imply that a higher standard exists than is required by law.*

Brazos River Authority commented that the term "acceptable quality" should be defined in §356.2(14). It also commented that the rule should clarify that only water designated for use within the district be counted as available water supply as opposed to water that is already designated for use outside the district's boundaries. *The board makes no changes to the proposed amendments based on these comments. Under the section, the term "acceptable quality" is to be defined by the groundwater conservation districts. Further, for planning purposes, it is appropriate to consider all water available per annum in the district. This water may then be identified as providing needs outside of the district.*

The East Texas Regional Water Planning Group commented that §356.4 is confusing and should be clarified to state what is to be forwarded to the regional water planning groups. *The board changes the proposed amendment as a result of this comment. The board adds the phrase "that region's" to the proposed language to make it clear that the management plan is being forwarded to the regional water planning group for the group's consideration in their planning process.*

East Texas Regional Water Planning Group commented that §356.5(a)(5)(C) should not use the term "estimates" but instead use "suggestions" or "recommendations." *The Board makes no changes to the proposed amendments based on this comment. The term "estimates" is appropriate since the intent is to obtain a quantification of the annual amount of recharge expected.*

Brazos River Authority commented that §356.5(b) should be amended to require that information used by the district be the best available data to be consistent with the proposed amendment to §356.5(a). *The board agrees that there is a problem with consistency as the rule is proposed. The board makes changes to §356.5 and §356.2 to provide consistency and clarification. The definition of best available data in §356.2 is deleted and the language is moved to §356.5(b). The citations in §356.5(b) are also updated to be consistent with §356.5(a).*

Brazos River Authority commented that §356.5(c) and (d) are in direct conflict with proposed amendments to §356.6(a)(5) and §356.10. The Authority stated there is a conflict with §356.5(c) because it requires the management plans to address water supply needs in a manner that does not conflict with the relevant approved regional water plan while §356.6(a)(5) merely requires the groundwater conservation district to identify potential conflicts between its plan and the relevant approved regional water plan. Further, §356.10 sets up a process for resolving conflicts between the management plans and the state water plan. The Authority recommends deleting §356.5(c) because of the conflict and §356.5(d) because it refers to §356.6(c). *The board makes no changes to the rules based on this comment. The changes made by Senate Bill 2 to Texas Water Code §36.1071(b) require the changes the board proposes to §356.6(a)(5), while amendments to Texas Water Code §36.1072(g) require the changes the board proposes to §356.10. However, as previously stated in the preamble, Texas Water Code §36.1071(e)(4) was not amended by the legislature. Therefore, the requirement that groundwater conservation district management plans address water supply needs in a manner not in conflict with the approved regional water plan continues to exist.*

Freese and Nichols and the Brazos River Authority commented that the phrase "a person with a legally defined interest in groundwater in a district" needs clarification in §356.10(a). Freese and Nichols also commented that the petition should be sent to any affected regional water planning group. *The board makes changes to the rules based on these comments. The board adds a definition that includes, but is not limited to, a person who owns land or groundwater rights in the district, has a legal interest in a well in the district, or has an authorization from or an application pending with the district to produce groundwater. The board also adds the requirement to have a copy of the petition sent to the chairperson of any involved regional water planning group.*

The amendments and new section are adopted under the authority of Texas Water Code §§6.101, 16.051, 16.053, and 36.1071

§356.2. Definitions of Terms.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Words defined in Texas Water Code, Chapter 36 that are not defined here shall have the meanings provided in Chapter 36.

(1) Amount of groundwater being used--The quantity of groundwater withdrawn or flowing from an aquifer naturally or artificially on an annual basis.

(2) Approved regional water plan--A water plan developed pursuant to Texas Water Code, §16.053 and which has been approved by the board.

(3) Artificial recharge--Increased recharge accomplished by the modification of the land surface, streams, or lakes to increase seepage or infiltration rates or by the direct injection of water into the subsurface through wells.

(4) Board--Texas Water Development Board.

(5) Conjunctive surface water management issues--Issues relating to the active use of both surface water and groundwater to achieve increased water supply or enhanced water quality.

(6) District--Any district or authority created under Texas Constitution, Article III, §52 or Article XVI, §59 that has the authority to regulate the spacing of water wells, the production from water wells, or both.

(7) Estimates--Calculations using best available data and methodologies specified in the management plan such that the quantifications will be reasonable for use by the district and can be tracked over time.

(8) Executive administrator--The executive administrator of the board.

(9) Management goals--The qualitative and quantitative ends toward which a district directs its efforts.

(10) Management plan--The groundwater management plan required pursuant to Texas Water Code, §36.1071.

(11) Most efficient use of groundwater--Those practices, techniques and technologies that the district determines will provide the least consumption of groundwater for each type of use balanced with the benefits of using groundwater.

(12) Projected water demand--The quantity of water needed per annum for beneficial use during the period covered by the management plan. The demands shall be projected for the types of use that are included in the state water plan. Each type of use may be subdivided into sub-types by the district.

(13) Projected water supply--The usable amount of groundwater of acceptable quality that is available per annum as determined by the district using the best available data and the quantity of surface water available per annum during the period covered by the management plan based on full implementation of any applicable, approved regional water plan.

(14) Recharge--The addition of water from precipitation or runoff by seepage or infiltration to an aquifer from the land surface, streams, or lakes directly into a formation or indirectly by way of leakage from another formation.

(15) Surface water management entities--Political subdivisions as defined by Texas Water Code, Chapter 15, and identified from Texas Natural Resource Conservation Commission records which are granted authority to store, take, divert, or supply surface water either directly or by contract under Texas Water Code, Chapter 11, for use within the boundaries of a district.

§356.4. Sharing with Regional Water Planning Groups.
For management plans certified after January 5, 2002, the district shall forward the plan to the chair of each regional water planning group with territory within the boundaries of the district for that region's consideration in their planning process.

§356.5. Required Content of Management Plan.

(a) The executive administrator shall certify a management plan as administratively complete if it uses a planning period of at least ten years and contains the following:

(1) management goals, as applicable:

(A) providing the most efficient use of groundwater;

(B) controlling and preventing waste of groundwater;

(C) controlling and preventing subsidence;

(D) addressing conjunctive surface water management issues;

(E) addressing natural resource issues which impact the use and availability of groundwater, and which are impacted by the use of groundwater;

(F) addressing drought conditions, and

(G) addressing conservation;

(2) management objectives that the district will use to achieve the management goals in paragraph (1) of this subsection. Management objectives are specific, quantifiable, and time-based statements of desired future accomplishments or outcomes, each linked to a management goal, which set the individual priority for district strategies. Each desired future accomplishment or outcome must be the result of actions that can be taken by district staff or assigns;

(3) performance standards for each management objective. Performance standards are indicators or measures used to evaluate the effectiveness and efficiency of district activities by quantifying the results of actions. Evaluation of the effectiveness of district activities measures the accomplishments of the district. Evaluation of the efficiency of district activities measures how well resources are used to produce an output, such as the amount of resources devoted per unit of accomplishment;

(4) actions, procedures, performance, and avoidance, necessary to effectuate the management plan, including specifications and proposed rules, all specified in as much detail as possible; and

(5) estimates of:

(A) the existing total usable amount of groundwater in the district;

(B) the amount of groundwater being used within the district on an annual basis;

(C) the annual amount of recharge, if any, to the groundwater resources within the district and how natural or artificial recharge may be increased; and

(D) the projected water supply and demand within the district;

(6) details of how the district will manage groundwater supplies in the district, including a methodology by which a district will track its progress on an annual basis in achieving its management goals.

(b) The management goals, performance standards and management objectives required in subsection (a)(1), (2), and (3) of this section and the actions, procedures, performance and avoidance specified in subsection (a)(4) of this section are to be established by each district based on specific needs of that district. Each district shall use the best information available to it, including an existing groundwater management plan of the district, to make the estimates required in subsection (a) of this section and to develop the plan required by these rules, except that the district shall use the groundwater availability modeling information provided by the executive administrator in conjunction with any available site-specific information provided by the district and acceptable to the executive administrator when developing the estimates required in subsection (a)(5) of this section.

(c) In addition to the requirements of subsection (a) of this section, the management plan shall address water supply needs in a manner that does not conflict with an approved regional water plan for each region in which any part of the district is located.

(d) The requirement of subsection (c) of this section may be waived if the executive administrator determines that conditions justify such waiver. Waiver will only be granted upon the written request of the district accompanied by evidence acceptable to the executive administrator in form and substance of conditions justifying such waiver.

§356.10. Possible Conflicts with State Water Plan.

(a) A person with a legally defined interest in groundwater in a district or the regional water planning group may file a written petition with the board stating that a conflict requiring resolution may exist between the district's certified groundwater conservation district management plan developed under Texas Water Code, §36.1071, and the state water plan developed under Texas Water Code, §16.051. A person with a legally defined interest in groundwater in a district includes, but is not limited to, a person who owns land or groundwater rights in the district, has a legal interest in a well in the district, or has an authorization from or application pending with the district to produce groundwater. A copy of the petition shall be provided to the district and to the chairperson of any involved regional water planning group. The petition must state:

(1) the specific nature of the conflict;

(2) the specific sections and provisions of the certified management plan and the state water plan that are in conflict, and

(3) the proposed resolution to the conflict.

(b) Within 30 days of receiving the petition, if the executive administrator determines that a conflict does exist, the executive administrator will facilitate coordination between the affected parties. Coordination may include any of the following processes:

(1) requiring the affected parties to respond to the petition in writing;

(2) meeting with representatives from the affected parties to informally mediate the conflict; and/or

(3) coordinating a formal mediation session between representatives of the affected parties.

(c) The executive administrator will inform the parties how long they have to attempt to resolve the conflict. If the parties do not reach resolution in that time period, the executive administrator will recommend a resolution to the conflict to the board. Before presenting the issue to the board, the executive administrator will provide the affected parties 30 days notice. The board shall adopt a resolution to the conflict at a public meeting. If the board finds that a conflict exists, the board shall adopt a resolution to the conflict at a public meeting. Resolution may include requiring a revision to the groundwater conservation district's certified management plan or consolidating the resolution with an action being taken by the board pursuant to §357.15 of this title (relating to Interaction with Groundwater Conservation District Management Plans)

(d) If the board requires a revision to the groundwater conservation district's certified management plan, the board shall suspend the certification of the plan and provide information to the groundwater conservation district on what revisions are required and why. The groundwater conservation district shall prepare any revisions to its plan required by the board and hold, after notice, at least one public hearing at a central location within the district. The groundwater conservation district shall consider all public and board comments, prepare, revise, and adopt its plan, and submit the revised plan to the board for certification pursuant to this subchapter.

(e) At the request of either the groundwater conservation district or the affected regional water planning group, the board shall include in the state water plan a discussion of the conflict and its resolution.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 357. REGIONAL WATER PLANNING GUIDELINES

31 TAC §§357.2, 357.7, 357.8, 357.11, 357.14, 357.15

The Texas Water Development Board (board) adopts amendments to 31 TAC §357.2, 357.7, 357.8, 357.11, and 357.14 and new §357.15, concerning Regional Water Planning Guidelines. Sections 357.2, 357.7, 357.8, 357.11, and 357.14 are adopted with changes to the proposed text as published in the November 2, 2001 issue of the *Texas Register* (26 TexReg 8737). Section 357.15 is adopted without changes and will not be republished. These amendments and new sections are adopted in response to Senate Bill 2, 77th Legislature, Regular Session, 2001 and pursuant to the four-year rule review requirement of Texas Government Code §2001.039.

The amendments to §357.2(4) and (5) are intended to remove definitions of terms that are no longer used in the chapter. The board determined in the first round of regional water planning that there is no need to separate water needs into long-term and near-term needs. Therefore, these terms are removed. This will not have a material impact on the regional planning process.

The board adopts amendments to §357.2(7) for clarification to the term "regional water plan." The definition is amended to state that a regional water plan is the plan adopted or amended by a regional water planning group pursuant to Texas Water Code §16.053 and this chapter. This removes the term "approved" from the definition, which is appropriate because the regional water planning group does not approve the plan. This amendment will not have a material impact on the rules.

Based on public comment, the board revises §357.2(8) to replace the phrase "planning period" in the last sentence with the phrase "period covered by the plan." This will avoid confusion and clarify the intent of the provision as requested by the comments submitted to the board.

The amendments to §357.7(a)(1) serve two purposes. First, the board adds subparagraph labels to elements of a regional water planning area description in order to improve readability of the paragraph and properly organize it. This change has no impact on the rule. The board also added information on water pipelines and other facilities as a required element of the regional water planning area, at §357.7(a)(1)(M). Based on public comment, the board revised §357.7(a)(1)(D) to add that major springs to be described are those that are important for water supply or natural resource protection purposes. This is to clarify that all important major springs are to be considered in the planning process. Also due to public comment, the board removed the word "initial" from §357.7(a)(1)(H) because the word is no longer appropriate now that the first round of regional water planning is complete. This is intended to comply with Texas Water Code §16.053(e)(3)(D). Senate Bill 2 amended §16.053(e)(3)(D) to require the regional water plans to identify information on water pipelines and other facilities that can be used for water conveyance, including, but not limited to, currently used and abandoned oil, gas, and water pipelines. The amendments to §357.7(a)(1)(M) add this information as a required part of the regional water plans. Because this information describes certain water transportation abilities within the region, adding the requirement to §357.7(a)(1) is appropriate and contributes to a more thorough description of the region that is directly relevant to planning decisions.

The board amends §357.7(a)(5) for clarification. The subsection currently requires regional water plans to include plans to be used during a drought of record. The term "plan" in this subsection creates confusion with the term "regional water plan." Therefore, the word "plan" is changed to "water management strategies," which is more accurate and appropriate. Due to this change and also consistent with elimination of the long-term planning for scenarios in §357.7(a)(9), the reference to water management strategies in the subsection is not necessary and

is deleted. This change does not materially impact the rules or the regional water planning process.

The board amends §357.7(a)(7)(A) to assure compliance with Texas Water Code §11.085. Section 11.085 requires applicants for interbasin transfer permits to develop and implement a water conservation plan that will result in the highest practicable level of water conservation and efficiency achievable within the jurisdiction of the applicant. In the first round of regional water planning, several regional water plans had water management strategies that recommended that water user groups and wholesale water providers obtain water from new interbasin transfers. It is appropriate that proposals for interbasin transfers are analyzed based on these requirements for water conservation so that the planning process more closely considers the realities of permitting. This analysis will provide a more executable water plan. This provision was further revised, based on public comment, to state that the regional water planning groups must consider water conservation practices, consistent with the substantive requirements of the Texas Natural Resource Conservation Commission's administrative rules related to §11.1271, for each need identified and include such practices for each water user group to which Texas Water Code §11.1271 applies. This revision ensures compliance with Texas Water Code §16.053(h)(7)(B). Public comment also prompted the board to require the regional water planning groups to consider conservation measures that exceed the minimum requirements and document why such measures are not included, if that is the case. This change will help ensure compliance with the duty to provide long-term protection for the state's water, agricultural, and natural resources. The board also amended the language concerning interbasin transfers, based on public comment, to clarify that the language pertains to interbasin transfers to which Texas Water Code §11.085(l) applies.

Due to public comment, the board revised §357.7(a)(7)(B) to state that the provision does not limit the use of drought management measures that involve voluntary arrangements by water users to forgo water usage during drought periods. This will ensure that all drought management measures are considered in the planning process. Public comment also prompted the board to revise this provision to require the regional water planning groups to consider drought management measures for each need identified and include such practices for each water user group to which Texas Water Code §11.1272 applies. This will ensure compliance with Texas Water Code §16.053(h)(7)(B).

The board adopts amendments to §357.7(a)(8)(A) to comply with Texas Water Code §16.053(h)(7)(C) which requires the regional water plans to be consistent with long-term protection of the state's water resources, agricultural resources, and natural resources as embodied in the guidance principles found in Chapter 358 of this title (relating to State Water Planning Guidelines). Section 357.7(a)(8)(A) currently requires the regional water planning groups to evaluate all water management strategies determined to be potentially feasible by reporting on the quantity, reliability, and cost of water delivered or treated and environmental factors for the water. The amendments also require such analysis based on impacts on agricultural resources. Combined with the existing language in §357.7(a)(7) regarding water conservation, the language regarding the long-term protection of water resource, agricultural and natural resource, and socioeconomic impacts in §357.7(a)(8)(B), (C), and (G), and the language in §357.7(a)(9) and (13), these amendments will require the regional water planning groups to develop regional water plans consistent with long-term protection of the state's water resources, agricultural resources, and natural resources and provide the standards for the board to use in measuring such compliance. Based on public comment, the proposed requirement to analyze third-party impacts of moving water from rural areas to urban areas has been removed from §357.7(a)(8)(A)(iii) and added to §357.7(a)(8)(G), which already contains third-party impact analysis requirements. This avoids repetition in effort.

New §357.7(a)(8)(H) is intended to comply with Texas Water Code §16.053(e)(3)(D). This statutory provision requires the regional water planning groups to identify information on water pipelines and other facilities that can be used for water conveyance, including, but not limited to, currently used and abandoned oil, gas, and water pipelines. The amendments to §357.7(a)(1)(M) add this information as a required part of the description of the regional water planning area. The amendment to §357.7(a)(8)(H) will require the regional water planning groups to consider how the pipelines and facilities they have identified pursuant to §357.7(a)(1)(M) can be used for water conveyance. These changes will comply with Texas Water Code §16.053(e)(3)(D) and will ensure that the regional water plans consider utilizing all available resources within the region.

Amendments to §357.7(a)(9) are intended to accomplish two purposes. First, the changes are intended to comply with Texas Water Code §16.053(h)(7)(C) which requires the regional water plans to be consistent with long-term protection of the state's water resources, agricultural resources, and natural resources as embodied in the guidance principles found in Chapter 358 of this title (relating to State Water Planning Guidelines). The amendments to §357.7(a)(9) have been revised, due to public comment, to require the regional water planning groups to select cost effective water management strategies that provide for the long-term protection of the state's water, natural, and agricultural resources. It was further revised to remove the language that permitted the regional water planning groups to demonstrate that the adoption of such a strategy is not appropriate since no such exception exists in Texas Water Code §16.053(h)(7)(C). Second, the changes are intended to remove the terms "near-term" and "long-term" from the water needs analysis. As stated previously, the board determined in the first round of regional water planning that dividing water needs into near- and long-term was unnecessary. The change to remove these terms will not materially affect the rules or the planning process.

The amendment to add §357.7(a)(12) is intended to comply with Texas Water Code §16.053(e)(8). Section 16.053(e)(8) was added by Senate Bill 2 to require the regional water plans to describe the impact of proposed water projects on water quality. The amendments to §357.7(a)(12) add this requirement as a necessary component of regional water plans. The amendments will require the regional water planning groups to provide a qualitative description of the major impacts of recommended water management strategies on key parameters of water quality. The parameters will be selected by the regional water planning groups because they are in the best position to determine the factors that are important to water quality for the water sources in their regions. The comparison to current conditions provides a picture of the actual impacts of planned strategies against existing quality, which will show the actual change that would occur. This analysis augments existing requirements to develop water management strategies that protect the environment and will incorporate a water quality component.

The amendment to add §357.7(a)(13) is intended to comply with Texas Water Code §16.053(h)(7)(C) which requires the regional water plans to be consistent with long-term protection of the state's water resources, agricultural resources, and natural resources as embodied in the guidance principles found in Chapter 358 of this title (relating to State Water Planning Guidelines). The guidance principles are also elements of §357.5 of this title (relating to Guidelines for Development of Regional Water Plans) and §357.7. The amendments to §357.7(a)(13) require the regional water planning groups to describe how they have made their plans consistent with the guidance principles, as required by §357.14 of this title (relating to Approval of Regional Water Plans by the Board), which sets out the rule provisions that the regional water planning groups must comply with to meet the requirements Texas Water Code §16.053(h)(7)(C). By having this description in the regional water plans, the board will be able to more clearly ascertain compliance with Texas Water Code §16.053(h)(7)(C) and will provide the public with a clear description of the water resources, agricultural resources, and natural resources protections in each regional water plan.

New §357.7(a)(14) is intended to comply with Texas Water Code §16.053(q), which was added by Senate Bill 2. This statutory provision requires the regional water planning groups to examine the financing needed to implement the water management strategies and projects identified in their most recent approved regional water plans. Section 357.7(a)(14) requires this information to be a chapter of the regional water plan. This will enable the regional water planning groups to comply with Texas Water Code §16.053(q) and will provide political subdivisions and the public with plans that have considered the financing implications of the recommended water management strategies. The consideration of how local governmental entities will pay for water infrastructure projects identified in the regional water plans will mean the plans have a greater chance of successful implementation.

The amendment to add new §357.7(c) and (d) is intended to comply with Texas Water Code §16.053(h)(7)(B), which was amended by Senate Bill 2 to require the regional water plans to include water conservation practices and drought management measures that incorporate, at a minimum, the provisions of Texas Water Code §11.1271 and §11.1272. These statutory provisions require applicants for new and amended water rights to submit a water conservation plan and for wholesale and retail public water suppliers and irrigation districts to develop drought contingency plans consistent with applicable regional water plans. The amendments to §357.7(a)(7)(A) and (B) require the regional water planning groups to include a model water conservation plan and a model drought contingency plan in their regional water plans. These models will serve as examples for other persons and entities that must comply with Texas Water Code §11.1271 and §12.1272.

The amendment to add §357.8(c) is intended to comply with Texas Water Code §16.053(e)(7), which was added by Senate Bill 2. This addition to the Texas Water Code requires regional water planning groups to assess the impact of their plans on unique river and stream segments identified in their plans or designated by the legislature as having a unique ecological value pursuant to §16.051(f). Due to public comment, this amendment was further revised to clarify that that regional water planning groups would only have to assess the impact on unique river and stream segments that were designated by the legislature during a legislative session that was adjourned not less than one year before the due date of the next regional water plan. The provision was also revised, due to public comment, to clarify that the regional water planning groups, and not the Texas Parks and Wildlife Department, have the responsibility under the rules for recommending river and stream segments for designation as unique. The addition of subsection (c) to §357.8 complies with Texas Water Code §16.053(e)(7) by requiring the regional water planning groups to assess the impact of their plans on the flows important to the river or stream segment, as determined by the regional water planning group, but will still provide them with the time needed to perform this analysis. It is appropriate for the regional water planning groups to determine which flows are important to the river or stream segment because they are in the best position to obtain that information. The analysis is based on the conditions described in the regional water plans and assumes full implementation of all recommended water management strategies.

The amendments to §357.11(f) are merely to rearrange the subsection, which is to be divided into two subsections. Section 357.11(f) contains only language that was in the existing subsection. There is no material impact from this change.

The addition of §357.11(g) takes the remaining language from subsection 357.11(f) and inserts additional language to comply with Texas Water Code §16.054(d). Senate Bill 2 amended §16.054(d) to provide a mechanism for political subdivisions to request regional water planning groups consider specific changes to their regional water plans based on changed conditions or new information. If the regional water planning group agrees that a change is necessary, it shall then amend its regional water plan. If the regional water planning group disagrees that a change is needed and does not amend its regional water plan as requested, the political subdivision may request that the board review the issue and consider changing the board-approved regional water plan. The board adopts amendments to §357.11(f) in order to comply with this statutory requirement. The resolution process will require the political subdivision to submit a written petition to the board to review the issue. The board will then coordinate a resolution between the regional water planning group and the political subdivision, if necessary. If no resolution is reached, the board may alter the approved regional water plan and the state water plan as necessary.

Changes are adopted to §357.14(2)(B) to comply with Texas Water Code §16.053(h)(7)(B). This statute was amended by Senate Bill 2 to require regional water plans to include water conservation practices and drought management measures incorporating, at a minimum, the provisions of Texas Water Code §11.1271 and §11.1272. The requirements of these statutory provisions have been proposed for addition to §357.7(c) and (d) (relating to Regional Water Plan Development), and, due to public comment, to §357.7(a)(7)(A) and (B). The addition of §357.14(2)(B) will require these practices and measures of §357.7(a)(7)(A) and (B) and §357.7(c) and (d) be incorporated into the regional water plans in order for the board to approve them.

The board adds §357.14(2)(C) to comply with Texas Water Code §16.053(h)(7)(C). This statutory provision was amended by Senate Bill 2. It requires the regional water plans to be consistent with long-term protection of the state's water resource, agricultural resources, and natural resources as embodied in the guidance principles adopted by the board in Chapter 358 of this title relating the State Water Plan. The board adds §357.14(2)(C) to require that the regional water plans be consistent with the principles in Chapter 358 of this title in order for the board to approve

them, as now required by the Texas Water Code. The section states the standard by which the board will judge the consistency of the regional water plans with long-term protection of the water resources, agricultural resources, and natural resources. If the regional water planning group has complied with other parts of the board rules in compiling the plan, it will comply with this consistency requirement since those provisions are designed to assure the analysis and decisions needed for long-term resource protection.

The board adopts new §357.15 to comply with Texas Water Code §16.053(p). This subsection of §16.053 was added by Senate Bill 2. Section 16.053(p) requires the board to have a process for handling potential conflicts between groundwater conservation district management plans and regional water plans. Pursuant to this law, the board adopts §357.15 to provide a mechanism for groundwater conservation districts to petition the board to assist with a potential conflict between the district's certified management plan and a board-approved regional water plan. The petition must be in writing and must state the specific nature of the conflict, the specific sections and provisions of the management plan and regional water plan that are in conflict, and the proposed resolution to the conflict. This information will assist the board in isolating the conflict and working more efficiently to resolve it. Within 30 days of receiving the petition, the executive administrator will determine if a conflict exists and, if so, coordinate a resolution. Coordination may include requiring the regional water planning group to respond in writing to the petition, meeting with the regional water planning group and groundwater conservation district for informal mediation, or arranging formal mediation. If the groundwater conservation district and the regional water planning group cannot resolve the conflict within 150 days from receipt of the groundwater conservation district's petition, then the executive administrator will bring the issue to the board at a public meeting for the board to adopt a resolution to the conflict. The board may require the groundwater conservation district, the regional water planning group, or both to amend their plans to resolve the conflict. If the groundwater conservation district is required to amend their management plan, then the board's certification of the plan will be suspended until the groundwater conservation district has revised its management plan, following a public hearing. If the regional water planning group is required to amend its regional water plan, the board's approval of the plan will be suspended until the regional water planning group complies with the amendment process set out in Chapter 357. Either the groundwater conservation district or the regional water planning group may request that the board include in the state water plan a discussion of the conflict and its resolution.

The board conducted a hearing on the proposed rules on November 28, 2001 in Room 118, Stephen F. Austin Building, 1700 N. Congress Ave., Austin, Texas. No comments were received at this hearing. The following made comments in writing within the prescribed period following the publication of the proposed rules: Freese and Nichols, Inc., Brazos River Authority, Lower Colorado River Authority, American Electric Power, the South Central Texas Regional Water Planning Group, National Wildlife Federation, the Lone Star Chapter of the Sierra Club, Environmental Defense, and the Texas Center for Policy Studies.

Freese and Nichols commented that the phrase "planning period" used in §357.2(8) needs clarification as to whether it is the 50 year period of the study or the five-year planning cycle and that there should be a cut off date for qualifying as a wholesale water provider for each planning cycle. *The board makes changes based on the comment regarding confusion of the meaning of the term "planning period." The language is revised to make it clear the definition refers to the period covered by the regional water plan. The board makes no changes based on the comment seeking a cut off date for wholesale water provider eligibility. A cut off date for wholesale water providers may cause planning efforts to leave out an important provider of water.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that it appeared from the first round of planning that many regional water planning groups considered descriptions of springs required in §357.7(a)(1) to only included those that supply significant water for human purposes. These entities commented that this is inappropriate and inconsistent with statutory requirements and recommend §357.7(a)(1)(D) be revised to state "sources of groundwater and surface water including major springs that are potentially important for human water supply or natural resources protection purposes." *The board makes changes to the proposed amendments based on this comment. The board revises §357.7(a)(1)(D) to mirror the recommendation but without the words "human" and "potentially."*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the word "initial" in §357.7(a)(1)(H) is no longer appropriate since the first round of regional water planning is complete and further assessment should be included. *The board agrees with this comment and makes changes to remove the word "initial."*

Freese and Nichols commented that, due to security reasons, the deadline for reporting pipeline information that is used in §357.7(a)(1)(M) and §357.7(a)(8)(H) should be extended until after the next legislative session. *The board makes no changes based on this comment because the deadline for reporting pipeline and conveyance facilities information, which is November 30, 2003 pursuant to §358.6 of this title, is already past the date the next legislative session will be concluded.*

Brazos River Authority commented that the proposed amendment to §357.7(a)(1)(M) is inconsistent with proposed §358.6(b)(1) of this title because §357.7(a)(1)(M) includes a requirement to describe pipelines and other facilities that could be used to transport water, including abandoned oil, gas, and water pipelines, while §358.6 specifically excludes oil and gas pipelines from the reporting requirements. *The board makes no changes to the proposed amendments based on this comment. As stated in the preamble to the proposed amendments to Chapter 358 of this title, the board is not requiring entities to report on oil and gas pipelines and conveyance facilities because that information has already been gathered by the Texas Railroad Commission. As stated in the preamble for §357.7(a)(1)(M), this change is proposed based on Senate Bill 2, which amended Texas Water code §16.053(e)(3)(D) to require the regional water plans to identify information on water pipelines and other facilities that can be used for water conveyance, including, but not limited to, currently used and abandoned oil, gas, and water pipelines.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the list of categories of water use in §357.7(a)(2) may not be exclusive, but that it is clear from the first round of regional water planning that water needs for natural

resource protection were largely ignored. They recommend that natural resource demands be added to the parenthetical list to enhance the reliability of the water plans. *The board makes no changes based on this comment. The planning process does not ignore natural resource protection. The rules as written require that all water management strategies protect natural resources. The rules further require that the strategies must be analyzed pursuant to either site specific environmental flow studies or consensus environmental flow criteria. These are designed to ensure that planning maintains environmental flows. A more precise protection of the environmental flows will occur in any required TNRCC permitting process. However, these planning requirements ensure that strategies are not developed in the planning process that would rely on water in excess of what can be permitted, given the need to maintain environmental flows. The planning structure has been designed to provide for environmental water needs by assuring that water development is planned in a way to leave sufficient water for environmental purposes in the waterways of the state. This is consistent with the current regulatory system for protection of water resources. While the regional water planning groups would be free, if they desired, to specifically target a water flow for environmental needs, this is not, in the Board's opinion, required either under the statutes nor is it the practice in the regulatory process. The consideration of environmental needs at the planning level, and consequently the protection of the natural resource, is achieved by consideration of needed environmental flows in relation to determinations of how much water would be available for each water management strategy (an inherent reservation of that water for environmental needs). Further, a main purpose of regional water planning is to develop water management strategies to be used during a drought of record. Texas Water Code §16.053(e)(5)(C) provides examples of water management strategies that may be used, including improved conservation, reuse, acquisition of existing water supplies and development of new water supplies. Lastly, the environmental needs are not currently quantified. The legislature has not provided the board with funds to finance an effort to quantify these needs, which would be a tremendous project entailing great expense.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that language should be added to §357.7(a)(5) to clarify that drought management measures as required by Texas Water Code §16.053(h)(7)(B) may include measures such as dry-year options. They recommend a new subparagraph be added to state "nothing in this paragraph shall be construed as limiting the use of drought management measures that involve voluntary arrangements by water users to forgo water usage during drought periods." *The board makes changes as a result of this comment. The board agrees the recommended language, with minor revision, is appropriate but believes it is more properly added to §357.7(a)(7)(B), which addresses drought management measures.*

Freese and Nichols commented that the statutory requirement, found in Texas Water Code §11.085, for the highest practicable levels of conservation and efficiency achievable should be used consistently throughout §357.7(a)(7)(A). *The board agrees with this comment. A review of the proposed rule amendments revealed that the word "practicable" was inadvertently left out in one instance. The board changes the proposed amendment to correct this.*

Lower Colorado River Authority commented that the second to last sentence of §357.7(a)(7)(A) should be amended to require the regional water planning groups to seek input not only from water user groups and wholesale water providers within the basin receiving the water permitted by the interbasin transfer but also from those groups within the basin of origin for the water. It commented that such an approach may result in different concepts of the highest practicable level of water conservation and efficiency available. *The board makes no changes to the proposed amendments based on this comment. The intent of this proposed amendment is to comply with Texas Water Code §11.085, which requires an interbasin transfer applicant, at subsection (l), to develop and implement a water conservation plan that will result in the highest practicable levels of water conservation and efficiency achievable within the jurisdiction of that applicant. The proposed amendments to §357.7(a)(7)(A) require the regional water planning groups to include a water conservation strategy for each water user group or wholesale water provider that is to obtain water from a new, unpermitted interbasin transfer because these entities are most likely to be the applicants for the transfer or would have water conservation requirements imposed in water supply contracts from such applicants. Also, these entities are better able to comment on the level of conservation achievable for their area.*

American Electric Power commented that the proposed changes to §357.7(a)(7)(A) exceed the statutory directive of Texas Water Code §11.085(l)(2). It commented that this process was more appropriately handled by the Texas Natural Resource Conservation Commission. It further commented that the language of §11.085 appears directed at political subdivisions since it uses the term "jurisdiction" and that there is no statutory directive to include this as part of a regional water plan. American Electric Power recommends deleting the proposed changes or, in the alternative, clarifying what is meant by "highest practicable levels of water conservation and efficiency achievable within the jurisdiction of the applicant" and stating that the changes only apply to water management strategies that propose interbasin transfers for applicants with defined jurisdictions. *The board makes no changes to the proposed amendments as a result of this comment. As stated in the preamble, there were several water management strategies in the first round of regional water planning that recommended water user groups and wholesale water providers obtain water from new interbasin transfers. Section 11.085(k)(2) requires the Texas Natural Resource Conservation Commission to consider discussions in the approved regional water plan when reviewing an interbasin transfer application. It is appropriate that the regional water plans consider and discuss the requirements for water conservation for interbasin transfers in a manner that ultimately reflects the permit standard of highest practicable levels of conservation as set out in §11.085(l) so that the planning process more closely considers the realities of the permits needed. Also, it would be impracticable to define "highest practicable levels of water conservation and efficiency achievable within the jurisdiction of the applicant" since that needs to be defined on a case-by-case basis. Lastly, the term "jurisdiction" is not defined in statute and the board does not believe it is the proper entity to do so.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that regional water planning groups no longer have the option of choosing not to develop water conservation strategies as a result of the changes to Texas Water Code §16.053(h)(7)(B). They comment that the new

statutory language requires a minimum substantive standard for water conservation measures, specifically they must be at least as stringent as Texas Water Code §11.1271, which is regulated by the Texas Natural Resource Conservation Commission in administrative rules. They commented that §357.7(a)(7)(A) should be clear that the law requires more than just incorporating the savings from the plumbing fixture codes or those that occur without any local effort. They recommend new language be added between the second and third sentence to set minimum conservation standards. They also state that statute gives the board latitude to require the regional water planning groups to consider conservation practices achieving the highest practicable levels of water use efficiency. They also recommend the phrase "from a new unpermitted interbasin transfer" in §357.7(a)(7)(A) be changed to read "through an interbasin transfer to which Texas Water Code §11.085(l) applies." They recommend the subparagraph also add "for municipal uses" after "gallons per capita per day" and before "based on its determination" since a gallons per capita per day computation is appropriate for municipal uses. For other proposed uses of interbasin transfers, they recommend another sentence be added to require the development of conservation water management strategies designed to achieve the highest practicable levels of water conservation. They recommend that the Texas Natural Resource Conservation Commission rules that implement Texas Water Code §11.085 be used as guidance. *The board makes changes based on the comment regarding adding language about Texas Water Code §11.1271. Section 357.7(a)(7)(A) is revised to state that the regional water planning groups must consider water conservation practices for each need identified and include such practices for each user group to which Texas Water Code §11.1271 applies. The practices must be consistent with the substantive requirements of the Texas Natural Resource Conservation Commission's administrative rules related to §11.127. The board makes changes based on the comment that the regional water planning groups should consider the highest practicable levels of water use efficiency but does not use this recommended language because that standard is only used pertaining to new interbasin transfers in Texas Water Code §11.085. To apply that standard to other situations would go beyond the scope of the law. Instead, the board adds §357.7(a)(7)(A)(ii) to require the regional water planning groups to consider conservation measures beyond the minimum levels and document the reasons why such measures are not recommended for any water user group. The board makes the suggested changes to the phrase "from a new unpermitted interbasin transfer" to more accurately describe the scope of Texas Water Code §11.085. The board makes changes to §357.7(a)(7)(A) to add the phrase "for municipal uses" as recommended and to add the reference to Texas Natural Resource Conservation Commission rules, as recommended. Because the recommended interbasin transfers were for municipal uses in the first round of planning, and that is anticipated to continue in future rounds, the board does not add a provision for other interbasin transfer uses.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that language should be added to §357.7(a)(7)(B) to make it clear that drought contingency plans are required for any need proposed to be met by an interbasin transfer to which Texas Water Code §11.085(l) applies. They also commented that new language should be added to require the regional water planning groups to consider drought management measures for each need identified and include such practices for each water user group to which Texas Water Code §11.1272 applies. *The board makes no changes based on the comment concerning drought contingency plans for interbasin transfers because the language of Texas Water Code §11.085 does not require drought contingency measures to a higher standard than other Water Code provisions, unlike the water conservation requirements. However, the board makes changes based on the comment regarding drought management measures pursuant to Texas Water Code §11.1272.*

Freese and Nichols commented that the use of a quantitative reporting requirement in §357.7(a)(8)(A) for the impacts of strategies on the state's water resources, agricultural resources, and natural resources may go beyond the scope of Senate Bill 2. *The board makes no changes based on this comment. The quantitative reporting requirement for state water resources and natural resources was already in §357.7(a)(8)(A). To comply with Senate Bill 2, the board proposes to add a quantitative reporting of impacts to agricultural resources, as well. Requiring a quantitative analysis is consistent with the Senate Bill 2 requirement to have plans consistent with long-term protection of the state's water resources, agricultural resources, and natural resources.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that §357.7(a)(8)(A)(ii) should include language about consideration of third-party impacts from the loss of environmental flows and seeks treatment of third party impacts to natural resources in the same way impacts on agricultural resources are reviewed in §357.7(a)(8)(A)(iii). *The board makes changes to §357.7(a)(8)(A)(iii) in response to this comment by deleting the referred to language, but makes no changes to §357.7(a)(7)(A)(ii) based on this comment because this requirement already exists in §357.7(a)(8)(G).*

Brazos River Authority commented that the language in §357.7(a)(8)(A)(iii) is vague and subjective. It commented that the terms "impacts," "agricultural resources," and "third-party impacts" need to be defined. It stated that the objective of the rule is unclear and that threats to agricultural and natural resources already are required to be addressed in §357.7(a)(8)(C). *The board makes changes to the proposed amendments based on this comment. The language in §357.7(a)(7)(A)(iii) is moved to §357.7(a)(8)(G). The board believes the terms used in the proposed amendment are clear and makes no further changes based on this comment.*

Lower Colorado River Authority commented that the requirement to analyze third-party impacts in §357.7(a)(8)(A)(iii) is duplicative of §357.7(a)(8)(G), which requires an analysis of third party social and economic impacts resulting from voluntary redistribution of water and recommended deletion of the provision in §357.7(a)(8)(A)(iii). *The board agrees and makes changes to the proposed amendments as a result of this comment. Section 357.7(a)(8)(A)(iii) is revised to remove the requirement to analyze third party impacts and the language is added to §357.7(a)(8)(G) for clarity.*

American Electric Power, National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the meaning and source of the term "environmentally sensitive" in §357.7(a)(9) is not clear. American Electric Power recommended the sentence read "Strategies shall be selected so that cost effective water management strategies which provide long-term protection of the state's water resources, agricultural resources, and natural resources are adopted unless the regional water planning

group demonstrates that adoption of such strategies is not appropriate." National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense also commented that the rule must provide some direction on how consistency with the standard of requiring long-term protection will be determined. They state that long-term protection of water resources requires a sustainable approach to management of water resources. Lastly, National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the rule should require selection of strategies that provide long-term protection of all three categories of resources. They state that this includes providing for environmental flow needs. *The board agrees with the comment regarding the term "environmentally sensitive and makes changes to the proposed amendment to remove the term "environmentally sensitive" and replace it with the language recommended by American Electric Power. The board makes no changes to the rules based on the comment that there needs to be direction on how to provide long-term protection because that guidance is already provided in the proposed amendments to §357.14(2)(C). The board does make changes to the proposed amendments based on the comment about providing an exception to providing long-term protection. The board agrees that this is not supported by the law and removes the provision. No changes were made to require resource management under a sustainable basis because this would exceed the scope of the law and would be inconsistent with the state's regulatory scheme.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the reference to "key parameters" in §357.7(a)(12) is redundant and one should be removed. *The board agrees and removes the second phrase and consolidates the paragraph for clarity.*

Brazos River Authority commented that §357.7(a)(13) is redundant because, if the requirements of Chapters 357 and 358 are followed, the regional water plan is consistent with the long-term protection of the state's water, agricultural, and natural resources and a separate chapter on this is unnecessary. *The board makes no changes to the proposed rules based on this comment. Senate Bill 2 amended Texas Water Code §16.053(h)(7)(C) to require the regional water plans to be consistent with the long-term protection of the state's water resources, agricultural resources, and natural resources. By requiring the regional water plans to state, in a separate chapter, how the plan meets this requirement, it will be clear to all parties interested in the plans how this requirement was met. The board discovered in the first round of planning that even though the plans include much analysis and consideration, some vital elements may not be readily apparent if they are not featured in a chapter. Therefore, it is important to bring this element out for ease of use and identification.*

South Central Texas Regional Water Planning Group commented that §357.7(a)(14) should be revised to reflect that the chapter discussing financing needs cannot be prepared until after the approval of the 2006 regional water plans. It commented that if the intent was to include this requirement in the 2006 regional water plans, the rule needs clarification. *The board makes no changes based on this comment. The regional water planning groups have obtained funding to perform an infrastructure resources survey and will have the data necessary to be included in the 2006 regional water plans.*

Freese and Nichols commented that §357.7(c) and (d) create a duplication of effort at the state level. They state that model conservation and drought contingency plans specific to different types of entities are available from the Texas Natural Resource Conservation Commission and that the board should coordinate with the Commission on these. *The board makes no changes to the proposed rules based on this comment. Proposed §357.7(c) and (d) are intended to comply with the Senate Bill 2 amendment to Texas Water Code §16.053(h)(7), which requires regional water plans to include water conservation practices and drought management measures incorporating, at a minimum, the provisions of Texas Water Code §11.1271 and §11.1272. The board will coordinate with TNRCC and will certainly accept the model plans provided by the TNRCC. The model conservation plans developed as part of the regional water planning process will also differ from TNRCC model plans in that they will be specific to what conservation is achievable and feasible in that region.*

Freese and Nichols commented that the proposed amendments to §357.8 are contrary to the intent of Senate Bill 2 and will deter regional water planning groups from designating unique stream segments. They state that the proposed rule provides additional protections to unique stream segments not covered by the amendments made by Senate Bill 2. *The board makes no changes to the proposed rule based on this comment. Senate Bill 2 added Texas Water Code §16.053(e)(7) to require the regional water planning groups to assess the impact of their plans on unique river and stream segments. The proposed addition of §357.8(c) is intended to provide guidance to the regional water planning groups in how to assess the impacts. This assessment is required by law and does not provide additional protections to unique river and stream segments.*

South Central Texas Regional Water Planning Group commented that §357.8(c) should be amended to reflect that the current regional water plans being developed will only need to assess the ecologically unique river and stream segments designated by the legislature in the 78th Regular Session or recommended for designation in the regional water plan. *The board agrees and makes changes based on this comment. The language is revised to clarify that any designations made during a legislative session that adjourns less than a year before the due date of the next regional water plan do not have to be considered by that plan.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that §357.8(c) should require consideration by the regional group of the important characteristics of the segment cited by the Texas Parks and Wildlife Department in any nomination of a segment by the Department for consideration for unique river or stream status and that the word "region's" in the last sentence should be changed to "Texas Parks and Wildlife Department." *The board makes changes based on this comment. Texas Water Code §16.053(e)(6) gives the responsibility of identifying and recommending river and stream segments of unique ecological value to the regional water planning groups. The board revises the proposed amendments to change the word "nomination" in the last sentence to "recommendation" to avoid confusion between the responsibilities of the regional planning groups and the Texas Parks and Wildlife Department.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that §357.11(g)(1) should be revised to require their petition to the board to include a description of the

efforts made by a political subdivision to work with the regional water planning group to get an amendment to a regional water plan. *The board agrees and adds the requirement as recommended.*

Freese and Nichols commented that the required model conservation and drought contigency plans should not be part of §357.14(2)(B). *The board makes no changes to the proposed rules based on this comment. As described previously, Senate Bill 2 requires regional water plans to include water conservation practices and drought management measures incorporating, at a minimum, the provisions of Texas Water Code §11.1271 and §11.1272 and specifies that board may only approve a regional water plan if it includes such provisions. This proposed amendment is intended to be part of compliance with that requirement.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that proposed amendments to §357.14(2)(B) that require regional water plans to include model water conservation and drought management models are not sufficient to meet the statutory requirements of Texas Water Code §11.1271 and §11.1272. They state the effect of this proposed rule is to read Texas Water Code §16.053(h)(7)(B) right out of the law and recommend the provision be revised to require compliance with §357.7(a)(7)(A) and (B), as well. *The board agrees and changes the provision as recommended.*

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that §357.14(2)(C) is insufficient to comply with Senate Bill 2. They state that the board has failed to propose revisions to the Texas Water Code §16.051(d) guidance to implement Texas Water Code §16.053(h)(7)(C) and that §357.14(2)(C) only makes a generic finding of consistency with the statutory requirement by referring to "development" of the plan, which is asserted to be procedural and not substantive. *The board makes changes to §357.14(2)(C) to mirror the language of Texas Water Code §16.053(h)(7)(C) to avoid the appearance of a generic finding of inconsistency. The board believes, though, that these proposed rules and amendments, in conjunction with existing rules provide more than sufficient guidance to the regional water planning groups to comply with Texas Water Code §16.053(h)(7)(C), and to the board in determining that the regional water plans have complied before issuance of its approval. The requirements of the cited sections that must be complied with effect substantive, and not merely procedural, compliance with Texas Water Code §16.053(h)(7)(C).*

The amendments and new section are adopted under the authority of Texas Water Code §§6.101, 16.051, and 16.053.

§357.2. Definitions.

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise. Words defined in the applicable provisions of the Texas Water Code, Chapter 16, and not defined here shall have the meanings provided in Chapter 16.

(1) Board--The Texas Water Development Board.

(2) Drought of record--The period of time when natural hydrological conditions provided the least amount of water supply.

(3) Executive administrator--The executive administrator of the board or a designated representative.

(4) Political subdivision--City, county, district or authority created under the Texas Constitution, Article III, §52, or Article XVI, §59, any other political subdivision of the state, any interstate compact commission to which the state is a party, and any nonprofit water supply corporation created and operating under Acts of the 43rd Legislature, 1933, 1st Called Session, Chapter 76, (Vernon's Texas Civil Statutes, Article 1434a).

(5) Regional water plan--The plan adopted or amended by a regional water planning group pursuant to the Texas Water Code, §16.053 and this chapter.

(6) Retail public utility--Any person, corporation, public utility, water supply or sewer service corporation, municipality, political subdivision or agency operation, maintaining, or controlling in this state facilities for providing potable water service or sewer service, or both, for compensation.

(7) State water plan--The most recent state water plan adopted by the board under the Texas Water Code, Chapter 16.

(8) Wholesale water provider--Any person or entity, including river authorities and irrigation districts, that has contracts to sell more than 1000 acre-feet of water wholesale in any one year during the five years immediately preceding the adoption of the last regional water plan. The regional water planning groups shall include as wholesale water providers other persons and entities that enter or that the regional water planning group expects or recommends to enter contracts to sell more than 1000 acre-feet of water wholesale during the period covered by the plan.

§357.7. Regional Water Plan Development.

(a) Regional water plan development shall include the following:

(1) description of the regional water planning area including:

(A) wholesale water providers,

(B) current water use,

(C) identified water quality problems,

(D) sources of groundwater and surface water including major springs that are important for water supply or natural resource protection purposes,

(E) major demand centers,

(F) agricultural and natural resources,

(G) social and economic aspects of the regional water planning area including information on current population and primary economic activities including businesses dependent on natural water resources,

(H) assessment of current preparations for drought within the regional water planning area,

(I) summary of existing regional water plans,

(J) summary of recommendations in state water plan,

(K) summary of local water plans,

(L) any identified threats to the agricultural and natural resources of the regional water planning area due to water quantity problems or water quality problems related to water supply, and

(M) information on water pipelines and other facilities that the regional water planning group determines are or could be used for water conveyance, including, but not limited to currently used and abandoned oil, gas, and water pipelines. This information will be developed from data provided by the board from its pipeline and facility reports received pursuant to §358.6 of this title (relating to Pipeline

and Facility Reports), data available from the Railroad Commission of Texas, and any other data gathered by the regional water planning groups;

(2) presentation of current and projected population and water demands. Results shall be reported:

(A) by

(i) city for cities with populations greater than 500 people,

(ii) retail public utility for counties that have less than five retail public utilities which provide more than 280 acre-feet per year for municipal use,

(iii) individual retail public utility or collective data for all such retail public utilities that form a logical reporting unit, such as being served by a common wholesale water provider or having a common source or other association appropriate for the area, in the judgment of the regional water planning group, for counties with more than five retail public utilities which provide more than 280 acre-feet per year for municipal use, and

(iv) categories of water use (including municipal not otherwise reported, manufacturing, irrigation, steam electric power generation, mining, and livestock watering) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin;

(B) for each wholesale water provider by category of water use (municipal, manufacturing, irrigation, steam electric power generation, mining, and livestock) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin. The wholesale water provider's current contractual obligations to supply water must be reported in addition to any demands projected for the wholesale water provider;

(C) to include an adjustment to each municipal demand due to water savings from using plumbing fixtures identified in Chapter 372 of the Texas Health and Safety Code. The regional water planning group shall determine and report the extent to which such plumbing fixtures impact projected municipal water use using parameters approved by the executive administrator.

(3) evaluation of adequacy of current water supplies legally and physically available to the regional water planning area for use during drought of record. The term "current" means water supply available at the beginning of this task. This evaluation shall consider surface water and groundwater data from the state water plan, existing water rights, contracts and option agreements, other planning and water supply studies, and analysis of water supplies currently available to the regional water planning area. Firm yields for reservoirs shall be presented. Analysis of surface water available during drought of record may be based on operational procedures other than firm yield from reservoirs upon the documented decision of the regional water planning group as long as the amount of water available due to the operational procedure does not exceed the amount of water that would be available using system firm yield. Firm yield is defined as the supply the reservoir can provide during a drought of record using reasonable sedimentation rates and the assumption that all senior water rights will be totally utilized. Until information is provided by the Texas Natural Resource Conservation Commission, regional water planning groups may use estimates of the projected amount of surface water that would be available from existing water rights during a drought of record. Once this information is available from the Texas Natural Resource Conservation Commission, the regional water planning group shall incorporate it in its next planning cycle unless better site-specific information is available. Until information is available from the board regarding groundwater availability from modeling, the regional water planning groups may use estimates of the projected amounts as long as they describe the method used to arrive at those estimates. Once the groundwater availability modeling information is available for an area within a region, that regional water planning group shall incorporate such information in its next planning cycle unless better site-specific information is available. The executive administrator, after coordination with staff of the Texas Natural Resource Conservation Commission and the Texas Parks and Wildlife Department, shall identify the methodology, in consultation with representatives of regional water planning groups, to be used by regional water planning groups to calculate water availability during drought of record. The executive administrator shall provide available technical assistance to the regional water planning groups upon request to assist them in selecting appropriate methods and data to be used to determine water supply availability. Water supplies based on contracted agreements shall be based on the terms of the contract, which may be assumed to renew at the contract termination date if the contract contemplates renewal or extensions. Results of evaluations shall be reported:

(A) by

(i) city for cities with populations greater than 500 people,

(ii) retail public utility for counties that have less than five retail public utilities which provide more than 280 acre-feet per year for municipal use,

(iii) individual utility or collective data for all such retail public utilities that form a logical reporting unit, such as being served by a common wholesale water provider or having a common source or other association appropriate for the area, in the judgment of the regional water planning group, for counties with more than five retail public utilities which provide more than 280 acre-feet per year for municipal use, and

(iv) categories of water use (including municipal not otherwise reported, manufacturing, irrigation, steam electric power generation, mining, and livestock watering) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin;

(B) for each wholesale water provider by category of water use (municipal, manufacturing, irrigation, steam electric power generation, mining, and livestock) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin. The wholesale water provider's current contractual obligations to supply water must be reported in addition to any demands projected for the wholesale water provider;

(4) water supply and demand analysis comparing:

(A) water demands as developed in paragraph (2)(A) of this subsection with current water supplies available to the regional water planning area as developed in paragraph (3)(A) of this subsection to determine if the water users identified in paragraph (2)(A) of this subsection in the regional water planning area will experience a surplus of supply or a need for additional supplies. The social and economic impact of not meeting these needs shall be evaluated by the regional water planning groups and reported by regional water planning area and river basin. The executive administrator shall provide available technical assistance to the regional water planning groups, upon request, on water supply and demand analysis, including methods to evaluate the social

and economic impacts of not meeting needs. Other results shall be reported by

(i) city for cities with populations greater than 500 people,

(ii) retail public utility for counties that have less than five retail public utilities which provide more than 280 acre-feet per year for municipal use,

(iii) individual utility or collective data for all such retail public utilities that form a logical reporting unit, such as being served by a common wholesale water provider or having a common source or other association appropriate for the area, in the judgment of the regional water planning group, for counties with more than five retail public utilities which provide more than 280 acre-feet per year for municipal use, and

(iv) categories of water use (including municipal not otherwise reported, manufacturing, irrigation, steam electric power generation, mining, and livestock watering) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin;

(B) water demands as developed in paragraph (2)(B) of this subsection with current water supplies available to the wholesale water provider as developed in paragraph (3) of this subsection to determine if the wholesale water providers in the regional water planning area will experience a surplus of supply or a need for additional supplies. Results shall be reported for each wholesale water provider by categories of water use (including municipal, manufacturing, irrigation, steam electric power generation, mining, and livestock watering) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin. The executive administrator shall provide available technical assistance to the regional water planning groups, upon request, on water supply and demand analysis;

(5) using the water supply needs identified in paragraph (4) of this subsection, water management strategies to be used during the drought of record to provide sufficient water supply to meet the needs identified in paragraph (4) of this subsection as follows:

(A) Water management strategies shall be developed for:

(i) city for cities with populations greater than 500 people,

(ii) retail public utility for counties that have less than five retail public utilities which provide more than 280 acre-feet per year for municipal use,

(iii) individual utility or collective data for all such retail public utilities that form a logical reporting unit, such as being served by a common wholesale water provider or having a common source or other association appropriate for the area, in the judgment of the regional water planning group, for counties with more than five retail public utilities which provide more than 280 acre-feet per year for municipal use, and

(iv) categories of water use (including municipal not otherwise reported, manufacturing, irrigation, steam electric power generation, mining, and livestock watering) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin;

(B) water management strategies shall be developed for wholesale water providers. The water management strategies shall also meet the new water supply obligations necessary to implement recommended water management strategies of other wholesale water providers and water users for which plans are developed under of this paragraph. Results shall be reported for each wholesale water provider by category of water use (municipal, manufacturing, irrigation, steam electric power generation, mining, and livestock) for each county or portion of a county in the regional water planning area. If a county or portion of a county is in more than one river basin, data shall be reported for each river basin;

(C) The plan to be used for water supply during drought of record shall meet all needs for the water use categories of municipal, manufacturing, irrigation, steam electric power generation, mining, and livestock watering except:

(i) plans may identify those needs for which no water management strategy is feasible. Full evaluation of water management strategies must be presented and reasons given for why no water management strategies are feasible; or

(ii) where a political subdivision that provides water supply (other than water supply corporations, counties, or river authorities) does not participate in the regional water planning effort for needs located within its boundaries or extraterritorial jurisdiction. The regional water planning group shall establish terms of participation that shall be equitable and shall not unduly hinder participation;

(6) presentations of the data required in paragraphs (2) - (5) of this subsection in subdivisions of the reporting units required such as reporting irrigation for a county by splitting it into two or more reporting units, if the regional planning group desires;

(7) evaluation of all water management strategies the regional water planning group determines to be potentially feasible, including:

(A) water conservation practices. The executive administrator shall provide technical assistance to the regional water planning groups on water conservation practices. The regional water planning group must consider water conservation practices for each need identified in paragraph (4) of this subsection.

(i) The regional water planning group shall include water conservation practices for each user group to which Texas Water Code §11.1271 applies. The impact of these water conservation practices on water needs must be consistent with the requirements in appropriate Texas Natural Resource Conservation Commission administrative rules related to §11.1271.

(ii) The regional water planning group shall consider water conservation practices for each user group beyond the minimum requirements of clause (i) of this subparagraph, whether or not the water user group is subject to Texas Water Code §11.1271. If it does not adopt a water conservation strategy that exceeds minimum levels, it shall document the reason.

(iii) For each water user group or wholesale water provider that is to obtain water from a proposed interbasin transfer to which Texas Water Code §11.085(l) applies, the regional water planning group shall include a conservation water management strategy, pursuant to §11.085(1), that will result in the highest practicable level of water conservation and efficiency achievable. The regional water planning group shall determine and report the projected water use in gallons per capita per day for municipal uses based on its determination of the highest practicable level of water conservation and efficiency achievable. The regional water planning group shall develop conservation water management strategies based on this determination. In

preparing the evaluation, the regional water planning group shall seek the input of the water user groups and wholesale water providers as to what is the highest practicable level of water conservation and efficiency achievable, in their opinion, and take that input into consideration. The regional water planning groups shall develop the conservation water management strategy consistent with the guidance provided by the Texas Natural Resource Conservation Commission in its administrative rules that implement Texas Water Code §11.085. The strategy evaluation shall include a quantitative description of the quantity, cost, and reliability of the water estimated to be conserved under the highest practicable level of water conservation and efficiency achievable;

(B) drought management measures including water demand management. The executive administrator shall provide technical assistance to the regional water planning groups on drought management measures. The regional water planning group must consider drought management measures for each need identified in paragraph (4) of this subsection and must include such measures for each user group to which Texas Water Code §11.1272 applies. The impact of these drought management measures on water needs must be consistent with the guidance provided by the Texas Natural Resource Conservation Commission in its administrative rules that implement Texas Water Code §11.1272. If the regional water planning group does not adopt a drought management strategy for a need that goes beyond the requirements of §11.1272, it must document the reason. Nothing in this paragraph shall be construed as limiting the use of voluntary arrangements by water users to forgo water usage during drought periods;

(C) reuse of wastewater;

(D) expanded use of existing supplies including systems optimization and conjunctive use of resources, reallocation of reservoir storage to new uses, voluntary redistribution of water resources including contracts, water marketing, regional water banks, sales, leases, options, subordination agreements, and financing agreements, subordination of existing water rights through voluntary agreements, enhancements of yields of existing sources, and improvement of water quality including control of naturally occurring chlorides;

(E) new supply development including construction and improvement of surface water and groundwater resources, brush control, precipitation enhancement, desalination, water supply that could be made available by cancellation of water rights based on data provided by the Texas Natural Resource Conservation Commission, aquifer storage and recovery;

(F) interbasin transfers; and

(G) other measures;

(8) evaluations of all water management strategies the regional water planning group determines to be potentially feasible by including:

(A) a quantitative reporting of:

(i) the quantity, reliability, and cost of water delivered and treated for the end user's requirements, incorporating factors to be used in the calculation of infrastructure debt payments, present costs, and discounted present value costs provided by the executive administrator;

(ii) environmental factors including effects on environmental water needs, wildlife habitat, cultural resources, and effect of upstream development on bays, estuaries, and arms of the Gulf of Mexico;

(iii) impacts on agricultural resources;

(B) impacts on other water resources of the state including other water management strategies and groundwater surface water interrelationships;

(C) for each threat to agricultural and natural resources identified pursuant to paragraph (1) of this subsection, a discussion of how that threat will be addressed or affected by the water management strategies evaluated;

(D) any other factors as deemed relevant by the regional water planning group including recreational impacts;

(E) equitable comparison and consistent application of all water management strategies the regional water planning groups determines to be potentially feasible for each water supply need;

(F) consideration of the provisions in Texas Water Code, §11.085(k)(1) for interbasin transfers of surface water. At a minimum, this consideration shall include a summation of water needs in the basin of origin and in the receiving basin, based on needs presented in the applicable approved regional water plan;

(G) consideration of third party social and economic impacts resulting from voluntary redistributions of water, including analysis of third-party impacts of moving water from rural and agricultural areas; and

(H) consideration of water pipelines and other facilities that can be used for water conveyance as described in subsection (a)(1)(M) of this section;

(9) specific recommendations of water management strategies to meet the needs in sufficient detail to allow state agencies to make financial or regulatory decisions to determine the consistency of the proposed action before the state agency with an approved regional water plan. Strategies shall be selected so that cost effective water management strategies which are consistent with long-term protection of the state's water resources, agricultural resources, and natural resources are adopted;

(10) regulatory, administrative, or legislative recommendations that the regional water planning group believes are needed and desirable to: facilitate the orderly development, management, and conservation of water resources and preparation for and response to drought conditions in order that sufficient water will be available at a reasonable cost to ensure public health, safety, and welfare; further economic development; and protect the agricultural and natural resources of the state and regional water planning area. The regional water planning group may develop information as to the potential impact once proposed changes in law are enacted;

(11) a chapter consolidating the water conservation and drought management recommendations of the regional water plan;

(12) a description of the major impacts of recommended water management strategies on key parameters of water quality identified by the regional water planning group as important to the use of the water resource and comparing conditions with the recommended water management strategies to current conditions using best available data;

(13) a chapter describing how the regional water plan is consistent with long-term protection of the state's water resources, agricultural resources, and natural resources as required in §357.14(2)(C) of this title (relating to Approval of Regional Water Plans by the Board); and

(14) a chapter describing the financing needed to implement the water management strategies recommended. The description

shall include how local governments, regional authorities, and other political subdivisions in the regional water planning area propose to pay for water management strategies identified in the regional water plan.

(b) Specific recommendations of water management strategies to meet an identified need will not be shown as meeting the need for a political subdivision if the political subdivision to supply or to be provided water supplies objects to inclusion of the strategy for such political subdivision and specifies its reasons for such objection. This does not prevent the inclusion of the strategy to meet other needs.

(c) The regional water planning group shall include in its regional water plan a model water conservation plan pursuant to Texas Water Code §11.1271 .

(d) The regional water planning group shall include in its regional water plan a model drought contingency plan pursuant to Texas Water Code §11.1272 .

(e) The executive administrator shall provide technical assistance within available resources to the regional water planning groups requesting such assistance in performing regional water planning activities and if requested, may facilitate resolution of conflicts within regional water planning areas.

§357.8. Ecologically Unique River and Stream Segments.

(a) Regional water planning groups may include in adopted regional water plans recommendations for all or parts of river and stream segments of unique ecological value located within the regional water planning area by preparing a recommendation package consisting of a physical description giving the location of the stream segment, maps, and photographs of the stream segment and a site characterization of the stream segment documented by supporting literature and data. The recommendation package shall address each of the criteria for designation of river and stream segments of ecological value found in subsection (b) of this section. The regional water planning group shall forward the recommendation package to the Texas Parks and Wildlife Department and allow the Texas Parks and Wildlife Department 30 days for its written evaluation of the recommendation. The adopted regional water plan shall include, if available, Texas Parks and Wildlife Department's written evaluation of each river and stream segment recommended as a river or stream segment of unique ecological value.

(b) A regional water planning group may recommend a river or stream segment as being of unique ecological value based upon the following criteria:

(1) biological function--stream segments which display significant overall habitat value including both quantity and quality considering the degree of biodiversity, age, and uniqueness observed and including terrestrial, wetland, aquatic, or estuarine habitats;

(2) hydrologic function--stream segments which are fringed by habitats that perform valuable hydrologic functions relating to water quality, flood attenuation, flow stabilization, or groundwater recharge and discharge;

(3) riparian conservation areas--stream segments which are fringed by significant areas in public ownership including state and federal refuges, wildlife management areas, preserves, parks, mitigation areas, or other areas held by governmental organizations for conservation purposes, or stream segments which are fringed by other areas managed for conservation purposes under a governmentally approved conservation plan;

(4) high water quality/exceptional aquatic life/high aesthetic value--stream segments and spring resources that are significant due to unique or critical habitats and exceptional aquatic life uses dependent on or associated with high water quality; or

(5) threatened or endangered species/unique communities--sites along streams where water development projects would have significant detrimental effects on state or federally listed threatened and endangered species, and sites along streams significant due to the presence of unique, exemplary, or unusually extensive natural communities.

(c) For every river and stream segment that has been designated as a unique river or stream segment by the legislature, during a session that ends not less than one year before the required date of submittal of an adopted regional water plan to the board, or recommended as a unique river or stream segment in the regional water plan, the regional water planning group shall assess the impact of the regional water plan on these segments. The assessment shall be a quantitative analysis of the impact of the plan on the flows important to the river or stream segment, as determined by the regional water planning group, comparing current conditions to conditions with implementation of all recommended water management strategies. The assessment shall also describe the impact of the plan on the unique features cited in the region's recommendation of that segment.

§357.11. Adoption of Regional Water Plans by Regional Water Planning Groups.

(a) Regional water planning groups shall concurrently submit to the executive administrator and release to the public an initially prepared regional water plan prior to adoption of the regional water plan. The initially prepared plan submitted to the executive administrator must be in the electronic and paper format specified by the executive administrator. The regional water planning groups must certify that the initially prepared regional water plan is complete and adopted by the regional water planning group.

(b) The regional water planning groups shall receive and consider the following comments when adopting a regional water plan:

(1) the executive administrator's written comments, which shall be provided to the regional water planning group within 120 days of receipt of the initially prepared plan;

(2) written comments received from any federal agency or Texas state agency, which the regional water planning groups shall accept for at least 120 days after the first public hearing notice is published pursuant to §357.12(a)(3) and (5) of this title (relating to Notice and Public Participation); and

(3) any written or oral comments received from the public after the first public hearing notice is published pursuant to §357.12(a)(3) and (5) of this title until at least 60 days after the public hearing is held pursuant to §357.12(a)(3) and (4) of this title.

(c) The regional water planning group shall submit in a timely manner to the executive administrator information on any known interregional conflict between regional water plans.

(d) The regional water planning group shall modify the regional water plan to incorporate board resolutions of interregional conflicts.

(e) The regional water planning group shall seek to resolve conflicts with other regional water planning groups and shall participate in any board sponsored efforts to resolve interregional conflicts.

(f) A regional water planning group may amend an adopted regional water plan at any meeting, after giving notice according to §357.12 of this title and providing the public, the board, and other governmental entities 30 days to submit written or oral comments on the proposed amendment. A regional water planning group may propose amendments to an approved regional water plan by submitting

proposed amendments to the board for its consideration and possible approval under the standards and procedures of this chapter.

(g) A political subdivision in the regional water planning area may request a regional water planning group to consider specific changes to an adopted regional water plan based on changed conditions or new information. A regional water planning group must formally consider such request within 180 days after its submittal and shall amend its adopted regional water plan if it determines an amendment is warranted. If the political subdivision is not satisfied with the regional water planning group's decision on the issue, it may file a petition with the executive administrator to request board review the decision and consider changing the approved regional water plan. The political subdivision shall send a copy of the petition to the chair of the affected regional water planning group.

(1) The petition must state:

(A) the changed condition or new information that affects the approved regional water plan;

(B) the specific sections and provisions of the approved regional water plan that are affected by the changed condition or new information;

(C) the efforts made by the political subdivision to work with the regional water planning group to obtain an amendment; and

(D) the proposed amendment to the approved regional water plan.

(2) If the executive administrator determines that the changed condition or new information warrants a change in the approved regional water plan, the executive administrator shall request the regional water planning group to consider making the appropriate change and provide the reason in writing. The political subdivision that submitted the petition will receive notice of any action requested of the regional water planning group by the executive administrator. If the regional water planning group does not amend its plan consistent with the request within 90 days, the executive administrator will present the issue to the board for consideration at a public meeting. Before presenting the issue to the board, the executive administrator will provide the regional water planning group, the political subdivision submitting the petition, and any political subdivision determined by the executive administrator to be affected by the issue 30 days notice.

(3) If the board determines that a change to the approved regional water plan is appropriate based on the changed condition or new information, it may direct the executive administrator to make the change. The executive administrator will make the required change to the approved regional water plan and any necessary changes to the state water plan as directed by the board.

§357.14. Approval of Regional Water Plans by the Board.

Upon receipt of a regional water plan adopted by the regional water planning group, the board will consider approval of such plan based on the following criteria.

(1) The board shall verify adoption of the regional water plan by the regional water planning group.

(2) The board shall approve the plan only after it has determined that:

(A) the regional water plan meets the requirements contained in the Texas Water Code, Chapter 16, this chapter, and Chapter 358 of this title (relating to State Water Planning Guidelines);

(B) the plan includes water conservation practices and drought management measures incorporating, at a minimum, the provisions of §357.7(a)(7)(A) and (B) and §357.7(c) and (d) of this title (relating to Regional Water Plan Development); and

(C) the plan is consistent with long-term protection of the state's water resources, agricultural resources, and natural resources as embodied in the guidance principles in Chapter 358 of this title (relating to State Water Planning Guidelines). The regional water plan is consistent with the guidance principles if it is developed in accordance with §358.3 of this title (relating to Guidelines), §357.5 of this title (relating to Guidelines for Development of Regional Water Plans), §357.7 of this title (relating to Regional Water Plan Development), §357.8 of this title (relating to Ecologically Unique River and Stream Segments), and §357.9 of this title (relating to Unique Sites for Reservoir Construction).

(3) The board shall approve the plan only after it considers information from regional water planning groups of the existence of an interregional conflict and finds that no interregional conflict exists. The board shall not consider approval of a regional water plan unless all regional water plans which could contain conflicts have also been submitted to the board for approval, or the board determines that such plans are not likely to be submitted.

(4) In the event the board finds that the regional water plan does not meet the requirements contained in the Texas Water Code, Chapter 16, this chapter, and Chapter 358 of this title (relating to State Water Planning Guidelines) the executive administrator shall:

(A) notify the affected regional water planning group of the nature of the problems; and

(B) request the affected regional water planning group's assistance in resolving the problems.

(5) In the event negotiations fail to produce a plan the executive administrator considers to resolve compliance problems noted under paragraph (4) of this subsection, the executive administrator shall:

(A) describe the remaining problems and recommended actions needed to resolve them;

(B) provide notice of its intent to hold a public hearing on remaining problems and proposed recommendations for resolution of the problems by publishing notice of the proposed change in the Texas Register and in a newspaper of general circulation in each county located in whole or in part in the regional water planning areas involved in the dispute 30 days before the public hearing and by mailing notice of the public hearing 30 days before public hearing to those persons or entities listed in §357.12(a)(5)(A)-(E) of this title (relating to Notice and Public Participation) in the affected regional water planning areas, and to each affected regional water planning group;

(C) hold a public comment hearing on the remaining problems and proposed recommendation for resolution of the problems at a time and place determined by the executive administrator. At the hearing, the executive administrator shall take comments from the regional water planning groups, political subdivisions, and members of the public on the issues identified by the board as unresolved problems; and

(D) make a recommendation to the board as to whether or not problems remain.

(6) The board shall consider the executive administrator's recommendation and statements by a representative for the regional water planning group and others and determine whether the regional water plan meets the requirements contained in the Texas Water Code,

Chapter 16, this chapter, and Chapter 358 of this title (relating to State Water Planning Guidelines).

(7) The executive administrator shall notify affected regional water planning groups of the board's decision including details of how affected regional water plans must be amended.

(8) In the event the board finds that an interregional conflict exists between adopted regional water plans, the executive administrator shall:

(A) notify the affected regional water planning groups of the nature of the interregional conflict;

(B) request affected regional water planning groups assistance in resolving the conflict; and

(C) negotiate resolutions of conflicts with regional water planning groups and other interested parties as determined by the executive administrator.

(9) In the event negotiations conducted under paragraph (8) of this subsection to resolve conflicts between adopted regional water plans are unsuccessful, the executive administrator shall:

(A) determine a proposed recommendation for resolution of the conflict;

(B) provide notice of its intent to hold a public hearing on proposed recommendations for resolution of the conflict by publishing notice of the proposed change in the Texas Register and in a newspaper of general circulation in each county located in whole or in part in the regional water planning areas involved in the dispute 30 days before the public hearing and by mailing notice of the public hearing 30 days before public hearing to those persons or entities listed in §357.12(a)(5)(A)-(E) of this title (relating to Notice and Public Participation) in the regional water planning areas proposed to be impacted, and to each county judge of a county located in whole or in part in the regional water planning areas proposed to be impacted and to each affected regional water planning group;

(C) hold a public hearing on the proposed recommendation for resolution of the conflict at a time and place determined by the executive administrator. At the hearing, the executive administrator shall take comments from the regional water planning groups, political subdivisions, and members of the public on the issues identified by the board as unresolved problems; and

(D) make a recommendation to the board for resolution of the conflict.

(10) The board shall consider the executive administrator's recommendation and statements by a representative for each regional water planning group and others and determine the resolution of the conflict.

(11) The executive administrator shall notify affected regional water planning groups of board's decision including details of how affected regional water plans must be amended.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 358. STATE WATER PLANNING GUIDELINES

The Texas Water Development Board (board) adopts amendments to 31 TAC §358.1 and §358.3 and new §358.5 and §358.6, concerning State Water Planning Guidelines. Section 358.3 and §358.6 are adopted with changes to the proposed text as published in the November 2, 2001 issue of the Texas Register (26 TexReg 8743). Section 358.1 and §358.5 are adopted without changes and will not be republished. These amendments and new sections are adopted in response to Senate Bill 2, 77th Texas Legislature, Regular Session, 2001 and pursuant to the four-year rule review requirement of Texas Government Code §2001.039.

The board will restructure the chapter into subchapter A, State Water Plan Development, consisting of §§358.1-358.4, and subchapter B, Data Collection, consisting of §358.5 and §358.6.

The board adopts amendments to §358.1 to mirror the language in Texas Water Code §16.051(a). Section 16.051(a) was amended by Senate Bill 2 to state that the board will prepare, develop, formulate, and adopt a comprehensive state water plan every five years. The amendments to §358.1 mirror this revised language to avoid confusion.

The amendments to §358.3, like those for §358.1, are intended to mirror the language of Texas Water Code §16.051(a). However, the amendments also detail the responsibilities of the executive administrator in this process. Pursuant to this rule, the board charges the executive administrator to prepare, develop, and formulate the state water plan and the board shall adopt a state water plan every five years. These changes will avoid potential conflict with the revised statutory language and specify the exact duties of the board and executive administrator. The division of responsibilities reflects the current rule's division, which specifies that the executive administrator develops the plan and the board adopts the plan.

Due to comments received from the public, the board revised §358.3(b)(4) to replace the phrase "environmentally sensitive" because it was confusing and to ensure compliance with Senate Bill 2. The board revised the provision to state that water management strategies must provide long-term protection of the state's water resources, agricultural resources, and natural resources, which complies with Texas Water Code §16.053(h)(7)(C).

New §358.5 is intended to comply with Texas Water Code, §16.012(m), which was added by Senate Bill 2. Section 16.012(m) authorizes the executive administrator to conduct surveys of entities using groundwater and surface water to gather data to be used for long-term water supply planning. Survey recipients are required by Texas Water Code §16.012(m) to complete and return the survey or they will be ineligible for funding from the board and new water permits, amendments, and renewals from the Texas Natural Resource Conservation Commission. The statutory provision also states that recipients

who fail to complete and return the survey commit a Class C misdemeanor. The completed survey forms from non-governmental recipients are not subject to disclosure under the Texas Public Information Act, Texas Government Code, Chapter 552, unless they authorize it in writing. New §358.5 incorporates these statutory requirements, adds timelines for survey responses, and describes how a survey must be administratively complete to comply with the requirements of law. The time frames provide the recipients with sufficient time to answer the surveys and provide notice of when a recipient will be deemed ineligible for board funding due to incomplete surveys. The board intends to send out 30-day reminders to all recipients to remind them of the deadlines for submission of the surveys. The surveys will be performed at least annually and may be done either in hard copy or electronic format.

The addition of §358.6 is intended to comply with Texas Water Code §16.053(d), which was amended by Senate Bill 2. Section 16.053(d) now requires the board to adopt a rule that requires holders of surface water permits, certified filings, certificates of adjudication for surface water, and permits for the export of groundwater from a groundwater conservation district, and retail public water suppliers, wholesale water providers, irrigation districts, and any person transporting groundwater or surface water 20 miles or more to report information on water pipelines and other facilities that can be used for water conveyance to the board. The language in §358.6(a) mirrors this statutory language. It is the intent of the board to send notification to those persons and entities anticipated as needing to file reports under this section. The proposed language in §358.6(a) has been amended, due to public comment, to make it clear entities required to report are not required to report on pipelines and conveyance facilities that are exempt under §358.6(b). At §358.6(b), the rule limits the types of pipelines and facilities on which a survey response should be submitted. Due to public comment, the proposed language has been amended to make it clear that pipelines and conveyance facilities that transport water for distances of less than 20 linear miles are exempt, to clarify that conveyance facilities that are part of retail public distribution systems are also exempt, and to provide definitions of the terms "main canal" and "lateral canal." The intent of these limitations is to restrict survey responses to those pipelines and facilities that transport water from one location to another that is at least 20 miles away or that would be of use for water conveyance between entities or areas, as opposed to internal distribution. Further, the limitations exclude pipelines and facilities that transport oil and gas. This is due to the fact that the Texas Railroad Commission already has a database of pipelines and facilities that transport these substances. Therefore, there is no need to require reporting of this information. Section 358.6(c) describes the reporting standards, which are similar to the United States Department of Transportation National Pipeline Mapping System standards for Pipeline and Liquefied Natural Gas Operator Submission. Because pipelines and facilities vary along their length, reports will be by segments. The rule defines a segment as a portion of the pipeline or facility that has the same attributes, such as size and construction date. The information that must be reported is described at §358.6(c)(1) and (2). The reporting standards will enable the board to identify the pipeline or facility, designate its location on map, contact the owner/operator, and determine its capabilities. This is information that will be provided to the regional water planning groups for consideration and use in the regional water planning process. Due to the amount of information required to be reported on the pipelines and facilities, §358.6(d) sets the deadline for submission of the first report as November 30, 2003. This will provide owners and operators with sufficient time to compile the report. After the initial report is submitted, the owners and operators will be asked to verify the accuracy of the report every five years. Further, they will be asked to submit revisions to the report within one year of a change of any required reporting element. This will enable the board to provide the regional water planning groups with accurate information that can be used to plan for the transport and distribution of water resources within and between regions.

The board conducted a hearing on the proposed rules on November 28, 2001 in Room 118, Stephen F. Austin Building, 1700 N. Congress Ave., Austin, Texas. No comments were received at this hearing. The following made comments in writing within the prescribed period following the publication of the proposed rules: Freese and Nichols, Inc, the City of Cleburne, Brazos River Authority, Lower Colorado River Authority, American Electric Power, South Central Texas Regional Water Planning Group, National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense.

The board received comments from American Electric Power, National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense on proposed changes to §357.7(a)(9) of this title that impacts §358.3(b)(4). They commented that the meaning and source of the term "environmentally sensitive" in §357.7(a)(9) is not clear. They recommended the phrase be substituted with language referring to the requirement for the regional water plans to provide long-term protection of the state's water resources, agricultural resources, and natural resources. Section 358.3(b)(4) also uses the term "environmentally sensitive." *The board makes changes to §358.3(b)(4) to remove this term and to add language to make this provision consistent with 31 TAC §357.7(a)(9). This will avoid confusion and be consistent with statutory language.*

Brazos River Authority commented that the word "person" in §358.5(a) should be defined to make it clear who can commit a Class C misdemeanor. *The board makes no changes to the proposed rules as a result of this comment. The term "person" is directly from the statute, Texas Water Code §16.012(m), and is not defined in law. As this is a criminal provision, the board is not the appropriate entity to define this term.*

Lower Colorado River Authority commented that §358.5 does not allow for the possibility that an emailed survey does not reach the recipient. It commented that there is no mechanism for confirming delivery of the email, which means the recipient may become ineligible for board funding without knowing it because the survey was never received. It commented that there should be a process by which the recipient can get relief from the penalty if the survey was not delivered. It also commented that the 60 day time period may not be enough if the board makes significant changes to the existing survey. *The board makes no changes to the proposed rule based on this comment. The process described by LCRA would be difficult, time consuming, and expensive to operate. The board will make every effort to send surveys in a manner where confirmation is possible but believes an administrative rule is not the appropriate place to put this level of detail. Further, the board does not intend, at this time, to make significant changes to the existing water use survey. Therefore, 60 days should be sufficient for competing the survey. If the board proposes to make significant changes to the survey, it will provide advance notice of these. Further, the board intends to*

provide 30-day reminders to all email recipients to remind them of the deadline for submitting each survey.

South Central Texas Regional Water Planning Group commented that §358.5 should specify that municipal water user groups will have to report information regarding water rates, utility funding mechanisms, peak-day water use, and other information of use to the regional water planning groups and that the board should provide convenient access to this information to the regional water planning groups. *The board makes no changes as a result of this comment. The specific items to be included on the water use survey are not appropriately addressed by rule because the specific items are subject to minor or major revision from survey to survey. Further, it is the board's intention and practice to make the information from the surveys available to the regional water planning groups to the extent it is available to the public.*

Freese and Nichols commented that the language of §358.6 is unclear as to who is required to file a report on conveyance pipelines and facilities. They asked if retail water suppliers had to report on retail distribution systems and if wholesale water providers had to report pipelines and conveyances that were less than 20 miles long. They commented that definitions of groundwater, surface water, conveyance facility, water pipeline, and other facilities should be added. They also commented that conveyance facilities used for retail distribution should also be exempted from reporting requirements. Lastly, they asked about the access to this information, once collected, due to heightened security concerns. *The board agrees that the language of §358.6 is unclear as proposed. The board makes changes to the proposed language based on this comment to make it clear that the entities required to file reports in §358.5(a) are not required to file a report if the pipeline or conveyance is exempted by §358.6(b). The proposed language is also amended to clarify that conveyance facilities other than pipelines are also exempt from reporting requirements if they are in a retail distribution system. Further, the board adds the word "conveyance" to any use of the word "facilities" to clarify the meaning. Also due to this comment, the board adds §358.6(b)(5) to make it clear that pipelines and conveyances that transport water between points separated by a linear distance of less than 20 miles are exempt from reporting requirements. Lastly, the board removes the word "water" from in front of "pipeline" to clarify the provision and avoid unnecessary confusion. As for security of data, the board does not make any changes to the proposed rules. The board will follow the requirements of the Texas Public Information Act, Chapter 552 of the Texas Government Code, and Senate Bill 2. Further, the legislature will meet again before these reports are due, which gives it the opportunity to address security issues, if it chooses. Lastly, the board does not make any changes to the proposed rules based on the comment regarding definitions of groundwater and surface water. The board believes these terms, as they are commonly used, are clear.*

Brazos River Authority commented that requiring reports, in §358.6, from those who own or operate a pipeline or conveyance facility will result in for duplication of effort. *The board makes no changes to the proposed rules based on this comment. While it is true that this could lead to duplication of effort if the owner and operator are separate entities and file separate reports, there is nothing in the rule that prevents them from collaborating and filing one report. Further, because this information is required for the regional water planning process, it is important to gather as much data as possible. The owner and operator may provide different information, which will lead to discovering which is correct, which will improve the planning efforts.*

The City of Cleburne also commented that definitions were needed in §358.6 for clarification and expressed concern for security of data. *As stated above, the board does not make changes to the proposed rules based on the comment regarding definitions. The board believes the terms used are clear. Further, as stated above, the board does not make any changes based on the comment about security of data. The board will handle all requests as required by the Texas Public Information Act and Senate Bill 2. Also, the first reports are not due until November 30, 2003, which is after the conclusion of the next legislative session. This provides the legislature with time to pass laws regarding this requirement if it chooses.*

American Electric Power commented that the board should consult with the legislature about postponing the implementation of §358.6 and deleting it from the proposed rules at this time due to concerns of security. *The board does not make any changes based on this comment. The board will handle the data as required by the Texas Public Information Act and Senate Bill 2. Also, the first reports are not due until November 30, 2003, which is after the conclusion of the next legislative session. This provides the legislature with time to pass laws regarding this requirement if it chooses.*

American Electric Power commented that the mechanism by which persons report information under §358.6(a) is unclear and needs clarification. It recommended that the board request the information as part of the water use survey under §358.5 or provide notice to the appropriate persons in advance of each reporting period. *The board makes no changes to the proposed rule as a result of this comment. It is the board's intention to use, in part, the mailing list for the water user survey as a source for sending notices to those persons and entities anticipated as needing to submit a pipeline and conveyance report.*

Lower Colorado River Authority commented that the terms "main canal" and "lateral canal," used in §358.6(b)(3), should be defined. *The board agrees that definitions of these terms should be added and makes changes to the proposed rule based on this comment. The board adds language to §358.6(b)(3) to define a main canal as a primary water delivery or conveyance canal and a lateral canal as a secondary water delivery canal that carries water from the main canal to the end user.*

American Electric Power commented that a fifth exception should be added to §358.6(b) to avoid confusion. It recommended the following text be added: "(5) the pipeline or conveyance facility is transporting groundwater or surface water for a linear distance of 20 miles or less from the point of diversion or production to the point of use. *The board has made changes to the proposed rule as a result of this comment.*

South Central Texas Regional Water Planning Group commented that the timing of the reports in §358.6(d)(1) should be such as to allow the information to be provided to the regional water planning groups by November 30, 2003. *The board makes no changes based on this comment. As noted by several commentors, there is concern for security and the dissemination of this data. The current deadlines provide the legislature with sufficient time to address these issues, if it chooses.*

American Electric Power commented that §358.6(d)(2) should be deleted because it is unnecessary and overly burdensome. It commented that the changes would be reported in the five-year reporting cycle. *The board makes no changes to this proposed*

rule as a result of this comment. Because this information is required for the regional water planning process, changes need to be reported sooner than the five-year cycle to ensure accurate planning. It should not be overly burdensome because only the changes are required to be reported.

National Wildlife Federation, Lone Star Chapter of the Sierra Club, Texas Center for Policy Studies, and Environmental Defense commented that the board has failed to propose guidelines in Chapter 358 that implement the Texas Water Code §16.053(h)(7)(C) requirement to provide long-term protection for the state's water, natural, and agricultural resources and for the protection to be consistent for all three resource categories. They state that the current rules do not establish standards for the board's consideration of long-term protection for water resources, particularly groundwater, and that a sustained yield approach is required. They also commented that there is no long-term protection of agricultural resources. *The board makes no changes based on these comments. Policy guidance for the long-term protection of the state's water, natural, and agricultural resources is embodied in 31 Texas Administrative Code Chapters 357 and 358. Chapter 358 provides the broad goals for planning while Chapter 357 contains specific guidance for the regional water plans, which are the core of the state water plan. As stated in the proposed amendments to §357.14, the guidance principles which must be met for the board to approve regional water plans are in §358.3 of this title (relating to Guidelines), §357.5 of this title (relating to Guidelines for Development of Regional Water Plans), §357.7 of this title (relating to Regional Water Plan Development), §357.8 of this title (relating to Ecologically Unique River and Stream Segments), and §357.9 of this title (relating to Unique Sites for Reservoir Construction). Some of these provisions existed before Senate Bill 2 and some were revised as a result of Senate Bill 2. Because the board already had several provisions aimed at long-term protection of the state's water, natural, and agricultural resources, revisions beyond what are proposed to those sections are not necessary. Board approval of regional water plans under the guidance in 31 Texas Administrative Code §357.14, their incorporation into the state water plan, and further policy development of the state water plan under the guidelines in Chapter 358 will provide detailed guidance for conformance with statutory requirements. Surface water planning achieves protection of the resource due to its renewing nature and the permitting standards established by TNRCC. This requirement generally adopts a firm-yield approach to municipal and industrial supply, and assures the renewability of the resource. The rules currently require planning on such basis, given the regulatory scheme in place. The board declines to make such changes to its rules to require groundwater planning on a sustainable yield basis. The Texas Legislature has placed the responsibility to make decisions on groundwater withdrawal standards on local groundwater districts, through the groundwater management planning process and permitting regulations, and on the regional water planning groups through their planning. The board considers that these determinations are best made at those levels. The board also makes no changes based on the comments that the rules are not clear in their standards for "consideration of environmental water needs," suggesting that the regional water planning groups have misunderstood the Board's current rule to consider environmental needs because only one regional water planning group actually included demand numbers for a category of environmental water needs. The rules as written require that all water management strategies protect natural resources. The rules further require that the strategies must be analyzed pursuant to either site specific environmental flow studies or consensus environmental flow criteria. These are designed to assure that planning maintains environmental flows. A more precise protection of the environmental flows will occur in any required TNRCC permitting process. However, requirements in the board's rules will assure that strategies are not developed in planning that would rely on water in excess of what can be permitted, given the need to maintain environmental flows. The planning structure has been designed to provide for environmental water needs by assuring that water development is planned in a way to leave sufficient water for environmental purposes in the waterways of the state. This is consistent with the current regulatory system for protection of water resources. While the regional water planning groups would be free, if they desired, to specifically target a water flow for environmental needs, this is not, in the Board's opinion, required either under the statute nor is it the practice in the regulatory process. The consideration of environmental needs at the planning level and consequently the protection of the natural resource is achieved by consideration of needed environmental flows in relation to determinations of how much water would be available for each water management strategy (an inherent reservation of that water for environmental needs).*

SUBCHAPTER A. STATE WATER PLAN DEVELOPMENT

31 TAC §358.1, §358.3

The amendments are adopted under the authority of Texas Water Code §§6.101, 16.051, and 16.053.

§358.3. Guidelines.

(a) The executive administrator shall prepare, develop, and formulate the state water plan and the board shall adopt a state water plan no later than January 5, 2002, and before the end of each successive five-year period after that date. The executive administrator shall identify the beginning of the 50-year planning period for the state and regional water plans. The executive administrator shall incorporate into the state water plan presented to the board those regional water plans approved by the board pursuant to Chapter 357 of this title (relating to Regional Water Planning Guidelines). The board shall, not less than 30 days before adoption or amendment of the state water plan, publish notice in the Texas Register of its intent to adopt a state water plan and shall mail notice to each regional water planning group. The board shall hold a hearing, after which it may adopt a water plan or amendments thereto.

(b) Development of the state water plan and of regional water plans shall be guided by the following principles:

(1) identification of those policies and actions that may be needed to meet Texas' near- and long-term water needs and preparation for and response to drought conditions, in order that sufficient water will be available at a reasonable cost to satisfy a reasonable projected use of water to ensure public health, safety and welfare, further economic development, and protect the agricultural and natural resources of the state;

(2) decision-making that is open to and accountable to the public with decisions based on accurate, objective and reliable information with full dissemination of planning results;

(3) consideration of the effect of policies or water management strategies on the public interest of the state, water supply, and those entities involved in providing this supply throughout the entire state;

(4) consideration of all water management strategies the board determines to be potentially feasible when developing plans to meet future water needs and to respond to drought so that cost effective water management strategies which are consistent with long-term protection of the state's water resources, agricultural resources, and natural resources are considered and approved;

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Suzanne Schwartz
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SUBCHAPTER B. DATA COLLECTION

31 TAC §358.5, §358.6

The new sections are adopted under the authority of Texas Water Code §§6.101, 16.051, and 16.053.

§358.6. Pipeline and Facility Reports

(a) The following entities and persons shall report to the board information on pipelines and other conveyance facilities that they own or operate and that can be used for water conveyance unless the pipeline and other conveyance facility is exempted in subsection (b) of this section:

(1) holders of surface water permits, certified filings for surface water, or certificates of adjudication for surface water;

(2) holders of permits for the export of groundwater from a groundwater conservation district;

(3) retail public water suppliers;

(4) wholesale water providers;

(5) irrigation districts; and

(6) any person or entity transporting groundwater or surface water between points separated by a linear distance of 20 miles or more.

(b) Information shall be reported on a pipeline and other conveyance facility segment that can be used for the conveyance of water unless:

(1) it has been used to transport wastewater, oil, gas, or any hazardous substance identified in 40 CFR, Chapter 1, Part 116, Designation of Hazardous Substances;

(2) it is a retail distribution system pipeline or other retail conveyance facility;

(3) it is a lateral canal or other open channel water conveyance facility that carries water from main canals. For purposes of this subsection, a main canal is a primary water delivery or conveyance canal and a lateral canal is a secondary water delivery canal that carries water from the main canal to the end user;

(4) it is a transmission pipeline of nominal diameter of six inches or less; or

(5) it is a pipeline or other conveyance facility transporting groundwater or surface water between points separated by a linear distance of less than 20 miles.

(c) Report standards. The executive administrator will provide reporting standards for pipeline and other water conveyance facilities information. These standards will be generally similar to the standards and reporting protocols described in the United States Department of Transportation National Pipeline Mapping System standards for Pipeline and Liquefied Natural Gas Operator Submission, dated March 1999. The information shall be reported on a segment-by-segment basis, with a description of which segments connect together. For purposes of this section, a segment is defined as a portion of the pipeline or water conveyance facility with the same attributes.

(1) Content standards. Pipeline and/or conveyance facility segment attributes to be reported include:

(A) owner;

(B) owner's contact information;

(C) operator;

(D) operator's contact information;

(E) system name;

(F) nominal diameter of the pipeline segment;

(G) top width and carrying capacity for open channel facility segments;

(H) construction material;

(I) construction date;

(J) whether or not, at the time of reporting, the pipeline or facility is operational; and

(K) other attributes as required by the executive administrator.

(2) Positional reporting standards. Provide the geographic information on the position and alignment of each pipeline and conveyance facility segment using one of the following methods:

(A) provide global position system coordinates with a mean accuracy of no less than +/- 10 meters;

(B) identify existing facilities now being reported on the board's Texas Strategic Mapping Program (StratMap) hydrography data layer that can be found at www.tnris.state.tx.; or

(C) draw the pipeline or conveyance facility on maps provided by the executive administrator, or modify existing StratMap data, from the board's statewide digital orthophoto quad data layer, fitting the pipeline or facility to the image as closely as possible (within +/- 10 meters is preferred).

(d) Schedule and standards for responses.

(1) The information shall be submitted to the executive administrator no later than November 30, 2003.

(2) Entities listed under subsection (a) of this section shall report changes to the elements required in subsection (c) of this section within 12 months of their occurrence.

(3) Before November 30, 2008 and every five years thereafter, the reporting entity shall verify the accuracy of the information provided to the executive administrator.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 382. WATER INFRASTRUCTURE FUND

The Texas Water Development Board (board) adopts new 31 TAC §§382.1 - 382.6, 382.21 - 382.26, and 382.41 - 382.43, comprising Chapter 382, Water Infrastructure Fund. Sections 382.2 - 382.6, 382.21 - 382.26, and 382.41 - 382.43 are adopted without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8746) and will not be republished. Section 382.1 is adopted with change to correct a cite. The sections of the new chapter govern applications for financial assistance for the implementation of water projects under the Water Infrastructure Fund Program established by Texas Water Code, Chapter 15, Subchapter O.

The Water Infrastructure Fund (WIF) was established by Senate Bill 2 of the 77th Texas Legislative Session (SB 2). SB 2 provides for direct loans, zero interest loans and grants in the Water Infrastructure Fund program. SB 2 also provides for indirect financial assistance in the form of loans or grants to persons, including individuals and private entities through eligible political subdivisions for projects that develop water resources and assist in diversifying and developing the economy of the political subdivision and the state. The provisions of the bill that address zero interest loans, grants, and financial assistance to persons, including individuals and entities, through economic development programs, have not been included in the proposed rules. These provisions of SB 2 cannot be implemented without general revenue or another cash funding source and such revenues were not provided during the legislative session. The only viable source of funding for the WIF that is currently available are Water Financial Assistance general obligation bonds. Constitutional restrictions on bonds issued by the board prevent the proceeds from being used to provide zero interest loans and grants to political subdivisions, and also prohibit any form of financial assistance to individuals or private entities.

Additionally, SB 2 required that the Water Financial Assistance bonds transferred to the WIF must be repaid by the WIF, which, without appropriation support, basically will require that loan rates be established which are sufficient to pay the full amount of debt service on the Water Financial Assistance bonds. This requirement results in a loan rate that is essentially the same as the current Water Development Fund II loan program.

New §§382.1 - 382.6 will comprise Subchapter A, Introductory Provisions. Section 382.1 describes the scope of the proposed new chapter and provides notice to customers that additional requirements from Chapter 363, Subchapter A, relating to General Provisions of Financial Assistance Programs, apply to the WIF, unless in conflict with the WIF rules. Section 382.2 provides definitions to terms which are consistent with the statutory language for this chapter and program. Section 382.3 provides for customers a brief summary of the uses which may be made of funds from the WIF, but sets out a percentage limitation on the various uses of the funds in compliance with SB 2. Section 382.4 requires the board to make an annual determination of the amounts of funds available for various uses for the fiscal year since the amounts as well as, sources will vary, which may effect their potential uses. Section 382.5 provides customers information regarding the interest rates that will be charged for loans from the WIF. Interest rates will be established in a manner which is consistent with similar Board programs. Section 382.6 provides notice that funds in the WIF will be invested in accordance with Chapter 365 of this title, relating to Investment Rules, in order to be consistent with state law and other Board programs.

New §§382.21 - 382.26 will comprise Subchapter B, Application Procedures. Section 382.21 notices applicants of the need to schedule a preapplication conference to enable applicant and board staff to meet and exchange information on the nature of the project and the Board's loan process. Such conferences facilitate the prosecution of the loan process. Section 382.22 provides notice to customers of the information that must be submitted in conjunction with an application for loan assistance to ensure that the applicant is authorized to incur debt and has the resources for repayment of the debt. It also provides information on the engineering planning, environmental and water conservation planning requirements that must be completed for the proposed project to be in compliance with state law. Section 382.23 advises customers of the process for utilizing pre-design funding process in order to speed the actual flow of funds for the project and of the requirements for using the option necessary to comply with state law. Section 382.24 provides establishes the process for board consideration of an application and notifying interested parties of the meeting at which the application will be considered, in a manner consistent with state law and other Board programs. Section 382.25 sets out the statutory findings that the board is required to make in order to approve a loan, as required by state law, and provides notice to the borrowers of the nature of the findings. Section 382.26 provides notice to customers of the options available to the board in consideration of an application and the board's requirement to include an expiration date in the application. The expiration date is necessary to enable the board to monitor and ensure the timely and appropriate use of public funds. It also notices applicants that the board may change a commitment at the time the application expiration date is extended, when appropriate, to accommodate changed circumstances.

New §§382.41 - 382.43 make up Subchapter C, Closing and Release of Funds. Section 382.41 provides notice to customers of the documents that must be submitted prior to closing a loan and sets out the terms and conditions of the loan. The terms and conditions ensure that the project is implemented and maintained in accordance with law and that the means of repaying the debt is properly monitored and documented. Section 382.42 advises customers of the permits and completion documents that will have to be submitted before funds are released. The section ensures that applicable laws and rules are complied with during the pre-construction and construction phases of the proposed

project. Section 382.43 provides for executive administrator approval of engineering design documents and identifies for applicants the information regarding engineering contracts, plans and specifications that is necessary to ensure that the project is in compliance with applicable laws and rules addressing construction.

No comments were received on the proposed new sections.

SUBCHAPTER A. INTRODUCTORY PROVISIONS

31 TAC §§382.1 - 382.6

The new sections are adopted under the authority of the Texas Water Code, §6.101 and §15.907.

§382.1. Scope of Chapter.

This chapter shall govern applications for financial assistance from the Water Infrastructure Fund, established by the Texas Water Code, Chapter 15, Subchapter O. The program described in this chapter shall be known as the Water Infrastructure Fund. Unless in conflict with the provisions of this chapter, the provisions of Chapter 363, Subchapter A of this title (relating to the General Provisions of Financial Assistance Programs) shall apply to applications for assistance from the Water Infrastructure Fund.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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SUBCHAPTER B. APPLICATION PROCEDURES

31 TAC §§382.21 - 382.26

The new sections are adopted under the authority of the Texas Water Code, §6.101 and §15.907.

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SUBCHAPTER C. CLOSING AND RELEASE OF FUNDS

31 TAC §§382.41 - 382.43

The new sections are adopted under the authority of the Texas Water Code, §6.101 and §15.907.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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CHAPTER 384. RURAL WATER ASSISTANCE FUND

The Texas Water Development Board (board) adopts new 31 TAC §§384.1 - 384.7, 384.21 - 384.26, and 384.41 - 384.45, comprising Chapter 384, Rural Water Assistance Fund. Sections 384.1, 384.4, 384.5, 384.7, 384.21 - 384.26, and 384.41 - 384.45 are adopted without changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8751) and will not be republished. Sections 384.2, 384.3 and 384.6 are adopted with changes as a result of comments received.

New Chapter 384 addresses the creation, purposes and administration of the Rural Water Assistance Fund Program (Program). The Program will provide low interest loans to rural political subdivisions for water and water related projects pursuant to the provisions of the Texas Water Code, Chapter 15, Subchapter P. Funds were not appropriated for the Rural Water Assistance Fund and full operation of the Program depends upon appropriated funds. For this reason, provisions of the legislation that address buy-down of interest rates on loans and the provision of outreach and technical assistance services have not been included in the initial Program rules. The Program can provide low interest loans in a limited manner if approval is given to the board's application to the Bond Review Board to issue tax exempt private activity bonds under the State's private activity bond volume cap.

New §§384.1 - 384.7 comprise Subchapter A, Introductory Provisions. Section 384.1 sets out the scope of the adopted new Chapter 384 and advises potential applicants that additional requirements from the provisions of Chapter 363, Subchapter A (relating to Financial Assistance Programs) will apply to the Program. Section 384.2 provides definitions to terms which are consistent with statutory language when the terms are used in the proposed chapter. Section 384.3 describes the uses of the Fund that are authorized by Texas Water Code, Chapter 15, Subchapter P. Section 384.4 provides for an annual determination of funds

that will be available through the Program. Funds will be limited and it will be necessary to make a determination of the amounts of funds that will be available for the different uses authorized pursuant to Texas Water Code, Chapter 15, §15.954.

Section 384.5 details for potential applicants the formulas used in determining the interest rates for loans. The proposed means of calculation implements the legislative intent to provide low-cost financing to rural communities and maintains consistency with existing Board programs. Section 384.6 states the documents that will be needed to meet the certification requirements of the Federal Tax Code for private activity bond proceeds. Section 384.7 provides for the prudent investment of the Program funds through the principals and strategies set out in the board's Investment Rules.

New §§384.21 - 384.26 comprise Subchapter B, Application Procedures. Section 384.21 instructs a potential loan applicant that is planning to construct a project to schedule a conference to enable the applicant and Board staff to meet and share information regarding the board's loan process and the particular nature of the project in the early stages of the planning process. This conference will provide valuable information to applicants on project requirements and how to apply for board loans and facilitate the loan process. Section 384.22 provides a list of the information that must be submitted by a political subdivision as part of an application for board funding in order to ascertain compliance with state law. Section 384.23 outlines the process whereby funds may be released for pre-design, design or building costs before all requirements are met for the release of funds for construction. This option provides the opportunity for customers to accelerate the process to receive and expend funds for planning and design activities before all pre-construction requirements have been completed. Section 384.24 states the specific factors that the board must by law consider in reviewing an application for funding through the Rural Water Assistance Fund. Section 384.25 states the statutory findings that the board is required to make in approving an application for funding and provides notice to borrowers. Section 384.26 describes the various actions that the board may take on an application and provides notice to applicants that board approvals for funding have time limitations which are detailed in the board resolution. The time limitations are necessary for the Board to monitor and ensure the timely and appropriate use of public funds.

New §§384.41 - 384.45 comprise Subchapter C, Closing and Release of Funds. Section 384.41 provides notice to applicants of the documents and contracts that will have to be submitted to the board before a loan closes and funds are released. These instruments are required under statute and prudent lending practices. Section 384.42 states the requirement that nonprofit water supply corporations must provide the board with a deed of trust on the corporation facilities and policy of title insurance. These documents will evidence clear title to the facilities and strengthen the security of the loan through the securing of collateral.

Section 384.43 lists additional documents that are required of the applicant and findings that must be made by executive administrator before funds may be released for pre-design or building purposes. The documents ensure that financial accountability will be maintained during the course of project development and that the proposed project utilizes sound engineering principals and complies with environmental regulations,

Section 384.44 provides that nonprofit water supply corporations may receive loan funds by entering into a loan agreement with the board. The loan agreement offers an alternative to the issuance of bonds and may be a less costly option for rural borrowers seeking smaller loans. Section 384.45 describes the engineering contracts and plans and specifications that must be submitted for a project to ensure that the project is in compliance with applicable laws and rules addressing construction.

Written comments were received on the proposed new sections from the Texas Rural Water Association (TRWA).

Comment--TRWA commented regarding §384.2, Definitions, that while the statutory language specifically provided for the submittal of a joint application by a rural political subdivision and a state or federal agency (as defined), the definition of "applicant" made no such provision.

Response--Board staff feel that adding provision for submittal of a joint application would be an appropriate clarification, and has incorporated the change into the definition.

Comment--TRWA commented regarding §384.6, Loans in Excess of 20 Years, that the certification required in that section could more appropriately be made by an engineer than by an attorney, since an engineer would have greater knowledge of the matter being certified; or alternately, by the applicant itself.

Response--Board staff agree that certification by an attorney is not appropriate in this circumstance, and that the responsibility for the certification required resides most appropriately with the applicant, based upon the information required to be submitted by the applicant's engineer. Section 384.6 has been changed accordingly.

Comment--TRWA commented regarding §384.3, Use of Funds, that no provisions were made for using the Rural Water Assistance Fund (Fund) to finance outreach and technical assistance programs, to buy down interest rates on loans, or for the payment of principal and interest on Water Financial Assistance bonds where the proceeds are deposited into the Fund. TRWA also noted that Senate Bill 2 specifically authorizes such uses.

Response--Board staff recognize that the referenced uses of the Fund for outreach and technical assistance and to buy down interest rates on loans are authorized by Senate Bill 2. However the specific uses in question require appropriated funds, which were not appropriated by the legislature. The omission of these uses of the Fund, and the reasons for the omission are discussed in the Preamble to the proposed rule. Staff feel that inclusion of these uses of the Fund would be misleading to potential applicants, and that in the event funds are appropriated, the necessary rule amendments can be accomplished in a timely manner. For these reasons, no changes are recommended as a result of this part of the comment. Regarding use of the Fund for the payment of principal and interest on Water Financial Assistance bonds, staff believes that addition of this provision to §384.3 would provide additional information to borrowers. Consequently a new paragraph is added to this section for this purpose.

Comment--TRWA requested that the proposed new chapter include a provision whereby the Executive Administrator would issue a certification for borrowers providing notice that the expenditures for the funded project are exempt from sales tax.

Response--Board staff believe that the matter requested to be certified is beyond the statutory authority of the Executive Administrator, and is not appropriate to be included in the proposed

rules. However staff will consult with staff of the State Comptroller and develop forms and procedures to simplify the acquisition of sales tax exemption documentation for borrowers.

SUBCHAPTER A. INTRODUCTORY PROVISIONS

31 TAC §§384.1 - 384.7

The new sections are adopted under the authority of the Texas Water Code, §6.101 and Chapter 15, Subchapter P.

§384.2. Definitions of Terms.

Words and terms used in this chapter shall have the following meanings, unless the context clearly indicates otherwise. Words defined in Texas Water Code Chapters 15 or 17 and not defined here shall have the meanings provided by the appropriate Texas Water Code chapter.

(1) Applicant--A rural political subdivision, including a rural political subdivision which has entered into an agreement with a Federal Agency or State Agency for the purpose of submitting a joint application.

(2) District--A conservation or reclamation district created under Texas Constitution, Section 52, Article III, or Section 59, Article XVI.

(3) Federal agency--An agency or other entity of the United States Department of Agriculture or an agency or entity that is acting through or on behalf of that department.

(4) Fund--The Rural Water Assistance Fund.

(5) Rural political subdivision--A nonprofit water supply or sewer service corporation, district, or municipality with a service area of 10,000 or less in population or that otherwise qualifies for financing from a federal agency or a county in which no urban area exceeds 50,000 in population.

(6) State agency--An agency or other entity of the state, including the Department of Agriculture and the Texas Department of Housing and Community Affairs and any agency or authority that is acting through or on behalf of the Department of Agriculture or the Texas Department of Housing and Community Affairs.

§384.3. Use of Funds.

The fund may be used:

(1) to provide low-interest loans to rural political subdivisions for water or water-related projects, including the purchase of well fields, the purchase or lease of rights to produce groundwater, and interim financing of construction projects;

(2) to enable a rural political subdivision to obtain water supplied by a larger political subdivision or to finance the consolidation or regionalization of neighboring political subdivisions, or both; or

(3) as a source of revenue for the repayment of principal and interest on water financial assistance bonds issued by the board if the proceeds of the sale of these bonds will be deposited into the fund.

§384.6. Loans in Excess of 20 Years.

For loans for which the average maturity exceeds 20 years, the applicant must provide the following information:

(1) a schedule, prepared by the applicant's engineer, which lists the major components of the project, the anticipated date of placement into service of the components, the estimated useful life, in years, of the components, and the average estimated useful life of the project; and

(2) a certification by the applicant that the average weighted maturity of the obligations does not exceed 120% of the average estimated useful life of the project.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 12, 2001.

TRD-200107832
Suzanne Schwartz
General Counsel
Texas Water Development Board
Effective date: January 1, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 463-7981

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SUBCHAPTER B. APPLICATION PROCEDURES

31 TAC §§384.21 - 384.26

The new sections are adopted under the authority of the Texas Water Code, §6.101 and Chapter 15, Subchapter P.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 12, 2001.

TRD-200107833
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Effective date: January 1, 2002
Proposal publication date: November 2, 2001
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SUBCHAPTER C. CLOSING AND RELEASE OF FUNDS

31 TAC §§384.41 - 384.45

The new sections are adopted under the authority of the Texas Water Code, §6.101 and Chapter 15, Subchapter P.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107834

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Effective date: January 1, 2002
Proposal publication date: November 2, 2001
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TITLE 34. PUBLIC FINANCE

PART 1. COMPTROLLER OF PUBLIC ACCOUNTS

CHAPTER 3. TAX ADMINISTRATION

SUBCHAPTER F. MOTOR VEHICLE SALES TAX

34 TAC §3.96

The Comptroller of Public Accounts adopts a new §3.96, concerning the imposition and collection of a surcharge on certain diesel powered motor vehicles, without changes to the proposed text as published in the September 21, 2001, issue of the *Texas Register* (26 TexReg 7219).

Senate Bill 5, passed by the 77th Texas Legislature, amends Tax Code, Chapter 152, by adding §152.0215, which provides for a surcharge to be imposed on the purchase of certain diesel powered motor vehicles, primarily heavy trucks, effective September 1, 2001. The surcharge is for the benefit of the Texas Emissions Reduction Plan Fund.

No comments were received regarding adoption of the new section.

This new section is adopted under Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2.

The new section implements Tax Code, §152.0215.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107898
Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
Effective date: January 3, 2002
Proposal publication date: September 21, 2001
For further information, please call: (512) 475-0387

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SUBCHAPTER O. STATE SALES AND USE TAX

34 TAC §3.315

The Comptroller of Public Accounts adopts an amendment to §3.315, concerning motor vehicle parking and storage, without changes to the proposed text as published in the October 5, 2001, issue of the *Texas Register* (26 TexReg 7820).

This section is being amended to add subsection (e) to implement House Bill 2877, 77th Legislature. House Bill 2877 added Government Code, §443.0153, that exempts from sales tax parking fees from parking meters and parking facilities that are funded or operated by the Texas State Preservation Board or by the Texas State History Museum. This section is also being amended to add subsection (d) to clarify the current policy that colleges, universities, and public schools are not required to collect sales tax on student, faculty, and staff parking permits and fees. Subsection (a) of this section is being amended to delete the effective date for the policy regarding transportation services since this is now long-standing policy. Subsections (a), (b), and (c) have been amended for clarification.

No comments were received regarding adoption of the amendment.

This amendment is adopted under Tax Code, §111.002, which provides the comptroller with the authority to prescribe, adopt, and enforce rules relating to the administration and enforcement of the provisions of Tax Code, Title 2.

The amendment implements Government Code, §443.0153 and Tax Code, Chapter 151.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107897
Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
Effective date: January 3, 2002
Proposal publication date: October 5, 2001
For further information, please call: (512) 305-9881

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PART 3. TEACHER RETIREMENT SYSTEM OF TEXAS

CHAPTER 25. MEMBERSHIP CREDIT

SUBCHAPTER O. ROLLOVER DISTRIBUTIONS AND TRANSFERS TO TRS

34 TAC §25.201

The Teacher Retirement System of Texas (TRS) adopts new §25.201, concerning acceptance of eligible rollover distributions or trustee-to-trustee transfers from other retirement plans in payment of deposits a member is permitted to make for TRS credit. The new section is adopted with one non-substantive change to the proposed text published in the November 9, 2001, issue of the *Texas Register*, (26 TexReg 9047).

The new section broadens the types of plans from which TRS may accept funds as payment when a member is eligible to establish credit in TRS. The purpose of the new section is to enable TRS to accept a rollover or transfer of funds from any type

of plan permitted under the federal tax law as payment for TRS credit a member is eligible to establish. The Economic Growth and Tax Relief Reconciliation Act of 2001 ("EGTRRA"), Public Law 107-16 (June 7, 2001), expanded the ability to rollover or transfer funds from one type of retirement plan to another, effective January 1, 2002.

The section is adopted with one non-substantive change to the proposed text. Specifically, an unnecessary phrase has been deleted in the last sentence of subsection (d), after the phrase "including return of the invalid contribution." The deleted phrase read: "and, if applicable, any earnings attributed thereto."

No comments were received regarding adoption of the proposal.

The new section is adopted under Government Code, Chapter 821, §821.004, which gives TRS the powers, privileges, and immunities of a corporation and the powers, privileges, and immunities conferred by Subtitle C; Chapter 823, §823.005, which authorizes the TRS to accept certain rollovers and fund transfers subject to rules adopted by the TRS Board of Trustees; Chapter 825, §825.101, which gives the TRS Board of Trustees responsibility for the general administration and operation of the system; Chapter 825, §825.102, which authorizes the TRS Board of Trustees to adopt rules for eligibility for membership, the administration of the funds of the system, and the transaction of business of the Board; and Chapter 825, §825.506, authorizing the TRS Board of Trustees to administer the provisions of Subtitle C in a manner that the retirement system's benefit plan will be considered a qualified plan under Internal Revenue Code provisions and to adopt rules necessary for the plan to be a qualified plan.

§25.201. Acceptance of Funds for Purchase of TRS Credit.

(a) In addition to funds required to be accepted under Government Code §823.005, the Teacher Retirement System of Texas (TRS) may accept the funds described in subsections (b) and (c) of this section, subject to the restrictions of this section.

(b) If permitted under and subject to the provisions of federal law, TRS may accept an eligible rollover distribution from another eligible retirement plan in payment of all or a portion of any deposit a member is permitted under applicable law to make with the system for TRS credit.

(1) An "eligible rollover distribution" is any distribution of all or any portion of the balance to the credit of the member from an eligible retirement plan. An eligible rollover distribution does not include the following:

(A) any distribution that is one of a series of substantially equal periodic payments (not less frequently than annually) made for the life (or life expectancy) of the member or the joint lives (or joint life expectancies) of the member and the member's designated beneficiary, or for a specified period of ten (10) years or more;

(B) any distribution to the extent such distribution is required under Internal Revenue Code §401(a)(9);

(C) any distribution which is made upon hardship of the member; or

(D) the portion of any distribution that is not includible in gross income.

(2) An "eligible retirement plan" is any program defined in Internal Revenue Code §§401(a)(31) and 402(c)(8)(B), from which the member has a right to an eligible rollover distribution, as follows:

(A) an individual retirement account under Internal Revenue Code §408(a);

(B) an individual retirement annuity under Internal Revenue Code §408(b) (other than an endowment contract);

(C) a qualified trust;

(D) an annuity plan under Internal Revenue Code §403(a);

(E) an eligible deferred compensation plan under Internal Revenue Code §457(b) which is maintained by an eligible employer under Internal Revenue Code §457(e)(1)(A); and

(F) an annuity contract under Internal Revenue Code §403(b).

(c) If permitted under and subject to the provisions of federal law, TRS may accept a direct trustee-to-trustee transfer of funds from a plan described under §403(b) or 457(b) of the Internal Revenue Code in payment of all or a portion of any deposit a member is permitted to make with TRS for permissive service credit in TRS.

(d) In order to authorize the rollover or transfer of funds described in this section, a member shall provide or cause to be provided to TRS information sufficient for TRS to reasonably conclude that the contribution is a valid rollover or direct trustee-to-trustee transfer as permitted under federal tax law. If TRS later determines that a contribution was an invalid rollover or direct trustee-to-trustee transfer or otherwise not permitted under federal tax law, TRS may take any action appropriate or required by the Internal Revenue Code or regulations issued thereunder, including return of the invalid contribution to the member within a reasonable time after the determination and cancellation of any credit purchased with the returned amounts.

(e) TRS shall construe and administer this section in a manner such that the TRS plan will be considered a qualified plan under §401(a) of the Internal Revenue Code of 1986, (United States Code, Title 26, §401).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107953
Charles L. Dunlap
Executive Director
Teacher Retirement System of Texas
Effective date: January 3, 2002
Proposal publication date: November 9, 2001
For further information, please call: (512) 542-6115

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CHAPTER 41. INSURANCE PROGRAMS SUBCHAPTER C. TEXAS SCHOOL EMPLOYEES GROUP HEALTH

34 TAC §41.30

The Teacher Retirement System of Texas (TRS) adopts new §41.30 concerning participation in the Texas School Employees Uniform Group Health Coverage Act by school districts, other educational districts, charter schools, and regional education service centers. The new section is adopted without changes to

the proposed text published in the October 12, 2001 issue of the *Texas Register* (26TexReg7987).

The new section is necessary for the proper and efficient administration of the notification, election, and participation requirements of Insurance Code article 3.50-7. It sets forth the manner, form, and effect of elections to opt in or out of participation in the coverage under the Act. The section includes provisions regarding the deadlines for certain entities to opt in or out of participation and the effect of such elections. The new section was previously adopted on an emergency basis.

No comments were received regarding adoption of the proposal.

The new section is adopted under the Government Code, Chapter 825, §825.102, which authorizes the Board of Trustees of the Teacher Retirement System to adopt rules for the administration of the funds of the retirement system and for the transaction of business of the board. The new section is also adopted under House Bill 3343, which was passed by the 77th Legislature, 2001.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 12, 2001.

TRD-200107787
Charles L. Dunlap
Executive Director
Teacher Retirement System of Texas
Effective date: January 1, 2002
Proposal publication date: October 12, 2001
For further information, please call: (512) 391-2115

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PART 5. TEXAS COUNTY AND DISTRICT RETIREMENT SYSTEM

CHAPTER 103. CALCULATIONS OR TYPES OF BENEFITS

34 TAC §103.4

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed repealed rule 34 TAC §103.4 relating to the partial years of a member's age from being used to determine eligibility for service retirement. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8757). No comments were received from the public.

The rule is being repealed pursuant to legislative changes enacted by the 77th Legislature in Senate Bill 523. The repeal of the rule will allow partial years of age to be considered in determining eligibility for service retirement.

Sections 844.207, 844.210, and 844.211, Government Code, are affected by this proposed repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107992
Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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34 TAC §103.10

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed repealed rule 34 TAC §103.10, which provides for the calculation of interest to be credited to an account closed because a member has not performed service within a specified time. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8757). No comments were received from the public.

The rule is being repealed pursuant to legislative changes enacted by the 77th Legislature in Senate Bill 523. The repeal of the rule will not change current law because the same calculation was added to Section 842.108(c), Government Code.

No statutory sections are affected by this proposed repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107993
Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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34 TAC §103.11

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed deletion of subsection (b) of 34 TAC §103.11, which requires claims for payment of supplemental death benefits based on extended coverage in the supplemental death benefit program to be filed within two years after the member's death. The deletion of subsection (b) of the rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8758). No comments were received from the public. Section 103.11 is adopted without change and will not be republished.

Subsection (b) of the rule is being deleted because the public benefit anticipated as a result of the deletion is the ability to pay supplemental death benefits in cases in which the retirement

system is not notified of a member's death within two years after that occurrence. The deletion of subsection (b) of the rule will allow extended coverage supplemental death benefits to be paid without regard to when a claim is filed.

Section 844.502, Government Code, is affected by this proposed amendment.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

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Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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CHAPTER 107. MISCELLANEOUS RULES

34 TAC §107.2

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed repealed rule 34 TAC §107.2, which limits the number of recipients of benefits on the death of a member or annuitant to three. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8758). No comments were received from the public.

The rule is being repealed because the public benefit anticipated as a result of the repeal is the greater flexibility of members and annuitants to determine the most appropriate distribution of their benefits. The repeal of the rule will allow any number of beneficiaries to receive death benefits.

No statutory sections are affected by this proposed repeal.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107995
Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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34 TAC §107.5

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed amended rule 34 TAC §107.5 concerning the termination of membership on withdrawal of contributions and the deadline for canceling a refund. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8759). No comments were received from the public. Section 107.5 is being adopted without change and will not be republished.

The rule is being adopted because the public benefit anticipated as a result of administering the rule is the ability of members with more than one account in the retirement system to receive a refund from one or more accounts while maintaining others. Under the proposed rule, membership will terminate only when a person withdraws contributions from all the person's accounts. The proposed rule extends from 30 to 60 days the period within which a refund may be canceled.

Sections 842.108 and 842.109, Government Code, are affected by this proposed rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107996
Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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34 TAC §107.11

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed new rule 34 TAC §107.11 concerning changes a subdivision may make in a plan for which it has assumed financial responsibility. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8759). No comments were received from the public. Section 107.11 is adopted without change and will not be republished.

The rule is being adopted pursuant to legislative changes enacted by the 77th Legislature in Senate Bill 523. Under the proposed rule, a successor subdivision may adopt an actuarially determined annual employer contribution rate for the plan. If it does, it may change the employee contribution rate, authorize credit for qualified military service, change the ratio by which it "matches" employee contributions, change eligibility provisions for service retirement, award cost-of-living increases to annuitants, authorize premembership service credit, authorize reestablishment of credit previously forfeited, or authorize a partial lump-sum distribution on retirement. A successor subdivision could also authorize supplemental death benefits.

No statutory section is affected by this proposed rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

TRD-200107997
Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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34 TAC §107.12

On October 19, 2001, the Texas County and District Retirement System (the "System") filed with the Texas Register Division of the Office of the Secretary of State proposed new rule 34 TAC §107.12 concerning retirement system payments that are due, have been suspended, or have not been negotiated on the date an annuitant dies. The rule was published for public comment in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8760). No comments were received from the public. Section 107.12 is adopted without change and will not be republished.

The rule is being adopted because the public benefit anticipated as a result of administering the rule is the greater ability of the system to implement the wishes of its annuitants through their selection of beneficiaries, instead of directing benefits through the estate administration process. Under the proposed rule, payments of an annuity that is suspended because a retiree returns to work with the retiree's previous employer and other payments that have not been made by the retirement system or negotiated by the annuitant will be payable to the annuitant's beneficiary. Multiple beneficiaries will need to agree on one beneficiary to receive the payments on behalf of all beneficiaries.

Section 842.110, Government Code, is affected by this proposed rule.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 17, 2001.

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Ray Henry
Deputy Director
Texas County and District Retirement System
Effective date: January 6, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 637-3230

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 7. TEXAS COMMISSION ON LAW ENFORCEMENT OFFICER STANDARDS AND EDUCATION

CHAPTER 211. ADMINISTRATION

37 TAC §211.1

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §211.1, concerning definitions, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7989).

For clarification purposes, the adopted amendment adds a definition for the term "training cycle". The amendment also adopts the renumbering of the paragraphs of this section as well as a change to the effective date in subsection (b) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107917
Edward T. Laine
Chief, Professional Standards and Administrative Operations
Texas Commission on Law Enforcement Officer Standards and Education
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Proposal publication date: October 12, 2001
For further information, please call: (512) 936-7700

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37 TAC §211.27

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §211.27, concerning the reporting responsibilities of individuals, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7989).

For consistency purposes, changes were made in subsections (a) and (c) of this section. The language, which previously read, "a person who holds a commission license or certificate," was deleted and was replaced by the term "licensee". The language is being provided to clarify that the Commission takes administrative action against licensees, not certificates that they hold. An adopted change was also made to the effective date in subsection (d) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

Chief, Professional Standards and Administrative Operations

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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CHAPTER 215. TRAINING AND EDUCATIONAL PROVIDERS AND RELATED MATTERS

37 TAC §215.3

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.3, concerning academy licensing, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7990).

For consistency purposes, changes were made to some of the terms used in a number of the subsections of this section. The subsections that were affected were (a)(3) and (6); (b)(5), (7) and (8), (8)(A), (B) and (C); (d); (e)(1) and (3); (h)(2); and a change was made in the effective date in subsection (j) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

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Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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37 TAC §215.5

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.5, concerning contractual training, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7991).

For clarification purposes the term "requesting party" was changed to the term "applicant" in subsection (e)(1)(A) of this section. The only other adopted change to this section was to the effective date in subsection (i).

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

Chief, Professional Standards and Administrative Operations

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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37 TAC §215.15

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.15, concerning enrollment standards and training credit, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7992).

Additional language provides clarification regarding the Commission's role, that training credit will be granted for courses conducted by a licensed academy as provided in the Commission's rules. In addition, the language provided in subsection (d)(1), (2) and (3) of this section explains what records an academy must have on file for individuals who enroll in any basic peace officer training program which provides instruction in defensive tactics, arrest procedures, firearms, or use of a motor vehicle for law enforcement purposes. In addition, the language provided in subsection (e)(4) of this section is intended to minimize incidents where licensees obtain training credit by deceitful means. The other adopted changes in §215.15 include the renumbering of the subsections of this section and an adopted change to the effective date in subsection (g) of this section.

One written comment was received from a facility training coordinator at Dickens County Correctional Center who disagrees with the proposed change regarding the acceptance of a high school equivalency certificate (GED) only with completed at least 12 hours at an institution of higher education with a at least a 2.0 grade point average on a 4.0 scale. No changes were made.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

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Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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37 TAC §215.17

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.17, concerning distance education, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7992).

Additional language provided in subsection (d) of this section provides clarification regarding distance education courses and the Commission's role. In addition, the added language provided in this subsection is intended to minimize incidents where licensees obtain distance education training credit by deceitful means. The only other adopted change in §215.17 includes a change to the effective date in subsection (f) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

Chief, Professional Standards and Administrative Operations

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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CHAPTER 217. LICENSING REQUIREMENTS

37 TAC §217.9

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code, §217.9, concerning continuing education credit for licensees, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7993).

In subsection (b) of this section the term, "shall" was deleted and the term "may" was substituted for clarification and consistency with the Commission's rules. In subsection (b)(5) of this section, the adopted amendment clarifies that the Commission may refuse credit for more than one presentation of a course by an instructor, per training cycle. The adopted amendment gives the Commission authority to take administrative action against licensees that claim credit in instances where credit was obtained by deceitful means. Additional language in subsection (b)(6) of this section also serves to clarify that the Commission may refuse credit for the continuing education course(s) if the course(s) is obtained by deceitful means. The amendment also adopts a change to the effective date in subsection (d) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine

Chief, Professional Standards and Administrative Operations

Texas Commission on Law Enforcement Officer Standards and Education

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For further information, please call: (512) 936-7700

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37 TAC §217.11

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.11, concerning legislatively required continuing education for licensees, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7994).

Adopted amendments to this section clarify that the Commission will track the legislatively required courses taken and completed by licensees every four years versus every two years. In subsections (a), (b) and (e) of this section language was added for clarification purposes. In subsection (h) of this section language was added to clarify when the commission may discipline an individual for failure to complete 40 hours of training in either or both of the 24 month units within a training cycle. In subsection (j) of this section language was added to clarify that individuals licensed as peace officers shall attend a course, developed by the commission, on asset forfeiture no later than September 1, 2002. In subsection (k) of this section, language was added to clarify that individuals licensed as peace officers shall attend a course, developed by the commission, on racial profiling no later than September 1, 2003. In subsection (l) of this section, language was added to clarify that all peace officers must meet the continuing education requirements except where exempt by law. This rule is written to conform with continuing education requirements for peace officers as set forth by the Legislature in the 2001 session. The only other adopted amendment was to the effective date in subsection (m) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine
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For further information, please call: (512) 936-7700

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37 TAC §217.17

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.17, concerning active license renewals, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7996).

The adopted amendment to this subsection clarifies that the Commission will track the legislatively required courses taken and completed by licensees every four years versus every two years and that active licensees who have met the current legislatively required continuing education courses will have their license(s) automatically renewed on the last day of the training cycle. The amendments to subsection (c) and (d) of this section adopts changes to the term reactivation and the term reinstated. These terms are being substituted by the terms reinstatement in subsection (c) and (d) of this section. A change is also adopted to the effective date in subsection (e) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine
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Texas Commission on Law Enforcement Officer Standards and Education
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For further information, please call: (512) 936-7700

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CHAPTER 221. PROFICIENCY CERTIFICATES AND OTHER POST-BASIC LICENSES

37 TAC §221.1

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.1, concerning proficiency certificate requirements, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7996).

The adopted amendment to this subsection clarifies that an active licensee, who is not commissioned, will still be able to accrue certificates. Currently, a active licensee cannot earn certificates if not commissioned. The amendment also adopts a change to the effective date in subsection (f) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine
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Texas Commission on Law Enforcement Officer Standards and Education
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For further information, please call: (512) 936-7700

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37 TAC §221.3

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.3, concerning peace officer proficiency, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7997).

The adopted amendment to subsection (b) clarifies that in order to qualify for an intermediate peace officer proficiency certificate, new legislation requires that an applicant must meet all proficiency requirements including two additional courses. In subsection (b)(3)(F) and (G) of this section new legislation mandates that two new courses, an asset forfeiture course and a racial profiling course be completed if the basic peace officer certificate was issued or qualified for on or after January 1, 1987, the licensee must also complete all of the current intermediate peace officer certification courses. The amendment also adopts a change to the effective date in subsection (d) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Commission on Law Enforcement Officer Standards and Education
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For further information, please call: (512) 936-7700

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37 TAC §221.13

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.13, concerning emergency telecommunications proficiency, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7998).

The adopted amendment to subsection (b)(3) and (4) of this section clarifies that in order to qualify for an intermediate emergency telecommunications proficiency certificate new legislation requires that an applicant must meet all proficiency requirements including 120 hours of training and if the basic telecommunications certificate was issued or qualified for on or after January 1, 2000, successful completion of the required courses as specified by the Commission, which include: Cultural Diversity, Ethics in Law Enforcement, Crisis Communications, TCIC/NCIC for Full Access Operators; NLETS/TLETS; or Criminal Law; and Spanish for Law Enforcement. Subsection (c)(3) of this section clarifies that to qualify for an advanced telecommunications proficiency certificate, an applicant must meet all proficiency requirements including: an intermediate telecommunications certificate, at least four years of experience in public safety telecommunications, and 240 training hours. The amendment also adopts a change to the effective date in subsection (d) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Edward T. Laine
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Texas Commission on Law Enforcement Officer Standards and Education
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For further information, please call: (512) 936-7700

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CHAPTER 223. ENFORCEMENT

37 TAC §223.3

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §223.3, concerning the answer required section, without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 7999).

For consistency purposes, the adopted amendment to subsection (d)(3) of this section, includes the deletion of the abbreviated term, "Tex. Admin." which will be substituted by the term, "Texas Administrative Code." The amendment also adopts a change to the effective date in subsection (f) of this section.

No written comments were received.

The amendment is adopted under Texas Occupations Code Annotated, Chapter 1701, §1701.151 which authorizes the Commission to promulgate rules for the administration of this chapter.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Commission on Law Enforcement Officer Standards and Education
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For further information, please call: (512) 936-7700

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 7. TEXAS COUNCIL ON PURCHASING FROM PEOPLE WITH DISABILITIES

CHAPTER 189. PURCHASES OF PRODUCTS AND SERVICES FROM PEOPLE WITH DISABILITIES

40 TAC §§189.3, 189.5 - 189.8, 189.11

The Texas Council on Purchasing from People with Disabilities adopts amendments to §§189.3, 189.5, 189.6, 189.7, 189.8, and 189.11, concerning purchases of products and services from people with disabilities. Section 189.7 is adopted with changes to the proposed text as published in the November 2, 2001, issue of the *Texas Register* (26 Texas Register 8783). Sections 189.3, 189.5, 189.6, 189.8 and 189.11 are adopted without changes and will not be republished.

The Texas Council on Purchasing from People with Disabilities amended Chapter 189 in order to provide details for assistance provided by the commission, contracting with one or more central nonprofit agencies, the responsibilities of central nonprofit

agencies, establishment of an advisory committee, the responsibilities of the advisory committee, and hiring staff to carry out council's duties. The amendments will also provide more detailed procedures for the council's responsibilities under the public information act, and detailed procedures regarding items purchased under exceptions.

Ten comments were received on the amended rules from TIBH Industries and Burke Center.

Comment: Preamble - Public Benefit/Cost Note; Although there are no state-appropriated funds directly involved in operating the Texas state use program and, therefore, there is no cost to the state in administering the proposed rules, additional reporting requirements proposed for Community Rehabilitation Programs (CRPs) and TIBH as the Central Nonprofit Agency will increase operating costs of all participants in the program.

Response: The Council disagrees with comments. Information such as contract data, list of products and services offered by CRPs, direct labor, list of products and services is already provided to the CNA. The Council believes that any additional reporting imposed on CRPs or the "CNA" as a result of complying with the proposed rules will be outweighed by the anticipated public benefits of enhanced fiscally responsible oversight and fulfillment of the state use program's purpose of assisting persons with disabilities to achieve independence through productive employment in accordance with 122.001, Human Resource Code.

Comment: Statutory Authority - The proposed rules cannot be promulgated under Government Code, Title 8, Chapter 122, as incorrectly stated at Page 8784, but must flow from Chapter 122, Texas Human Resources Code and recently enacted House Bill 1691, 77th Legislative Session.

Response: The Council agrees with the comment and has changed the language as follows: The amendments to §§ 189.3, 189.5, 189.6, 189.7, 189.8, 189.11 are proposed under the authority of the Texas Human Resource Code, Title 8, Chapter 122 which provides the Texas Council on Purchasing from People with Disabilities with the authority to promulgate rules necessary to implement the legislative intent of House Bill 1691 77th Legislature

Comment: §189.6(a)- The "document process for the certification of the community rehabilitation programs" will require compliance reports by CRPs, which already must comply with a variety of other state and federal requirements.

Response: The Council disagrees with comments: In-order to protect the integrity of the State Use Program, the Council must have available through the records of the CNA that participating CRP's meet the requirements of Rule 189.6 (c)

Comment: §189.6(n)- The "verified instances of conflict of interest for a CRP" is a term not defined in existing or proposed Council rules.

Response: The Council disagrees with comments: "Conflict of Interest" is defined in the Memorandum of Agreement between The Council on Purchasing from People with Disabilities and TIBH, Industries, Inc. The Council believes the Human Resources Code 122.013 Rules (a) gives the Council the authority to adopt rules that include conflict of interest as grounds for termination of a contract with a CNA.

Comment: §189.7(a)- The proposed rule strays from and changes the language and effect of the newly- enacted House Bill 1691 in the following respects:

(1) The new statutory wording in Sec. 122.019(a), Human Resources Code, reads The council may select and contract with one or more central nonprofit agencies....", while the proposed rule reads, "The council may contract with one or more..." The reason for this alteration is unclear.

Response: The Council agrees with comment. The Council has amended the Proposed Texas Council amendments to Tex. Admin. Code to reflex the language of House Bill 1691 " The Council may select and contract with one or more central nonprofit agencies...."

(2) The proposed rules ignore Sec. 122.019(d) Human Resource Code, which provides an alternative to a request or proposal method of selecting a CNA and permits the council simply to renew and renegotiate a contract with the current CNA.

Response: The Council disagrees with comment. House Bill 1691 Section 122.019(d) requires The Council on Purchasing from People Disabilities to review, and renegotiate (if necessary) the five year contract once during its duration to evaluate the performance of the CNA, and to renegotiate the terms of the contract if necessary due to unforeseen events or changes in the law.

Comment: §189.7(f)- There is no authority under Chapter 122, Human Resource Code, to enter into "an emergency contract" by requests for proposals or negotiations.

Response: The Council disagrees with comment. Authorization from Human Resources Code 122.013 (a)The Council may adopt rules for the implementation, extension, administration or improvement of the program authorized by this chapter in accordance with Chapter 2001, Government Code.

Comment: §189.7(i)- Additional reporting by CRPs to the CNA and then to the Council will require additional accounting and reporting functions, with increased operating costs for CRPs and the CNA.

Response: The Council disagrees with comment. This information has been required in the past for the Annual Report to the Governor and the Quarterly Reports to the Council from the CNA. The request for this information is to protect the integrity of the State Use Program.

Comment: §189.7(o)(1)- A "conflict of interests" (not defined in the proposed rules) is not one of the grounds for terminating the central nonprofit agency (CNA) specified Section 122.019(g), Human Resources Code.

Response: The Council disagrees with comment. "Conflict of Interest" is defined in the Memorandum of Agreement between The Council on Purchasing from People with Disabilities and TIBH, Industries, Inc. The Council believes the Human Resources Code 122.013 (a) gives the Council the authority to adopt rules that include conflict of interest as grounds for termination of a contract with a CNA.

Comment: §189.11(b)and(c)- Properly restate the text of the new Sec. 122.0215(a) and (b), recently enacted by the legislature.

Response: The Council disagrees with comment. HB 1691 section 122.0215 Access to Information and Records (c), "The council shall adopt rules establishing procedures to ensure that the information and records maintained by the council under this chapter are kept confidential and protected from release to unauthorized persons."

Comment: §189.11(d)- The procedure proposed in (d) layers a new records-access process atop the Texas Public Information Act, Chap. 552 Texas Government Code, which provides public access to public information held by a government body. The tone of the proposed rule assumes that internal records of CRPs or the CNA are public information records or documents which is not the case and thereby become subject to rulings by the chair of the Council under the open records act. The CRPs and CNA are not governmental bodies. The proposed rule also contemplates access to CRP or CNA internal records by "...any other individual or entity...." The newly-enacted Sec. 122.0215 references records access only by the council and the council's staff, and not by third parties. There is no authority to alter the boundaries of the Texas Public Information Act (Chapter 552) or the limited records access specified in Section 122.0215.

Response: The Council disagrees with comment. HB 1691 section 122.0215 Access to Information and Records (c), "The council shall adopt rules establishing procedures to ensure that the information and records maintained by the council under this chapter are kept confidential and protected from release to unauthorized persons" Notwithstanding this subsection, it is the intent of this chapter to ensure that the information and records maintained by the counsel under this chapter are kept confidential and protected from release to unauthorized persons.

The amendments to §§189.3, 189.5, 189.6, 189.7, 189.8, 189.11 are adopted under the authority of the Texas Human Resource Code, Title 8, Chapter 122 which provides the Texas Council on Purchasing from People with Disabilities with the authority to promulgate rules necessary to implement the legislative intent of House Bill 1691 77th Legislature Rules

§189.7. Contracting with Central Non-profit Agencies.

(a) The council may select and contract with one or more central nonprofit agencies and shall contract through a request for proposals for a period not to exceed five years to perform, at a minimum, the duties set forth in §122.019(a) and (b) of Chapter 122 of the Human Resources Code.

(b) The management fee rate charged by a central nonprofit agency for its services to the CRP(s) and its method of calculation must be approved by the council. The maximum management fee rate must be:

(1) computed as a percentage of the selling price of the product; or

(2) the contract price of a service; and

(3) must be included in the selling price or contract price; and

(4) must be paid at the time of sale.

(c) The council, at its sole discretion, may negotiate and approve varying management fees for a CNA to provide a fee structure that corresponds to the level of service being given by a CNA to each of the CRPs.

(d) A percentage of the management fee described in subsection (b) of this section shall be set by the council and paid to the council in an amount necessary to reimburse the general revenue fund for direct and reasonable costs incurred by the commission in administering its duties under Chapter 122.

(e) In accordance with the Texas Human Resources Code, §122.019(d), the council shall, at least once during the contract period, but more often if the council deems necessary, review services by and the performance of a CNA, and the revenue required to accomplish the program. The purpose of the review shall be to determine whether a CNA has complied with statutory requirements, contract requirements, and performance standards set forth in §189.12 of this title (relating to performance standards for a central nonprofit agency). Following the review of a CNA as required by §122.019(d) of the Human Resources Code, the council at its sole discretion, may approve the performance of the central nonprofit agency and the continuation of the contract through its termination date; or

(f) The council may issue a request for proposals or negotiate an emergency contract not to exceed one year, when a contract with a CNA is terminated by the council because:

(1) the central nonprofit agency ceases operations;

(2) the central nonprofit agency gives notice that it can not complete the contract;

(3) the central nonprofit agency's performance contract has been terminated due to its failure to perform its contractual obligations; or

(4) review of the central nonprofit agency results in disapproval of its performance.

(g) In the event a new CNA succeeds to the contract for any reason provided in these rules, the prior CNA shall cooperate fully and assist the new CNA to take over CNA duties and responsibilities as soon as possible with minimal disruption to the operations of the program. Such cooperation and assistance will include turning over to the council the terminated CNA's records described in the Texas Human Resources Code §122.009(a), which includes but is not limited to a marketing plan, a listing of CRPs participating in the state use program, copies of all contracts with CRPs participating in the state use program, a listing of state agencies that purchase state use products and services, program funding requirements, and job descriptions for staffing a CNA to perform its duties under its contract with the council.

(h) Not later than the 60th day before the date the council adopts or renews a contract, the council shall publish notice of the proposed contract in the *Texas Register*.

(i) No later than October 1st of each year the CNA will provide to the council, regarding CRP(s) which have contracted with the CNA, the following information for the period of July 1st through June 30th of each year:

(1) for CRPs:

(A) a collective executive summary of the CRPs annual state use program evaluations;

(B) the number of disabled persons employed by type of disability and the number of non-disabled workers employed in programs managed by the CRP(s) or who are employed by businesses or workshops that receive supportive employment from CRPs;

(C) the amount of annual wages and the average and range of weekly earnings for disabled and non-disabled workers who are employed in CRPs under this chapter;

(D) a summary of the sale of products offered by the CRP(s);

(E) a list of products and/or services offered by a CRP;

(F) the geographic distribution of CRP(s); and

(G) a report of all CRPs that have not met the criteria for participation in the state use program in a format approved by the council.

(2) from each CRP data on individual outplacement or supported employment to include:

(A) the number of individuals in outplacement employed;

(B) the hourly wage range;

(C) the range of hours worked; and

(D) the number of disabled persons employed by primary type of disability.

(j) In accordance with the Texas Human Resource Code, §§122.019 (c) and (d), a CNA will provide or make available to the council:

(1) quarterly reports for each calendar quarter of its contract of sales of products or services, wages paid and hours worked by persons with disabilities for CRPs participating in the state use program;

(2) quarterly reports for each calendar quarter listing CRPs that do not meet criteria for participation in the state use program and the reasons that each CRP listed does not meet the criteria;

(3) at least once a year by October 31st, and prior to any review and/or re-negotiation of the contract:

(A) an updated marketing plan;

(B) a proposed annual budget with estimated sales, commissions, and expenses;

(C) a program budget with details on how the expected revenue and expenses will be allocated to directly support and expand the state use program and other programs that expand direct services and/or the enhancement of employment opportunities for persons with disabilities; and

(D) an audited annual financial statement which should include information on FDIC coverage of all cash balances, earnings attributed to the management fee for the state use program, accounts receivable, cash reserves, line of credit borrowings, interest payments, bad debt, administrative overhead and any detailed supporting documentation requested by the council;

(4) quarterly reports of categories of expenditures in reporting format approved by the council;

(5) records in accordance with the Texas Human Resources Code §§122.009 (a) and 122.0019(d) for audit purposes, provided however, that any records provided by a CNA which may be subject to any exception to Chapter 552 of the Texas Government Code, would not be disclosed to any third party except with the permission of the CNA or in accordance with the provisions of Chapter 552, Government Code (the "Public Information Act"); and

(6) any other information the council requests as set forth in Chapter 189 of this title (relating to Purchase of Products and Services from Persons with Disabilities).

(k) Duties of a CNA include, but not be limited to:

(1) recruit and assist community rehabilitation programs in developing and submitting applications for the selection of suitable products and services;

(2) facilitate the distribution of orders among community rehabilitation programs;

(3) manage and coordinate the day-to-day operations of the program, including the general administration of contracts with community rehabilitation programs;

(4) promote increased supported employment opportunities for persons with disabilities;

(5) investigate products and services before they are proposed by CRPs for the state use program and after their approval for compliance with Texas Government Code §§2155.138 and 2155.069; and

(6) monitor CRPs to ensure that all criteria for participation in the state use program are met.

(l) The services of a central nonprofit agency may include marketing and marketing support services, such as:

(1) assistance to CRPs regarding solicitation and negotiation of contracts;

(2) direct marketing of products and services to state agencies and political subdivisions;

(3) research and development of products and services;

(4) public relations activities to promote the program;

(5) customer relations;

(6) education and training;

(7) accounting services related to purchase orders, invoices, and payments to CRPs; and

(8) other duties as designated by the council that may include:

(A) establishing a payment system with a goal to pay CRPs within fourteen (14) to twenty-one (21) calendar days, but not less than thirty (30) days of completion of work and proper invoicing;

(B) resolving contract issues and/or problems as they arise between the CRPs and customers of the program, referring those that cannot be resolved to the council;

(C) maintaining a system that tracks and monitors product and service sales; and

(D) tracking and reporting quality and delivery times of products and services.

(m) Each year by October 31st, a central nonprofit agency will establish performance goals for the next fiscal year in support of objectives set by the council. Those performance goals will include, but not be limited to:

(1) sales of products or services;

(2) wages paid to persons with disabilities;

(3) hours worked by persons with disabilities;

(4) response time to customers' inquiries and/or complaints; and

(5) quality standards and delivery goals for CRP programs operations.

(n) The CNA shall have an authorized representative present at all council meetings who can bind the CNA to any representations, agreements or decisions regarding agenda items subject to the council's authority.

(o) The council may terminate a contract with a central nonprofit agency if:

(1) the council finds substantial evidence of the central non-profit agency's noncompliance with contractual obligations or of conflict of interest; and

(2) the council has provided at least 30 days written notice to that central non-profit agency of the termination of the contract.

(p) The council may request an audit by the state auditor of:

(1) the management fee set for any central non-profit agency; or

(2) the financial condition of any central non-profit agency.

(q) A person may not operate a community rehabilitation program and at the same time contract with the council as a central non-profit agency.

(r) The council must annually review the management fees the CRPs are charged by the CNAs.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 14, 2001.

TRD-200107951
William J. Philbin
Social Services and Assistance
Texas Council on Purchasing from People with Disabilities
Effective date: January 3, 2002
Proposal publication date: November 2, 2001
For further information, please call: (512) 463-3244

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 1. MANAGEMENT

SUBCHAPTER F. ADVISORY COMMITTEES

43 TAC §§1.80 - 1.85

The Texas Department of Transportation adopts amendments to §§1.80-1.85 concerning advisory committees. Sections 1.80-1.85 are adopted without changes to the proposed text as published in the October 19, 2001, issue of the Texas Register (26 TexReg 8332) and will not be republished.

EXPLANATION OF AMENDMENTS

Government Code, §2110.005, provides that a state agency that is advised by an advisory committee shall adopt rules stating the purpose of the committee and describing the task of the committee and the manner in which the committee will report to the agency. Government Code, §2110.008, requires the commission to sunset advisory committees at least every four years. The Texas Department of Transportation's advisory committees are abolished at the end of this year unless continued by the commission. These amendments will clarify the procedures applicable to advisory committees and address the desirability of continuing or abolishing the various advisory committees.

Sections 1.80 and 1.81 are amended to conform to current terminology used in the Texas Register.

Section 1.82(c)(2) is amended to ensure that advisory committee meetings are held in Texas and in places that are readily accessible to the public. This change ensures that meetings will be fully open to the public.

Section 1.82(i) is amended to reauthorize the department's statutory advisory committees, which include the Aviation Advisory Committee, the Public Transportation Advisory Committee, and the Port Authority Advisory Committee. In each case, the department has determined that the committee serves a useful continuing function by providing a conduit for the exchange of information with the affected industry. The Port Authority Advisory Committee has voted 3-0, with one abstention, to recommend its continuation. Each committee is continued in existence until December 31, 2003. This date will permit the commission to conduct another comprehensive review of its advisory committees after the 2003 legislative session. The Border Trade Advisory Committee is already specifically scheduled to expire on December 31, 2005, and is therefore unaffected.

Section 1.83 has been amended to shorten the process for advisory committee review of proposed rules. The current process involves two steps, preliminary approval and final approval. This has proved cumbersome because most advisory committees do not meet often enough to permit two evaluations within a reasonable time. The amendment replaces formal preliminary approval with informal preliminary notification. The new procedure will permit advisory committee members to provide individual input during the early stage of rule development, while still meeting formally to offer their collective advice at the stage of final approval. Additional nonsubstantive changes are made to clarify the language of this section.

Section 1.84(b) and (d) are deleted and succeeding subsections are renumbered accordingly. The amendments abolish two statutory advisory committees, the Household Goods Carriers Advisory Committee and the Vehicle Storage Facility/Tow Truck Rules Advisory Committee. These committees are being abolished because the department has developed more informal, successful ways to receive input from household goods carriers, vehicle storage facilities, tow truck operators, and consumers on single issues or programs. Each committee has fulfilled its original purpose, and neither has met in more than two years. Under these circumstances, continuation of these committees at this time would no longer be in the public interest.

Section 1.85(a)(2) is deleted and succeeding subsections are renumbered accordingly. Section 1.85(a)(2) established a Statewide Transportation Policy Committee. This committee has been inactive for several years. To obtain input into the planning process, the department has relied instead on public meetings and other methods of obtaining public input. Therefore, the Statewide Transportation Policy Committee no longer serves a useful function.

Section 1.85(c) is amended to reauthorize advisory committees created by the department on its own authority. These include project advisory committees, rulemaking advisory committees, the Intelligent Transportation Systems Steering Committee, and the Bicycle Advisory Committee. In each case, the department has determined that the committee serves a useful continuing function by providing a conduit for the exchange of information with the public. Each committee is continued in existence until December 31, 2003. This date will permit the commission to conduct another comprehensive review of its advisory committees after the 2003 legislative session.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation. In addition, the amendments are adopted under Government Code, Chapter 2110, which provides that a state agency that is advised by an advisory committee shall adopt rules that state the purpose of the committee, describe the task of the committee, state the manner in which the committee will report to the agency, and establish a date on which the committee is abolished unless the governing body of the agency affirmatively votes to continue the committee in existence.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TRD-200107856
Richard D. Monroe
General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-8630

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CHAPTER 9. CONTRACT MANAGEMENT
SUBCHAPTER A. GENERAL

43 TAC §9.5

The Texas Department of Transportation adopts amendments to §9.5 concerning special labor provisions for public works contracts. Section 9.5 is adopted without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8005) and will not be republished.

EXPLANATION OF AMENDMENTS

Government Code, Chapter 2258, Subchapter A, prescribes the method by which a public body shall determine the general prevailing rate of per diem wages for public works contracts. Pursuant to this authority, the commission has previously adopted §9.5 to specify the process by which the department will establish prevailing wage rates for department building and highway improvement contracts.

Senate Bill 311, 77th Legislature, 2001, amended Government Code, Subchapter A by amending §2258.022 to provide for additional wage survey and determination requirements associated with counties bordering the United Mexican States or counties adjacent to counties bordering the United Mexican States. Section 9.5(c) is therefore amended to include these additional wage survey and determination requirements in order to comply with S.B. 311.

For highway improvement contracts in the affected area, the department shall conduct a statewide wage rate survey and a separate wage rate survey in each county of the affected area. The prevailing wage rate for each job classification will be established on a countywide basis in the affected area based on the higher of the rate determined from the county survey, the arithmetic mean between the rate determined from the county survey and the rate determined by the statewide survey, or the arithmetic mean between the rate determined from the county survey and the rate determined by the United States Department of Labor, if the survey used to determine that rate was conducted within the preceding three-year period. For those municipalities within the affected area that have a population of 500,000 or more, the prevailing wage rate for each job classification will be determined for the geographic limits of the municipality in the manner previously described.

For highway improvement contracts in non-affected areas, the department shall continue to adopt the prevailing wage rate for each job classification as determined by the United States Department of Labor in accordance with the Davis-Bacon Act, 40 United States Code §276a, and its subsequent amendments, provided the rates are based on a survey conducted within the preceding three-year period.

For building contracts, the department shall continue to adopt the prevailing wage rate for each job classification as determined by the General Services Commission.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Government Code, §2258.022, which authorizes the Texas Department of Transportation, as a public body, to determine the general prevailing rate of per diem wages for public work contracts.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Richard D. Monroe
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Texas Department of Transportation
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CHAPTER 15. TRANSPORTATION PLANNING AND PROGRAMMING
SUBCHAPTER I. BORDER COLONIA ACCESS PROGRAM

43 TAC §§15.100 - 15.106

The Texas Department of Transportation adopts new §§15.100-15.106, concerning the border colonia access program. Section 15.100 and §§15.102-15.106 are adopted without changes

to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8007) and will not be republished. Section 15.101 is adopted with changes to the definition of minimum colonia access road standards.

EXPLANATION OF NEW SECTIONS

Senate Bill 1296, 77th Legislature, 2001, added Government Code, Chapter 1403, which requires the Texas Public Finance Authority, in accordance with requests from the Office of the Governor, to issue general obligation bonds and notes in an aggregate amount not to exceed $175 million, and as directed by the department, to distribute the proceeds to counties as financial assistance for colonia access roadway projects to serve border colonias. Senate Bill 1296 requires the commission to establish a program to administer the use of the proceeds of the bonds and notes. Rider 52 to the department's appropriations for Fiscal Years 2002-2003 requires the department to establish a transportation program to improve access to colonias.

Senate Bill 1296 and Rider 52 require the commission and the department to consult with the Office of the Governor, the Secretary of State, the Texas Water Development Board, and the Texas A&M University Center for Housing and Urban Development in developing the rules and procedures for the border colonia access program. The department participated in a working group including representatives of each of these entities in developing rules for the commission's consideration.

New §§15.100-15.106 implement the requirements of Senate Bill 1296 and Rider 52, set forth the procedures by which an eligible county may apply for assistance under Senate Bill 1296 and Rider 52, and establish criteria by which the commission will select projects.

New §15.100 describes the purpose of new Subchapter I, Border Colonia Access Program.

New §15.101 provides definitions for words and terms used in new Subchapter I. This section defines a border colonia as a community, located in an eligible county, which is identified in the Texas Water Development Board's colonia database. In 1989, the Texas Legislature created the Economically Distressed Areas Program (Water Code, §§16.341-16.356), administered by the Texas Water Development Board, to bring water and wastewater services to economically distressed areas, as defined in Water Code, §16.341. Economically distressed areas are also commonly referred to as colonias. In 1992, the Texas Water Development Board conducted a comprehensive assessment of the state's water and wastewater needs in economically distressed areas. This 1992 Colonia Water and Wastewater Needs Report and its subsequent updates identified communities that meet the definition of economically distressed area. The identified colonias are maintained in a colonia database. As a lead state agency working with border colonias for a number of years, the Texas Water Development Board is generally viewed as having the most comprehensive database of colonias in the state. Counties wishing to participate in Economically Distressed Areas Program are required to adopt model rules for the development of subdivisions and water and wastewater services in those subdivisions that have been promulgated by the Texas Water Development Board under Water Code, §16.343. Colonias generally lack adequate infrastructure and basic services such as water and wastewater services and paved roads in or to the colonia. In order to ensure that both adequate infrastructure and basic services are available in a colonia, a county must adopt the model rules in order to be eligible for participation in the border colonia access program.

New §15.102 prescribes requirements a project must meet in order to be eligible for consideration. To be eligible, a project must be located in an eligible county, defined as a county located in the department's El Paso, Laredo, or Pharr district, and Terrell County, that has adopted the model rules. The purpose of the program is to improve access to and from border colonias through the construction and improvement of roads serving the colonias. In order to provide colonia residents with improved access to other parts of the state, and to facilitate the provision of goods and services to the colonias, this section requires a project to have a terminus at or within a border colonia and a terminus at a public road. In order to ensure that projects are designed and constructed in a safe and durable manner, this section requires a project to comply with road standards described in the appropriate American Association of State Highway and Transportation Official design guidelines, or in road standards adopted by a county under Local Government Code, §232.025, and approved by the executive director or designee as sufficient to protect the safety of the traveling public.

New §15.103 prescribes the procedures by which a county may apply for assistance under the program. The department's border district offices will issue a program call to eligible counties, informing those counties of the availability of funds. In order to ensure that a project is eligible and complies with program requirements, and that project development will be carried out in an expeditious manner, an application must include a description of the work proposed, an implementation plan, a map delineating project location and termini, and documentation addressing the criteria considered by the commission in selecting projects for funding under the program.

New §15.104 prescribes criteria for project selection. These criteria are consistent with the factors in Rider 52 that the department is directed to consider in developing rules and procedures for this program. Generally, the higher the border colonia population, the more in need of goods and services that colonia will be. The condition of existing roads in and to a colonia, and whether those roads are paved, helps determine the relative need of a colonia for new and improved roads providing access to and from the colonia. In order to provide adequate educational services to children residing in colonias and provide school buses with adequate access to colonias, the commission will consider whether a project is on an existing or planned school bus route. In order to ensure that a project provides the most efficient service to the maximum number of colonia residents, while also ensuring that funding is not concentrated in a limited number of colonias, the commission will consider the number resulting from dividing the border colonia population whose residences abut the project limits by the number of miles of roadway in the project. In order to provide an objective means of ranking and selecting projects, each criterion will be assigned an equal number of points, and projects will be considered in descending rank order based on the number of points received.

New §15.105 describes the manner in which the department will apportion and distribute available funds to eligible counties under the program. In order to ensure that adequate funds are provided to those counties containing colonias with the most pressing needs, the first 50% of the available funds will be proportionally distributed to the counties based on their colonia population. Generally, the higher the border colonia population, the

more in need of goods and services that colonia will be. Moreover, this will ensure that each county participating in the program receives funds for roadway projects. In order to provide an objective means of selecting additional projects, and to ensure the remaining funds are expended on the most needed projects, the remaining 50% of available funds will be distributed to the counties on a project by project basis, with projects funded in descending rank order as available funding permits. Unused funds dedicated to a county will be distributed on a project by project basis, as will funds reimbursed by a county because of uncompleted projects, or funds available as a result of a county being prohibited from participation in the program under §15.106. In order to ensure that funds are available for the maximum number of projects, funds will be distributed for a project based on a county's project cost estimates. Project costs above that estimate are the responsibility of the county, which may seek additional funds for a project under subsequent program calls.

In order to assist the department in administering the program, new §15.106 prescribes requirements that counties participating in the program must follow. Prior to receiving funds under the program, a county must enter into an agreement with the department. In that agreement, a county must agree to place a project on the county road system and must agree to maintain the road. In doing so, the state ensures that the roads will be adequately maintained. Moreover, Government Code, §1403.002(d)(4), as added by Senate Bill 1296, requires the commission to establish minimum road standards by rule. In order to ensure that project development or access on a new project is not impeded, §15.106 requires a county to agree to complete the placement of any necessary water and wastewater services in or across project right of way prior to constructing the project. In order to ensure that the environment is protected when projects are developed, a county must comply with all applicable federal, state, and local environmental laws and regulations and permitting requirements. In order to ensure that program funds are spent for authorized purposes, and to comply with the requirements for providing grants to local governments under Government Code, Chapter 783, a county may only expend funds received on eligible costs, must comply with the Uniform Grant Management Standards promulgated by the Office of the Governor, and must submit a financial report showing how it will use the funds to build the project. The department may prohibit a county from participating in the program or continuing to participate in the program if the county has not complied with program requirements. In order to ensure that counties use program funds for approved projects, the department may eliminate a project from participation in the program if it is not implemented within a reasonable time, as determined by the department in consultation with the county, and may seek reimbursement of funds received by a county if the county does not complete a project.

COMMENTS

On October 29, 2001, a public hearing was held to receive comments, views, or testimony concerning the proposed adoption of §§15.100-15.106. Comments in favor of the proposed rule were received at the hearing from Oscar Bernal of the City of Asherton; Jesus Ortiz, Val Verde County Commissioner; Raul Lozano of Hidalgo County; Jerry Agan, Presidio County Judge; Kermit Black from the Texas A&M University Center for Housing and Urban Development; Rodrigo Jaime from Dimmit County; and Henry Nevares, Director of Texas Border & Mexican Affairs Division, Secretary of State's office. Mr. Lozano, Mr. Agan, and Mr. Black spoke on the proposed new language. One set of written comments were also received.

Comment: One commenter said that requiring eligible counties to have enacted the subdivision model rules in §15.101 will be a burden for counties since many colonias were in existence prior to the subdivision model rules being promulgated by the Texas Water Development Board under Water Code, §16.343.

Response: The department believes that the subdivision model rules are needed to ensure that the colonias receiving funds from the border colonia access program also adhere to other state statutes concerning subdivision development. For this reason, the department declines to modify the section as originally proposed.

Comment: One commenter suggested that the program should be expanded to provide funds for roads that are not directly connected to colonias as there are additional road improvement needs near the colonias.

Response: Senate Bill 1296, Senate Joint Resolution 37, and Rider 52 all refer to providing improved access to border colonias. Section 15.102 states that eligible projects must have one terminus at or within a border colonia. This is consistent with the stated intent of the legislation. For this reason, the department declines to modify the section as originally proposed.

Comment: One commenter disliked having colonia population as a project selection criterion in §15.104 and for funding allocation in §15.105. He felt that his county would be at a disadvantage for the program because of its low colonia population.

Response: The department believes that colonia population is a necessary criterion as it is identified as a project selection criterion in Rider 52. As to funding allocation, §15.105 allocates 50% of the funds based on colonia population with the remaining 50% of the funds allocated on a project-by-project basis. This funding allocation approach was proposed to ensure that the heavily populated colonias received sufficient funds while also recognizing that significant funds should be allocated to those projects with high scores from the project selection criteria.

For these reasons, the department declines to modify the language originally proposed for §15.104 and §15.105.

Comment: One commenter wanted to change the fifth project selection criterion in §15.104 from "abut" to "within an eighth of a mile of." He felt that this would enable the program to serve more people in the colonias.

Response: The department believes that the intent of the program is to provide paved roads to access colonias. Projects that provide direct access or abut homes is a more preferable criterion than one that would still have people travelling up to an eighth of mile to access a paved road. For this reason, the department declines to modify the language originally proposed in this section.

Comment: One commenter wanted to know how the program would work when a project lies inside a city's limits. He was concerned about how the arrangement would work since the program is set up to provide funds to counties, not cities.

Response: The department has the ability to enter into interlocal agreements whereby the county would receive the program funds and transfer them to the city. This arrangement would still meet the intent of the program, which is to provide funds to improve the access to border colonias.

Comment: Two commenters also wanted clarification that the program funds could be used to improve drainage to protect paved roads.

Response: Section 15.101 states that providing drainage for a project is an eligible cost. The department believes this would allow the program to fund road drainage projects on both unpaved and paved roads.

Comment: One commenter wanted to know who will do the scoring for projects.

Response: Ultimate responsibility for scoring lies with the commission, using project selection criteria as described in §15.104. Project scores will be submitted by department staff as a recommendation to the commission.

Comment: One commenter wanted to expand the project selection criteria in §15.104 to include the consideration of access to colonias of public services, such as fire and ambulance vehicles, law enforcement, and solid waste services.

Response: One of the project selection criteria identified in Rider 52 of the department's appropriation bill is to consider school bus routes. Section 15.104 includes school bus routes, both existing and proposed, as a project selection criterion. The department believes that selecting projects that will provide for school bus routes will also be largely sufficient to handle other public service vehicles. For this reason, the department declines to modify the proposed language in this section.

Comment: One commenter stated that the fourth project selection criterion in §15.104 is repetitious since he believes it is similar to the second project selection criterion.

Response: Rider 52 identifies both condition of current roads and access to other parts of the region as factors the department should consider for the program. The department has those two factors listed in §15.104, as the second and fourth project selection criteria. The condition of current roads, the second criterion, encompasses whether the road is paved or not, its current condition, and the drainage condition of the road. The fourth criterion, access to other parts of the region, encompasses how many roads connect the colonia to the public road system. Although there may be some perceived similarities to the two criterion, they are distinct.

For these reasons, the department declines to modify the language in the proposed section as originally written.

Comment: One commenter suggests an additional project selection criteria in §15.104 to aid the ability of colonia residents to reach libraries, community centers, and schools.

Response: The department believes that the program is intended to provide paved road access from colonias to the public road system. Having access to the public road system then allows colonia resident to reach libraries, community centers, and schools. For this reason, the department declines to modify the proposed language in this section as originally written.

Comment: One commenter asked if the program funds could be used to repair existing paved colonia roads.

Response: Section 15.101 states that acquiring materials used in maintaining colonia access roads is an eligible cost. The department believes this includes the use of program funds to repair existing paved colonia roads. For this reason, the department declines to modify the proposed language in this section as originally written.

The department has revised the definition of minimum colonia access road standards under §15.101 to make the road standards more flexible. The requirement to have the more stringent standards from AASHTO or the county's road standards has been removed. Instead, if the county does not follow the AASHTO road standards, then the executive director or designee may approve the county's road standards. This change will allow the department and the county to reach a mutually acceptable road standard that will provide safe roads for the traveling public while maximizing the program funds.

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Government Code, §1403.002 and Rider 52 to the department's appropriations for Fiscal Years 2002-2003, which require the commission to adopt rules for the administration of the border colonia access program.

§15.101. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) AASHTO - The American Association of State Highway and Transportation Officials.

(2) Border colonia - A community, located in an eligible county, that is identified as a colonia in the Texas Water Development Board's colonia database.

(3) Border districts - The El Paso, Laredo, Pharr, and Odessa department districts.

(4) Commission - The Texas Transportation Commission.

(5) County road - A road owned and maintained by a county.

(6) Department - The Texas Department of Transportation.

(7) Eligible costs - The cost of constructing, administering, or providing drainage for a project or acquiring materials used in maintaining a project.

(8) Eligible county - A county located in the El Paso, Laredo, or Pharr department districts, and Terrell County, that has adopted the model rules promulgated by the Texas Water Development Board under Water Code, §16.343.

(9) Executive director - The executive director of the department.

(10) Minimum colonia access road standards - Road standards for the applicable transportation facility, as described in:

(A) the latest editions of appropriate AASHTO design guidelines; or

(B) road standards adopted by a county under Local Government Code, §232.025 and approved by the executive director or designee as sufficient to protect the safety of the traveling public.

(11) Public road - A road owned and maintained by a municipality, county, or the department.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Richard D. Monroe
General Counsel
Texas Department of Transportation
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For further information, please call: (512) 463-8630

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SUBCHAPTER J. DESIGN CONSIDERATIONS

43 TAC §§15.120 - 15.122

The Texas Department of Transportation adopts new §§15.120-15.122, concerning the consideration of various design factors when developing transportation projects. Section 15.120 and §15.122 are adopted without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8011), and will not be republished. Section 15.121 is adopted with changes.

EXPLANATION OF ADOPTED NEW SECTIONS

Senate Bill 1128, 77th Legislature, 2001, added Transportation Code, §201.614, requiring the department to consider specified design factors when developing transportation projects that involve the construction, reconstruction, rehabilitation, or resurfacing of a highway, other than a maintenance resurfacing project. Section 201.614 requires the commission to adopt rules to implement that section.

In order to implement the requirements of Transportation Code, §201.614, and to ensure the uniform and consistent development of transportation plans and projects, new §§15.120-15.122 describe how the design factors specified in Transportation Code, §201.614 will be considered during the development of certain transportation projects in which the department has design and construction or funding responsibilities.

New §15.120 describes the purpose of new Subchapter J, Design Considerations, including the implementation of Transportation Code, §201.614.

New §15.121 provides definitions for words and terms used in the new subchapter.

New §15.122 describes how the specified design factors will be considered and assessed as transportation projects are developed in order to provide transportation systems and alternatives that are comfortable, safe, durable, cost-effective, accessible, environmentally sensitive, aesthetically pleasing, and that consider other transportation modes. New §15.122 provides that the design factors will be considered by department districts, and by local governments and metropolitan planning organizations when planning and designing projects that are funded by the department.

As required by Transportation Code, §201.614, the design factors will be considered when developing projects that involve the construction, reconstruction, rehabilitation, or resurfacing of a highway, other than maintenance resurfacing projects. The department and the transportation engineering industry typically categorize projects, other than those on new location, as reconstruction, rehabilitation, restoration, or resurfacing. Transportation Code, §201.614 does not specifically mention restoration projects. However, resurfacing projects, other than maintenance resurfacing projects, would typically be defined by the transportation industry as restoration work. The industry definition of resurfacing typically refers to what Transportation Code, §201.614 calls maintenance resurfacing.

COMMENTS

No comments were received on the proposed new sections. However, the definitions for the industry terms resurfacing, restoration, rehabilitation, and reconstruction have been revised to improve clarity and to show, where applicable, the appropriate design criteria that applies to each type of project.

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Transportation Code, §201.614, which requires the commission to adopt rules to implement that section.

§15.121. Definitions.

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Construction project - A transportation project in which the primary activities involve building a segment of highway or public road in a new configuration or on a new location.

(2) Department - The Texas Department of Transportation.

(3) District - One of the 25 geographical areas, managed by a district engineer, in which the department conducts its primary work activities, including project development.

(4) Local government - Any county, city, other political subdivision of this state, or special district that has the authority to plan and design a highway or roadway project.

(5) Metropolitan planning organization (MPO) - The forum for cooperative transportation decision making for the metropolitan planning area. The MPO is also the organization that is responsible for carrying out the transportation planning process for the metropolitan area as required by 23 U.S.C. §134.

(6) Resurfacing - A transportation project to apply new or recycled layer(s) of pavement material to the existing pavement to restore the ride quality or skid resistance and to preserve the structural integrity of the pavement.

(7) Restoration (2R) - A transportation project to restore the pavement to its original condition. This may include, in addition to the resurfacing described in paragraph (6) of this section, such activities as restoring the pavement structure, minor pavement widening or the addition of shoulders, and drainage improvements. These projects meet the 2R design criteria shown in the department's Roadway Design Manual.

(8) Rehabilitation (3R) - A transportation project to extend the service life and enhance the safety of a roadway. In addition to the work described under resurfacing and restoration, the activities include upgrading the geometric design and safety of the facility. Work does not include the addition of through travel lanes. These projects meet the 3R design criteria shown in the department's Roadway Design Manual.

(9) Reconstruction (4R) - A transportation project to upgrade an existing roadway to meet the geometric design criteria for a new facility. In addition to the work described under resurfacing, restoration and rehabilitation, reconstruction work generally includes substantial changes in the geometric character of a highway, such as widening to provide additional through lanes and horizontal or vertical realignment, and major improvements to the pavement structure to provide long term service. These projects meet the 4R design criteria shown in the department's Roadway Design Manual.

(10) Transportation Project - The planning, development, design and construction work necessary to construct, reconstruct, rehabilitate or restore a highway or public road that the department has the responsibility to finance or undertake. A project may include, but is not limited to, improvements to a bridge, toll road, transit facility, or high occupancy vehicle lane, or other facilities necessary for an integrated transportation system, but does not include a resurfacing project.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

TRD-200107859
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: January 2, 2002
Proposal publication date: October 12, 2001
For further information, please call: (512) 463-8630

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CHAPTER 21. RIGHT OF WAY
SUBCHAPTER A. LAND ACQUISITION PROCEDURES

43 TAC §§21.1, 21.2, 21.6, 21.7, 21.10, 21.11, 21.13, 21.15

The Texas Department of Transportation adopts amendments to §§21.1, 21.2, 21.6, 21.7, 21.10, 21.11, 21.13, and 21.15, concerning land acquisition procedures. These sections are adopted without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8013) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The amendments are required due to changes in state and federal law. The amendments will bring the land acquisition regulations up to date and into compliance with current law, including the name change of the former State Highway and Public Transportation Commission to the Texas Transportation Commission.

The amendments to §21.1 expand the application of this section to all state highways, as right of way acquisition procedures and department involvement are basically the same for both interstate and other state highways. The amendment allows the acquisition of right of way to be accomplished either directly by the staff of the department or by the use of contracted right of way acquisition providers as now authorized by the recently adopted amendments to Title 43, Texas Administrative Code, Chapter 9, Subchapter F. Additionally, this amendment clarifies that local public entities (municipalities and counties) may also acquire right of way for the department by contractual agreement.

Section 21.2 is amended to reflect a name change from the State Highway and Public Transportation Commission to the Texas Transportation Commission.

The amendments to §21.6 expand the alternative procedures for verifying title information when title insurance policies cannot be utilized. This allows other department staff members to verify titles from information provided by abstract companies when department staff attorneys are not available. This amendment is necessary because very few of the department's districts have staff attorneys.

The amendments to §21.7 add a reference to Chapter 1, Subchapter G of this title (relating to Donations) and include provisions required both by Subchapter G and Government Code, Chapter 575, regarding department action required to accept a donation.

The amendments to §21.10 add procedures and requirements to provide a copy of an appraisal to the landowner at the time an initial offer is made, as required by a revision to the Property Code. Additionally, to bring this regulation into complete compliance with the Code of Federal Regulations, Title 49, Subtitle A, Subpart B, (Real Property Acquisition) §24.102 (Basic Acquisition Policies), revised procedures are included regarding the proper amounts to deposit into the registry of the court when possession of property is required before final judgment is obtained in an eminent domain court proceeding.

Section 21.11 is amended to more precisely describe the type of documentation provided to a local public entity when that entity is requested to directly acquire right of way for the department, with such documentation to be property legal descriptions plus right of way maps. The former wording could have been misunderstood, particularly the word "plat," as the department is not required to follow formal platting and replatting requirements concerning highway right of way acquisitions. Also, the former designation of the State Highway and Public Transportation Commission has been changed to the Texas Transportation Commission.

The amendments to §21.13 remove the word "confidential" because the amendments in §21.10 of this chapter and Property Code, §21.0111 now require the department to provide to the property owner a copy of the appraisal upon which the amount of the offer is based. A broader description of what constitutes an appraisal has been added in a parenthetical statement because department procedures and federal regulations allow various methods for valuing a property, some of which are shorter or more informal such as the procedures listed in the parenthetical statement.

The amendments to §21.15 change the designation of the type of contracts utilized for appraisers, technical experts, and estimators, from "personal" service contracts to "professional" service contracts. This amendment conforms with Government Code, Chapter 2254, Subchapter A and recently amended 43 TAC Chapter 9, Subchapter F, which provides the procedures for handling such professional service contracts.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission

with the authority to establish rules for the conduct of the work of the Texas Department of Transportation.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

TRD-200107860
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: January 2, 2002
Proposal publication date: October 12, 2001
For further information, please call: (512) 463-8630

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CHAPTER 25. TRAFFIC OPERATIONS
SUBCHAPTER B. PROCEDURES FOR ESTABLISHING SPEED ZONES

43 TAC §25.21

The Texas Department of Transportation adopts amendments to §25.21, concerning the department's procedures for establishing speed zones. Section 25.21 is adopted without changes to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8015) and will not be republished.

EXPLANATION OF ADOPTED RULE

These amendments are adopted under Transportation Code, §545.353, subsections (h) and (i), as added by House Bill 299, 77th Legislature, 2001, which allows the Texas Transportation Commission (commission) to establish 75 mile per hour daytime speed limits on certain portions of the state highway system. Speed limits established under this amended section will apply to passenger vehicles, but will not apply to trucks (other than light trucks and light trucks pulling a trailer), truck tractors, trailers, and semitrailers.

House Bill 299 allows the commission to establish such a speed limit on portions of the state highway system located in counties with a population density of less than 10 persons per square mile.

The amendment to §25.21(b)(4)(B) adds the reference to Transportation Code, §545.353, subsections (h) and (i), which allow the department to establish a 75 mile per hour maximum daytime speed limit in certain counties. This amended section states which counties are eligible for this speed limit based on the population limitations contained in the statute. In order to establish such a speed limit, the commission must find that it is safe and reasonable. The amended section also states that a 75 mile per hour speed limit does not apply to large trucks.

COMMENTS

No comments were received on the proposed amendments.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission with the authority to establish rules for the conduct of the work of the Texas Department of Transportation, and more specifically, Transportation Code, §545.353 subsections (h) and (i), which allows the Texas Transportation Commission to establish a 75 mile per hour daytime speed limit on certain portions of the state highway system in certain counties.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on December 13, 2001.

TRD-200107861
Richard D. Monroe
General Counsel
Texas Department of Transportation
Effective date: January 2, 2002
Proposal publication date: October 12, 2001
For further information, please call: (512) 463-8630

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TEXAS DEPARTMENT OF INSURANCE

Notification Pursuant to the Insurance Code, Chapter 5, Subchapter L

As required by the Insurance Code, Article 5.96 and 5.97, the ***Texas Register*** publishes notice of proposed actions by the Texas Board of Insurance. Notice of action proposed under Article 5.96 must be published in the ***Texas Register*** not later than the 30th day before the board adopts the proposal. Notice of action proposed under Article 5.97 must be published in the ***Texas Register*** not later than the 10th day before the Board of Insurance adopts the proposal. The Administrative Procedure Act, the Government Code, Chapters 2001 and 2002, does not apply to board action under Articles 5.96 and 5.97.

The complete text of the proposal summarized here may be examined in the offices of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78714-9104.)

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Administrative Procedure Act.

Texas Department of Insurance

Proposed Action on Rules

The Commissioner of Insurance, at a public hearing under Docket No. 2510 scheduled for February 12, 2002 at 9:30 A.M., in Room 102 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street in Austin, Texas, will consider a proposal made in a staff petition, designated as "Second Petition...." Staff's petition seeks amendment of the Texas Automobile Rules and Rating Manual (the Manual), to adopt new and/or adjusted 2002 model Private Passenger Automobile Physical Damage Rating Symbols and revised identification information. Staff's petition (Ref. No. A-1201-22-I), was filed on December 13, 2001.

The new and/or adjusted symbols for the Manual's Symbols and Identification Section reflect data compiled on damageability, repairability, and other relevant loss factors for the listed 2002 model vehicles.

A copy of the petition, including an exhibit with the full text of the proposed amendments to the Manual is available for review in the office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas. For further information or to request copies of the petition, please contact Sylvia Gutierrez at (512) 463-6327; refer to (Ref. No. A-1201-22-I).

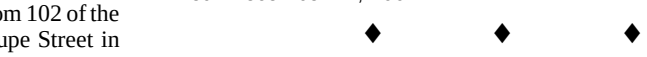
Comments on the proposed changes must be submitted in writing within 30 days after publication of the proposal in the Texas Register, to the Office of the Chief Clerk, Texas Department of Insurance, P. O. Box 149104, MC 113-2A, Austin, Texas 78714-9104. An additional copy of comments is to be submitted to Marilyn Hamilton, Associate Commissioner, Property & Casualty Program, Texas Department of Insurance, P. O. Box 149104, MC 104-PC, Austin, Texas 78714-9104.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Government Code, Chapter 2001 (Administrative Procedure Act).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

TRD-200107899

Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 14, 2001



Proposed Action on Rules

The Commissioner of Insurance at a public hearing under Docket No. 2511 scheduled for February 12, 2002 at 9:30 a.m. in Room 100 of the William P. Hobby Building, 333 Guadalupe Street in Austin, Texas will consider adoption of the Texas - Audit Additional Premium and Retrospective Additional Premium Endorsement WC 42 04 07 contained in the Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance (the Manual) proposed by the staff of the Workers' Compensation Division. The Manual provides insurers licensed in Texas to write workers' compensation insurance with the rules, classifications endorsements, forms and experience-rating plan applicable to Texas workers' compensation policies. Staff's petition (Ref. No. W-1201-23-I), was filed on December 14, 2001.

This endorsement is proposed to establish a due date for audit additional premiums and retrospective additional premiums pursuant to the National Association of Insurance Commissioners (NAIC) Statement of Statutory Accounting Principles (SSAP) No. 6. According to SSAP No. 6, the policy or contract provisions governing the audit premiums and retrospective premiums must address the due date for these types of premium if the uncollected premium (either accrued or billed) is considered as an admitted asset by the insurance company.

The Commissioner has jurisdiction over this matter pursuant to the Insurance Code, Articles 5.56, 5.57 and 5.96.

A copy of the full text of the proposed endorsement is available for review in the Office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78714-9104. For further information or to request a copy of the proposed endorsement, please contact Ms. Sylvia Gutierrez (512) 463-6327 (refer to Ref. No. W-W-12-01-23-I)

The staff and the Commissioner request that written comments to this proposed endorsement be submitted prior to the public hearing on February 12, 2002. The written comments should be directed to Lynda H. Nesenholtz, General Counsel and Chief Clerk, Texas Department of Insurance, P. O. box 149104, MC 113-2A, Austin, Texas 78714-9104. An additional copy of the comments should be submitted to Nancy Moore, Deputy Commissioner, Workers' Compensation, Texas Department of Insurance, P. O. Box 149104, MC 105-2A, Austin, Texas 78714-9104. Public testimony at the hearing on February 12, 2002 is also invited and encouraged.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Government code, Chapter 2001 (Administrative Procedure Act).

TRD-200108070
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 18, 2001

REVIEW OF AGENCY RULES

This Section contains notices of state agency rules review as directed by Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review*, which invite public comment to specified rules; and (3) notices of *readoption*, which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the ***Texas Administrative Code*** on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the ***Texas Register*** office.

Proposed Rule Reviews

Texas Commission on Fire Protection

Title 37, Part 13

The Texas Commission on Fire Protection (the "TCFP") will review and consider for readoption, review, or repeal sections of Chapter 435, Fire Fighter Safety, of Title 37, Part 13 of the Texas Administrative Code, in accordance with the General Appropriations Act, Article IX, §167, 75th Leg. and Texas Government Code, §2001.039.

Specifically, the following sections of Chapter 435 shall be reviewed: §435.1 Protective Clothing, §435.3 Self-contained Breathing Apparatus, §435.5 Commission Recommendations, and §435.7 Fire Department Staffing Studies.

As required by the above authorities, the TCFP will consider, among other things, whether the reasons for adoption of these rules continue to exist. As part of the review process, the TCFP is proposing new §435.9 Personal Alert Safety System (PASS), new §435.11 Incident Management System (IMS), new §435.13 Personnel Accountability System, new §435.15 Operating At Emergency Incidents, new §435.17 Procedures for Interior Structural Fire Fighting (2-In/2-Out Rule), and new §435.19 Commission Enforcement of Chapter 435. The proposed new sections may be found in the Proposed Rules section of the December 28, 2001 issue of the *Texas Register*.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments on the proposal may be submitted in writing within 30 days following the publication of this notice in the *Texas Register* to Gary L. Warren, Sr., Executive Director.

Any questions pertaining to this notice of intention to review should be directed to the Texas Register Liaison, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

TRD-200107837
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Filed: December 13, 2001

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The Texas Commission on Fire Protection (the "TCFP") will review and consider for readoption, review, or repeal sections of Chapter 437, Fees, of Title 37, Part 13 of the Texas Administrative Code, in accordance with the General Appropriations Act, Article IX, §167, 75th Leg. and §2001.039 of the Texas Government Code.

Specifically, the following sections of Chapter 437 shall be reviewed: §437.1 Fees--Purpose and Scope, §437.3 Fees-- Certification, §437.5 Fees--Renewal, §437.7 Fees--Standards Manual and Certification Curriculum Manual; §437.11 Fees-- Copying; §437.13 Fees--Basic Certification Examination; §437.15 Fees--International Fire Service Accreditation Congress (IFSAC) Seal; §437.17 Fees--Records Review; and §437.19 Late Filing Penalty.

As required by the above authorities, the TCFP will consider, among other things, whether the reasons for adoption of these rules continue to exist. As part of the review process, the TCFP is proposing an amendment to §437.3 Fees--Certification. The proposed amendment may be found in the Proposed Rules section of the December 28, 2001 issue of the *Texas Register*.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments on the proposal may be submitted in writing within 30 days following the publication of this notice in the *Texas Register* to Gary L. Warren, Sr., Executive Director.

Any questions pertaining to this notice of intention to review should be directed to the Texas Register Liaison, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

TRD-200107839
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Filed: December 13, 2001

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The Texas Commission on Fire Protection (the "TCFP") will review and consider for readoption, review, or repeal sections of Chapter 461, General Administration, of Title 37, Part 13 of the Texas Administrative Code, in accordance with the General Appropriations Act, Article IX, §167, 75th Leg. and Texas Government Code, §2001.039.

Specifically, the following sections of Chapter 461 shall be reviewed: §461.1 Committee Members, §461.2 Meetings, §461.3 Commission Inspection, and §461.4 Definitions.

As required by the above authorities, the TCFP will consider, among other things, whether the reasons for adoption of these rules continue to exist. The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments on the proposal may be submitted in writing within 30 days following the publication of this notice in the *Texas Register* to Gary L. Warren, Sr., Executive Director.

Any questions pertaining to this notice of intention to review should be directed to the Texas Register Liaison, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

TRD-200107841
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Filed: December 13, 2001

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The Texas Commission on Fire Protection (the "TCFP") will review and consider for readoption, review, or repeal sections of Chapter 463, Application Criteria, of Title 37, Part 13 of the Texas Administrative Code, in accordance with the General Appropriations Act, Article IX, §167, 75th Leg. and §2001.039 of the Texas Government Code.

Specifically, the following sections of Chapter 463 shall be reviewed: §463.1 Application Process; §463.2 Limitations on Loans, Scholarships, and Grants, §463.3 Application Form; §463.4 Competitive Needs Criteria, §463.5 Criteria for Eligibility for Loans, and §463.6 Contract Information.

As required by the above authorities, the TCFP will consider, among other things, whether the reasons for adoption of these rules continue to exist. As part of the review process, the TCFP is proposing an amendment to §463.4 Competitive Needs Criteria. The proposed amendment may be found in the Proposed Rules section of the December 28, 2001 issue of the *Texas Register*.

The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments on the proposal may be submitted in writing within 30 days following the publication of this notice in the *Texas Register* to Gary L. Warren, Sr., Executive Director.

Any questions pertaining to this notice of intention to review should be directed to the Texas Register Liaison, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

TRD-200107842
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Filed: December 13, 2001

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The Texas Commission on Fire Protection (the "TCFP") will review and consider for readoption, review, or repeal sections of Chapter 465, Equipment, Facilities, and Training Standards, of Title 37, Part 13 of the Texas Administrative Code, in accordance with the General Appropriations Act, Article IX, §167, 75th Leg. and Texas Government Code, §2001.039.

Specifically, the following sections of Chapter 465 shall be reviewed: §465.1 Equipment Standards, §465.2 Facility Standards, and §465.3 Education and Training Standards.

As required by the above authorities, the TCFP will consider, among other things, whether the reasons for adoption of these rules continue to exist. The comment period will last for 30 days beginning with the publication of this notice of intention to review. Comments on the proposal may be submitted in writing within 30 days following the publication of this notice in the *Texas Register* to Gary L. Warren, Sr., Executive Director.

Any questions pertaining to this notice of intention to review should be directed to the Texas Register Liaison, Texas Commission on Fire Protection, P. O. Box 2286, Austin, Texas 78768-2286 or e-mailed to info@tcfp.state.tx.us.

TRD-200107844
Jake Soteriou
Fire Service Standards and Certification Division Director
Texas Commission on Fire Protection
Filed: December 13, 2001

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Texas State Board of Medical Examiners

Title 22, Part 9

The Texas State Board of Medical Examiners proposes to review Chapter 161 (§§161.1-161.5), concerning general provisions pursuant to the Appropriations Act of 1997, House Bill 1, Article IX, §167.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners proposes the repeal of §§161.1-161.5 and new §§161.1-161.13.

The Texas State Board of Medical Examiners will consider, among other things, whether the reasons for adoption of these rules continue to exist.

Comments on the proposed review may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018.

TRD-200108008
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: December 17, 2001

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The Texas State Board of Medical Examiners proposes to review Chapter 181 (§§181.1-181.7), concerning contact lens prescriptions, pursuant to the Appropriations Act of 1997, House Bill 1, Article IX, §167.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners proposes amendments to §§181.1-181.3, 181.5-181.7.

The Texas State Board of Medical Examiners will consider, among other things, whether the reasons for adoption of these rules continue to exist.

Comments on the proposed review may be submitted to Pat Wood, P.O. Box 2018, MC-901, Austin, Texas 78768-2018.

TRD-200108009

Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: December 17, 2001

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Texas Parks and Wildlife Department

Title 31, Part 2

The Texas Parks and Wildlife Department files this notice of intention to review Texas Administrative Code Title 31, Part 2, as follows:

Chapter 58. OYSTERS AND SHRIMP

Subchapter A. Statewide Oyster Fishery Proclamation

§58.10. Application.

§58.11. Definitions.

§58.12. Texas Oyster Fishery Management Plan.

§58.21. Taking or Attempting To Take Oysters from Public Oyster Beds: General Rules.

§58.22. Commercial Fishing.

§58.23. Non-Commercial (Recreational) Fishing.

§58.24. Penalties.

§58.30. Private Oyster Leases.

§58.40. Oyster Transplant Permits.

§58.50. Oyster Harvest Permits.

§58.60. Transplant or Harvest Permit Cancellation.

NOTE: Sections 58.11, 58.30, 58.40, 58.50, and 58.60 have been proposed for rule action. The proposal appeared in the December 14, 2001, issue of the *Texas Register* (26 TexReg 10232).

This review is pursuant to the Texas Government Code, §2001.039, and the General Appropriations Act of 1997, Article IX, §167, 75th Legislature, Regular Session.

The Commission will accept comments for 30 days following the publication of this notice in the Texas Register as to whether the reasons for adopting the sections under review continue to exist and to determine whether the rules reflect current legal, policy, and procedural considerations. Final consideration of this rules review is scheduled for the Parks and Wildlife Commission on April 4, 2002.

Any questions or written comments pertaining to this notice of intention to review should be directed to Gene McCarty, Chief of Staff, Texas Parks and Wildlife Department, 4200 Smith School Road, Austin, TX , 78744. Any proposed changes to rules as a result of the review will be published in the Proposed Rules Section of the Texas Register and will be open for an additional 30-day public comment period prior to final adoption or repeal of the Commission.

TRD-200108010
Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
Filed: December 17, 2001

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Texas State Board of Pharmacy

Title 22, Part 15

The Texas State Board of Pharmacy files this notice of intent to review Subchapter C of Chapter 291, (§§291.51, 291.52, 291.53, 291.54, 291.55), concerning Nuclear Pharmacy (Class B), pursuant to the Texas Government Code §2001.039, regarding Agency Review of Existing Rules.

In conjunction with this review, the agency is proposing amendments to Subchapter C of Chapter 291 published elsewhere in this issue of the Texas Register.

Comments regarding whether the reason for adopting the rule (with the proposed amendments) continues to exist, may be submitted to Steve Morse, R.Ph., Director of Compliance, Texas State Board of Pharmacy, 333 Guadalupe Street, Austin, Texas 78701. Comments must be received by 5 p.m., January 31, 2002.

TRD-200107737
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: December 11, 2001

♦ ♦ ♦

The Texas State Board of Pharmacy files this notice of intent to review Chapter 309 (§§309.1, 309.2, 309.3, 309.4, 309.5, 309.6, 309.7, 309.8), concerning Generic Substitution, pursuant to the Texas Government Code §2001.039, regarding Agency Review of Existing Rules.

In conjunction with this review, the agency is proposing amendments to Chapter 309 published elsewhere in this issue of the Texas Register.

Comments regarding whether the reason for adopting the rule (with the proposed amendments) continues to exist, may be submitted to Steve Morse, R.Ph., Director of Compliance, Texas State Board of Pharmacy, 333 Guadalupe Street, Austin, Texas 78701. Comments must be received by 5 p.m., January 31, 2002.

TRD-200107739
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Filed: December 11, 2001

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Adopted Rule Reviews

Texas Health Care Information Council

Title 25, Part 16

The Texas Health Care Information Council (Council) has completed the review of Title 25, Part 16, Chapter 1301, Subchapter D §§1301.51-1301.54, concerning Rules and Procedures for Council Officers, Council Employees, Donors and Donations, pursuant to the Government Code, §2001.039.

The proposed review was published in the October 5, 2001, issue of the *Texas Register* (26 TexReg 7897).

No comments were received regarding the review of the Subchapter.

The Council finds that the reasons for adopting sections §§1301.51-1301.54 continue to exist; therefore THCIC readopts §§1301.51-1301.54 originally adopted on April 21, 1999.

This concludes the review of Chapter 1301, Subchapter D.

TRD-200107957

Jim Loyd
Executive Director
Texas Health Care Information Council
Filed: December 17, 2001

♦ ♦ ♦

The Texas Health Care Information Council (Council) has completed the review of Title 25, Part 16, Chapter 1301, Subchapter H §1301.71, concerning Historically Underutilized Businesses, pursuant to the Government Code, §2001.039.

The proposed review was published in the October 5, 2001, issue of the *Texas Register* (26 TexReg 7897).

No comments were received regarding the review of the Subchapter.

The Council finds that the reasons for adopting section §1301.71 continues to exist; therefore THCIC readopts §1301.71 originally adopted on February 21, 1999.

This concludes the review of Chapter 1301, Subchapter H.

TRD-200107958
Jim Loyd
Executive Director
Texas Health Care Information Council
Filed: December 17, 2001

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Texas Commission on Law Enforcement Officer Standards and Education

Title 37, Part 7

In accordance with Review of Agency Rules whereas State agencies are directed to review their administrative rules by the Government Code §2001.039, added by Acts, 1999, 76th Legislature, Chapter 1499, Art. 1, Section 1.11, the Texas Commission on Law Enforcement Officer Standards and Education files this notice to adopt Texas Administrative Code, Title 37 - Public Safety, Part 7 Texas Commission on Law Enforcement Officer Standards and Education, to the proposed text as published in the October 12, 2001, issue of the *Texas Register* (26 TexReg 8197).

The Texas Commission on Law Enforcement Officer Standards and Education comprehensive rules review is conducted following every legislative session and reported to the Commission at its regularly scheduled meeting in June. Rules, which do not require revision, are presented at the September meeting for reinstatement. Rules, which require revision, or new rules, are developed and presented as proposals at the September Commission meeting. Rules, which require revision, or new rules coming to the attention of the Commission at any other time, are considered and developed, as necessary.

The Commission on Law Enforcement initiated this plan September 28, 1999.

Chapter 1701 of the Occupations Code gives the Commission its authority. Section 1701.151 General Powers of Commission; Rulemaking Authority, states that the Commission may adopt rules for the administration of this chapter.

No written comments were received.

The Commission on Law Enforcement approved on December 7, 2001, the below adopted amendments to Title 37, Texas Administrative Code.

§211.1. Definitions.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §211.1 concerning definitions. For clarification purposes, the adopted amendment adds a definition for the term "training cycle". The amendment also adopts the renumbering of the subsections of this section as well as a change to the effective date in subsection (b) of this section.

§211.27. Reporting Responsibilities of Individuals.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §211.27 concerning the reporting responsibilities of individuals. For consistency purposes, changes were made in subsections (a) and (c) of this section. The language, which previously read, "a person who holds a commission license or certificate," was deleted and replaced by the term "licensee". The language is being provided to clarify that the Commission takes administrative action against licensees, not certificates that they hold. An adopted change was also made to the effective date in subsection (d) of this section.

§215.3. Academy Licensing.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.3 concerning academy licensing. For consistency purposes, changes were made to some of the terms used in a number of the subsections of this section. The subsections that were affected were (a)(3) and (6); (b)(5), (7) and (8); (A)(B) and (C); (d); (e)(1) and (3); (h)(2) of this section; and a change was made in the effective date in subsection (j) of this section.

§215.5. Contractual Training.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.5 concerning contractual training. For clarification purposes the term "requesting party" was changed to the term "applicant" in subsection (e)(1)(A) of this section. The only other adopted change to this section was to the effective date in subsection (i) of this section.

§215.15. Enrollment Standards and Training Credit.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.15 concerning enrollment standards and training credit. Additional language provides clarification regarding the Commission's role, that training credit will be granted for courses conducted by a licensed academy as provided in the Commission's rules. In addition, the language provided in subsection (d)(1), (2) and (3) of this section explains what records an academy must have on file for individuals who enroll in any basic peace officer training program which provides instruction in defensive tactics, arrest procedures, firearms, or use of a motor vehicle for law enforcement purposes. In addition, the language provided in subsection (e)(4) of this section is intended to minimize incidents where licensees obtain training credit by deceitful means. The other adopted changes in §215.15 include the renumbering of the subsections and adopted change to the effective date in subsection (g) of this section.

§215.17. Distance Education.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §215.17 concerning distance education. Additional language provided in subsection (d) of this section provides clarification regarding distance education courses and the Commission's role. In addition, the added language provided in this subsection is intended to

minimize incidents where licensees obtain distance education training credit by deceitful means. The only other adopted change in §215.17 includes a change to the effective date in subsection (f) of this section.

§217.1. Minimum Standards for Initial Licensure.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.1 concerning minimum standards for initial licensure. In §217.1 subsection (a)(4), additional language clarifies that the ten-year period for community supervision or probation begins from the date of the court order. Subsection (a)(14) of this section, new language clarifies that an individual applying for initial licensure, could not have previously had a commission license denied by final order, revoked, currently on suspension for a criminal violation, or currently have a voluntary surrender of license in effect. In subsection (g)(1)(B)(i) and (ii) of this section, the term, "POST developed," was added for clarification purposes. The additional language in this subsection explains that "successful completion of a commission recognized POST developed basic law enforcement training course is to include, out of state licensure or certification and submission of the current basic peace officer course taken at a licensed academy." In addition, the language further clarifies that the commission may approve an academic alternative program that is part of a degree plan program and consists of the commission-approved transfer curriculum, the peace officer sequence courses and, after September 1, 2003, at least an associate's degree. Guidelines are being provided to agencies that are seeking to obtain a provisional license in subsections (k), (l) and (m) of this section. In subsection (n) of this section, clarification is provided regarding the cases and the terms for which a temporary jailer license may not be reissued and when it expires. The only other adopted change is the effective date in subsection (o) of this section.

§217.7. Reporting the Appointment and the Termination of a Licensee.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.7 concerning reporting the appointment and the termination of a licensee.

For consistency purposes, in §217.7, subsection (a), the language "person who already holds a commission license," is being deleted and replaced by the term "licensee." The same applies in subsection (d) of this section, the term "person" is being deleted and replaced by the term "licensee." Due to legislative changes, additional language is being provided in subsection (h) of this section. Title 10, Chapter 1701, §1701.454, of the Occupations Code, was affected by the passage of Senate Bill 1583. The adopted new language in subsection (h) of this section explains that a report or statement submitted under this section is exempt from disclosure under the Public Information Act, Chapter 552, Government Code, unless the person resigned or was terminated due to substantiated incidents of excessive force or violations of the law other than traffic offenses.

§217.9 Continuing Education Credit for Licensees.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.9 concerning continuing education credit for licensees. In subsection (b) of this section the term, "shall" was deleted and the term "may" was substituted for clarification and consistency with the Commission's rules. In subsection (b)(5) of this section, the adopted amendment clarifies that the Commission may refuse credit for more than one presentation of a course by an instructor, per training cycle. The adopted amendment gives the Commission authority to take administrative action against licensees that claim credit in instances where credit was obtained by deceitful means. Additional language in subsection (b)(6) of this section, also serves to clarify that the Commission may refuse credit for the continuing education course(s) if the course(s) is obtained by deceitful means. The amendment also adopts a change to the effective date in subsection (d) of this section.

§217.11. Legislatively Required Continuing Education for Licensees.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.11 concerning legislatively required continuing education for licensees. Adopted amendments to this section clarify that the Commission will track the legislatively required courses taken and completed by licensees every four years versus every two years. In subsections (a), (b) and (e) of this section language was added for clarification purposes. In subsection (h) of this section language was added to clarify when the commission may discipline an individual for failure to complete 40 hours of training in either or both of the 24 month units within a training cycle. In subsection (j) of this section language was added to clarify that individuals licensed as peace officers shall attend a course, developed by the commission, on asset forfeiture no later than September 1, 2002. In subsection (k) of this section, language was added to clarify that individuals licensed as peace officers shall attend a course, developed by the commission, on racial profiling no later than September 1, 2003. In subsection (l) of this section, language was added to clarify that all peace officers must meet the continuing education requirements except where exempt by law. This rule is written to conform to continuing education requirements for peace officers as set forth by the Legislature in the 2001 session. The only other adopted amendment was to the effective date in subsection (m) of this section.

§217.17. Active License Renewal

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.17 concerning active license renewals. The adopted amendment to this subsection clarifies that the Commission will track the legislatively required courses taken and completed by licensees every four years versus every two years and that active licensees who have met the current legislatively required continuing education courses will have their license(s) automatically renewed on the last day of the training cycle. The amendments to subsection (c) and (d) of this section adopts changes to the term reactivation and the term reinstated. These terms are being substituted by the terms reinstatement in subsection (c) and (d) of this section. A change is also adopted to the effective date in subsection (e) of this section.

§217.19. Reactivation of a License.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §217.19 concerning reactivation of a license. The adopted amendment to this subsection clarifies the process that will be used by the Commission to allow individuals to maintain an active license status by completing the legislatively required continuing education. Subsection (f) of this section also clarifies the process that will be used for any jailer license issued after March 1, 2001. Jailers will be required to retest if out more than 2 years effective March 1, 2001. The amendment also adopts a change to the effective date in subsection (h) of this section.

§221.1. Proficiency Certificate Requirements.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.1 concerning proficiency certificate requirements.

The adopted amendment to this subsection clarifies that an active licensee, who is not commissioned, will still be able to accrue certificates. Currently, a active licensee cannot earn certificates if not commissioned. The amendment also adopts a change to the effective date in subsection (f) of this section.

§221.3. Peace Officer Proficiency.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.3 concerning peace officer proficiency. The adopted amendment to this section clarifies that in order to qualify for an intermediate peace officer proficiency certificate, new legislation requires that an applicant must meet all proficiency requirements including two additional courses. In subsection (3)(F) and (G) of this section new legislation mandates that two new courses, an asset forfeiture course and a racial profiling course be completed if the basic peace officer certificate was issued or qualified for on or after January 1, 1987, the licensee must also complete all of the current intermediate peace officer certification courses. The amendment also adopts a change to the effective date in subsection (d) of this section.

§221.13. Emergency Telecommunications Proficiency.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §221.13 concerning emergency telecommunications proficiency. The adopted amendment to subsection (b)(3) and (4) of this section clarifies that in order to qualify for an intermediate emergency telecommunications proficiency certificate, new legislation requires that an applicant must meet all proficiency requirements including 120 hours of training and if the basic telecommunications certificate was issued or qualified for on or after January 1, 2000, successful completion of the required courses as specified by the Commission, which include: Cultural Diversity, Ethics in Law Enforcement, Crisis Communications, TCIC/NCIC for Full Access Operators; NLETS/TLETS; or Criminal Law; and Spanish for Law Enforcement. Subsection (c)(3) of this section clarifies that to qualify for an advanced telecommunications proficiency certificate, an applicant must meet all proficiency requirements including: an intermediate telecommunications certificate, at least four years of experience in public safety telecommunications, and 240 training hours. The amendment also adopts a change to the effective date in subsection (d) of this section.

§223.3 Answer Required.

The Texas Commission on Law Enforcement Officer Standards and Education (Commission) adopts an amendment to Title 37, Texas Administrative Code §223.3 concerning the answer required section. For consistency purposes, the adopted amendment to subsection (d)(3) of this section, includes the deletion of the abbreviated term, "Tex. Admin." which will be substituted by the term, "Texas Administrative Code." The amendment also adopts a change to the effective date in subsection (f) of this section.

The Texas Commission on Law Enforcement approved on December 7, 2001, the below re-adoptions with no changes to Title 37, Texas Administrative Code.

§211.3. Public Information.

§211.5. Licensee Lists.

§211.7. Meeting Dates and Procedures.

§211.9. Execution of Orders Showing Action Taken at Commission Meetings.

§211.11. Contemplated Rule Making.

§211.13. Notice of Commission Rulemaking.

§211.15. Specific Authority to Waive Rules.

§211.17. Fees and Payment.

§211.19. Forms and Applications.

§211.21. Issuance of Duplicate or Delayed Documents.

§211.23. Date of Licensing or Certification.

§211.25. Date of Appointment.

§211.29. Responsibilities of Agency Chief Administrators.

§211.31. Memorandum of Understanding on Continuity of Care.

§211.33. Law Enforcement Achievement Awards.

§215.1. Licensing of Training Providers.

§215.7. Training Provider Advisory Boards.

§215.9. Training Coordinator.

§215.11. Training Provider Evaluations.

§215.13. Risk Assessment.

§217.3. Application for License and Initial Report of Appointment.

§217.5. Denial.

§217.13. Reporting Legislatively Required Continuing Education.

§217.15. Waiver of Legislatively Required Continuing Education.

§217.21. Firearms Proficiency Requirements.

§217.23. Training Standards for Conditional Reserve License.

§219.1. Eligibility to Take State Examinations.

§219.3. Examination Administration.

§219.5. Examinee Requirements.

§219.7. Scoring of Examinations.

§221.5. Jailer Proficiency.

§221.7. Investigative Hypnosis Proficiency.

§221.9. Standardized Field Sobriety Testing Proficiency (SFST).

§221.11. Mental Health Officer Proficiency.

§221.15. Crime Prevention Inspector Proficiency.

§221.17. Homeowners Insurance Inspector Proficiency.

§221.19. Firearms Instructor Proficiency.

§221.21. Firearms Proficiency for Community Supervision Officers.

§221.23. Academic Recognition Award.

§221.25. Civil Process Proficiency.

§221.27. Instructor Proficiency.

§223.1. License Action and Notification.

§223.5. Filing of Documents.

§223.7. Contested Cases and Hearings.

§223.9. Place and Nature of Hearings.

§223.11. Proposal for Decision and Exceptions or Briefs.

§223.13. Voluntary Surrender of License.

§223.15. Suspension of License.

§223.17. Reinstatement of a License.

§223.19. Revocation of License.

§223.21. Appeal.

§225.1. Issuance of Contract Jailer License.

§229.1. General Eligibility of Deceased Texas Peace Officers.

§229.3. Specific Eligibility of Deceased Texas Peace Officers.

§229.5. Determination Standards.

§229.7. Deaths Not Included.

TRD-200107933
Edward T. Laine
Chief, Professional Standards and Administration Operations
Texas Commission on Law Enforcement Officer Standards and Education
Filed: December 14, 2001

♦ ♦ ♦

Texas State Board of Medical Examiners

Title 22, Part 9

The Texas State Board of Medical Examiners adopts the review of Chapter 166 (§§166.1-166.6), concerning Physician Registration, pursuant to the Appropriations Act of 1997, House Bill 1, Article IX, §167.

The proposed rule review was published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8855)

No comments were received regarding adoption of the rule review.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners adopts amendments to §§166.1-166.6.

The Texas State Board of Medical Examiners finds that the reason for adoption of these rules continue to exist.

This concludes the review of Chapter 166, Physician Registration.

TRD-200107990
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: December 17, 2001

♦ ♦ ♦

The Texas State Board of Medical Examiners adopts the review of Chapter 175 (§§175.1-175.5), concerning Fees, Penalties and Applications, pursuant to the Appropriations Act of 1997, House Bill 1, Article IX, §167.

The proposed rule review was published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8855)

No comments were received regarding adoption of the rule review.

Elsewhere in this issue of the *Texas Register*, the Texas State Board of Medical Examiners adopts amendments to §§175.1-175.4, the repeal and replacement of §175.4 and the repeal of §175.5.

The Texas State Board of Medical Examiners finds that the reason for adoption of these rules continue to exist.

This concludes the review of Chapter 175, Fees, Penalties and Applications.

TRD-200107991
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: December 17, 2001

♦ ♦ ♦

The Texas State Board of Medical Examiners adopts the review of Chapter 187 (§§187.1-187.41), concerning Procedure, pursuant to the Appropriations Act of 1997, House Bill 1, Article IX, §167.

The proposed rule review was published in the July 6, 2001, issue of the *Texas Register* (26 TexReg 5076).

No Comments were received regarding adoption of the review.

The Texas State Board of Medical Examiners finds the reasons for adoption of these rules continue to exist.

This concludes the review of Chapter 187, Procedure.

TRD-200108098
Donald W. Patrick, MD, JD
Executive Director
Texas State Board of Medical Examiners
Filed: December 19, 2001

♦ ♦ ♦

Texas Water Development Board

Title 31, Part 10

Pursuant to the notice of proposed rule review published in the November 2, 2001 issue of the *Texas Register*, 26 TexReg 8855, the Texas Water Development Board (board) has reviewed and considered for readoption, revision or repeal 31 TAC, Part 10, Chapter 356, Groundwater Management Plan Certification, in accordance with the Texas Government Code, §2001.039.

The board considered, among other things, whether the reasons for adoption of these rules continues to exist. No comments were received on the proposed rule review.

As a result of the review, the board determined that the rules are still necessary and readopts the sections because they govern the board's procedures for reviewing and certifying management plans as administratively complete. As a result of the review, the board concurrently adopts amendments to §§356.1-356.6 and new §356.10. This completes the Board's review of Chapter 356.

TRD-200107871
Suzanne Schwartz
General Counsel
Texas Water Development Board
Filed: December 13, 2001

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the November 2, 2001 issue of the *Texas Register*, 26 TexReg 8856, the Texas Water Development Board (board) has reviewed and considered for readoption, revision or repeal 31 TAC, Part 10, Chapter 357, Regional Water Planning Guidelines, in accordance with the Texas Government Code, §2001.039.

The board considered, among other things, whether the reasons for adoption of these rules continues to exist. No comments were received on the proposed rule review.

As a result of the review, the board determined that the rules are still necessary and readopts the sections because they govern designation

of regional water planning areas, designation of regional water planning groups, consideration of existing planning efforts by regional water planning groups, the format of information to be presented in regional water plans, development of regional water plans, adoption of regional water plans by regional water planning groups, and approval of regional water plans by the board. As a result of the review, the board concurrently adopts amendments to §§357.2, 357.7, 357.8, 357.11, and 357.14 and new §357.15. This completes our review of Chapter 357.

TRD-200107872
Suzanne Schwartz
General Counsel
Texas Water Development Board
Filed: December 13, 2001

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the November 2, 2001 issue of the *Texas Register*, 26 TexReg 8856, the Texas Water Development Board (board) has reviewed and considered for readoption, revision or repeal 31 TAC, Part 10, Chapter 358, State Water Planning Guidelines, in accordance with the Texas Government Code, §2001.039.

The board considered, among other things, whether the reasons for adoption of these rules continues to exist. No comments were received on the proposed rule review.

As a result of the review, the board determined that the rules are still necessary and readopts the sections because they govern the board's development of the state water plan. As a result of the review, the board concurrently adopts amendments to §358.1 and §358.3 and new §358.5 and §358.6. This completes our review of Chapter 358.

TRD-200107873
Suzanne Schwartz
General Counsel
Texas Water Development Board
Filed: December 13, 2001

♦ ♦ ♦

TABLES & GRAPHICS

Graphic material from the emergency, proposed, and adopted sections is published separately in this tables and graphics section. Graphic material is arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic material is indicated in the text of the emergency, proposed, and adopted rules by the following tag: the word "Figure" followed by the TAC citation, rule number, and the appropriate subsection, paragraph, subparagraph, and so on.

Figure: 1 TAC Chapter 355--Preamble

Outpatient Hospital Estimated Impact

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
State Portion	$16,402,641	$18,603,405	$20,277,711	$22,102,705	$24,091,949
Federal Portion	$24,778,984	$27,835,449	$30,340,639	$33,071,297	$36,047,713

Figure 1: 7 TAC §1.1207(7)

CONSUMER CREDIT DISCLOSURE – PROMISSORY NOTE with SECURITY AGREEMENT

ACCOUNT / CONTRACT NO. _____ **DATE OF NOTE** _____

CREDITOR / LENDER _____ **BORROWER** _____

ADDRESS _____ **ADDRESS** _____

_____ _____

"I" and "me" mean the Borrower and if more than one Borrower means each Borrower. "You" means the Lender.

ANNUAL PERCENTAGE RATE The cost of my credit as a yearly rate.	**FINANCE CHARGE** The dollar amount the credit will cost me.	Amount Financed The amount of credit provided to me or on my behalf.	Total of Payments The amount I will have paid after I have made all payments as scheduled.
%	$	$	$

My Payment Schedule will be:

_____ consecutive monthly payments of $_____ each beginning _____ except that the final payment shall be $_____ due on _____

Security: You will have a security interest in the following described collateral

_____.

Late Charge: If all or any part of a payment is late 10 days or more I may be charged 5% of the amount of payment.

Prepayment: If I pay off early, I may be entitled to a refund of part of the finance charge if the amount financed is $30 or more.

Additional Information: See the contract documents for any additional information about nonpayment, default, any required repayment in full before the scheduled date, and prepayment refunds and penalties.

ITEMIZATION OF THE FINANCE CHARGE

Acquisition Charge .....$ _____
Installment Account
Handling Charge .....$_____

ITEMIZATION OF THE AMOUNT FINANCED

Previous Account #_____
Late Charge on
Previous Account $_____
Previous Balance $_____
Less Refund..... $_____
Net Balance Renewed .....$_____
Cash to me .....$_____
Amount Financed .....$_____

In return for my loan, I promise to pay the Total of Payments to the order of you, the lender. I will make the payments at your address above. I will make the payments on the dates and in the amounts shown in the Payment Schedule. If I don't pay an entire payment within 10 days after it is due, you can charge me a late charge. The late charge will be 5% of the scheduled payment. If I don't pay all I owe by the date the final payment is due, I will pay interest on the amount that is still unpaid. That interest will be at a rate of 18% per year and will begin the date after the final payment is due.

I can make any payment early. The acquisition charge on this loan will not be refunded if I pay off early. If this loan is for more than $30 and I pay off all I owe early, I will save part of the installment account handling charge. You will figure the amount I save by the Sum of the Periodic Balances Method. This method is explained in the Finance Code. You don't have to refund or credit any amount less than $1.

If I ask for more time to make any payment and you allow me more time, I will pay additional interest to extend the payment. The additional interest will be figured as provided in the Finance Commission rules.

If I break any of my promises in this document, you can demand that I immediately pay all that I owe. You can also do this if you in good faith believe that I am not going to be willing or able to keep any of my promises. I agree that you don't have to give me notice that you are demanding or intend to demand immediate payment of all that I owe. You will never charge or collect any unearned interest.
If I give you a check that isn't paid when sent to my bank or other institution, I agree to pay you a reasonable fee up to $25. You can add the fee to the amount I owe under this agreement or collect it separately.

I give you a security interest in the property listed below to secure what I owe you. The property and anything that becomes attached to it is called the collateral. If I don't keep any of my promises, you can take the collateral. However, you will do this lawfully and without a breach of the peace. If you take my collateral, you will tell me how much I have to pay to get it back. If I don't pay you to get the collateral back, you can sell it. You will send me notice at least 10 days before you sell it. My right to get the collateral back ends when you sell it. You can use the money you get from selling it to pay amounts the law allows and to reduce the amount I owe. If any money is left, you will pay it to me. If the money from the sale is not enough to pay all I owe, I must pay the rest of what I owe to you. You can charge me interest on the amount still owed at the rate of 18% per year until I pay all I owe.

Property Securing This Loan

Motor Vehicle:

MAKE	MODEL	YEAR	ENGINE NO.	SERIAL NO.	OTHER IDENTIFICATION

Other:_____

_____

_____

Witness_____ Reciba la Forma Informa de Prestamo .

X_____ _____

Borrower Borrower Notice: See Reverse Side for Important Information

Figure 2: 7 TAC §1.1207(7)

This lender is licensed and examined by the State of Texas Office of Consumer Credit Commissioner.

Call the Consumer Credit Hotline or write for credit information or assistance with credit problems.

Office of Consumer Credit Commissioner
2601 North Lamar Boulevard, Austin, Texas 78750-4207
www.occc.state.tx.us
(512) 936-7600 or (800) 538-1579

I agree:

1. I own the collateral. I won't sell or transfer it without your written permission. I won't allow anyone else to have an interest in the collateral except you.

2. I will keep the collateral at my address shown on the reverse side. I will promptly tell you in writing if I change my address. I won't permanently remove the collateral from Texas unless you give me written permission.

3. You can mail any notice to me at my last address in your records. Your duty to give me notice will be satisfied when you mail it.

4. I will timely pay all taxes and license fees on the collateral. I will keep it in good repair. I won't use the collateral illegally.

5. I promise that all information I gave you is true.

6. If you don't enforce your rights every time, you can still enforce them later.

7. Any change to this agreement has to be in writing. Both you and I have to sign it.

8. Federal law and Texas law apply to this contract.

9. I will keep all of my promises in this document. If there is more than one Borrower, each Borrower agrees to keep all of the promises in this document, even if the other Borrowers do not.

10. I don't have to pay interest or other amounts that are more than the law allows.

NOTICE: SEE REVERSE SIDE FOR IMPORTANT INFORMATION

Figure: 22 TAC §1.191(b)

Subjects Related to Design & Construction Documents	Minimum Training Units Required
Programming	10
Site and Environmental Analysis	10
Schematic Design	15
Engineering Systems Coordination	15
Building Cost Analysis	10
Code Research	15
Design Development	40
Construction Documents	135
Specifications & Materials Research	15
Documents Checking & Coordination	10
Elective Units in Design & Construction Documents	75

Figure: 22 TAC §1.191(c)

Subjects Related To Construction Administration	Minimum Training Units Required
Bidding & Contract Negotiation	10
Construction Phase (office)	15
Construction Phase (observation)	15
Elective Units in Construction Administration	30

Figure: 22 TAC §1.191(d)

Subjects Related To Management	Minimum Training Units Required
Project Management	15
Office Management	10
Elective Units in Management	10

Figure: 22 TAC §1.191(g)

Training Setting	Maximum Training Units Awarded
Training Setting A Training under the Direct Supervision of a registered architect when the organization's practice (1) is in the charge of a registered architect practicing as a principal and (2) encompasses the comprehensive practice of architecture	No limit Every Applicant must earn at least 235 Training Units in Training Setting A.
Training Setting B Training under the Direct Supervision of a registered architect when the organization's practice *does not* encompass the comprehensive practice of architecture	465 Training Units
Training Setting C Training in a firm engaged in the practice of architecture outside the U.S. when such training is under the Direct Supervision of a person practicing architecture who is not registered in a U.S. jurisdiction	235 Training Units
Training Setting D Experience directly related to architecture under the Direct Supervision of a registered engineer practicing as a structural, civil, mechanical, or electrical engineer in the field of building construction or under the Direct Supervision of a registered landscape architect	235 Training Units
Training Setting E Experience (other than that noted above in A through D) in activities involving the design and construction of the built environment, such as analysis of existing buildings, planning, programming, design of interior space, review of technical submissions, and engaging in building construction activities, when such experience is under the Direct Supervision of a person experienced in the activity	117 Training Units
Training Setting F Full-time teaching or research in an NAAB-accredited professional degree program	245 Training Units To earn Training Units in Training Setting F, an Applicant must be employed as a teacher or researcher on a full-time basis.
Training Setting G Performing professional and community service when not in any of the settings described above in A through F	10 Training Units

Figure: 22 TAC §3.191(a)

DESCRIPTION OF EXPERIENCE		Portion of Credit Awarded	Maximum Credit Awarded
LA-1	Diversified experience directly related to landscape architecture as an employee working under the direct supervision of a registered landscape architect	full credit	no limit
LA-2	Diversified experience directly related to landscape architecture as an employee working under the direct supervision of a registered architect or civil engineer	full credit	1 year
LA-3	Diversified experience in landscape architecture directly related to on-site construction, maintenance, or installation procedures when the experience is not under the direct supervision of a registered landscape architect, architect, or civil engineer	half credit	1 year
LA-4	Teaching on a full-time basis in an LAAB-accredited program in landscape architecture	full credit	1 year

Figure: 22 TAC §5.201(a)

Approved Education		Minimum Experience Required
ID-1 (Per §5.31(a)(1))	Graduation from a program granted professional status by the Foundation for Interior Design Education Research (FIDER) or the National Architectural Accreditation Board (NAAB) or from an interior design education program outside the U.S. that is substantially equivalent to a FIDER-accredited or NAAB-accredited professional program	2 years
ID-2 (Per §5.31(a)(2))	A doctorate, master's degree, or baccalaureate degree in interior design from a degree program that does not satisfy the requirements of category ID-1	3 years
ID-3 (Per §5.31(a)(3))	A baccalaureate degree in a field other than interior design plus an associate's degree or a two-year or three-year certificate from an interior design program at an institution accredited by an agency recognized by the Texas Higher Education Coordinating Board (THECB)	3 years
ID-4 (Per §5.31(a)(4))	A baccalaureate degree in a field other than interior design plus an associate's degree or a two-year or three-year certificate from a foreign interior design program approved or accredited by an agency acceptable to the Board	3 ½ years
ID-5 (Per §5.31(a)(5))	An associate's degree in interior design from an institution accredited by an agency recognized by THECB plus credit for the equivalent of at least 60 semester credit hours toward any baccalaureate degree	6 years under the direct supervision of a registered interior designer or a registered architect
ID-6 (Per §5.31(a)(6))	Completion of a FIDER-accredited pre-professional assistant level program plus credit for the equivalent of at least 60 semester credit hours toward any baccalaureate degree	4 years under the direct supervision of a registered interior designer or a registered architect

Figure: 22 TAC §5.202(a)

DESCRIPTION OF EXPERIENCE		Credit Allowed	Maximum Credit
ID-7	Diversified experience directly related to interior design as an employee working under the direct supervision of a registered interior designer or architect	full credit	No limit
ID-8	Diversified experience directly related to interior design when the experience is not under the direct supervision of a registered interior designer or architect	half credit	1 year
ID-9	Teaching on a full-time basis in a FIDER-accredited program in interior design	full credit	1 year

Figure: 28 TAC §3.3844(g)(1)

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

Figure: 28 TAC §21.2106(b)(6)

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with [name of carrier].

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call [name of carrier] at [customer service or related department phone number], or write us at [carrier's customer service or related department address].
Form Number 1467 Colorectal Cancer Screening

IN ADDITION

The ***Texas Register*** is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings, changes in interest rate and applications to install remote service units, and consultant proposal requests and awards.

To aid agencies in communicating information quickly and effectively, other information of general interest to the public is published as space allows.

Coastal Coordination Council

Notice and Opportunity to Comment on Requests for Consistency Agreement/Concurrence Under the Texas Coastal Management Program

On January 10, 1997, the State of Texas received federal approval of the Coastal Management Program (CMP) (62 Federal Register pp. 1439-1440). Under federal law, federal agency activities and actions affecting the Texas coastal zone must be consistent with the CMP goals and policies identified in 31 TAC Chapter 501. As required by federal law, the public is given an opportunity to comment on the consistency of proposed activities in the coastal zone undertaken or authorized by federal agencies. Pursuant to 31 TAC §§506.25, 506.32, and 506.41, the public comment period for these activities extends 30 days from the date published on the Coastal Coordination Council web site. Requests for federal consistency review were received for the following projects(s) during the period of December 7, 2001, through December 13, 2001. The public comment period for these projects will close at 5:00 p.m. on January 18, 2002.

FEDERAL AGENCY ACTIONS:

Applicant: Brownsville Navigation District; Location: The proposed project site is located at 16900 Joe Garza Sr. Road at the Port of Brownsville on the Brownsville Ship Channel in Cameron County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Palmito Hill, Texas. Approximate UTM Coordinates: Zone: 14; Easting: 663619; Northing: 2871776. CCC Project No.: 01-0418-F1; Description of Proposed Action: The applicant proposes to mechanically dredge a 40-foot wide by 560-foot long by 23-foot deep ship dismantling slip from uplands. The applicant will place the dredge material adjacent to the excavation site. The applicant also requests a 10-year maintenance dredging option. Type of Application: U.S.A.C.E. permit application #22507 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403).

Pursuant to §306(d)(14) of the Coastal Zone Management Act of 1972 (16 U.S.C.A. §§1451-1464), as amended, interested parties are invited to submit comments on whether a proposed action is or is not consistent with the Texas Coastal Management Program goals and policies and whether the action should be referred to the Coastal Coordination Council for review.

Further information for the applications listed above may be obtained from Ms. Diane P. Garcia, Council Secretary, Coastal Coordination Council, 1700 North Congress Avenue, Room 617, Austin, Texas 78701-1495, or diane.garcia@glo.state.tx.us. Comments should be sent to Ms. Garcia at the above address or by fax at 512/475-0680.

TRD-200108096
Larry R. Soward
Chief Clerk, General Land Office
Coastal Coordination Council
Filed: December 19, 2001

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Comptroller of Public Accounts

Local Sales Tax Rate Changes Effective January 1, 2002

An additional 1/2% city sales and use tax for improving and promoting economic and industrial development as permitted under Article 5190.6, Section **4B** will become effective January 1, 2002 in the cities listed below.

City Name	Local Code	New Rate	Total Rate
Cleburne (Johnson Co)	2126027	.015000	.077500
Lockney (Floyd Co)	2077017	.015000	.077500
Mount Enterprise (Rusk Co)	2201043	.015000	.077500
Pflugerville (Travis Co)	2227043	.015000	.082500
Pflugerville (Williamson Co)	2227043	.015000	.077500
Sundown (Hockley Co)	2110043	.015000	.077500

An additional 1% city sales and use tax for improving and promoting economic and industrial development that includes an additional 1/2% as permitted under Article 5190.6, Section **4A** plus an additional 1/2% as permitted under Article 5190.6, Section **4B** will become effective January 1, 2002 in the city listed below.

City Name	Local Code	New Rate	Total Rate
Bremond (Robertson Co)	2198048	.020000	.082500

The additional 1/2% sales and use tax for improving and promoting economic and industrial development as permitted under Article 5190.6, Section **4A** will be replaced with an additional 1/2% sales and use tax as permitted under Article 5190.6, Section **4B** in the city listed below. This tax type change will become effective January 1, 2002. There will be no change in the local rate or total rate.

City Name	Local Code	Local Rate	Total Rate
Rio Grande City	2214020	.020000	.082500

An additional 1/2% city sales and use tax for a Municipal Development Corporation as permitted under the provisions of Chapter 379A of the Local Government Code will become effective in the city listed below.

City Name	Local Code	New Rate	Total Rate
Coppell (Dallas Co)	2057262	.020000	.082500
Coppell (Denton Co)	2057262	.020000	.082500

An additional 1/4% City Sales and Use Tax for Municipal Street Maintenance and Repair as permitted under Section 327 of the Texas Tax Code will become effective January 1, 2002, in the city listed below.

City Name	Local Code	New Rate	Total Rate
Sunset Valley	2227070	.017500	.080000

The 1/2% Special Purpose District sales and use tax was **continued** in the Special Purpose District listed below. The continuation effective date will be January 1, 2002.

SPD Name	Local Code	Rate	Total Rate
River Oaks Crime Control	5220576	.005000	See Note 1

A 1% Special Purpose District sales and use tax will become effective January 1, 2002 in the Special Purpose District listed below.

SPD Name	Local Code	New Rate	Total Rate
Aldine Community Improvement District	5101534	.010000	See Note 2

NOTE 1: The boundaries of River Oaks Crime Control District are the same boundaries as the City of River Oaks. The total rate in the City of River Oaks will be .082500.

NOTE 2: The Aldine Community Improvement District is located in north central Harris County. The Aldine Community Improvement District is partially located within the Houston MTA, which has a transit sales and use tax, but the district does **not** include any area within the City of Houston. ZIP codes 77032, 77039, 77093, and 77396 are partially located within the Aldine Community Improvement District. Contact the district representative at 713/541-0447 for additional boundary information.

TRD-200108126
Martin Cherry
Deputy General Counsel for Taxation
Comptroller of Public Accounts
Filed: December 19, 2001

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Notice of Award

Notice of Request for Proposals: Pursuant to Chapter 2254, Subchapter B, Texas Government Code, the Comptroller of Public Accounts (Comptroller) announces this notice of consulting contract award.

The notice of request for proposals (RFP #128a) was published in the September 21, 2001, issue of the *Texas Register* (26 Tex Reg 7326).

The consultant will advise Comptroller on statistical issues of the Property Value Study.

The contract was awarded to: Analytical Systems, Inc., P. O. Box 3041, Galveston, Texas 77552. The total amount of the contract is not to exceed $25,000.00. The project will culminate in a report and various services provided thru August 31, 2002.

The term of the contract is December 7, 2001, thru August 31, 2002.

TRD-200107894
Pamela Ponder
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: December 14, 2001

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Notice of Request for Proposals

Pursuant to Sections 403.011, 2155.001, and 2156.121, Texas Government Code, and Chapter 54, Subchapters F and G, Texas Education Code, the Comptroller of Public Accounts (Comptroller) on behalf of the Texas Prepaid Higher Education Tuition Board (Board) announces its Request for Proposals (RFP #131c) for the purpose of obtaining actuarial services for the Board. The selected contractor ("Contractor") will advise and assist the Board and the Comptroller in administering all of the Board's actuarial activities related to the Texas Tomorrow Constitutional Trust Fund ("Fund"). The Fund currently includes a prepaid tuition program and will include a college savings plan as authorized under Section 529 of the Internal Revenue Code. The Comptroller, as Chair and Executive Director of the Board, is issuing this RFP in order that the Board may move forward with retaining the necessary Contractor. The Comptroller and the Board reserve the right to award more than one contract under the RFP. If approved by the Board, the Contractor will be expected to begin performance of the contract on or about March 1, 2002.

Contact: Parties interested in submitting a proposal should contact John C. Wright, Assistant General Counsel, Contracts, Comptroller of Public Accounts, 111 E. 17th St., Room G-24, Austin, Texas 78774, (512) 305-8673, to obtain a complete copy of the RFP. The Comptroller will mail copies of the RFP only to those parties specifically requesting a copy. The RFP will be available for pick-up at the above referenced address on Friday, December 28, 2001, between 2:00 p.m. and 5:00 p.m. Central Zone Time (CZT), and during normal business hours thereafter. The Comptroller will also make the entire RFP available electronically on the Texas Marketplace after Friday, December 28, 2001, 2:00 p.m. CZT. The Texas Marketplace website address is http://esbd.tbpc.state.tx.us.

Questions and Non-Mandatory Letters of Intent: All written inquiries, questions, and non-mandatory Letters of Intent to propose must be received at the above-referenced address not later than 2:00 p.m. (CZT) on Friday, January 11, 2002. Prospective proposers are encouraged to

fax non-mandatory Letters of Intent and Questions to (512) 475-0973 to ensure timely receipt. The Letter of Intent must be addressed to John C. Wright, Assistant General Counsel, Contracts, and must contain the information as stated in the corresponding Section of the RFP and be signed by an official of that entity. Non-mandatory Letters of Intent and Questions received after this time and date will not be considered. On or before Thursday, January 17, 2002, the Comptroller expects to post responses to questions as a revision to the Texas Marketplace notice of issuance of this RFP.

Closing Date: Proposals must be delivered to the Office of Assistant General Counsel, Contracts, at the location specified above (ROOM G24) no later than 2:00 p.m. (CZT), on Friday, January 25, 2002. Proposals received in ROOM G24 after this time and date will not be considered.

Evaluation Criteria: Proposals will be evaluated under the evaluation criteria outlined in the RFP. The Board makes the final decision on award(s).

The Comptroller and the Board each reserve the right to accept or reject any or all proposals submitted. The Comptroller and the Board are not obligated to execute a contract on the basis of this notice or the distribution of any RFP. The Comptroller and the Board shall not pay for any costs incurred by any entity in responding to this Notice or the RFP.

The anticipated schedule of events pertaining to this solicitation is as follows: Issuance of RFP - December 28, 2001, 2:00 p.m. CZT; Non-Mandatory Letter of Intent to propose and Questions Due - January 11, 2002, 2:00 p.m. CZT; Official Responses to Questions posted - January 17, 2002; Proposals Due - January 25, 2002, 2:00 p.m. CZT; Contract Execution - March 1, 2002, or as soon thereafter as practical; Commencement of Work - March 1, 2002. Revisions to this schedule will be posted as revisions to the Texas Marketplace notice of issuance of this RFP.

TRD-200108050
Pamela Ponder
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: December 17, 2001

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Notice of Requests for Proposals

Pursuant to Chapters 404, Subchapter G, and Chapter 2254, Subchapter B, Texas Government Code, the Texas Treasury Safekeeping Trust Company (Trust Company), announces its Request for Proposals (RFP) for investment consulting and related services for the Trust Company. The successful respondent or respondents, if any, will assist the Trust Company in administering the daily investment activities of approximately $28 billion dollars in short and long term funds belonging to the State of Texas and political subdivisions thereof and must be able to begin performance of the contract no later than February 1, 2002. The Trust Company reserves the right, in its sole judgment and discretion, to award one or more contracts as a result of the issuance of this RFP. Contact: Parties interested in submitting a proposal or reviewing the RFP should contact Pamela Ponder, Deputy General Counsel for Contracts, Comptroller of Public Accounts, 111 E. 17th St., Rm G-24, Austin, Texas, 78774, telephone number: (512) 305-8673, to obtain a copy of the RFP. The Trust Company will mail copies of the RFP only to those specifically requesting a copy. The complete RFP will be available for pick-up at the above-referenced address on Friday, December 28, 2001, between 2:00 p.m. and 5:00 p.m., Central Zone Time (CZT), and during normal business hours thereafter. The Trust Company will also make the complete RFP available electronically on the Texas Marketplace after Friday, December 28, 2001, 2:00 p.m. CZT. Questions: All questions concerning the RFP must be in writing and submitted no later than January 9, 2002, 2:00 p.m. Mandatory Letters of Intent to propose are also due by 2:00 p.m. on January 9, 2002. Questions must be faxed to (512) 475-0973, Attn: Pamela Ponder, Deputy General Counsel for Contracts. Proposals will not be accepted from firms that do not submit Mandatory Letters of Intent to propose by this deadline. On or before January 11, 2002 (or as soon thereafter as practical) the Trust Company expects to post answers to these written questions as a revision to the Texas Marketplace notice of the issuance of this RFP. The address of the Texas Marketplace is http://esbd.tbpc.state.tx.us. Contract execution is expected to take place on or before January 28, 2002 (or as soon thereafter as practical). Closing Date: Proposals must be received in and stamped in by the Deputy General Counsel's Office at the address specified above no later than 2:00 p.m. (CZT), on Friday, January 18, 2002. Proposals received after this time and date will not be considered, regardless of the reason for the delay in receipt. Respondents are solely responsible for verifying timely receipt of proposals and are highly encouraged to do so via telephone call to 512-305-8673 no later than 1:00p.m. (CZT) on Friday, January 18, 2002.

Evaluation and Award Procedure: All proposals will be subject to evaluation by a committee based on the evaluation criteria and procedures set forth in the RFP. The Trust Company will make the final decision.

The Trust Company reserves the right to accept or reject any or all proposals submitted. The Trust Company is under no legal or other obligation to execute a contract on the basis of this notice or the distribution of any RFP. The Trust Company shall pay no costs or any other amounts incurred by any entity in responding to this Notice or the RFP.

The anticipated schedule of events is as follows: Issuance of RFP - December 28, 2001, 2:00 p.m. CZT; Mandatory Letters of Intent Due:--January 9, 2002, 2:00 p.m., CZT, Questions Due - January 9, 2002, 2:00 p.m. CZT, Answers to Questions Posted - on January 11, 2002, or as soon thereafter as practical; Proposals Due - January 18, 2002, 2:00 p.m. CZT, Contract Execution - January 28, 2002, or as soon thereafter as practical; and Commencement of Work - February 1, 2002.

TRD-200108099
Pamela G. Ponder
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: December 19, 2001

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in 303.003, 303.009, and 304.003, Tex. Fin. Code.

The weekly ceiling as prescribed by Sec. 303.003 and Sec. 303.009 for the period of 12/24/01 - 12/30/01 is 18% for Consumer [1]/Agricultural/Commercial [2]/credit thru $250,000.

The weekly ceiling as prescribed by Sec. 303.003 and Sec. 303.009 for the period of 12/24/01 - 12/30/01 is 18% for Commercial over $250,000.

The judgment ceiling as prescribed by Sec. 304.003 for the period of 01/01/02 - 01/31/02 is 10% for Consumer/Agricultural/Commercial/credit thru $250,000.

The judgment ceiling as prescribed by Sec. 304.003 for the period of 01/01/02 - 01/31/02 is 10% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

TRD-200108060
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: December 18, 2001

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Court of Criminal Appeals

Solicitations for Personnel Analyst

The Court of Criminal Appeals is inviting solicitations to bid on a contract for a personnel analysis of the grantee organizations in its Judicial Education Program. The objectives of the analysis are to determine: (1) how compensation levels of employees in the grantee organizations compare with those of employees in similar type organizations; (2) if compensation levels are in line with assigned workloads. The analysis should be completed and a final report submitted to the Court no later than June 30, 2002. The contract will be awarded to the bidder who best demonstrates their ability to perform a quality analysis based on previous experience. Bids must include references, resumes of those who would perform the work, and a description as to how the work would be conducted to meet the objectives given. Bids must be received no later than Friday, January 18, 2002. Send bids to Mr. Bill Hill, Auditor, Court of Criminal Appeals, State of Texas, P.O. Box 12308, Capitol Station, Austin, Texas 78711.

TRD-200107852
Troy Bennett
Clerk
Court of Criminal Appeals
Filed: December 13, 2001

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Credit Union Department

Application(s) to Expand Field of Membership

Notice is given that the following applications have been filed with the Credit Union Department and are under consideration:

An application was received from Community Credit Union, Plano, Texas to expand its field of membership. The proposal would permit persons who work or reside within a 5-mile radius of the following CCU branch locations: 215 N. Carrier Parkway, Grand Prairie, Texas to be eligible for membership in the credit union.

An application was received from S & S Credit Union, Houston, Texas to expand its field of membership. The proposal would permit employees of McCall Automotive Group, Houston, Texas to be eligible for membership in the credit union.

Comments or a request for a meeting by any interested party relating to an application must be submitted in writing within 30 days from the date of this publication. Credit unions that wish to comment on any application must also complete a Notice of Protest form. The form may be obtained by contacting the Department at (512) 837-9236. Any written comments must provide all information that the interested party wishes the Department to consider in evaluating the application. All information received will be weighed during consideration of the merits of an application. Comments or a request for a meeting should be addressed to the Texas Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699.

TRD-200108058
Harold E. Feeney
Commissioner
Credit Union Department
Filed: December 18, 2001

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Notice of Final Action Taken

In accordance with the provisions of 7 TAC Section 91.103, the Credit Union Department provides notice of the final action taken on the following application(s):

Application(s) to Expand Field of Membership - Approved

Entex Credit Union, Houston, Texas - See Texas Register issue dated September 28, 2001.

Houston Energy Credit Union, Houston, Texas - See Texas Register issue dated September 28, 2001.

Members Choice Credit Union, Houston, Texas - See Texas Register issue dated September 28, 2001.

OmniAmerican Credit Union (4 Applications), Fort Worth, Texas - See Texas Register issue dated September 28, 2001.

Premier America Credit Union, Chatsworth, California - See Texas Register issue dated January 26, 2001.

Star One Credit Union, Fort Worth, Texas - See Texas Register issue dated June 29, 2001.

Star One Credit Union, Fort Worth, Texas - See Texas Register issue dated July 27, 2001.

Application(s) to Amend Articles of Incorporation - Approved

ChevronTexaco Credit Union, Houston, Texas - See Texas Register issue dated October 26, 2001.

Applications(s) for a Merger or Consolidations - Approved

Briggs-Weaver Employees Credit Union (Coppell) and Neighborhood Credit Union (Dallas) - See Texas Register issue dated October 26, 2001.

TRD-200108059
Harold E. Feeney
Commissioner
Credit Union Department
Filed: December 18, 2001

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Texas Commission for the Deaf and Hard of Hearing

Request for Information

The Texas Commission for the Deaf and Hard of Hearing (TCDHH) hereby gives notice of Request for Information (RFI). The primary purpose of the RFI is to obtain information regarding adaptive telecommunications equipment or services available to persons with disabilities that impair effective access to the telephone network.

By authority of the Utilities Code, Chapter 56, TCDHH is designated to assist persons with disabilities to obtain adaptive telecommunications devices or services suitable to meet their needs for telephone access. TCDHH will receive applications, determine eligibility and issue vouchers to be used to purchase telecommunications devices or services for eligible individuals. The voucher can only be used to purchase the equipment or service specified on the voucher. Registered vendors

will be reimbursed the face amount of the voucher, or actual cost of the equipment or service, which ever is less, through this program.

TCDHH is required to establish a reasonable price for basic telecommunications devices or services for persons with disabilities. These prices established will be used to establish the value of the voucher. To this end, TCDHH requests that potential vendors provide information concerning available models of equipment and service that could be purchased under this program and specify prices for this equipment or service under the voucher program.

All equipment/services purchased under this program must be new. Used or reconditioned equipment is not eligible for use with the voucher. Attach printed data, which should be referenced and identified to the specific sections of the RFI.

This RFI is for informational purposes only. For further information about this RFI contact Margaret Susman at (512) 407-3250 or (512) 407-3251/TTY. Responses must be received in the TCDHH office by 5:00 p.m., January 16, 2002, at 4800 N. Lamar, Suite 310, Austin, TX 78756.

I Provide technical descriptions and specifications for the equipment/services which include name brand and retail value.

TDD/TTY w/direct connect and printer

TDD/TTY software

Video call kit with software

Separate flashing light ring signaler

Amplified telephone

Headset for use with amplified telephone

Hands free amplified headset

Voice Carry Over (VCO) telephone

Portable amplifier

Handset amplifier

In-line amplifier

Separate loud ring signaler

Artificial larynx

Hearing Carry Over (HCO) telephone

Talking Aid Device

Speech communication aid

Moisture guard for speech communication aid

Key guard for speech communication aid

Speech amplified telephone

Speech amplification system

Anti-stuttering device

Picture telephone

Back talking box

Telecommunications Braille Device

Tactile ring signaler

TTY w/large visual display

VCO w/large visual display

Augmentative communications aid device

Big button telephone

Big button braille telephone

Big button braille telephone with amplification

Telephone with speakerphone

Hands free telephone with headset

Neck loop

Cochlear implant telephone adapter cord

Cochlear telephone

Voice dialer

Voice activated telephone with switch capability

Lapel microphone

Air switch

Pillow switch

Headset with microphone

Wheelchair mount kit

Switch mount kit

Talking/memory dial telephone

Emergency response telephone

II What other types of telecommunication equipment and/or services can your company offer persons with telecommunication barriers?

III Do you guarantee the prices quoted above will be the purchase cost under STAP?

Attach a typed inventory complete with retail value, name brand and specifications of specialized equipment and/or services available through your company in addition to the completed Request for Information.

IV Vendor Information

Company Name:

Address:

City:

State:

Zip:

TRD-200108056
David W. Myers
Executive Director
Texas Commission for the Deaf and Hard of Hearing
Filed: December 18, 2001

♦ ♦ ♦

Texas Council for Developmental Disabilities

Notice of Revised Request for Proposals

The Texas Council for Developmental Disabilities previously published this Notice of Request for Proposals in the December 14, 2001, issue of the *Texas Register* (26 TexReg 10416) with an error regarding the e-mail and website information. The correct references are: e-mail: txddc@txddc.state.tx.us and website: www.txddc.state.tx.us. The Texas Council for Developmental Disabilities republishes the correct version of the Request for Proposals as follows:

The Texas Council for Developmental Disabilities announces the availability of funds for grant projects addressing four different activity areas. The Texas Council for Developmental Disabilities is established by and funded under state and federal law and is responsible to promote the development of supports and services necessary for individuals with developmental disabilities to be fully included in their communities. The Council has a commitment to support projects that will be carried out by organizations that share the Council's vision and values.

Project Area #1: New Initiatives

Funds are available for up to four new projects that address field-based, innovative applications that propose strategies to implement goals and objectives in the Council's State Plan. Applicant may request up to $75,000 per year per project for up to three years. The Council anticipates awarding up to $200,000 annually for all projects funding under this title.

Project Area #2: Project DOCC

Funds are available for up to four projects to establish parent driven training programs for first year pediatric residents in up to four teaching hospitals with pediatric residency programs in Texas. Project DOCC, modeled after similar projects in other states, is designed to increase physicians' awareness and understanding of the impact of chronic/long term illness or disabilities on both the children and their families. Funds are available for up to four projects with funds of up to $75,000 per year available for each site for up to four years.

Project Area #2: Advanced Leadership Training

Funds are available for an Advanced Leadership Training Workshop for people with disabilities or their families who have already completed some type of leadership training and have been active in the disability advocacy community. The Workshop is planned for fall 2002 and will provide opportunities to develop and enhance existing skills in board participation, grant writing, mediation, and advocacy. Funds are available for 1 project, with funding up to $125,000 available for one budget year.

Project Area #3: Biennial Report

The Texas Legislature mandated the Texas Council for Developmental Disabilities and the Texas Office for Prevention of Developmental Disabilities jointly develop a biennial disability report prior to each regular legislative session to report on the state of services to persons with disabilities in Texas. This announces the availability of funds to conduct research and analysis for the 2002 Biennial Report on three identified issues relating to the unmet needs of people with disabilities living in the community. The three issues are 1) the need for and availability of personal attendants; 2) the causes and effects of the development of secondary and tertiary conditions that most frequently occur in the lives of people with disabilities; and 3) the costs of failing to provide sufficient supports in the community for people with disabilities. Applicants may propose to research one, two, or all three issues. Applicants may apply for up to $125,000 for all 3 projects, with funds available for one budget period of up to 9 months. The Council anticipates funds for each research area to not exceed $40,000.

Continuation Funding: Projects funded under RFP Titles 1 & 2 may be eligible for continuation funding. Funding for each continuation year will not be automatic. Consideration for continuation funding will include a review of the project's accomplishments, progress towards stated goals and objectives, financial management of funds, compliance with reporting requirements, the most recent annual independent audit, results of TCDD's onsite reviews, and development of sustainability beyond TCDD funding where applicable.

Application Materials: For the full request for proposals, application forms and instructions, please submit a written, fax or e-mail request to Patrice LeBlanc, Grants Management Specialist, Texas Council for Developmental Disabilities, 4900 North Lamar Boulevard, Austin, Texas, 78751-2339, (512) 424-4080 (voice) or (512) 424-4097 (fax), e-mail: txddc@txddc.state.tx.us. This information also may be obtained through TCDD's website at http://www.txddc.state.tx.us. The completed application must be mailed or hand delivered. Application packets cannot be faxed.

Proposal Process and Submission Deadlines:

An original and seven copies of the proposal must be received in the TCDD office at 6201 East Oltorf, Suite 600, Austin no later than 4:00 PM on the due date OR postmarked before midnight on the due date and mailed to TCDD at: 4900 North Lamar, Austin, Texas 78751-2399.

Component--Timeline

Deadline to submit proposals for competitive review.

Biennial Disability Report--February 1, 2002

Project DOCC--March 1, 2002

Advanced Leadership Training--March 1, 2002

New Initiatives--March 15, 2002

Review by independent review panels.

Biennial Disability Report--February 15, 2002 - February 21, 2002

Project DOCC, Advanced Leadership Training, New Initiatives--March 15, 2002 - March 30, 2002

Letters to applicants about funding decisions. Organizations whose proposal(s) are recommended for funding will be sent materials for the development of a Grant Workplan.

Biennial Disability Report--March 1, 2002

Project DOCC, Advanced Leadership Training, New Initiatives--May 1, 2002

TRD-200108076
Roger A. Webb
Executive Director
Texas Council for Developmental Disabilities
Filed: December 19, 2001

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Texas Education Agency

Notice of Voluntary Assessment of Private School Students with the Texas Assessment of Academic Skills (TAAS) and Texas End-of-Course Tests

In accordance with the Texas Education Code (TEC), §39.033, the Texas Education Agency (TEA) will make available for administration to private and home schools the Texas Assessment of Academic Skills (TAAS) tests for Grades 3-8 and the exit level and the Texas end-of-course examinations for Algebra I, Biology, English II, and U.S. History at a per-student cost that does not exceed the cost of administering the same test to a Texas public school student.

Each private and home school choosing to participate in this assessment will be required to sign an agreement with TEA in which it agrees to maintain security and confidentiality of the test instruments, test all eligible students in all subjects at a particular grade level, follow all procedures specified in the applicable test administration materials, provide to the commissioner of education the information listed in the TEC, §39.051(b), and reimburse TEA for the cost of the assessment.

Private and home schools interested in participating in the spring 2002 assessment may obtain a copy of the agreement packet by contacting NCS Pearson, 2201 Donley Drive, Austin, Texas 78758, (512) 835-4833. All required components of the agreement must be returned no later than January 17, 2002.

Additional information may be obtained from Linda Brase, NCS Pearson, 2201 Donley Drive, Austin, Texas 78758, (512) 835-4833.

TRD-200108090
Cristina De La Fuente-Valadez
Manager, Policy Planning
Texas Education Agency
Filed: December 19, 2001

♦ ♦ ♦

Office of the Governor

Request for Grant Applications for Texas Crime Stoppers Fund Program

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications to provide grants to Texas Crime Stoppers organizations in Texas under the fiscal year 2003 grant cycle.

Purpose: The purpose of the funding is to enhance and assist the community's efforts in solving serious crimes.

Available Funding: State funding is authorized for these projects under the Texas Code of Criminal Procedure, Article 102.013, which designates CJD as the funds administering agency. The source of funding is a biennial appropriation by the Texas Legislature from funds collected through court costs and fees.

Standards: Grantees must comply with the applicable grant management standards adopted under Title I, Part I, Chapter 3, Texas Administrative Code, which are hereby adopted by reference.

Prohibitions: Grantees may not use grant funds for promotional advertisements of any kind, office space rental, entertainment or refreshments, purchase or improvement of real estate, rewards, lobbying, or attorney fees.

Eligible Applicants: Crime Stoppers organizations as defined by Section 414.001, Texas Government Code, as follows: (1) a private, nonprofit organization that is operated on a local or statewide level, that accepts and expends donations for rewards to persons who report to the organization information about criminal activity and that forwards the information to the appropriate law enforcement agency; or (2) a public organization that is operated on a local or statewide level, that pays rewards to persons who report to the organization information about criminal activity, and that forwards the information to the appropriate law enforcement agency.

Project Period: Grant funded projects must begin on or after November 1, 2002, unless exempted by the Executive Director of CJD.

Application Process: Interested applicants should write the Office of the Governor, Criminal Justice Division, P.O. Box 12428, Austin, Texas 78711. Detailed specifications are in the application kits, which are available on the Office of the Governor's web site address located at http://www.governor.state.tx.us.

Preferences: None.

Closing Date for Receipt of Applications: All original applications, plus an additional copy, must be submitted directly to the Criminal Justice Division. Applications will be accepted starting on January 15, 2002, and must be received or postmarked no later than May 15, 2002.

Selection Process: Completed applications will be reviewed for eligibility and cost effectiveness by CJD. The Executive Director of CJD will make all final funding decisions.

Contact Person: If additional information is needed contact Betty Bosarge, at (512) 463-1784 or bbosarge@governor.state.tx.us.

TRD-200107961
David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 17, 2001

♦ ♦ ♦

Request for Grant Applications for Texas Narcotics Control Program

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications for local and regional special projects and multi-jurisdictional efforts that target drug-related crime, violent crime, and serious offenders under the fiscal year 2003 grant cycle.

Purpose: The purpose of the program is to reduce and prevent illegal drug activity, crime, and violence and to improve the functioning of the criminal justice system. All projects must meet at least one of the following purpose areas. (1) Multi-jurisdictional and multi-county task force projects that integrate federal, state and local drug law enforcement agencies and prosecutors for the purpose of enhancing interagency coordination, acquiring intelligence information, and facilitating multi-jurisdictional investigations. TNCP task forces must use the Criminal Law Enforcement Reporting (CLERIS) and provide input of task force drug intelligence information into the System. Multi-jurisdictional and multi-county task force projects must be composed of law enforcement agencies located in no less than two contiguous counties within the State of Texas; (2) projects designed to target the domestic sources of controlled and illegal substances, such as precursor chemicals, diverted pharmaceuticals, clandestine laboratories, and cannabis cultivation; (3) projects that will improve the operational effectiveness of law enforcement through the use of crime analysis techniques, street sales enforcement, schoolyard violator projects, and gang related and low income housing drug control projects; (4) law enforcement and prevention projects that address problems with gangs or youth who are at risk of becoming involved in gangs; (5) financial investigation projects that target the identification of money-laundering operations and assets obtained through illegal drug trafficking, including the development of proposed model legislation, financial investigative training, and financial information sharing systems; (6) projects that improve the operational effectiveness of the court process by expanding prosecution, defender, and judicial resources and by implementing court delay-reduction programs; (7) criminal justice information systems, including automated fingerprint identification systems, that assist law enforcement, prosecution, courts and corrections' organizations; (8) innovative projects that demonstrate new and different approaches to the enforcement, prosecution, and adjudication of drug offenses and other serious crimes; (9) drug control evaluation projects that state and local units of government may use to evaluate projects directed at state drug-control activities; (10) projects to develop and implement antiterrorism training projects and to procure equipment for use by local law enforcement authorities; (11) improving or developing forensic laboratory capabilities to analyze DNA for identification purposes; (12) demand reduction education programs in which law enforcement officers participate; (13) career criminal prosecution programs including the development of proposed model drug control legislation; (14) programs designed to provide additional public correctional resources and improve the corrections system, including treatment in prisons and jails,

intensive supervision programs, and long-range corrections and sentencing strategies; (15) providing prison industry projects designed to place inmates in a realistic working and training environment which will enable them to acquire marketable skills and to make financial payments for restitution to their victims, for support of their own families, and for support of themselves in the institution; (16) providing programs which identify and meet the treatment needs of adult and juvenile drug-dependent and alcohol-dependent offenders; (17) developing and implementing programs which provide assistance to jurors and witnesses, and assistance (other than compensation) to victims of crimes; (18) developing programs to improve drug control technology, such as pretrial drug testing programs, programs which provide for the identification, assessment, referral to treatment, case management and monitoring of drug dependent offenders, and enhancement of State and local forensic laboratories; (19) improving the criminal and juvenile justice system's response to domestic and family violence, including spouse abuse, child abuse, and abuse of the elderly; (20) providing alternatives to prevent detention, jail, and prison for persons who pose no danger to the community; (21) providing community and neighborhood programs that assist citizens in preventing and controlling crime, including special programs that address the problems of crimes committed against the elderly and special programs for rural jurisdictions; (22) disrupting illicit commerce in stolen goods and property; (23) improving the investigation and prosecution of white-collar crime (e.g., organized crime, public corruption crimes, and fraud against the government with priority attention to cases involving drug-related official corruption); (24) developing and implementing anti-terrorism plans for deep draft ports, international airports, and other important facilities; (25) addressing the problems of drug trafficking and the illegal manufacture of controlled substances in public housing; (26) programs of which the primary goal is to strengthen urban enforcement and prosecution efforts targeted at street drug sales; (27) prosecution of driving while intoxicated charges and the enforcement of other laws relating to alcohol use and the operation of motor vehicles; (28) addressing the need for effective bindover systems for the prosecution of violent 16- and 17-year-old juveniles in courts with jurisdiction over adults for (certain enumerated) violent crime; (29) enforcing child abuse and neglect laws, including laws protecting against child sexual abuse, and promoting programs designed to prevent child abuse and neglect; or (30) establishing or supporting cooperative programs between law enforcement and media organizations to collect, record, retain, and disseminate information useful in the identification and apprehension of suspected criminal offenders.

Available Funding: Federal funding is authorized for these projects under Omnibus Crime Control and Safe Streets Act of 1968, as amended, Title I, codified as amended at 42 U.S.C., §3750, which is available through the Edward Byrne Memorial Fund.

Standards: Grantees must comply with the applicable grant management standards adopted under Texas Administrative Code, §3.19, which are hereby adopted by reference.

Eligible Applicants: (1) state agencies; (2) units of local government; (3) crime control and prevention districts; and (4) Indian tribes that perform law enforcement functions (as determined by the Secretary of the Interior) are eligible to apply for grants under this fund.

Project Period: Grant funded projects must begin on or after June 1, 2002, unless exempted by the Executive Director of CJD.

Application Process: Interested parties should request an application kit for Texas Narcotics Control Programs or Criminal Justice Information Systems from the Office of the Governor, Criminal Justice Division, P.O. Box 12428, Austin, TX 78711, telephone (512) 463-1919. Application kits may also be obtained through the Office of the Governor's web site address located at http://www.governor.state.tx.us.

Preferences: Preference will be given to applicants who provide local and regional programs that focus on reducing and preventing illegal drug activity, crime, and violence and improving the functioning of the criminal justice system. Preference may also be given to continuation projects.

Closing Date for Receipt of Applications: All original applications, plus an additional copy, must be submitted directly to the Criminal Justice Division and must be received or postmarked by January 14, 2002.

Selection Process: Completed applications will be reviewed for eligibility and cost effectiveness by CJD and rated competitively by a committee selected by the director of CJD. CJD reserves the right to renew grants for up to two additional years without the selected applications entering a competitive selection process. The Executive Director of CJD will make all final funding decisions.

Contact Person: If additional information is needed contact Taylor Petty at (512) 463-2822.

TRD-200108052
David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 18, 2001

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Texas Department of Health

Licensing Actions for Radioactive Materials

The Texas Department of Health has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Alice	Adcock Pipe and Supply Inc	L05491	Alice	00	12/14/01
Fort Worth	Law Engineering and Environmental Services Inc	L05490	Fort Worth	00	11/30/01
Lubbock	Brogan Heart Center PA	L05488	Lubbock	00	12/12/01
McAllen	Advanced Nuclear Imaging Inc	L05467	McAllen	00	11/30/01
Paris	Texas Oncology PA	L05489	Paris	00	12/12/01
Sherman	David F Davis MD FACC PA	L05477	Sherman	00	12/05/01
Throughout Tx	Terra-Solve Inc	L05497	Dallas	00	12/04/01

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Abilene	Hendrick Medical Center	L02433	Abilene	73	12/06/01
Alice	Physicians and Surgeons Hospital of Alice LP	L02390	Alice	29	12/10/01
Austin	Texas Cardiovascular Consultants PA	L05246	Austin	03	12/10/01
Austin	Daughters of Charity Health Services of Austin	L00268	Austin	70	12/11/01
Austin	Motorola	L05347	Austin	02	12/12/01
Baytown	Baytown Cardiology Associates	L05040	Baytown	04	12/03/01
Baytown	Baycoast Medical Center	L02462	Baytown	37	11/30/01
Beeville	Christus Spohn Health System Corporation	L04510	Beeville	13	12/05/01
Big Springs	Big Springs Hospital Corporation	L00763	Big Springs	41	12/11/01
Bremond	Texas-New Mexico Power Company	L04280	Bremond	06	12/06/01
Brownsville	Brownsville Medical Center	L01526	Brownsville	31	12/11/01
Brownsville	Columbia Valley Regional Medical Center	L02274	Brownsville	32	12/06/01
College Station	College Station Hospital LP	L02559	College Station	39	12/10/01
Corpus Christi	PROMED Company of the Coastal Bend	L05317	Corpus Christi	02	12/10/01
Dallas	Lone Star Cardiology Consultants PA	L04997	Dallas	25	12/05/01
Dallas	Lockheed Martin Corporation	L02670	Dallas	27	11/30/01
Dallas	Cooper Clinic PA	L05138	Dallas	04	12/13/01
Dallas	Bristol-Myers Squibb Medical Imaging Inc	L02481	Dallas	22	12/14/01
Dallas	Presbyterian Hospital of Dallas	L01586	Dallas	77	12/14/01
Del Rio	Val Verde Regional Medical Center	L01967	Del Rio	19	12/12/01
Denton	NRX Acquisition Corp	L05433	Denton	01	12/10/01
Denton	Columbia Medical Center of Denton Subsidiary LP	L02764	Denton	47	12/11/01
El Paso	Chevron Products Co	L02669	El Paso	11	12/06/01
Fort Worth	All Saints/Health South Gamma Knife LLC	L05473	Fort Worth	01	12/06/01
Harlingen	Valley Baptist Medical Center	L01909	Harlingen	49	12/13/01

CONTINUED AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Houston	Saint-Gobain Ceramics and Plastics	L04895	Houston	03	12/10/01
Houston	Guidant Corporation VI	L05178	Houston	09	11/14/01
Houston	Richmond Imaging Affiliates LTD	L04342	Houston	44	12/07/01
Houston	MBA Laboratories	L02571	Houston	12	12/06/01
Houston	Petnet Pharmaceuticals Inc	L05342	Houston	03	12/06/01
Houston	H & G Inspection Company Inc	L02181	Houston	141	12/05/01
Houston	Memorial Herman Hospital System Inc	L00650	Houston	57	12/05/01
Houston	Richmond Imaging Affiliates LTD	L05455	Houston	01	12/03/01
Houston	Guidant Corporation VI	L05178	Houston	10	12/10/01
Houston	Houston Northwest Medical Center	L02253	Houston	51	12/14/01
Houston	Memorial Hermann Hospital System	L00439	Houston	75	12/14/01
Irving	Baylor Medical Center at Irving	L02444	Irving	40	12/07/01
Irving	COR Specialty Associates of North Texas PA	L05373	Irving	03	12/03/01
Irving	Baylor Medical Center at Irving	L02444	Irving	41	12/12/01
Jourdanton	Jourdanton Hospital Corporation	L04966	Jourdanton	08	12/06/01
Killeen	Hillcrest Heart Associates	L05099	Killeen	01	12/05/01
Longview	Good Shepherd Medical Center	L02411	Longview	63	12/11/01
Lubbock	ISORX Radiopharmacy	L05284	Lubbock	04	12/03/01
Lubbock	Texas Tech University Environmental Health and Safety	L01536	Lubbock	70	12/11/01
Lubbock	Cardiologist of Lubbock PA	L05038	Lubbock	09	12/12/01
Muenster	Muenster Hospital District	L04887	Muenster	05	12/01/01
Nederland	Beaumont Hospital Holdings Inc	L01756	Nederland	39	12/12/01
Orange	RTPS Acquisition Company LLC	L05204	Orange	06	12/07/01
Pampa	Mundy Contract Maintenance Inc	L04360	Pampa	19	11/30/01
Pampa	Mundy Maintenance and Service LLC	L04360	Pampa	20	12/12/01
Paris	Christus St Josephs Health System	L03199	Paris	20	12/10/01
Paris	Turner International Piping Systems	L05237	Paris	02	11/30/01
Pasadena	Gulf Coast Cancer Center Inc	L05194	Pasadena	03	12/11/01
Plano	Texas Regional Heart Center PA	L03704	Plano	23	12/14/01
Point Comfort	Formosa Plastics Corporation – Texas	L03893	Point Comfort	23	12/05/01
Port Arthur	S K Rao MD PA	L05415	Port Arthur	02	11/30/01
Port Neches	Huntsman Corporation	L04067	Port Neches	12	12/06/01
Richardson	The University of Texas at Dallas	L02114	Richardson	45	12/07/01
Rockdale	ALCOA Power Plant Sandow Station	L04386	Rockdale	11	12/07/01
San Antonio	Radiology Associates of San Antonio PA	L04927	San Antonio	16	12/08/01
San Antonio	Radiology Associates of San Antonio PA	L04305	San Antonio	28	12/07/01
San Antonio	South Texas Radiology Imaging Centers	L03518	San Antonio	29	11/30/01
San Antonio	Southwest Research Institute	L04958	San Antonio	06	12/07/01
San Antonio	Methodist Healthcare System of San Antonio LTD	L02266	San Antonio	75	12/12/01
San Antonio	Methodist Healthcare System of San Antonio	L00594	San Antonio	161	12/10/01
San Antonio	South Texas Radiology Imaging	L03518	San Antonio	30	12/14/01
San Antonio	South Texas Radiology Imaging Centers	L00325	San Antonio	113	12/14/01
Sunray	Diamond Shamrock Refining Company LP	L04398	Sunray	10	12/05/01
Temple	Scott and White Memorial Hospital and Scott Sherwood and Brindley Foundation	L00331	Temple	63	12/12/01
Throughout Tx	Texas Department of Transportation Construction Division Materials Section	L00197	Austin	90	12/14/01

CONTINUED AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout Tx	X-Ray Inspection Inc	L05275	Beaumont	18	12/05/01
Throughout Tx	X-Ray Inspection Inc	L05275	Beaumont	19	12/14/01
Throughout Tx	Paragon Wireline Inc	L05367	Bryan	02	12/12/01
Throughout Tx	Celanese LTD	L00409	Corpus Christi	64	11/30/01
Throughout Tx	Century Inspection Inc	L00062	Dallas	96	12/05/01
Throughout Tx	Rone Engineers	L02356	Dallas	22	12/14/01
Throughout Tx	Probe Technology Services	L05112	Fort Worth	11	12/10/01
Throughout Tx	M & K Chemical Engineering Consultants Inc	L05155	Houston	03	12/11/01
Throughout Tx	Wood Group Logging Services Inc	L05262	Houston	07	12/11/01
Throughout Tx	H & G Inspection Company Inc	L02181	Houston	142	12/10/11
Throughout Tx	Tuboscope Vetco International Inc	L00287	Houston	108	12/10/01
Throughout Tx	M & K Chemical Engineering Consultants Inc	L05155	Houston	02	12/06/01
Throughout Tx	Ground Technology Inc	L05125	Houston	05	12/06/01
Throughout Tx	RJR Engineering LTD LLP	L05416	Houston	01	12/06/01
Throughout Tx	Cooperheat-MQS Inc	L00087	Houston	90	11/30/01
Throughout Tx	METCO	L03018	Houston	117	12/12/01
Throughout Tx	Southern Services Inc	L05270	Lake Jackson	18	12/11/01
Throughout Tx	Luling Perforators Inc	L03958	Luling	09	12/11/01
Throughout Tx	Sonic Surveys	L02622	Mont Belvieu	15	12/07/01
Throughout Tx	Eagle X-Ray	L03246	Mont Belvieu	68	12/06/01
Throughout Tx	Sivalls Inc	L02298	Odessa	28	12/07/01
Throughout Tx	Westex Inspection Inc	L04775	Odessa	08	11/30/01
Throughout Tx	Thermo Measuretech	L03524	Round Rock	61	12/10/01
Throughout Tx	Arias & Kezar Inc	L04964	San Antonio	16	12/06/01
Throughout Tx	Zachry Construction Corporation	L05230	San Antonio	05	12/13/01
Throughout	Blazer Inspection Inc	L04619	Texas City	26	12/07/01

Tx					
Tyler	NUTECH Inc	L04274	Tyler	37	12/05/01
Wichita Falls	United Regional Health Care System Inc	L00350	Wichita Falls	81	12/04/01

RENEWALS OF EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
El Paso	Guillermo A Pinzon MD PA	L04277	El Paso	08	12/03/01
Jacksonville	East Texas Medical Center Jacksonville	L00169	Jacksonville	33	12/12/01
San Antonio	Methodist Healthcare System of San Antonio LTD	L02232	San Antonio	42	12/06/01
San Antonio	Baptist Imaging Center	L04506	San Antonio	30	12/11/01
Throughout Tx	Patterson Tubular Services Inc	L03148	Channelview	22	12/06/01

In issuing new licenses, amending and renewing existing licenses, or approving exemptions to Title 25 Texas Administrative Code (TAC) Chapter 289, the Texas Department of Health, Bureau of Radiation Control, has determined that the applicants are qualified by reason of training and experience to use the material in question for the purposes requested in accordance with 25 TAC Chapter 289 in such a manner as to minimize danger to public health and safety or property and the environment; the applicants' proposed equipment, facilities and procedures are adequate to minimize danger to public health and safety or property and the environment; the issuance of the new, amended, or renewed license (s) or the issuance of the exemption (s) will not be inimical to the health and safety of the public or the environment; and the applicants satisfy any applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a licensee, applicant, or person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A licensee, applicant, or person affected may request a hearing by writing Richard A. Ratliff, P.E., Chief, Bureau of Radiation Control (Director, Radiation Control Program), Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756-3189. For information call (512) 834-6688.

TRD-200108092
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 19, 2001

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Notice of Agreed Order on Castle Dental Centers, Inc. of Houston

On December 3, 2001, the director of the Bureau of Radiation Control (bureau), Texas Department of Health, approved the settlement

agreement between the bureau and Castle Dental Centers, Inc. (registrant-R09023) of Houston. A total administrative penalty in the amount of $10,000 was assessed the registrant for violations of 25 Texas Administrative Code, Chapter 289.

A copy of all relevant material is available for public inspection Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays). Contact Chrissie Toungate, Custodian of Records, Bureau of Radiation Control, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756-3189, by calling (512) 834-6688, or by visiting the Exchange Building, 8407 Wall Street, Austin, Texas.

TRD-200108094
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 19, 2001

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Notice of Amendment of License for Waste Control Specialists, LLC

Notice is hereby given by the Texas Department of Health (department), Bureau of Radiation Control that it has amended Radioactive Material License Number L04971 issued to Waste Control Specialists, LLC (WCS) located in Andrews County, Texas, one mile North of State Highway 176; 250 feet East of the Texas/New Mexico State Line; 30 miles West of Andrews, Texas.

The issuance of amendment number 16 authorizes, by the addition of Condition 25.D to the license, the licensee to hold radioactive waste mixed with hazardous waste, that is mixed waste, which is undergoing a treatability study for time periods consistent with that permitted for the storage of such waste under the provisions of the licensee's permit with the Texas Natural Resources Conservation Commission for hazardous waste containing radioactive constituents in accordance with the provisions of Title 40, Code of Federal Regulations, §§261.4(f)(5) and 268.50.

The department has determined that the amendment of the license, 25 Texas Administrative Code (TAC), Chapter 289, and the documentation submitted by the licensee provide reasonable assurance that the licensee's radioactive waste facility is sited, designed, operated, and will be decommissioned and closed in accordance with the requirements of 25 TAC, Chapter 289; the amendment of the license will not be inimical to the health and safety of the public or the environment; and the activity represented by the amendment of the license will not have a significant effect on the human environment.

This notice affords the opportunity for a public hearing upon written request within 30 days of the date of publication of this notice by a person affected as required by Texas Health and Safety Code, §401.116 and as set out in 25 TAC, §289.205(f). A "person affected" is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to a county, in which the radioactive material is or will be located; or (b) doing business or has a legal interest in land in the county or adjacent county.

A person affected may request a hearing by writing Mr. Richard A. Ratliff, P.E., Chief, Bureau of Radiation Control, 1100 West 49th Street, Austin, Texas 78756-3189. Any request for a hearing must contain the name and address of the person who considers himself affected by this action, identify the subject license, specify the reasons why the person considers himself affected, and state the relief sought. If the person is represented by an agent, the name and address of the agent must be stated. Should no request for a public hearing be timely filed, the agency action will be final.

A public hearing, if requested, shall be conducted in accordance with the provisions of Texas Health and Safety Code, Chapter 401, the Administrative Procedure Act (Chapter 2001, Texas Government Code), the formal hearing procedures of the department (25 Texas Administrative Code, §1.21 et seq.) and the procedures of the State Office of Administrative Hearings (1 Texas Administrative Code, Chapter 155).

A copy of the license amendment and supporting materials are available for public inspection and copying at the office of the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, 8:00 a.m. to 5:00 p.m. Monday-Friday (except holidays). Information relative to inspection and copying the documents may be obtained by contacting Chrissie Toungate, Custodian of Records, Bureau of Radiation Control.

TRD-200107903
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 14, 2001

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Notice of Default Order on Kevin Landry, D.C., dba Hillcroft X-Ray Center

A default order was entered regarding Kevin Landry, D.C., doing business as Hillcroft X-Ray Center, Docket Number A2721-575-2001; Texas Department of Health (TDH) Certificate of Registration Number R22780 (Revoked); Compliance Number ER01-059 on November 28, 2001, assessing $10,000 in administrative penalties.

Information concerning this order is available for public inspection Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays). Contact Chrissie Toungate, Custodian of Records, Bureau of Radiation Control, Texas Department of Health, 1100 West 49th Street, Austin, Texas 78756- 3189, by calling (512) 834-6688, or by visiting the Exchange Building at 8407 Wall Street, Austin, Texas.

TRD-200108093
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 19, 2001

♦ ♦ ♦

Notice of Emergency Cease and Desist Order for Chapman Chiropractic

Notice is hereby given that the Bureau of Radiation Control (bureau) ordered Chapman Chiropractic (registrant-R20678) of Wichita Falls to cease and desist performing Lumbo-Sacral Spine (AP) x-ray procedures with the Universal x-ray unit (Model Number 110-0030G13; Serial Number 23-1168631DP) until the exposure at skin entrance is within regulatory limits. The bureau determined that continued radiation exposure to patients in excess of that required to produce a diagnostic image constitutes an immediate threat to public health and safety, and the existence of an emergency. The order will remain in effect until the bureau authorizes the registrant to perform the procedure.

A copy of all relevant material is available for public inspection at the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200107901

Susan Steeg
General Counsel
Texas Department of Health
Filed: December 14, 2001

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Notice of Emergency Cease and Desist Order on Medical Testing and Examination Center of Fort Worth, Inc., dba Medtex of Fort Worth

Notice is hereby given that the Bureau of Radiation Control (bureau) ordered Medical Testing and Examination Center of Fort Worth, Inc., doing business as Medtex of Fort Worth, (registrant- R26187) of Fort Worth to cease and desist performing chest (PA)(Grid) procedures with the Xonics x-ray unit (Model Number A56700-3; Serial Number 019-0684-010) until the exposure at skin entrance is within regulatory limits. The bureau determined that continued radiation exposure to patients in excess of that required to produce a diagnostic image constitutes an immediate threat to public health and safety, and the existence of an emergency. The order will remain in effect until the bureau authorizes the registrant to perform the procedure.

A copy of all relevant material is available for public inspection at the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200108062
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 18, 2001

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Notice of Intent to Revoke Certificates of Registration

Pursuant to 25 Texas Administrative Code §289.205, the Bureau of Radiation Control (bureau), Texas Department of Health (department), filed complaints against the following registrants: West Park Physicians, L.L.P., Arlington, R02175; Protech Evaluation Services, Inc., Stafford, R19376; Preston Medical Center, Dallas, R20012; Leo L. Altenberg, M.D., P.A., Euless, R23743; S. Steve Watson, M.D., Frisco, R23776; Healthsouth, Irving, R24512; Healthsouth Medical Clinic, El Paso, R25292; Arlington Wellness Center, Arlington, R25293; Clear Lake Regional Medical Center, Inc., Webster, Z00279; Mercy Health Systems of Texas, Laredo, Z01227; A Better Way No-Needle Electrolysis, Dallas, Z01372; Spectrum Medical Services, Dallas, Z01183.

The complaints allege that these registrants have failed to pay required annual fees. The department intends to revoke the certificates of registration; order the registrants to cease and desist use of radiation machine(s); order the registrants to divest themselves of such equipment; and order the registrants to present evidence satisfactory to the bureau that they have complied with the orders and the provisions of the Texas Health and Safety Code, Chapter 401. If the fee is paid within 30 days of the date of each complaint, the department will not issue an order.

This notice affords the opportunity to the registrants for a hearing to show cause why the certificates of registration should not be revoked. A written request for a hearing must be received by the bureau within 30 days from the date of service of the complaint to be valid. Such written request must be filed with Richard A. Ratliff, P.E., Chief, Bureau of Radiation Control (Director, Radiation Control Program), 1100 West 49th Street, Austin, Texas 78756-3189. Should no request for a public hearing be timely filed or if the fee is not paid, the certificates of registration will be revoked at the end of the 30-day period of notice.

A copy of all relevant material is available for public inspection at the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200108063
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 18, 2001

♦ ♦ ♦

Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation for Technical Welding Laboratory, Inc.

Notice is hereby given that the Bureau of Radiation Control (bureau), Texas Department of Health (department), issued a notice of violation and proposal to assess an administrative penalty to Technical Welding Laboratory, Inc. (licensee-L02187) of Pasadena. A total penalty of $8,000 is proposed to be assessed to the licensee for alleged violations of a radioactive materials license condition and 25 Texas Administrative Code, §§289.255 and 289.257.

A copy of all relevant material is available for public inspection at the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200107902
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 14, 2001

♦ ♦ ♦

Notice of Preliminary Report for Assessment of Administrative Penalties and Notice of Violation on Arthur W. Coleman, D.D.S. and Associates

Notice is hereby given that the Bureau of Radiation Control (bureau), Texas Department of Health (department), issued a notice of violation and proposal to assess an administrative penalty to Arthur W. Coleman, D.D.S. and Associates (registrant-R24360, revoked) of Houston. A total penalty of $10,000 is proposed to be assessed to the registrant for the alleged violation of the Revocation Order issued by the bureau on October 4, 2001.

A copy of all relevant material is available for public inspection at the Bureau of Radiation Control, Texas Department of Health, Exchange Building, 8407 Wall Street, Austin, Texas, telephone (512) 834-6688, Monday-Friday, 8:00 a.m. to 5:00 p.m. (except holidays).

TRD-200108061
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 18, 2001

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Schedules of Controlled Substances

PURSUANT TO THE TEXAS CONTROLLED SUBSTANCES ACT, HEALTH AND SAFETY CODE, CHAPTER 481, THESE SCHEDULES, ESTABLISHED JANUARY 1, 2002, SUPERCEDE

PREVIOUS SCHEDULES AND CONTAIN THE MOST CURRENT VERSION OF THE SCHEDULES OF ALL CONTROLLED SUBSTANCES FROM THE PREVIOUS SCHEDULES AND MODIFICATIONS.

January 1, 2002

Changes to the schedules are designated by an asterisk (*). Additional information can be obtained by contacting the Texas Department of Health, Bureau of Food and Drug Safety, 1100 West 49th Street, Austin, Texas 78756. The telephone number is (512) 719-0237 and the website address is .

SCHEDULES

Nomenclature: Controlled substances listed in these schedules are included by whatever official, common, usual, chemical, or trade name they may be designated.

SCHEDULE I

Schedule I consists of:

Schedule I opiates - the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, unless specifically excepted, if the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Acetyl-alpha-methylfentanyl (N-[1-(1-methyl-2-phenethyl)-4-piperidinyl]- N- phenylacetamide);

(2) Allylprodine;

(3) Alphacetylmethadol (except levo-alphacetylmethadol, also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM);

(4) Alpha-methylfentanyl or any other derivative of Fentanyl;

(5) Alpha-methylthiofentanyl (N-[1-methyl-2-(2-thienyl) ethyl-4-piperidinyl]-N- phenyl-propanamide);

(6) Benzethidine;

(7)Beta-hydroxyfentanyl (N-[1-(2-hydroxy-2-phenethyl)-4-piperidinyl]-N-phenyl-propanamide);

(8) Beta-hydroxy-3-methylfentanyl (N-[1-(2-hydroxy-2-phenethyl)-3-methyl- 4- piperidinyl]-N- phenylpropanamide);

(9) Betaprodine;

(10) Clonitazene;

(11) Diampromide;

(12) Diethylthiambutene;

(13) Difenoxin;

(14) Dimenoxadol;

(15) Dimethylthiambutene;

(16) Dioxaphetyl butyrate;

(17) Dipipanone;

(18) Ethylmethylthiambutene;

(19) Etonitazene;

(20) Etoxeridine;

(21) Furethidine;

(22) Hydroxypethidine;

(23) Ketobemidone;

(24) Levophenacylmorphan;

(25) Meprodine;

(26) Methadol;

(27) 3-methylfentanyl (N-[3-methyl-1-(2-phenylethyl)-4-piperidyl]-N- phenylpropanamide), its optical and geometric isomers;

(28) 3-methylthiofentanyl (N-[3-methyl-1-(2-thienyl)ethyl-4-piperidinyl]-N- phenylpropanamide);

(29) Moramide;

(30) Morpheridine;

(31) MPPP (1-methyl-4-phenyl-4-propionoxypiperidine);

(32) Noracymethadol;

(33) Norlevorphanol;

(34) Normethadone;

(35) Norpipanone;

(36) Para-fluorofentanyl (N-(4-fluorophenyl)-N-[1-(2-phenethyl)-4-piperidinyl]- propanamide);

(37) PEPAP (1-(2-phenethyl)-4-phenyl-4-acetoxypiperidine);

(38) Phenadoxone;

(39) Phenampromide;

(40) Phencyclidine;

(41) Phenomorphan;

(42) Phenoperidine;

(43) Piritramide;

(44) Proheptazine;

(45) Properidine;

(46) Propiram;

(47) Thiofentanyl (N-phenyl-N-[1-(2-thienyl)ethyl-4-piperidinyl]-propanamide);

(48) Tilidine; and

(49) Trimeperidine;

Schedule I opium derivatives - the following opium derivatives, their salts, isomers, and salts of isomers, unless specifically excepted, if the existence of these salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Acetorphine;

(2) Acetyldihydrocodeine;

(3) Benzylmorphine;

(4) Codeine methylbromide;

(5) Codeine-N-Oxide;

(6) Cyprenorphine;

(7) Desomorphine;

(8) Dihydromorphine;

(9) Drotebanol;

(10) Etorphine (except hydrochloride salt);

(11) Heroin;

(12) Hydromorphinol;

(13) Methyldesorphine;

(14) Methyldihydromorphine;

(15) Monoacetylmorphine;

(16) Morphine methylbromide;

(17) Morphine methylsulfonate;

(18) Morphine-N-Oxide;

(19) Myrophine;

(20) Nicocodeine;

(21) Nicomorphine;

(22) Normorphine;

(23) Pholcodine; and

(24) Thebacon;

Schedule I hallucinogenic substances - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following hallucinogenic substances or that contains any of the substance's salts, isomers, and salts of isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation (for the purposes of this Schedule I hallucinogenic substances section only, the term "isomer" includes optical, position, and geometric isomers):

(1) Alpha-ethyltryptamine (some trade or other names: etryptamine; Monase; alpha- ethyl-1H-indole-3-ethanamine; 3-(2-aminobutyl) indole; alpha-ET; AET);

(2) 4-bromo-2,5-dimethoxyamphetamine (some trade or other names: 4-bromo-2,5- dimethoxy-alpha-methylphenethylamine; 4-bromo-2,5-DMA);

(3) 4-bromo-2,5-dimethoxyphenethylamine (some trade or other names: Nexus; 2C-B; 2-(4-bromo-2,5-dimethoxyphenyl)-1-aminoethane; alpha-desmethyl DOB);

(4) 2,5-dimethoxyamphetamine (some trade or other names: 2,5-dimethoxy-alpha- methylphenethylamine; 2,5-DMA);

(5) 2,5-dimethoxy-4-ethylamphetamine (some trade or other names: DOET);

(6) 5-methoxy-3,4-methylenedioxy-amphetamine;

(7) 4-methoxyamphetamine (some trade or other names: 4-methoxy-alpha- methylphenethylamine; paramethoxyamphetamine; PMA);

(8) 1-methyl-4-phenyl-1,2,5,6-tetrahydro-pyridine (MPTP);

(9) 4-methyl-2,5-dimethoxyamphetamine (some trade and other names: 4-methyl-2,5- dimethoxy-alpha-methyl-phenethylamine; "DOM"; and "STP");

(10) 3,4-methylenedioxy-amphetamine;

(11) 3,4-methylenedioxy-methamphetamine (MDMA, MDM);

(12) 3,4-methylenedioxy-N-ethylamphetamine (some trade or other names: N-ethyl-alpha-methyl-3,4(methylenedioxy)phenethylamine; N-ethyl MDA; MDE; MDEA);

(13) 3,4,5-trimethoxy amphetamine;

(14) N-hydroxy-3,4-methylenedioxyamphetamine (Also known as N-hydroxy MDA);

(15) Bufotenine (some trade and other names: 3-(beta-Dimethylaminoethyl)-5- hydroxyindole; 3-(2-dimethylaminoethyl)-5-indolol; N,N-dimethylserotonin; 5-hydroxy- N,N-dimethyltryptamine; mappine);

(16) Diethyltryptamine (some trade and other names: N,N-Diethyltryptamine; DET);

(17) Dimethyltryptamine (some trade and other names: DMT);

(18) Ethylamine Analog of Phencyclidine (some trade or other names: N-ethyl-1- phenylcyclohexylamine; (1-phenylcyclohexyl) ethylamine; N-(1-phenylcyclohexyl)-ethylamine; cyclohexamine; PCE);

(19) Ibogaine (some trade or other names: 7-Ethyl-6,6-beta, 7,8,9,10,12,13-octhydro-2- methoxy-6,9-methano-5H-pyrido[1',2':1,2] azepino [5,4-b] indole; taber-nanthe iboga);

(20) Lysergic acid diethylamide;

(21) Marihuana;

(22) Mescaline;

(23) N-ethyl-3-piperidyl benzilate;

(24) N-methyl-3-piperidyl benzilate;

(25) Parahexyl (some trade or other names: 3-Hexyl-1-hydroxy-7,8,9,10-tetrahydro- 6,6,9-trimethyl-6H-dibenzo [b,d] pyran; Synhexyl);

(26) Peyote, unless unharvested and growing in its natural state, meaning all parts of the plant classified botanically as *Lophophora*, whether growing or not, the seeds of the plant, an extract from a part of the plant, and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or extracts;

(27) Psilocybin;

(28) Psilocin;

(29) Pyrrolidine analog of phencyclidine (some trade or other names: 1-(1-phenyl- cyclohexyl)-pyrrolidine, PCPy, PHP);

(30) Tetrahydrocannabinols;

(31) Synthetic equivalents of the substances contained in the plant *Cannabis*, or in the resinous extractives of that plant, and synthetic substances, derivatives, and their isomers with similar chemical structure and pharmacological activity such as: delta-1 cis or trans tetrahydrocannabinol, and their optical isomers; delta-6 cis or trans tetrahydrocannabinol, and their optical isomers; delta-3,4 cis or trans tetrahydrocannabinol, and its optical isomers; (Compounds of these structures, regardless of numerical designation of atomic positions, since nomenclature of these substances is not internationally standardized);

(32) Thiophene analog of phencyclidine (some trade or other names: 1-[1-(2-thienyl) cyclohexyl] piperidine; 2-thienyl analog of phencyclidine; TPCP); and

(33) 1-[1-(2-thienyl)cyclohexyl]pyrrolidine (some trade or other names: TCPy);

Schedule I stimulants - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances having a stimulant effect on the central nervous system, including the substance's salts, isomers, and salts of isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Aminorex (some other names: aminoxaphen; 2-amino-5-phenyl-2-oxazoline; 4,5-dihydro- 5-phenyl-2-oxazolamine);

(2) Cathinone (some trade or other names: 2-amino-1-phenyl-1-propanone; alpha- aminopropiophenone; 2-aminopropiophenone and norephedrone);

(3) Fenethylline;

(4) Methcathinone (some other names: 2-(methylamino)-propiophenone; alpha- (methylamino) propiophenone; 2-(methylamino)-1-phenylpropan-1-one; alpha-N-methylaminopropiophenone; monomethylpropion; ephedrone; N-methylcathinone; methylcathinone; AL-464; AL-422; AL-463; and UR1432);

(5) 4-methylaminorex;

(6) N-ethylamphetamine; and

(7) N,N-dimethylamphetamine (some other names: N,N-alpha-trimethylbenzene- ethaneamine; N,N-alpha-trimethylphenethylamine).

Schedule I depressants - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances having a depressant effect on the central nervous system, including the substance's salts, isomers, and salts of isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Gamma-hydroxybutyric acid (some other names include GHB; gamma-hydroxybutyrate; 4-hydroxybutyrate; 4-hydroxybutanoic acid; sodium oxybate; sodium oxybutyrate);

(2) Mecloqualone; and,

(3) Methaqualone.

SCHEDULE II

Schedule II consists of:

Schedule II substances, vegetable origin or chemical synthesis - the following substances, however produced, except those narcotic drugs listed in other schedules:

(1) Opium and opiate, and a salt, compound, derivative, or preparation of opium or opiate, other than thebaine-derived butorphanol, naloxone and its salts, naltrexone and its salts, and nalmefene and its salts, but including:

(1-1) Codeine;

*(1-2) Dihydroetorphine;

(1-3) Ethylmorphine;

(1-4) Etorphine hydrochloride;

(1-5) Granulated opium;

(1-6) Hydrocodone;

(1-7) Hydromorphone;

(1-8) Metopon;

(1-9) Morphine;

(1-10) Opium extracts;

(1-11) Opium fluid extracts;

(1-12) Oxycodone;

(1-13) Oxymorphone;

(1-14) Powdered opium;

(1-15) Raw opium;

(1-16) Thebaine; and,

(1-17) Tincture of opium;

(2) a salt, compound, isomer, derivative, or preparation of a substance that is chemically equivalent or identical to a substance described by Paragraph (1) of Schedule II substances, vegetable origin or chemical synthesis, other than the isoquinoline alkaloids of opium;

(3) Opium poppy and poppy straw;

(4) Cocaine, including:

(4-1) its salts, its optical, position, and geometric isomers, and the salts of those isomers; and,

(4-2) coca leaves and a salt, compound, derivative, or preparation of coca leaves that is chemically equivalent or identical to a substance described by this paragraph, other than decocainized coca leaves or extractions of coca leaves that do not contain cocaine or ecgonine; and,

(5) Concentrate of poppy straw, meaning the crude extract of poppy straw in liquid, solid, or powder form that contains the phenanthrene alkaloids of the opium poppy;

Opiates - the following opiates, including their isomers, esters, ethers, salts, and salts of isomers, if the existence of these isomers, esters, ethers, and salts is possible within the specific chemical designation:

(1) Alfentanil;

(2) Alphaprodine;

(3) Anileridine;

(4) Bezitramide;

(5) Carfentanil;

(6) Dextropropoxyphene, bulk (nondosage form);

(7) Dihydrocodeine;

(8) Diphenoxylate;

(9) Fentanyl;

(10) Isomethadone;

(11) Levo-alphacetylmethadol (some trade or other names: levo-alpha-acetylmethadol, levomethadyl acetate, LAAM);

(12) Levomethorphan;

(13) Levorphanol;

(14) Metazocine;

(15) Methadone;

(16) Methadone-Intermediate, 4-cyano-2-dimethylamino-4,4-diphenyl butane;

(17) Moramide-Intermediate, 2-methyl-3-morpholino-1,1-diphenyl-propane-carboxylic acid;

(18) Pethidine (meperidine);

(19) Pethidine-Intermediate-A, 4-cyano-1-methyl-4-phenylpiperidine;

(20) Pethidine-Intermediate-B, ethyl-4-phenylpiperidine-4-carboxylate;

(21) Pethidine-Intermediate-C, 1-methyl-4-phenylpiperidine-4-carboxylic acid;

(22) Phenazocine;

(23) Piminodine;

(24) Racemethorphan;

(25) Racemorphan;

(26) Remifentanil; and

(27) Sufentanil;

Schedule II stimulants - unless listed in another schedule and except as provided by the Texas Controlled Substances Act, Health and Safety Code, Section 481.033, a material, compound, mixture, or preparation that contains any quantity of the following substances having a potential for abuse associated with a stimulant effect on the central nervous system:

(1) Amphetamine, its salts, optical isomers, and salts of its optical isomers;

(2) Methamphetamine, including its salts, optical isomers, and salts of optical isomers;

(3) Methylphenidate and its salts; and,

(4) Phenmetrazine and its salts;

Schedule II depressants - unless listed in another schedule, a material, compound, mixture or preparation that contains any quantity of the following substances having a depressant effect on the central nervous system, including the substance's salts, isomers, and salts of isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Amobarbital;

(2) Glutethimide;

(3) Pentobarbital; and,

(4) Secobarbital;

Schedule II hallucinogenic substances

(1) Nabilone (Another name for nabilone: (±)-trans-3-(1,1-dimethylheptyl)-6,6a,7,8, 10,10a-hexahydro-1-hydroxy-6,6-dimethyl-9H-dibenzo[b,d]pyran-9-one);

Schedule II precursors - unless specifically excepted or listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances:

(1) Immediate precursor to methamphetamine:

(2) Phenylacetone and methylamine if possessed together with intent to manufacture methamphetamine;

(3) Immediate precursor to amphetamine and methamphetamine:

(4) Phenylacetone (some trade or other names: phenyl-2-propanone; P2P; benzyl methyl ketone; methyl benzyl ketone); and

(5) Immediate precursors to phencyclidine (PCP):

(6) 1-phenylcyclohexylamine; and,

(7) 1-piperidinocyclohexanecarbonitrile (PCC).

SCHEDULE III

Schedule III consists of:

Schedule III depressants - unless listed in another schedule and except as provided by the Texas Controlled Substances Act, Health and Safety Code, Section 481.033, a material, compound, mixture, or preparation that contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) a compound, mixture, or preparation containing amobarbital, secobarbital, pentobarbital, or any of their salts and one or more active medicinal ingredients that are not listed in a schedule;

(2) a suppository dosage form containing amobarbital, secobarbital, pentobarbital, or any of their salts and approved by the Food and Drug Administration for marketing only as a suppository;

(3) a substance that contains any quantity of a derivative of barbituric acid, or any salt of a derivative of barbituric acid, except those substances that are specifically listed in other schedules;

(4) Chlorhexadol;

(5) Any drug product containing gamma hydroxybutyric acid, including its salts, isoners, and salts of isomers, for which an application is approved under section 505 of the Federal Food Drug and Cosmetic Act:

(6) Ketamine, its salts, isomers, and salts of isomers. Some other names for ketamine: (±)-2-(2-chlorophenyl)-2-(methylamino)-cyclohexanone;

(7) Lysergic acid;

(8) Lysergic acid amide;

(9) Methyprylon;

(10) Sulfondiethylmethane;

(11) Sulfonethylmethane;

(12) Sulfonmethane; and

(13) Tiletamine and zolazepam or any salt thereof. Some trade or other names for a tiletamine-zolazepam combination product: Telazol. Some trade or other names for tiletamine: 2-(ethylamino)-2-(2-thienyl)-cyclohexanone. Some trade or other names for zolazepam: 4-(2-fluorophenyl)-6,8-dihydro-1,3,8-trimethyl-pyrazolo-[3,4-e][1,4]-diazepin-7(1H)-one, flupyrazapon;

Nalorphine

Schedule III narcotics - a material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any of their salts:

(1) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium;

(2) not more than 1.8 grams of codeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(3) not more than 300 milligrams of dihydrocodeinone (hydrocodone), or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium;

(4) not more than 300 milligrams of dihydrocodeinone (hydrocodone), or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(5) not more than 1.8 grams of dihydrocodeine, or any of its salts, per 100 milliliters or not more than 90 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

(6) not more than 300 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or not more than 15 milligrams per dosage unit, with

one or more active, non-narcotic ingredients in recognized therapeutic amounts;

(7) not more than 500 milligrams of opium per 100 milliliters or per 100 grams, or not more than 25 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts; and,

(8) not more than 50 milligrams of morphine, or any of its salts, per 100 milliliters or per 100 grams with one or more active, nonnarcotic ingredients in recognized therapeutic amounts;

Schedule III stimulants - unless listed in another schedule, a material, compound, mixture or preparation that contains any quantity of the following substances having a stimulant effect on the central nervous system, including the substance's salts, optical, position, or geometric isomers, and salts of the substance's isomers, if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Benzphetamine;

(2) Chlorphentermine;

(3) Clortermine; and,

(4) Phendimetrazine;

Schedule III anabolic steroids and hormones - anabolic steroids, including any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogens, progestins, and corticosteroids) that promotes muscle growth, and includes the following:

(1) Boldenone;

(2) Chlorotestosterone (4-chlortestosterone);

(3) Clostebol;

(4) Dehydrochlormethyltestosterone;

(5) Dihydrotestosterone (4-dihydrotestosterone);

(6) Drostanolone;

(7) Ethylestrenol;

(8) Fluoxymesterone;

(9) Formebolone;

(10) Mesterolone;

(11) Methandienone;

(12) Methandranone;

(13) Methandriol;

(14) Methandrostenolone;

(15) Methenolone;

(16) Methyltestosterone;

(17) Mibolerone;

(18) Nandrolone;

(19) Norethandrolone;

(20) Oxandrolone;

(21) Oxymesterone;

(22) Oxymetholone;

(23) Stanolone;

(24) Stanozolol;

(25) Testolactone;

(26) Testosterone; and

(27) Trenbolone.

Schedule III hallucinogenic substances

(1) Dronabinol (synthetic) in sesame oil and encapsulated in a soft gelatin capsule in U.S. Food and Drug Administration approved drug product. (Some other names for dronabinol: (6aR-trans)-6a,7,8,10a-tetrahydro-6,6,9-tri-methyl-3-pentyl-6H-dibenzo[b,d]pyran-1-ol, or (-)-delta-9-(trans)-tetrahydrocannabinol).

SCHEDULE IV

Schedule IV consists of:

Schedule IV depressants - except as provided by the Texas Controlled Substances Act, Health and Safety Code, Section 481.033, a material, compound, mixture, or preparation that contains any quantity of the following substances having a potential for abuse associated with a depressant effect on the central nervous system:

(1) Alprazolam;

(2) Barbital;

(3) Bromazepam;

(4) Camazepam;

(5) Chloral betaine;

(6) Chloral hydrate;

(7) Chlordiazepoxide;

(8) Clobazam;

(9) Clonazepam;

(10) Clorazepate;

(11) Clotiazepam;

(12) Cloxazolam;

(13) Delorazepam;

(14) Diazepam;

*(15) Dichloralphenazone;

(16) Estazolam;

(17) Ethchlorvynol;

(18) Ethinamate;

(19) Ethyl loflazepate;

(20) Fludiazepam;

(21) Flunitrazepam;

(22) Flurazepam;

(23) Halazepam;

(24) Haloxazolam;

(25) Ketazolam;

(26) Loprazolam;

(27) Lorazepam;

(28) Lormetazepam;

(29) Mebutamate;

(30) Medazepam;

(31) Meprobamate;

(32) Methohexital;

(33) Methylphenobarbital (mephobarbital);

(34) Midazolam;

(35) Nimetazepam;

(36) Nitrazepam;

(37) Nordiazepam;

(38) Oxazepam;

(39) Oxazolam;

(40) Paraldehyde;

(41) Petrichloral;

(42) Phenobarbital;

(43) Pinazepam;

(44) Prazepam;

(45) Quazepam;

(46) Temazepam;

(47) Tetrazepam;

(48) Triazolam;

(49) Zaleplon: and

(50) Zolpidem;

Schedule IV stimulants - unless listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances having a stimulant effect on the central nervous system, including the substance's salts, optical, position, or geometric isomers, and salts of those isomers if the existence of the salts, isomers, and salts of isomers is possible within the specific chemical designation:

(1) Cathine [(+)-norpseudoephedrine];

(2) Diethylpropion;

(3) Fencamfamin;

(4) Fenfluramine;

(5) Fenproporex;

(6) Mazindol;

(7) Mefenorex;

(8) Modafinil;

(9) Pemoline (including organometallic complexes and their chelates);

(10) Phentermine;

(11) Pipradrol;

(12) SPA [(-)-1-dimethylamino-1,2-diphenylethane]; and

(13) Sibutramine

Schedule IV narcotics - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation containing limited quantities of the following narcotic drugs or their salts:

(1) Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit; and

(2) Dextropropoxyphene (Alpha-(+)-4-dimethylamino-1,2-diphenyl-3-methyl-2- propionoxybutane).

Schedule IV other substances - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation that contains any quantity of the following substances, including the substance's salts:

(1) Butorphanol, including its optical isomers; and,

(2) Pentazocine, its salts, derivatives, compounds, or mixtures.

SCHEDULE V

Schedule V consists of:

Schedule V narcotics - unless specifically excepted or unless listed in another schedule, a material, compound, mixture, or preparation containing any of the following narcotic drugs and their salts:

(1) Buprenorphine;

Schedule V narcotics containing non-narcotic active medicinal ingredients - a compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs that also contain one or more nonnarcotic active medicinal ingredients in sufficient proportion to confer on the compound, mixture or preparation valuable medicinal qualities other than those possessed by the narcotic drug alone:

(1) Not more than 200 milligrams of codeine, or any of its salts, per 100 milliliters or per 100grams;

(2) Not more than 100 milligrams of dihydrocodeine, or any of its salts, per 100 milliliters or per 100 grams;

(3) Not more than 100 milligrams of ethylmorphine, or any of its salts, per 100 milliliters or per 100 grams;

(4) Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit;

(5) Not more than 15 milligrams of opium per 29.5729 milliliters or per 28.35 grams; and,

(6) Not more than 0.5 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit;

Schedule V stimulants - unless specifically exempted or excluded or unless listed in another schedule, a compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers and salts of isomers:

(1) Pyrovalerone.

TRD-200108100
Susan Steeg
General Counsel
Texas Department of Health
Filed: December 19, 2001

♦ ♦ ♦

Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission is submitting to the Centers for Medicare and Medicaid Services a Medicaid state plan amendment to provide for supplemental payment to eligible rural hospitals serving high volumes of Medicaid and uninsured patients.

The increase in aggregate annual expenditure for state fiscal year 2002 is estimated to be $14 million. Transfers from hospital districts will fund the state share.

For further information, contact Steve Lorenzen, Director of Medicaid Rate Setting, Texas Health and Human Services Commission, P.O. Box 13247, Austin, Texas 78711-3247, (512) 424-6633, steve.lorenzen@hhsc.state.tx.us.

TRD-200108101
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

♦ ♦ ♦

Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-04, Amendment Number 589.

The amendment replaces facility specific prospective per diem rates for state operated ICF/MRs with interim class per diem rates subject to cost settlement. The amendment is effective September 1, 2001.

If additional information is needed, please contact Deborah Hankey, Texas Department of Mental Health Mental Retardation at 512-206-5743.

TRD-200108102
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

♦ ♦ ♦

Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-05, Amendment Number 600.

The amendment revises the nursing facility reimbursement methodology relating to the enhanced direct care staffing rate. The amendment is effective July 1, 2001.

If additional information is needed, please contact Carolyn Pratt, Texas Department of Human Services at 512-438-4057.

TRD-200108103
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-06, Amendment Number 601.

The amendment revises the nursing facility reimbursement methodology to establish pediatric nursing facilities as a separate class for reimbursement. The amendment is effective September 1, 2001.

If additional information is needed, please contact Carolyn Pratt, Texas Department of Human Services at 512-438-4057.

TRD-200108104
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-08, Amendment Number 603.

The amendment updates the State Plan by increasing the personal needs allowance of institutionalized Medicaid recipients from $45.00 to $60.00. The amendment is effective September 1, 2001.

If additional information is needed, please contact Judy Coker, Texas Department of Human Services at 512-438-3227.

TRD-200108105
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-09, Amendment Number 604.

The amendment establishes a separate payment rate for veteran nursing facilities. The amendment is effective September 1, 2001.

If additional information is needed, please contact Pam McDonald, Texas Department of Human Services at 512-438-4086.

TRD-200108106
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-10, Amendment Number 605.

The amendment establishes an additional criterion that hospitals may use to qualify for disproportionate share hospital (DSH) payments. The amendment is effective September 1, 2001.

If additional information is needed, please contact Henry Welles, Health and Human Services Commission at 512-794-6858.

TRD-200108107
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-13, Amendment Number 608.

The amendment establishes a new optional Medicaid eligibility group for individuals who were in foster care under the conservatorship of the Texas Department of Protective and Regulatory Services on their 18th birthday. The amendment is effective September 1, 2001.

If additional information is needed, please contact Kathy Hall, Texas Department of Protective and Regulatory Services at 512-438-3678.

TRD-200108108
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-14, Amendment Number 609.

The amendment revises the rate determination methodology for Targeted Case Management for individuals receiving services from the Texas Department of Protective and Regulatory Services. The amendment is effective October 1, 2001.

If additional information is needed, please contact Kathy Hall, Texas Department of Protective and Regulatory Services at 512-438-3678.

TRD-200108109
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-15, Amendment Number 610.

The amendment modifies the Health and Human Services Commission (HHSC) Single State Agency's organizational structure to reflect the transition of the Texas Department of Health, Health Care Financing to HHSC. The amendment is effective September 1, 2001.

If additional information is needed, please contact Sharon Dobbs, Health and Human Services Commission 512-424-6569.

TRD-200108110
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-17, Amendment Number 612.

The amendment revises the nursing facility reimbursement methodology for the direct care staffing enhancement. The amendment allows nursing facilities located in high wage areas that fail to meet the staffing requirements to continue to be eligible for the enhancement if the nursing facilities can demonstrate the enhancement was spent on direct care staff. The amendment is effective September 1, 2001.

If additional information is needed, please contact Carolyn Pratt, Texas Department of Human Services at 512-438-4057.

TRD-200108111
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-21, Amendment Number 616.

The amendment specifies that the conversion factor for professional services will not be updated for the 2002/2003 biennium. The amendment is effective October 1, 2001.

If additional information is needed, please contact Joe Branton, Health and Human Services Commission at 512/424-6524.

TRD-200108112
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Public Notice

The Health and Human Services Commission State Medicaid Office has received approval from the Center for Medicare and Medicaid Services to amend the Title XIX Medical Assistance Plan by Transmittal Number 01-12, Amendment Number 607.

The amendment revises the reimbursement methodology for ICF/MR services. The amendment is effective October 1, 2001.

If additional information is needed, please contact Deborah Hankey, Texas Mental Health Mental Retardation, at 512/206-5743.

TRD-200108113
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

♦ ♦ ♦

Release of Publication: Long-Term Care Plan for Persons with Mental Retardation and Related Conditions

In accordance with its responsibilities as defined under the Texas Health and Safety Code, Section 533.062, the Texas Health and

Human Services Commission publishes this "Long-Term Care Plan for Persons with Mental Retardation and Related Conditions."

The report is available on the HHSC website at http://www.hhsc.state.tx.us beginning December 28, 2002. Interested parties may also obtain copies of the report at the offices of HHSC, 4900 North Lamar Boulevard, Fourth Floor, Austin, Texas, 78751.

TRD-200108114
Marina S. Henderson
Executive Deputy Commissioner
Texas Health and Human Services Commission
Filed: December 19, 2001

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Texas Department of Housing and Community Affairs

Multifamily Housing Revenue Bonds (Steeplechase Townhomes) Series 2002

Notice is hereby given of a public hearing to be held by the Texas Department of Housing and Community Affairs (the "Department") at the Brazoria County Library, 105 S. Gordon, Alvin, Texas 77511 at 6 p.m. on January 15, 2002 with respect to an issue of tax-exempt multifamily residential rental project revenue bonds in the aggregate principal amount not to exceed $12,507,831 and taxable bonds, if necessary, in an amount to be determined, to be issued in one or more series (the "Bonds"), by the Texas Department of Housing and Community Affairs (the "Issuer"). The proceeds of the Bonds will be loaned to Steeplechase Townhomes Limited Partnership, a limited partnership, or a related person or affiliate thereof (the "Borrower") to finance a portion of the costs of acquiring, constructing and equipping a multifamily housing project (the "Project") described as follows: 160-unit multifamily residential rental development to be constructed on approximately 20.95 acres of land located at the intersection of Nelson Road and Mustang Road in Alvin, Brazoria County, Texas 77511. The project will be initially owned and operated by the Borrower.

All interested parties are invited to attend such public hearing to express their views with respect to the Project and the issuance of the Bonds. Questions or requests for additional information may be directed to Robert Onion at the Texas Department of Housing and Community Affairs, 507 Sabine, Austin, Texas 78701; (512) 475-3872 and/or ronion@tdhca.state.tx.us.

Persons who intend to appear at the hearing and express their views are invited to contact Robert Onion in writing in advance of the hearing. Any interested persons unable to attend the hearing may submit their views in writing to Robert Onion prior to the date scheduled for the hearing.

Individuals who require auxiliary aids in order to attend this meeting should contact Gina Esteves, ADA Responsible Employee, at (512) 475-3943 or Relay Texas at 1 (800) 735-2989 at least two days before the meeting so that appropriate arrangements can be made.

TRD-200108057
Ruth Cedillo
Acting Executive Director
Texas Department of Housing and Community Affairs
Filed: December 18, 2001

♦ ♦ ♦

Houston-Galveston Area Council

Request for Proposal

AGENCY:

Houston-Galveston Area Council (H-GAC)

CONTACT:

Earl J. Washington

Sr. Transportation Planner

Houston-Galveston Area Council

3555 Timmons Lane, Suite 500

Houston, TX 77027-6426

(713) 993-2494

Description: The Houston-Galveston Area Council (H-GAC), as the Metropolitan Planning Organization (MPO), is requesting written proposals to conduct a comprehensive corridor analysis of the US90A Corridor from the Houston CBD to State Highway 36 Bypass in the cities of Richmond \ Rosenberg situated in Fort Bend County. The purpose of the study is to evaluate the future transportation needs of the corridor and assess the feasibility of implementing commuter rail as one transportation option for meeting these needs.

A pre-proposal meeting will be held on Thursday January 3, 2002 at H-GAC offices located at 3555 Timmons Lane, Houston, Texas 77027. The deadline for proposals to be received in the H-GAC offices is 4 p.m. central time Monday January 28, 2002.

Interested firms may obtain the Request for Proposal by contacting the H-GAC Transportation Department by phone at (713) 627-3200 or via the World Wide Web (www.hgac.cog.tx.us). For more information, please contact Alan Clark, MPO Director at (713) 993-4585.

TRD-200108097
Alan Clark
MPO Director
Houston-Galveston Area Council
Filed: December 19, 2001

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Texas Department of Insurance

Company Licensing

Application to change the name of BENEFIT LAND TITLE INSURANCE COMPANY to COMMERCE TITLE INSURANCE COMPANY, a foreign title company. The home office is in Santa Ana, California.

Application for incorporation to the State of Texas by HORIZONS LEGAL SERVICES, INC., a domestic prepaid legal company. The home office is in Houston, Texas.

Any objections must be filed with the Texas Department of Insurance, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas 78701.

TRD-200108091
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 19, 2001

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Notice

The Commissioner of Insurance, or his designee, will consider approval of a rate filing request submitted by Trinity Universal Insurance

Company of Kansas, Inc. proposing to use rates for private passenger automobile insurance that are outside the upper or lower limits of the flexibility band promulgated by the Commissioner of Insurance, pursuant to TEX. INS. CODE ANN. art 5.101 §3(g). The Company is requesting the following flex percent of +49% for Liability (Bodily Injury, Property Damage, UM, Medical payments, and PIP) and +46% for Physical Damage for all classes and territories. This overall rate change is +15.2%.

Copies of the filing may be obtained by contacting Judy Deaver, at the Texas Department of Insurance, Automobile/Homeowners Division, P.O. Box 149104, Austin, Texas 78714-9104, telephone (512) 322-3478.

This filing is subject to Department approval without a hearing unless a properly filed objection, pursuant to art. 5.101 §3(h), is made with the Chief Actuary for P&C, Mr. Phil Presley, at the Texas Department of Insurance, MC 105-5F, P.O. Box 149104, Austin, Texas 78701 by January 11, 2002.

TRD-200107853
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 13, 2001

♦ ♦ ♦

Notice of Application by a Small Employer Carrier to be a Risk-Assuming Carrier

Notice is given to the public of the application of the listed small employer carrier to be a risk-assuming carrier under Texas Insurance Code Article 26.52. A small employer carrier is defined by Chapter 26 of the Texas Insurance Code as a health insurance carrier that offers, delivers or issues for delivery, or renews small employer health benefit plans subject to the chapter. A risk-assuming carrier is defined by Chapter 26 of the Texas Insurance Code as a small employer carrier that elects not to participate in the Texas Health Reinsurance System. The following small employer carrier has applied to be a risk-assuming carrier:

United Healthcare Insurance Company.

The application is subject to public inspection at the offices of the Texas Department of Insurance, Legal & Compliance Division - Jimmy G. Atkins, 333 Guadalupe, Hobby Tower 1, 9th Floor, Austin, Texas.

If you wish to comment on the application to be a risk-assuming carrier, you must submit your written comments within 60 days after publication of this notice in the Texas Register to Lynda H. Nesenholtz, Chief Clerk, Mail Code 113-1C, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-91204. An additional copy of the comments must be submitted to Mike Boerner, Managing Actuary, Actuarial Division of the Financial Program, Mail Code 304-3A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. Upon consideration of the application, if the Commissioner is satisfied that all requirements of law have been met, the Commissioner or his designee may take action to approve the application to be a risk-assuming carrier.

TRD-200107943
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 14, 2001

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Notice of Public Hearing

The Commissioner of Insurance, at a public hearing under Docket No. 2510 scheduled for February 12, 2002 at 9:30 A.M., in Room 102 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street in Austin, Texas, will consider a proposal made in a staff petition, designated as "Second Petition...." Staff's petition seeks amendment of the Texas Automobile Rules and Rating Manual (the Manual), to adopt new and/or adjusted 2002 model Private Passenger Automobile Physical Damage Rating Symbols and revised identification information. Staff's petition (Ref. No. A-1201-22-I), was filed on December 13, 2001.

The new and/or adjusted symbols for the Manual's Symbols and Identification Section reflect data compiled on damageability, repairability, and other relevant loss factors for the listed 2002 model vehicles.

A copy of the petition, including an exhibit with the full text of the proposed amendments to the Manual is available for review in the office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas. For further information or to request copies of the petition, please contact Sylvia Gutierrez at (512) 463-6327; refer to (Ref. No. A-1201-22-I).

Comments on the proposed changes must be submitted in writing within 30 days after publication of the proposal in the Texas Register, to the Office of the Chief Clerk, Texas Department of Insurance, P. O. Box 149104, MC 113-2A, Austin, Texas 78714-9104. An additional copy of comments is to be submitted to Marilyn Hamilton, Associate Commissioner, Property & Casualty Program, Texas Department of Insurance, P. O. Box 149104, MC 104-PC, Austin, Texas 78714-9104.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Government Code, Chapter 2001 (Administrative Procedure Act).

This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

TRD-200107900
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 14, 2001

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Notice of Public Hearing

The Commissioner of Insurance will hold a public hearing under Docket 2512 on Thursday, January 10, 2002, at 1:00 p.m. in Room 102 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas.

The purpose of this hearing is to consider a grievance filed on October 3, 2001 by the Center for Economic Justice relating to the approval of Progressive County Mutual Insurance Company's Personal Auto Endorsement, Loan/Lease Payoff Coverage Endorsement Form No. 9817TX, TDI File No. 92212419554, Link No. 59718. In the filing, Progressive County Mutual Insurance Company sought approval of a Loan/Lease Payoff Coverage Endorsement for optional use with the Texas Personal Auto Policy, In general, the Loan/Lease Payoff Coverage Endorsement provides coverage that pays, in the event of a total loss, the difference between the actual cash value of the automobile and the outstanding loan or lease balance. The filing was approved on September 28, 2001 pursuant to Insurance Code Article 5.06. The hearing will be held pursuant Insurance Code Article 5.11. Interested parties are invited to attend and participate. Individuals who wish to present comments at the hearing will be asked to register immediately prior to the hearing.

The request for hearing filed by Mr. Birnbaum is subject to public inspection. Copies may be obtained from the Office of the Chief Clerk, Texas Department of Insurance, William P. Hobby, Jr. State Office building, 333 Guadalupe Street, Tower 1, 13th Floor, Austin, Texas.

TRD-200108071
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 18, 2001

♦ ♦ ♦

Notice of Public Hearing

The Commissioner of Insurance at a public hearing under Docket No. 2511 scheduled for February 12, 2002 at 9:30 a.m. in Room 100 of the William P. Hobby Building, 333 Guadalupe Street in Austin, Texas will consider adoption of the Texas - Audit Additional Premium and Retrospective Additional Premium Endorsement WC 42 04 07 contained in the Texas Basic Manual of Rules, Classifications and Experience Rating Plan for Workers' Compensation and Employers' Liability Insurance (the Manual) proposed by the staff of the Workers' Compensation Division. The Manual provides insurers licensed in Texas to write workers' compensation insurance with the rules, classifications endorsements, forms and experience-rating plan applicable to Texas workers' compensation policies. Staff's petition (Ref. No. W-1201-23-I), was filed on December 14, 2001.

This endorsement is proposed to establish a due date for audit additional premiums and retrospective additional premiums pursuant to the National Association of Insurance Commissioners (NAIC) Statement of Statutory Accounting Principles (SSAP) No. 6. According to SSAP No. 6, the policy or contract provisions governing the audit premiums and retrospective premiums must address the due date for these types of premium if the uncollected premium (either accrued or billed) is considered as an admitted asset by the insurance company.

The Commissioner has jurisdiction over this matter pursuant to the Insurance Code, Articles 5.56, 5.57 and 5.96.

A copy of the full text of the proposed endorsement is available for review in the Office of the Chief Clerk of the Texas Department of Insurance, 333 Guadalupe Street, Austin, Texas 78714-9104. For further information or to request a copy of the proposed endorsement, please contact Ms. Sylvia Gutierrez (512) 463-6327 (refer to Ref. No. W-W-12-01-23-I)

The staff and the Commissioner request that written comments to this proposed endorsement be submitted prior to the public hearing on February 12, 2002. The written comments should be directed to Lynda H. Nesenholtz, General Counsel and Chief Clerk, Texas Department of Insurance, P. O. box 149104, MC 113-2A, Austin, Texas 78714-9104. An additional copy of the comments should be submitted to Nancy Moore, Deputy Commissioner, Workers' Compensation, Texas Department of Insurance, P. O. Box 149104, MC 105-2A, Austin, Texas 78714-9104. Public testimony at the hearing on February 12, 2002 is also invited and encouraged.

This notification is made pursuant to the Insurance Code, Article 5.96, which exempts it from the requirements of the Government code, Chapter 2001 (Administrative Procedure Act).

TRD-200108072
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 18, 2001

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Third Party Administrator Applications

The following third party administrator (TPA) applications have been filed with the Texas Department of Insurance and are under consideration.

Application for admission to Texas of Herbert V. Friedman, Inc., a foreign third party administrator. The home office is Rockeville Centre, New York.

Any objections must be filed within 20 days after this notice was filed with the Secretary of State, addressed to the attention of Charles M. Waits, MC 107-5A, 333 Guadalupe, Austin, Texas 78714-9104.

TRD-200108095
Lynda H. Nesenholtz
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 19, 2001

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Texas Lottery Commission

Instant Game No. 273 "Ride to Riches"

1.0 Name and Style of Game.

A. The name of Instant Game No. 273 is "RIDE TO RICHES". The play style is "beat score".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 273 shall be $1.00 per ticket.

1.2 Definitions in Instant Game No. 273.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - One of the symbols which appears under the Latex Overprint on the front of the ticket. Each Play Symbol is printed in Symbol font in black ink in positive. The possible play symbols are: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $25.00, $50.00, and $5,000.

D. Play Symbol Caption - the small printed material appearing below each Play Symbol which explains the Play Symbol. One and only one of these Play Symbol Captions appears under each Play Symbol and each is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Table 1 of this section Figure 1:16 TAC GAME NO. 273 - 1.2D

Figure 1: GAME NO. 273 - 1.2D

PLAY SYMBOL	CAPTION
1	ONE
2	TWO
3	THR
4	FOR
5	FIV
6	SIX
7	SVN
8	EGT
9	NIN
10	TEN
11	ELV
12	TLV
13	TRN
14	FTN
15	FFN
16	SXN
$1.00	ONE$
$2.00	TWO$
$4.00	FOUR$
$5.00	FIVE$
$10.00	TEN$
$20.00	TWENTY
$25.00	TWY FIV
$50.00	FIFTY
$5,000	FIV THOU

Table 2 of this section. Figure 2:16 TAC GAME NO. 273 - 1.2E

E. Retailer Validation Code - Three small letters found under the removable scratch-off covering in the play area, which retailers use to verify and validate instant winners. The possible validation codes are:

Figure 2: GAME NO. 273 .2E

CODE	PRIZE
$1.00	ONE
$2.00	TWO
$4.00	FOR
$5.00	FIV
$10.00	TEN
$20.00	TWN

Low-tier winning tickets use the required codes listed in Figure 2:16. Non-winning tickets and high-tier tickets use a non-required combination of the required codes listed in Figure 2:16 with the exception of ∅, which will only appear on low-tier winners and will always have a slash through it.

F. Serial Number - A unique 13 digit number appearing under the latex scratch-off covering on the front of the ticket. There is a four (4) digit security number which will be boxed and placed randomly within the Serial Number. The remaining nine (9) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The format will be : 0000000000000.

G. Low-Tier Prize - A prize of $1.00, $2.00, $4.00, $5.00, $10.00, or $20.00.

H. Mid-Tier Prize - A prize of $50.00, or $100.

I. High-Tier Prize - A prize of $5,000.

J. Bar Code - A 22 character interleaved two (2) of five (5) bar code which will include a three (3) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the nine (9) digit Validation Number. The bar code appears on the back of the ticket.

K. Pack-Ticket Number - A twenty-two (22) digit number consisting of the three (3) digit game number (273), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 000 and end with 249 within each pack. The format will be: 273-0000001-000.

L. Pack - A pack of "RIDE TO RICHES" Instant Game tickets contain 250 tickets, which are packed in plastic shrink-wrapping and fanfolded in pages of five (5). Tickets 000 to 004 will be on the top page; tickets 005 to 009 on the next page; etc.; and tickets 245 to 249 will be on the last page. Tickets 000 and 249 will be folded down to expose the pack-ticket number through the shrink-wrap.

M. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401.

N. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "RIDE TO RICHES" Instant Game No. 273 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery Rule 401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "RIDE TO RICHES" Instant Game is determined once the latex on the ticket is scratched off to expose 12 (twelve) play symbols. If the player's YOUR SCORE beats the THEIR SCORE within an event, the player will win the prize shown for that event. No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 12 (twelve) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 12 (twelve) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 12 (twelve) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures.

17. Each of the 12 (twelve) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets will not have identical play data, spot for spot.

B. No duplicate Your Score play symbols on a ticket.

C. No duplicate Their Score play symbols on a ticket.

D. No duplicate non-winning prize symbols on a ticket.

E. No ties between the Your Score play symbol and the Their Score play symbol in an event on a ticket.

2.3 Procedure for Claiming Prizes.

A. To claim a "RIDE TO RICHES" Instant Game prize of $1.00, $2.00, $4.00, $5.00, $10.00, $20.00, $50.00, or $100, a claimant shall sign the back of the ticket in the space designated on the ticket and present

the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not, in some cases, required to pay a $50.00 or $100 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and 2.3.C of these Game Procedures.

B. To claim a "RIDE TO RICHES" Instant Game prize of $5,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "RIDE TO RICHES" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The risk of sending a ticket remains with the claimant. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct a sufficient amount from the winnings of a person who has been finally determined to be:

1. delinquent in the payment of a tax or other money collected by the Comptroller, the Texas Workforce Commission, or Texas Alcoholic Beverage Commission;

2. delinquent in making child support payments administered or collected by the Attorney General; or

3. delinquent in reimbursing the Texas Department of Human Services for a benefit granted in error under the food stamp program or the program of financial assistance under Chapter 31, Human Resource Code;

4. in default on a loan made under Chapter 52, Education Code; or

5. in default on a loan guaranteed under Chapter 57, Education Code

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "RIDE TO RICHES" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of more than $600 from the "RIDE TO RICHES" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game. Any prize not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated therefor, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated therefor, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated therefor. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 14,888,000 tickets in the Instant Game No. 273. The approximate number and value of prizes in the game are as follows:

Table 3 of this section Figure 3:16 TAC GAME NO. 273- 4.0

Figure 3: GAME NO. 273 - 4.0

Prize Amount	Approximate Number of Prizes*	Approximate Odds are 1 in **
$1.00	1,846,168	8.06
$2.00	535,968	27.78
$4.00	357,368	41.66
$5.00	119,298	124.80
$10.00	89,203	166.90
$20.00	59,552	250.00
$50.00	22,199	670.66
$100	6,225	2,391.65
$5,000	35	425,371.43

*The number of actual prizes may vary based on sales, distribution, testing, and number of prizes claimed.

**The overall odds of winning a prize are 1 in 4.90. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 273 without advance notice, at which point no further tickets in that game may be sold.

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 273, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC, Chapter 401, and all final decisions of the Executive Director.

TRD-200107892
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: December 14, 2001

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Texas Natural Resource Conservation Commission

Enforcement Orders

A default order was entered regarding HADEN E. ARCHER, Docket Number 2000-0488-OSI-E on December 10, 2001 assessing $3,125 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JOSHUA OLSZEWSKI, Staff Attorney at (512) 239-3645, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding TARRANT COUNTY PROCESSORS, INC., Docket Number 2000-1283-AIR-E on December 10, 2001 assessing $6,250 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting BILL DAVIS, Enforcement Coordinator at (512) 239-6793, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PANACO, INC., Docket Number 2001-0413-AIR-E on December 10, 2001 assessing $5,400 in administrative penalties with $1,080 deferred.

Information concerning any aspect of this order may be obtained by contacting TRINA GRIECO, Enforcement Coordinator at (713) 767-3607, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SANDY CREEK YACHT CLUB, L.P. DBA SANDY CREEK MARINA, Docket Number 2001-0751-PWS-E on December 10, 2001 assessing $2,000 in administrative penalties with $400 deferred.

Information concerning any aspect of this order may be obtained by contacting SHAWN STEWART, Enforcement Coordinator at (512) 239-6684, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding CHEM-PRUF DOOR CO., LTD., Docket Number 2001-0507-AIR-E on December 10, 2001 assessing $2,700 in administrative penalties with $540 deferred.

Information concerning any aspect of this order may be obtained by contacting SANDRA ALANIZ, Enforcement Coordinator at (956) 430-6044, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding T. B .MORAN COMPANY, Docket Number 2001-0669-MLM-E on December 10, 2001 assessing $2,250 in administrative penalties with $200 deferred.

Information concerning any aspect of this order may be obtained by contacting CAROL MCGRATH, Enforcement Coordinator at (361) 825-3275, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ASSA ABLOY DOOR GROUP, LLC, Docket Number 2001-0646-IHW-E on December 10, 2001 assessing $6,250 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JAIME GARZA, Enforcement Coordinator at (956) 430-6030, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PLEASURE POINT WATER SUPPLY CORPORATION, Docket Number 2001-0428-PWS-E on December 10, 2001 assessing $125 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting SHEILA SMITH, Enforcement Coordinator at (512) 239-1670, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding HARRIS COUNTY WATER CONTROL & IMPROVEMENT DISTRICT NO. 1, Docket Number 2001-0300-MWD-E on December 10, 2001 assessing $7,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting SHAWN STEWART, Enforcement Coordinator at (512) 239-6684, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding LAKE NAVIGATION COMPANY, Docket Number 2001-0106-PWS-E on December 10, 2001 assessing $876 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting LAWRENCE KING, Enforcement Coordinator at (512) 339-2929, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding TOWN OF VAN HORN, Docket Number 2000-1428-MWD-E on December 10, 2001 assessing $4,000 in administrative penalties with $800 deferred.

Information concerning any aspect of this order may be obtained by contacting BETHANY CARL, Enforcement Coordinator at (915) 834-4965, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding DOUGLAS UTILITY COMPANY, Docket Number 2001-0234-MWD-E on December 10, 2001 assessing $9,000 in administrative penalties with $1,800 deferred.

Information concerning any aspect of this order may be obtained by contacting TONI TOLIVER, SEP Coordinator at (512) 239-6122, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding CARROLL WATER SUPPLY CORPORATION, Docket Number 2000-1340-PWS-E on December 10, 2001 assessing $638 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting TONI TOLIVER, SEP Coordinator at (512) 239-6122, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding BAILEY CHOATE, Docket Number 2001-0778-MSW-E on December 10, 2001 assessing $2,000 in administrative penalties with $400 deferred.

Information concerning any aspect of this order may be obtained by contacting CAROLYN EASLEY, Enforcement Coordinator at (915) 698-9674, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ROLANDO ZAMORA DBA D&D WASTE OIL SERVICE, Docket Number 2001-0749-MSW-E on December 10, 2001 assessing $250 in administrative penalties with $50 deferred.

Information concerning any aspect of this order may be obtained by contacting TOM GREIMEL, Enforcement Coordinator at (512) 239-5690, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding WINNER'S CORNERS INC. DBA WINNER'S CORNER NO. 2, Docket Number 2001-0533-PST-E on December 10, 2001 assessing $900 in administrative penalties with $180 deferred.

Information concerning any aspect of this order may be obtained by contacting CATHERINE ALBRECHT, Enforcement Coordinator at (713) 767-3672, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding 7 ELEVEN INC., Docket Number 2001-0648-PST-E on December 10, 2001 assessing $7,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JUDY FOX, Enforcement Coordinator at (817) 588-5825, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MR. KENNETH HADDAD & MR. MAYNARD HADDAD DBA H&H CAR WASH, Docket Number 2001-0094-AIR-E on December 10, 2001 assessing $1,800 in administrative penalties with $360 deferred.

Information concerning any aspect of this order may be obtained by contacting MERRILEE GERBERDING, Enforcement Coordinator at (512) 239-4490, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding DUKE & LONG DISTRIBUTING COMPANY, INC., Docket Number 2001-0247-EAQ-E on December 10, 2001 assessing $15,625 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting REBECCA CLAUSEWITZ, Enforcement Coordinator at (210) 403-4012, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding BENNETT SHORTES, Docket Number 2001-0656-OSS-E on December 10, 2001 assessing $875 in administrative penalties with $175 deferred.

Information concerning any aspect of this order may be obtained by contacting CARL SCHNITZ, Enforcement Coordinator at (512) 239-1892, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding TWIN COVES WATER SUPPLY CORPORATION, Docket Number 2001-0267-PWS-E on December 10, 2001 assessing $4,813 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JORGE IBARRA, Enforcement Coordinator at (817) 588-

5890, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding OGRE, INC. DBA THE MUR-TEX COMPANY, Docket Number 2000-1292-AIR-E on December 10, 2001 assessing $12,500 in administrative penalties with $2,500 deferred.

Information concerning any aspect of this order may be obtained by contacting TONI TOLIVER, SEP Coordinator at (512) 239-6122, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MEDINA LIVESTOCK SALES CO., LTD. DBA LAS AVES RV RESORT, Docket Number 2001-0254-PWS-E on December 10, 2001 assessing $2,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting REBECCA CLAUSEWITZ, Enforcement Coordinator at (210) 403-4012, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MR. RICK FREDERICK DBA WALNUT GROVE WATER SYSTEM, Docket Number 2001-0530-PWS-E on December 10, 2001 assessing $125 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting DAVID VAN SOEST, Enforcement Coordinator at (512) 239-0468, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SETTLERS WATER DISTRICT INC., Docket Number 2001-0561-PWS-E on December 10, 2001 assessing $150 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting DAVID VAN SOEST, Enforcement Coordinator at (512) 239-0468, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding MR. DAVID A. FENOGLIO & MR. EDWARD A. FENOGLIO DBA PERRIN WATER SYSTEM AND DBA SUNSET WATER SYSTEM, Docket Number 2001-0491-PWS-E on December 10, 2001 assessing $250 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting DAVID VAN SOEST, Enforcement Coordinator at (512) 239-0468, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding KOCH MIDSTREAM SERVICES COMPANY LLC, Docket Number 2001-0456-AIR-E on December 10, 2001 assessing $2,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JAMES JACKSON, Enforcement Coordinator at (254) 751-0335, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding YOUNG MATERIALS CORP, Docket Number 2001-0097-AIR-E on December 10, 2001 assessing $1,500 in administrative penalties with $300 deferred.

Information concerning any aspect of this order may be obtained by contacting SUSAN JOHNSON, Enforcement Coordinator at (512) 239-2555, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RAY SMITH DBA SOUTHERN PROTECTIVE COATINGS, Docket Number 2001-0002-AIR-E on December 10, 2001 assessing $6,250 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting TERRY MURPHY, Enforcement Coordinator at (512) 239-5025, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding WILLIAMS CONCRETE PRODUCTS INCORPORATED, Docket Number 2000-1290-AIR-E on December 10, 2001 assessing $2,500 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting SUZANNE WALRATH, Enforcement Coordinator at (512) 239-2134, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding CITY OF EL PASO, Docket Number 2001-0099-AIR-E on December 10, 2001 assessing $900 in administrative penalties with $180 deferred.

Information concerning any aspect of this order may be obtained by contacting TONI TOLIVER, SEP Coordinator at (512) 239-6122, Texas Natural Resource Conservation Commission, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-200108086
LaDonna Castañuela
Chief Clerk
Texas Natural Resource Conservation Commission
Filed: December 19, 2001

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Notice of District Petition

Notices mailed during the period November 17, 2001 through December 12, 2001.

TNRCC Internal Control 07312001-D04; B & T Realty Services, Inc., and G & G Development Partnership, Ltd., (Petitioners) have filed a petition for the creation of Lancaster Municipal Utility District No. 1 (District) with the Texas Natural Resource Conservation Commission (TNRCC). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TNRCC. The petition states that: (1) the Petitioners are the owners of a majority in value of the land to be included in the proposed District; (2) the petition states that there are no lien holders on the property to be included in the proposed District; (3) the proposed District will contain approximately 326.98 acres located within Dallas County, Texas; and (4) the proposed District is in the extraterritorial jurisdiction of the City of Lancaster, Texas. By Resolution No. 22-01, effective May 14, 2001, the City of Lancaster passed, approved and gave its consent to create District, and has given its authorization to initiate proceedings to create such political subdivision within its jurisdiction. According to the petition, a preliminary investigation has been made to determine the cost of the project, and it is estimated by the Petitioners, from the information available at this time, that the cost of said project will be approximately $18,680,000.

The TNRCC may grant a contested case hearing on this petition if a written hearing request is filed within 30 days after the newspaper publication of this notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the petitioner and the TNRCC Internal Control Number; (3) the statement "I/we request a contested case

hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed district's boundaries. You may also submit your proposed adjustments to the petition which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below.

The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TNRCC Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court.

Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TNRCC, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, the same address. For additional information, individual members of the general public may contact the Office of Public Assistance, at 1-800-687-4040. General information regarding the TNRCC can be found at our web site at www.tnrcc.state.tx.us.

TRD-200108087
LaDonna Castañuela
Chief Clerk
Texas Natural Resource Conservation Commission
Filed: December 19, 2001

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Proposal for Decision

The State Office Administrative Hearing (SOAH) issued a Proposal for Decision and Order to the Texas Natural Resource Conservation Commission (TNRCC) on December 6, 2001, Executive Director of the Texas Natural Resource Conservation Commission, Petitioner v. Harry Trippet; Respondent; SOAH Docket Number 582-01-2454; TNRCC Docket Number 1998-1378-OSI-E. In the matter to be considered by the Texas Natural Resource Conservation Commission on a date and time to be determined by the Chief Clerk's Office in Room 201S of Building E, 12118 North Interstate 35, Austin, Texas. This posting is Notice of Opportunity to Comment on the Proposal for Decision and Order. The comment period will end 30 days from date of publication. Written public comments should be submitted to the Office of the Chief Clerk, MC-105, TNRCC, P.O. Box 13087, Austin, Texas 78711-3087. If you have any questions or need assistance, please contact Doug Kitts, Chief Clerk's Office, (512) 239-3317.

TRD-200108088
Douglas A. Kitts
Agenda Coordinator
Texas Natural Resource Conservation Commission
Filed: December 19, 2001

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Proposal for Decision

The State Office Administrative Hearing (SOAH) issued a Proposal for Decision and Order to the Texas Natural Resource Conservation Commission (TNRCC) on December 5, 2001, Executive Director of the Texas Natural Resource Conservation Commission, Petitioner v. Rheem Manufacturing Company; Respondent; SOAH Docket Number 582-00-2100; TNRCC Docket Number 1999-0432-IHW-E. In the matter to be considered by the Texas Natural Resource Conservation Commission on a date and time to be determined by the Chief Clerk's Office in Room 201S of Building E, 12118 North Interstate 35, Austin, Texas. This posting is Notice of Opportunity to Comment on the Proposal for Decision and Order. The comment period will end 30 days from date of publication. Written public comments should be submitted to the Office of the Chief Clerk, MC-105, TNRCC, P.O. Box 13087, Austin, Texas 78711-3087. If you have any questions or need assistance, please contact Doug Kitts, Chief Clerk's Office, (512) 239-3317.

TRD-200108089
Douglas A. Kitts
Agenda Coordinator
Texas Natural Resource Conservation Commission
Filed: December 19, 2001

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Texas Parks and Wildlife Department

Notice of Consultant Contract Award

This consultant selection report is filed in accordance with the provisions of Texas Government Code, §2254.030. The consultant proposal request was published in the November 2, 2001, issue of the *Texas Register* (26 TexReg 8911).

The consultant shall conduct a comprehensive management audit to include examination of issues raised by the State Auditor's Office, analysis of financial and business practices employed by the department, review of proposed fee increases, and identification of strategic issues to be addressed by a new Executive Director.

The name and address of the consultant is Elton Bomer, 1199 F.M.837. Montalba, Texas 75853. The total value of this award is $162,000. The services are expected to be completed by March 31, 2002.

TRD-200107877
Gene McCarty
Chief of Staff
Texas Parks and Wildlife Department
Filed: December 13, 2001

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Public Utility Commission of Texas

Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On December 11, 2001, NOW Communications, Inc. filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60167. Applicant intends to remove the resale-only restriction.

The Application: Application of NOW Communications, Inc. for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 25070.

Persons with questions about this docket, or who wish to intervene or otherwise participate in these proceedings should make appropriate filings or comments to the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326 no later than January 3, 2002. You may contact the commission's Customer Protection Division at (512) 936-7120. Hearing and speech- impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25070.

TRD-200107845

Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On December 13, 2001, FairPoint Communications Solutions Corp. filed an application with the Public Utility Commission of Texas (PUC) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60334. Applicant intends to relinquish its certificate.

The Application: Application of FairPoint Communications Solutions Corp. for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 25158.

Persons with questions about this docket, or who wish to intervene or otherwise participate in these proceedings should make appropriate filings or comments to the Public Utility Commission of Texas, at P.O. Box 13326, Austin, Texas 78711-3326 no later than January 3, 2002. You may contact the PUC Customer Protection Division at (512) 936-7120. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25158.

TRD-200107895
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 14, 2001

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Notice of Application for Service Provider Certificate of Operating Authority

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) of an application on December 12, 2001, for a service provider certificate of operating authority (SPCOA), pursuant to §§54.151 - 54.156 of the Public Utility Regulatory Act (PURA). A summary of the application follows.

Docket Title and Number: Application of Communica Incorporated for a Service Provider Certificate of Operating Authority, Docket Number 25156 before the Public Utility Commission of Texas.

Applicant intends to provide plain old telephone service.

Applicant's requested SPCOA geographic area includes the area of Texas currently served by Southwestern Bell Telephone Company.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326, or call the commission's Customer Protection Division at (512) 936-7120 no later than January 3, 2002. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136.

TRD-200107850
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Notice of Application for Service Provider Certificate of Operating Authority

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on December 13, 2001, for a service provider certificate of operating authority (SPCOA), pursuant to §§54.151 - 54.156 of the Public Utility Regulatory Act (PURA). A summary of the application follows.

Docket Title and Number: Application of Southern Telecom, Inc. for a Service Provider Certificate of Operating Authority, Docket Number 25161 before the Public Utility Commission of Texas.

Applicant intends to provide Optical Services, and Dark Fiber, Inner Ducts, and Conduit.

Applicant's requested SPCOA geographic area includes the entire State of Texas.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas, at P.O. Box 13326, Austin, Texas 78711-3326, or call the commission's Customer Protection Division at (512) 936-7120 no later than January 3, 2002. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136.

TRD-200107896
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 14, 2001

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Notice of Notification of Relinquishment of a Service Provider Certificate of Operating Authority

On November 7, 2001, beMANY! filed notification with the Public Utility Commission of Texas (commission) to relinquish its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60407. Applicant intends to relinquish its certificate.

The Application: Notification of beMANY! to Relinquish its Service Provider Certificate of Operating Authority, Docket Number 25006.

Persons with questions about this docket, or who wish to intervene or otherwise participate in these proceedings should make appropriate filings or comments to the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326 no later than January 3, 2002. You may contact the commission's Customer Protection Division at (512) 936-7120. Hearing and speech- impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25006.

TRD-200107893
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 14, 2001

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Public Notice of Amendment to Interconnection Agreement

On December 10, 2001, United Telephone Company of Texas, Inc. doing business as Sprint, Central Telephone Company of Texas doing business as Sprint (collectively, Sprint), and IG2, Inc., formerly

Computer Business Sciences, Inc., collectively referred to as applicants, filed a joint application for approval of amendment to an existing interconnection agreement under Section 252(i) of the federal Telecommunications Act of 1996, Public Law Number 104-104, 110 Statute 56, (codified as amended in scattered sections of 15 and 47 United States Code) (FTA) and the Public Utility Regulatory Act, Texas Utilities Code Annotated, Chapters 52 and 60 (Vernon 1998 & Supplement 2002) (PURA). The joint application has been designated Docket Number 25145. The joint application and the underlying interconnection agreement are available for public inspection at the commission's offices in Austin, Texas.

The commission must act to approve the interconnection agreement within 35 days after it is submitted by the parties.

The commission finds that additional public comment should be allowed before the commission issues a final decision approving or rejecting the amendment to the interconnection agreement. Any interested person may file written comments on the joint application by filing ten copies of the comments with the commission's filing clerk. Additionally, a copy of the comments should be served on each of the applicants. The comments should specifically refer to Docket Number 25145. As a part of the comments, an interested person may request that a public hearing be conducted. The comments, including any request for public hearing, shall be filed by January 7, 2002, and shall include:

1) a detailed statement of the person's interests in the agreement, including a description of how approval of the agreement may adversely affect those interests;

2) specific allegations that the agreement, or some portion thereof:

a) discriminates against a telecommunications carrier that is not a party to the agreement; or

b) is not consistent with the public interest, convenience, and necessity; or

c) is not consistent with other requirements of state law; and

3) the specific facts upon which the allegations are based.

After reviewing any comments, the commission will issue a notice of approval, denial, or determine whether to conduct further proceedings concerning the joint application. The commission shall have the authority given to a presiding officer pursuant to P.U.C. Procedural Rule §22.202. The commission may identify issues raised by the joint application and comments and establish a schedule for addressing those issues, including the submission of evidence by the applicants, if necessary, and briefing and oral argument. The commission may conduct a public hearing. Interested persons who file comments are not entitled to participate as intervenors in the public hearing.

Persons with questions about this project or who wish to comment on the joint application should contact the Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326. You may call the commission's Customer Protection Division at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25145.

TRD-200107847
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Public Notice of Intent to File Pursuant to P.U.C. Substantive Rule §26.215

Notice is given to the public of the filing with the Public Utility Commission of Texas of a long run incremental cost (LRIC) study pursuant to P.U.C. Substantive Rule §26.215.

Docket Title and Number. Southwestern Bell Telephone Company's Application for Approval of LRIC Study for Private Line Service (Interoffice Channel Termination) Pursuant to P.U.C. Substantive Rule §26.215 on or about December 27, 2001, Docket Number 25168.

Any party that demonstrates a justiciable interest may file with the administrative law judge, written comments or recommendations concerning the LRIC study referencing Docket Number 25168. Written comments or recommendations should be filed no later than 45 days after the date of sufficiency and should be filed at the Public Utility Commission of Texas, 1701 North Congress Avenue, P. O. Box 13326, Austin, Texas 78711-3326. You may call the Public Utility Commission Customer Protection Division at (512) 936-7120. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

TRD-200108042
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 17, 2001

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Public Notice of Interconnection Agreement

On December 6, 2001, Southwestern Bell Telephone Company and CityNet Telecommunications, Inc., collectively referred to as applicants, filed a joint application for approval of interconnection agreement under Section 252(i) of the federal Telecommunications Act of 1996, Public Law Number 104-104, 110 Statute 56, (codified as amended in scattered sections of 15 and 47 United States Code) (FTA) and the Public Utility Regulatory Act, Texas Utilities Code Annotated, Chapters 52 and 60 (Vernon 1998 & Supplement 2002) (PURA). The joint application has been designated Docket Number 25130. The joint application and the underlying interconnection agreement are available for public inspection at the commission's offices in Austin, Texas.

The commission must act to approve the interconnection agreement within 35 days after it is submitted by the parties.

The commission finds that additional public comment should be allowed before the commission issues a final decision approving or rejecting the interconnection agreement. Any interested person may file written comments on the joint application by filing ten copies of the comments with the commission's filing clerk. Additionally, a copy of the comments should be served on each of the applicants. The comments should specifically refer to Docket Number 25130. As a part of the comments, an interested person may request that a public hearing be conducted. The comments, including any request for public hearing, shall be filed by January 7, 2002, and shall include:

1) a detailed statement of the person's interests in the agreement, including a description of how approval of the agreement may adversely affect those interests;

2) specific allegations that the agreement, or some portion thereof:

a) discriminates against a telecommunications carrier that is not a party to the agreement; or

b) is not consistent with the public interest, convenience, and necessity; or

c) is not consistent with other requirements of state law; and

3) the specific facts upon which the allegations are based.

After reviewing any comments, the commission will issue a notice of approval, denial, or determine whether to conduct further proceedings concerning the joint application. The commission shall have the authority given to a presiding officer pursuant to P.U.C. Procedural Rule §22.202. The commission may identify issues raised by the joint application and comments and establish a schedule for addressing those issues, including the submission of evidence by the applicants, if necessary, and briefing and oral argument. The commission may conduct a public hearing. Interested persons who file comments are not entitled to participate as intervenors in the public hearing.

Persons with questions about this project or who wish to comment on the joint application should contact the Public Utility Commission of Texas, 1701 North Congress Avenue, P. O. Box 13326, Austin, Texas 78711-3326. You may call the commission's Customer Protection Division at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25130.

TRD-200107846
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Public Notice of Interconnection Agreement

On December 10, 2001, United Telephone Company of Texas, Inc., doing business as Sprint, Central Telephone Company of Texas doing business as Sprint (collectively, Sprint), and Premiere Network Services, Inc., collectively referred to as applicants, filed a joint application for approval of interconnection agreement under Section 252(i) of the federal Telecommunications Act of 1996, Public Law Number 104-104, 110 Statute 56, (codified as amended in scattered sections of 15 and 47 United States Code) (FTA) and the Public Utility Regulatory Act, Texas Utilities Code Annotated, Chapters 52 and 60 (Vernon 1998 & Supplement 2002) (PURA). The joint application has been designated Docket Number 25146. The joint application and the underlying interconnection agreement are available for public inspection at the commission's offices in Austin, Texas.

The commission must act to approve the interconnection agreement within 35 days after it is submitted by the parties.

The commission finds that additional public comment should be allowed before the commission issues a final decision approving or rejecting the interconnection agreement. Any interested person may file written comments on the joint application by filing ten copies of the comments with the commission's filing clerk. Additionally, a copy of the comments should be served on each of the applicants. The comments should specifically refer to Docket Number 25146. As a part of the comments, an interested person may request that a public hearing be conducted. The comments, including any request for public hearing, shall be filed by January 7, 2002, and shall include:

1) a detailed statement of the person's interests in the agreement, including a description of how approval of the agreement may adversely affect those interests;

2) specific allegations that the agreement, or some portion thereof:

a) discriminates against a telecommunications carrier that is not a party to the agreement; or

b) is not consistent with the public interest, convenience, and necessity; or

c) is not consistent with other requirements of state law; and

3) the specific facts upon which the allegations are based.

After reviewing any comments, the commission will issue a notice of approval, denial, or determine whether to conduct further proceedings concerning the joint application. The commission shall have the authority given to a presiding officer pursuant to P.U.C. Procedural Rule §22.202. The commission may identify issues raised by the joint application and comments and establish a schedule for addressing those issues, including the submission of evidence by the applicants, if necessary, and briefing and oral argument. The commission may conduct a public hearing. Interested persons who file comments are not entitled to participate as intervenors in the public hearing.

Persons with questions about this project or who wish to comment on the joint application should contact the Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326. You may call the commission's Customer Protection Division at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25146.

TRD-200107848
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Public Notice of Interconnection Agreement

On December 10, 2001, United Telephone Company of Texas, Inc., doing business as Sprint, Central Telephone Company of Texas doing business as Sprint (collectively, Sprint), and Southwestern Bell Telephone Company, collectively referred to as applicants, filed a joint application for approval of interconnection agreement under Section 252(i) of the federal Telecommunications Act of 1996, Public Law Number 104-104, 110 Statute 56, (codified as amended in scattered sections of 15 and 47 United States Code) (FTA) and the Public Utility Regulatory Act, Texas Utilities Code Annotated, Chapters 52 and 60 (Vernon 1998 & Supplement 2002) (PURA). The joint application has been designated Docket Number 25147. The joint application and the underlying interconnection agreement are available for public inspection at the commission's offices in Austin, Texas.

The commission must act to approve the interconnection agreement within 35 days after it is submitted by the parties.

The commission finds that additional public comment should be allowed before the commission issues a final decision approving or rejecting the interconnection agreement. Any interested person may file written comments on the joint application by filing ten copies of the comments with the commission's filing clerk. Additionally, a copy of the comments should be served on each of the applicants. The comments should specifically refer to Docket Number 25147. As a part of the comments, an interested person may request that a public hearing be conducted. The comments, including any request for public hearing, shall be filed by January 7, 2002, and shall include:

1) a detailed statement of the person's interests in the agreement, including a description of how approval of the agreement may adversely affect those interests;

2) specific allegations that the agreement, or some portion thereof:

a) discriminates against a telecommunications carrier that is not a party to the agreement; or

b) is not consistent with the public interest, convenience, and necessity; or

c) is not consistent with other requirements of state law; and

3) the specific facts upon which the allegations are based.

After reviewing any comments, the commission will issue a notice of approval, denial, or determine whether to conduct further proceedings concerning the joint application. The commission shall have the authority given to a presiding officer pursuant to P.U.C. Procedural Rule §22.202. The commission may identify issues raised by the joint application and comments and establish a schedule for addressing those issues, including the submission of evidence by the applicants, if necessary, and briefing and oral argument. The commission may conduct a public hearing. Interested persons who file comments are not entitled to participate as intervenors in the public hearing.

Persons with questions about this project or who wish to comment on the joint application should contact the Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326. You may call the commission's Customer Protection Division at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25147.

TRD-200107849
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 13, 2001

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Public Notice of Interconnection Agreement

On December 17, 2001, Colorado Valley Telephone Cooperative, Inc. and Dobson Cellular Systems, Inc., collectively referred to as applicants, filed a joint application for approval of interconnection agreement under Section 252(i) of the federal Telecommunications Act of 1996, Public Law Number 104-104, 110 Statute 56, (codified as amended in scattered sections of 15 and 47 United States Code) (FTA) and the Public Utility Regulatory Act, Texas Utilities Code Annotated, Chapters 52 and 60 (Vernon 1998 & Supplement 2002) (PURA). The joint application has been designated Docket Number 25170. The joint application and the underlying interconnection agreement are available for public inspection at the commission's offices in Austin, Texas.

The commission must act to approve the interconnection agreement within 35 days after it is submitted by the parties.

The commission finds that additional public comment should be allowed before the commission issues a final decision approving or rejecting the interconnection agreement. Any interested person may file written comments on the joint application by filing ten copies of the comments with the commission's filing clerk. Additionally, a copy of the comments should be served on each of the applicants. The comments should specifically refer to Docket Number 25170. As a part of the comments, an interested person may request that a public hearing be conducted. The comments, including any request for public hearing, shall be filed by January 17, 2002, and shall include:

1) a detailed statement of the person's interests in the agreement, including a description of how approval of the agreement may adversely affect those interests;

2) specific allegations that the agreement, or some portion thereof:

a) discriminates against a telecommunications carrier that is not a party to the agreement; or

b) is not consistent with the public interest, convenience, and necessity; or

c) is not consistent with other requirements of state law; and

3) the specific facts upon which the allegations are based.

After reviewing any comments, the commission will issue a notice of approval, denial, or determine whether to conduct further proceedings concerning the joint application. The commission shall have the authority given to a presiding officer pursuant to P.U.C. Procedural Rule §22.202. The commission may identify issues raised by the joint application and comments and establish a schedule for addressing those issues, including the submission of evidence by the applicants, if necessary, and briefing and oral argument. The commission may conduct a public hearing. Interested persons who file comments are not entitled to participate as intervenors in the public hearing.

Persons with questions about this project or who wish to comment on the joint application should contact the Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326. You may call the commission's Customer Protection Division at (512) 936-7120 or toll free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136. All correspondence should refer to Docket Number 25170.

TRD-200108068
Rhonda Dempsey
Rules Coordinator
Public Utility Commission of Texas
Filed: December 18, 2001

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Texas Water Development Board

Request for Proposals

The Texas Water Development Board (TWDB) requests the submission of proposals to conduct investigations related to potential water and energy savings that might result from rehabilitation of irrigation conveyance systems in certain counties in the Rio Grande Valley of Texas. This Request for Proposals (RFP) solicits information that will enable the TWDB and a designee from the program area to evaluate proposals submitted by individuals, firms, or institutions (henceforth referred to firms or offeror) that may provide technical services to the TWDB and irrigation districts. Both price and qualifications will be considered. This proposed effort will be funded by the TWDB using Oil Overcharge proceeds to be deposited in the Water Bank Account from the State Energy Conservation Office (SECO).

Scope of Work. The scope of services for the proposal will be to: develop methodologies and procedures for estimating water and energy savings associated with possible rehabilitation of irrigation conveyance systems (Principal conveyance systems and laterals, but not beyond the

farm turnouts) in the program area; apply these methodologies, protocols to quantify potential savings; identify and develop a monitoring program to eventually verify the actual savings; provide the necessary documentation of procedures and data requirements to the districts for implementation of the recommendations. This information will be used by the irrigation districts as supporting data required by the U.S. Bureau of Reclamation's June 2001 Guidelines in complying with the Lower Rio Valley Water Resources Conservation and Improvement Act of 2000 (P.L. 106-576, December 28, 2000). The basic approach will be to focus on specific data for the four irrigation districts located in Cameron and Hidalgo Counties, Texas that are included in the existing legislation (Act). It is also expected from the offeror that any methodologies, tools, models, etc., developed using information for these four districts have the capability of being applicable to the other irrigation districts in the program area (Cameron, Hidalgo, Maverick, Webb, Zapata, Starr, Willacy, El Paso, and Hudspeth counties) that have similar characteristics.

Guidelines for Content of Qualification Statements. The evaluation of the proposals will be based on the contents of the RFP package including price, and any subsequent written clarification required, interview information presented (should interviews be held) , or references information obtained. The text of the proposal **must not** exceed a total of 25 pages (excluding pages needed for the transmittal letter, statement for insurance, and conflict of interest statement, task budget and cost sheets) of 8.5 " by 11" paper. For detailed instructions and procedures for preparing and submitting the proposals, consult the TWDB web site (www.twdb.state.tx.us) under "What's New!" or contact Mr. Jeff Walker at (512) 463-7779. This information should be requested as soon as possible in order to prepare and submit a complete proposal by the deadline.

Submittal Deadline. The offeror shall submit seven (7) hard copies of the proposal and also an electronic version (PDF Format to Jeff.Walker@twdb.state.tx.us) to the TWDB. Mailed proposals must be received in sealed envelopes no later than **5:00 p.m.** (Central Standard Time) on **January 28, 2002**. Submittals should be sent to: Mr. Jeff Walker, P.O. Box 13231, Austin, Texas 78711-3231.

Evaluation Factors and Relative Importance. The following factors, in order of relative importance, will be used in evaluating the proposals:

1. Offeror's understanding of the Scope of Work. Explanation of how the work will be accomplished, proposed approach, data requirements, methods, techniques, types of analysis, anticipated field work, etc., that would be used.

2. Offeror's experience and familiarity with local irrigation/operational practices in the Program Area.

3. Offeror's experience with similar type projects and irrigation/operational practices elsewhere outside the Program Area.

4. Offeror's (including subcontractors) performance record of past projects with similar scope of work and meeting time and budget constraints.

5. Offeror's professional qualifications of the individuals (including subcontracted personnel) who will perform the work and appropriateness of assignment of expertise to particular work tasks.

6. Offeror's price for services and identification of detailed budget tasks, level of effort, and reasonableness/justification of costs.

7. Offeror's anticipated workload during period of engagement and availability of the personnel.

8. Offeror's organizational structure and quality control.

9. Offeror's presence in the Program Area.

10. Offeror's availability of equipment resources.

11. Offeror's insurability and status of current work-related litigation, arbitration, or administrative proceedings.

The TWDB and a designee from the program area will evaluate and rank the proposals and come up with a short list. The TWDB intends to negotiate a fair and reasonable contract and price with a prospective firm. The TWDB does not discriminate on basis of race, color, national origin, sex, religion, age or disability in employment or provision of services, programs or activities. Small, minority, and women business enterprises are encouraged to submit proposals for consideration.

Contract Terms and Negotiation Schedule. The selected offeror will be expected to utilize an agreement for services, which is acceptable to the TWDB. The offeror will be notified and shall be expected to submit a draft contract and any additional information if needed. A draft contract and additional information (if requested) shall be provided within 8 days after being notified. If unable to negotiate a mutually acceptable contract, the TWDB will terminate negotiations with the highest ranked firm and begin negotiating with the second highest and then third highest as necessary until an acceptable contract is obtained. Award of the contract and notice to proceed will be contingent on approval by the TWDB Board.

TRD-200108069
Suzanne Schwartz
General Counsel
Texas Water Development Board
Filed: December 18, 2001

How to Use the Texas Register

Information Available: The 13 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following a 30-day public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Open Meetings - notices of open meetings.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 26 (2001) is cited as follows: 26 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "26 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 26 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For subscription information, see the back cover or call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC)*** is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac. The following companies also provide complete copies of the TAC: Lexis-Nexis (1-800-356-6548), and West Publishing Company (1-800-328-9352).

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15:

1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 19, April 13, July 13, and October 12, 2001). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

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