TEXAS REGISTER

Volume 35 Number 51 *December 17, 2010* *Pages 11133 – 11438*

Ashley Turner
10th Grade

School children's artwork is used to decorate the front cover and blank filler pages of the *Texas Register*. 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.

The artwork featured on the front cover is chosen at random. Inside each issue, the artwork is published on what would otherwise be blank pages in the *Texas Register*. These blank pages are caused by the production process used to print the *Texas Register*.

Texas Register, **(ISSN 0362-4781, USPS 120-090),** is published weekly (52 times per year) for $211.00 ($311.00 for first class mail delivery) by LexisNexis Matthew Bender & Co., Inc., 1275 Broadway, Albany, N.Y. 12204-2694.

The ***Texas Register*** is published under the Government Code, Title 10, Chapter 2002. Periodicals Postage Paid at Albany, N.Y. and at additional mailing offices.

POSTMASTER: Send address changes to the ***Texas Register,*** 136 Carlin Rd., Conklin, N.Y. 13748-1531.

a section of the
Office of the Secretary of State
P.O. Box 13824
Austin, TX 78711-3824
(512) 463-5561
FAX (512) 463-5569

http://www.sos.state.tx.us
register@sos.state.tx.us

IN THIS ISSUE

RULE REVIEW

TABLES AND GRAPHICS

IN ADDITION

Texas Department of Agriculture

Office of the Attorney General

Coastal Coordination Council

Comptroller of Public Accounts

Office of Consumer Credit Commissioner

Deep East Texas Council of Governments

Texas Commission on Environmental Quality

Department of Family and Protective Services

Office of the Governor

Texas Health and Human Services Commission

Department of State Health Services

Texas Department of Insurance

Panhandle Regional Planning Commission

Texas State Board of Examiners of Psychologists

Public Utility Commission of Texas

Texas Department of Transportation

The Texas A&M University System

Open Meetings

Statewide agencies and regional agencies that extend into four or more counties post meeting notices with the Secretary of State.

Meeting agendas are available on the *Texas Register*'s Internet site:
http://www.sos.state.tx.us/open/index.shtml

Members of the public also may view these notices during regular office hours from a computer terminal in the lobby of the James Earl Rudder Building, 1019 Brazos (corner of 11th Street and Brazos) Austin, Texas. To request a copy by telephone, please call 512-463-5561. Or request a copy by email: register@sos.state.tx.us

For items ***not*** available here, contact the agency directly. Items not found here:

- minutes of meetings
- agendas for local government bodies and regional agencies that extend into fewer than four counties
- legislative meetings not subject to the open meetings law

The Office of the Attorney General offers information about the open meetings law, including Frequently Asked Questions, the *Open Meetings Act Handbook*, and Open Meetings Opinions.
http://www.oag.state.tx.us/open/index.shtml

The Attorney General's Open Government Hotline is 512-478-OPEN (478-6736) or toll-free at (877) OPEN TEX (673-6839).

Additional information about state government may be found here:
http://www.texas.gov

...

Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or Braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting notice several days before the meeting by mail, telephone, or RELAY Texas. TTY: 7-1-1.

THE GOVERNOR

As required by Government Code, §2002.011(4), the *Texas Register* publishes executive orders issued by the Governor of Texas. Appointments and proclamations are also published. Appointments are published in chronological order. Additional information on documents submitted for publication by the Governor's Office can be obtained by calling (512) 463-1828.

Proclamation 41-3244

TO ALL TO WHOM THESE PRESENTS SHALL COME:

WHEREAS, a vacancy now exits in the membership of the Texas House of Representatives in District No. 44 which consists of Gonzales, Guadalupe, and Wilson Counties; and

WHEREAS, the 82nd Session of Texas Legislature will convene on January 11, 2011, and the residents of District No. 44 will be without representation; and

WHEREAS, Section 203.002 of the Texas Election Code requires that a special election be ordered upon such vacancy and Section 203.004 of the Texas Election Code requires that if the election is to be held as an emergency election, it shall be held on a Tuesday or Saturday occurring on or after the 36th day and before the 50th day after the date the election is ordered; and

WHEREAS, Section 201.053 of the Texas Election Code requires that when a vacancy occurs after the general election in both the unexpired portion of the current term and in the succeeding full term that was filled at the general election, the special election shall be ordered to fill only the full term; and

WHEREAS, the governor of Texas is granted the discretion under Section 41.0011 of the Election Code to declare an emergency warranting holding a special election before the appropriate uniform election date; and

WHEREAS, Section 3.003 of the Texas Election Code, requires the election to be ordered by proclamation of the Governor.

NOW, THEREFORE, I, RICK PERRY, Governor of Texas, under the authority vested in me by the Constitution and Statutes of the State of Texas, do hereby order an emergency special election to be held in District No. 44 on December 14, 2010, for the purpose of electing a State Representative for House District No. 44 to serve the term which begins January 11, 2011.

Candidates who wish to have their names placed on the special election ballot must file their applications with the Secretary of State no later than 5:00 p.m. on Monday, November 15, 2010.

Early voting by personal appearance shall begin on Monday, November 29, 2010, in accordance with Section 85.001 of the Texas Election Code.

A copy of this order shall be mailed immediately to the County Judges of Gonzales, Guadalupe, and Wilson Counties; and all appropriate writs will be issued and all proper proceedings will be followed for the purpose that said election may be held to fill the vacancy in District No. 44 and its result proclaimed in accordance with law.

IN TESTIMONY WHEREOF, I have hereto signed my name and have officially caused the Seal of State to be affixed at my Office in the City of Austin, Texas, this the 8th day of November, 2010.

Rick Perry, Governor of Texas

Attested by: Esperanza "Hope" Andrade, Secretary of State

TRD-201006959

♦ ♦ ♦

THE ATTORNEY GENERAL

The *Texas Register* publishes summaries of the following: Requests for Opinions, Opinions, Open Records Decisions.

An index to the full text of these documents is available from the Attorney General's Internet site http://www.oag.state.tx.us. Telephone: 512-936-1730. For information about pending requests for opinions, telephone 512-463-2110.

An Attorney General Opinion is a written interpretation of existing law. The Attorney General writes opinions as part of his responsibility to act as legal counsel for the State of Texas. Opinions are written only at the request of certain state officials. The Texas Government Code indicates to whom the Attorney General may provide a legal opinion. He may not write legal opinions for private individuals or for any officials other than those specified by statute. (Listing of authorized requestors: http://www.oag.state.tx.us/opinopen/opinhome.shtml.)

Request for Opinions

RQ-0933-GA

Requestor:

Ms. Cheryln K. Townsend

Executive Director

Texas Youth Commission

Post Office Box 4260

Austin, Texas 78765

Re: Information that must be provided by the Texas Youth Commission to an independent school district as a "statement of offense" required by article 15.27(b), Code of Criminal Procedure (RQ-0933-GA)

Briefs requested by January 3, 2011

RQ-0934-GA

Requestor:

The Honorable Jeff Wentworth

Chair, Senate Select Committee on Veteran's Health

Texas State Senate

Post Office Box 12068

Austin, Texas 78711-2068

Re: Requirements for real property to qualify as an "ecological laboratory" under section 23.51, Tax Code (RQ-0934-GA)

Briefs requested by January 3, 2011

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

TRD-201006931
Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: December 7, 2010

♦ ♦ ♦

Opinions

Opinion No. GA-0823

Ms. Gail Lowe, Chair

State Board of Education

1701 North Congress Avenue

Austin, Texas 78701-1494

Re: Public school textbook adoption under recent legislative amendments to the Education Code (RQ-0887-GA)

S U M M A R Y

Section 31.101(c-1) of the Education Code requires a school district or an open-enrollment charter school to purchase "a classroom set of textbooks" according to the statute's terms. TEX. EDUC. CODE ANN. §31.101(c-1) (West Supp. 2010). We cannot address whether the State Board of Education ("SBOE") has appropriately implemented the section without information about the SBOE's specific legal concerns and its interpretation of its rules. However, university open-source textbooks adopted pursuant to Education Code section 31.023 or 31.035 may serve as a classroom set of textbooks under section 31.101(c-1). Also, a classroom set under section 31.101(c-1) may include textbooks on the nonconforming list that do not cover the entire state curriculum. Education Code section 26.006(c), which requires a school district or charter school to honor a parent's request to allow the student to take home any textbook used by the student if it is available, applies to a textbook that is part of a classroom set of textbooks.

The SBOE has no authority under section 31.0241 of the Education Code to decline to place an open-source textbook on the conforming or nonconforming textbook list if the SBOE disagrees with an eligible institution's determination that the textbook qualifies for placement on the conforming or nonconforming list. Assuming that a university is properly characterized as a publisher with respect to an open-source textbook, the SBOE has authority to impose an administrative penalty on such a university for violations under subchapter D, chapter 31 of the Education Code. If an open-enrollment charter school or school district acquires a university open-source textbook at a cost below the cost limit established under section 31.025(a) of the Education Code, the school or district is entitled to a credit.

Section 31.102 of the Education Code, which provides that "[e]ach textbook purchased as provided by this chapter is the property of this state," does not include technological equipment as property of the state. *Id.* §31.102(a) (West 2006).

Opinion No. GA-0824

The Honorable Joe Shannon, Jr.

Tarrant County Criminal District Attorney

Tim Curry Criminal Justice Center

401 West Belknap

Fort Worth, Texas 76196-0201

Re: Whether a court investigator appointed by a statutory county probate judge is covered by the Tarrant County civil service system (RQ-0889-GA)

S U M M A R Y

A court investigator appointed by a county probate judge is covered by the Tarrant County civil service system.

Opinion No. GA-0825

Mr. William H. Kuntz, Jr.

Executive Director

Texas Department of Licensing and Regulation

Post Office Box 12157

Austin, Texas 78711-2157

Re: Scope of licensed pool-related electrical service under chapter 1305 of the Occupations Code (RQ-0891-GA)

S U M M A R Y

A residential appliance installer licensed under Occupations Code chapter 1305 may work only on pools that are installed as a unit in a single-family or multifamily dwelling that does not exceed four stories. The residential appliance installer's license does not authorize an individual to work on commercial pools.

Opinion No. GA-0826

The Honorable Chuck Hopson

Chair, Committee on General Investigating and Ethics

Texas House of Representatives

Post Office Box 2910

Austin, Texas 78768-2910

Re: Whether a member of the city council of Texarkana, Texas, may simultaneously serve as a paid municipal fire fighter in Texarkana, Arkansas (RQ-0892-GA)

S U M M A R Y

Generally, a municipality is not a "business entity" for purposes of the conflict of interest provisions of chapter 171 of the Texas Local Government Code. The self-employment aspect of the Texas common-law incompatibility doctrine does not apply to preclude a person from serving simultaneously in two positions when neither position supervises the other.

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

TRD-201006950
Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: December 7, 2010

♦ ♦ ♦

Proposed rules include new rules, amendments to existing rules, and repeals of existing rules. A state agency shall give at least 30 days' notice of its intention to adopt a rule before it adopts the rule. A state agency shall give all interested persons a reasonable opportunity to submit data, views, or arguments, orally or in writing (Government Code, Chapter 2001).

Symbols in proposed rule text. Proposed new language is indicated by underlined text. [~~Square brackets and strikethrough~~] indicate existing rule text that is proposed for deletion. "(No change)" indicates that existing rule text at this level will not be amended.

TITLE 10. COMMUNITY DEVELOPMENT

PART 6. TEXAS DEPARTMENT OF RURAL AFFAIRS

CHAPTER 255. TEXAS COMMUNITY DEVELOPMENT PROGRAM

SUBCHAPTER A. ALLOCATION OF PROGRAM FUNDS

10 TAC §255.1, §255.9

The Texas Department of Rural Affairs (TDRA) proposes amendments to §255.1 and §255.9, concerning the General Provisions and Colonia Fund. On November 3, 2010, the TDRA Board of Directors approved the publication of this rule proposal for comment. The proposed amendment would conform the Texas Administrative Code to the approved 2011 Texas CDBG Action Plan and Riders 6 and 7 of the General Appropriations Act of the 81st Legislature.

The proposed amendments are to §255.1 and §255.9.

Charles (Charlie) S. Stone, Executive Director, has determined that for the first five-year period the proposed amendments are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections, as amended.

Mr. Stone also has determined that for each year of the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the sections will be the equitable allocation of CDBG non-entitlement area funds to eligible units of general local government in Texas. There will be no effect on small or large businesses. There is no anticipated economic cost to persons who are required to comply with the sections as proposed.

Comments on the proposal may be submitted to Mark Wyatt, Director, Community Development, Texas Department of Rural Affairs, P.O. Box 12877, Austin, Texas 78711, telephone: (512) 936-6701. Comments must be received no later than 30 days from the date of publication of the proposed amendments in the *Texas Register.*

The amendments to §255.1 and §255.9 are proposed under the Texas Government Code §487.052, which provides the TDRA with the authority to adopt rules and administrative procedures to carry out the provisions of Chapter 487 of the Texas Government Code.

No other code, article, or statute is affected by the proposed amendments.

§255.1. General Provisions.

(a) - (q) (No change.)

(r) Funds recaptured from withdrawn awards. For an award that is withdrawn from an application, the Department follows different procedures for the use of those recaptured funds depending on the fund category where the award is withdrawn.

(1) Funds recaptured under the community development fund from the withdrawal of an award made from the first year of the biennial funding are offered to the next highest ranked applicant from that region that was not recommended to receive an award from the first year regional allocation. Funds recaptured under the community development fund from the withdrawal of an award made from the second year of the biennial funding are offered to the next highest ranked applicant from that region that was not recommended to receive full funding (the applicant recommended to receive marginal funding) from the second year regional allocation. Any funds remaining from the second year regional allocation after full funding is accepted by the second year marginal applicant are offered to the next highest ranked applicant from the region as long as the amount of funds still available exceeds the minimum community development fund grant amount. Any funds remaining from the second year regional allocation that are not accepted by an applicant from the region or that are not offered to an applicant from the region may be used for other TxCDBG fund categories and, if unallocated to another fund, are then subject to the procedures described in subsection (l) of this section.

(2) Funds recaptured under the planning and capacity building fund from the withdrawal of an award made from the first year of the biennial funding are offered to the next highest ranked applicant from that statewide competition that was not recommended to receive an award from the first year allocation. Funds recaptured under the planning and capacity building fund from the withdrawal of an award made from the second year of the biennial funding are offered to the next highest ranked applicant from that statewide competition that was not recommended to receive full funding (the applicant recommended to receive marginal funding) from the second year allocation. Any funds remaining from the second year allocation after full funding is accepted by the second year marginal applicant are offered to the next highest ranked applicant from the statewide competition. Any funds remaining from the second year allocation that are not accepted by an applicant from the statewide competition or that are not offered to an applicant from the statewide competition may be used for other TxCDBG fund categories and, if unallocated to another fund, are then subject to the procedures described in subsection (l) of this section.

(3) Funds recaptured under the colonia construction component [~~fund~~] from the withdrawal of an award remain available to potential colonia program fund applicants during that program year to meet the 10 percent colonia set-aside requirement and, if unallocated within the colonia fund, may be used for other TxCDBG fund categories. Remaining unallocated funds are then subject to the procedures in subsection (l) of this section.

(4) Funds recaptured under the colonia planning component [~~fund~~] from the withdrawal of an award remain available to potential colonia program fund applicants during that program year to meet the 10 percent colonia set-aside requirement and, if unallocated within the colonia fund, may be used for other TxCDBG fund categories. Remaining unallocated funds are then subject to the procedures in subsection (l) of this section.

(5) Funds recaptured under the program year allocation for the colonia economically distressed areas program fund from the withdrawal of an award remain available to potential colonia economically distressed areas program fund applicants during that program year. If there are an insufficient number of TWDB EDAP projects ready for Colonia Economically Distressed Areas Program (CEDAP) funding, the CEDAP funds may be transferred as appropriate. If [~~Any funds remaining from the program year allocation that are not used to fund colonia economically distressed areas program fund applications within twelve months after the Department receives the federal letter of credit would remain available to potential colonia program fund applicants during that program year to meet the 10 percent colonia set-aside requirement and, if~~] unallocated within the colonia fund, the funds may be used for other TxCDBG fund categories. Remaining unallocated funds are then subject to the procedures in subsection (l) of this section.

(6) Funds recaptured under the program year allocation for the disaster relief/urgent need fund from the withdrawal of an award are subject to the procedures described in subsection (l) of this section.

(7) Funds recaptured under the small towns environment program fund (STEP) from the withdrawal of an award will be made available in the next round of STEP competition following the withdraw date in the same program year. If the withdrawn award had been made in the last of the two competitions in a program year, the funds would go to the next highest scoring applicant in the same STEP competition. If there are no unfunded STEP applicants, then the recaptured funds would be available for other TxCDBG fund categories. Any unallocated STEP funds are subject to the procedures described in subsection (l) of this section.

(8) Funds recaptured under the Texas Capital Fund from the withdrawal of an award are subject to the procedures described in subsection (l) of this section.

(9) For both the community development fund, if there are no remaining unfunded eligible applications in the region from the same biennial application period to receive the withdrawn funding, then the withdrawn funds are considered as deobligated funds, subject to the procedures described in subsection (l) of this section.

(s) - (z) (No change.)

§255.9. Colonia Fund.

(a) General provisions. This fund covers the payment of assessments, access fees, and capital recovery fees for low and moderate income persons for eligible water and sewer improvements projects, all other program eligible activities, eligible planning activities projects, and the establishment of colonia self-help centers to serve severely distressed unincorporated areas of counties which meet the definition of a colonia under this fund. A colonia is defined as: any identifiable unincorporated community that is within 150 miles of the border between the United States and Mexico, except that the term does not include any standard metropolitan statistical area that has a population exceeding 1,000,000; and that is determined to be a colonia on the basis of objective criteria, including lack of potable water supply, lack of adequate sewage systems, and lack of decent, safe, and sanitary housing; and was in existence as a colonia prior to the Cranston-Gonzalez National Affordable Housing Act (November 28, 1990). For an eligible county to submit an application on behalf of eligible colonia areas, the colonia areas must be within 150 miles of the Texas-Mexico border region, except that any county that is part of a standard metropolitan statistical area with a population exceeding one million is not eligible under this fund.

(1) An applicant may not submit an application under this fund and also under any other TxCDBG fund category at the same time if the proposed activity under each application is the same or substantially similar.

(2) In addition to the threshold requirements of §255.1(h) and (n) of this title (relating to General Provisions), in order to be eligible to apply for colonia funds, an applicant must document that at least 51% of the persons who would directly benefit from the implementation of each activity proposed in the application are of low to moderate income.

(3) Eligibility for the Department's [~~Office's~~] colonia economically distressed areas program EDAP fund (colonia EDAP fund) is limited to counties, and nonentitlement cities (that meet other eligibility requirements including the geographic requirements of the Colonia Fund), located in those counties, that are eligible under the TxCDBG Colonia Fund and Texas Water Development Board's EDAP. Eligible colonia EDAP fund projects shall be located in unincorporated colonias and in eligible nonentitlement cities that annexed the eligible colonia where improvements are to be made within five years after the effective date of the annexation, or are in the process of annexing the colonia where improvements are to be made. A colonia EDAP fund application cannot be submitted until the construction of the Texas Water Development Board's Economically Distressed Areas Program financed water or sewer system begins.

(4) In accordance with Subchapter Z, Chapter 43, §43.907 [~~§43.905~~] of the Texas Local Government Code, eligible colonia areas meeting specified criteria that are annexed by municipalities on or after September 1, 1999, remain [~~remains~~] eligible for five years after the effective date of the annexation to receive any form of assistance for which the colonia would be eligible if the annexation had not occurred. A nonentitlement city located in a county that is eligible under the TxCDBG Colonia Fund and Texas Water Development Board's Economically Distressed Areas Program that has annexed a colonia area is an eligible applicant for the Department's [~~Office's~~] colonia EDAP fund. However, an application for TxCDBG colonia construction fund or colonia planning fund assistance for a colonia area annexed by a municipality on or after September 1, 1999, may only be submitted by the county where the annexed colonia area is located.

(b) Eligible activities. The only eligible activities under the colonia fund are:

(1) the payment of assessments (including any charge made as a condition of obtaining access) levied against properties owned and occupied by persons of low and moderate income to recover the capital cost for a public water and/or sewer improvement;

(2) payment of the cost of planning community development (including water and sewage facilities) and housing activities; costs for the provision of information and technical assistance to residents of the area in which the activities are located and to appropriate nonprofit organizations and public agencies acting on behalf of the residents; and costs for preliminary surveys and analyses of market needs, preliminary site engineering and architectural services, site options, applications, mortgage commitments, legal services, and obtaining construction loans;

(3) other activities eligible under the Housing and Community Development Act of 1974, §105, as amended, designed to meet the needs of residents of colonias;

(4) the establishment of colonia self-help centers and activities conducted by colonia self-help centers in accordance with the provisions of Chapter 2306, Subchapter Z, of the Texas Government Code.

(5) For the Department's [~~Office's~~] colonia EDAP fund, eligible activities are limited to those that provide assistance to low and moderate income colonia residents that cannot afford the costs associated with connections and service to water or sewer systems funded through the Texas Water Development Board's Economically Distressed Areas Program. In accordance with Rider 7 of the General Appropriations Act, 81st Legislature, the [~~The~~] eligible activities are residential service lines, hookups, and plumbing improvements associated with being connected to a water supply or sewer service system, any part of which is financed under the Texas Water Development Board's Economically Distressed Areas Program. [~~water distribution lines connecting to water lines installed through the Texas Water Development Board's Economically Distressed Areas Program (when approved by the TxCDBG), sewer collection lines connecting to sewer lines installed through the Texas Water Development Board's Economically Distressed Areas Program (when approved by the TxCDBG), water or sewer connection fees, water or sewer taps, water meters, water or sewer yard service lines, plumbing improvements associated with the provision of water or sewer service to an occupied housing unit, water or sewer house service connections, reasonable associated administrative costs, and reasonable associated engineering costs.~~]

(c) Types of applications.

(1) Colonia Planning and Construction Fund.

(A) Colonia Construction Component. The allocation is available on a biennial basis for funding from program years 2011 [~~2009~~] and 2012 [~~2010~~] through a 2011 [~~2009~~] annual competition. Applications received by the 2011 [~~2009~~] program year application deadline are eligible to receive grant awards from the 2011 [~~2009~~] and 2012 [~~2010~~] program year allocations. Funding priority shall be given to TxCDBG applications from localities that have been funded through the Texas Water Development Board Economically Distressed Areas Program (TWDB EDAP) where the TxCDBG project will provide assistance to colonia residents that cannot afford the cost of residential service lines, hookups, [~~service connections,~~] and plumbing improvements associated with being connected [~~access~~] to the TWDB EDAP-funded water or sewer system. A colonia construction application must include an assessment of the effect of the Model Subdivision Rules established pursuant to §16.343 of the Water Code and enforcement actions throughout the county and provide the colonia identification number for the colonias that would receive the project benefit. An eligible county applicant may submit one (1) application for the following eligible construction activities:

(i) Assessments for Public Improvements--The payment of assessments (including any charge made as a condition of obtaining access) levied against properties owned and occupied by persons of low- and moderate-income to recover the capital cost for a public improvement.

(ii) Other Improvements--Other activities eligible under 42 U.S.C. §5305 [~~Section 5305~~] designed to meet the needs of colonia residents.

(B) Colonia Planning Component. A portion of the funds will be allocated to two separate biennial competitions for applications that include planning activities targeted to selected colonia areas (Colonia Area Planning activities), and for applications that include countywide comprehensive planning activities (Colonia Comprehensive Planning activities). Applications received by the 2011 [~~2009~~] program year application deadline are eligible to receive a grant award from the 2011 [~~2009~~] and 2012 [~~2010~~] program year allocations. A Colonia Planning activities application must receive a minimum score for the Project Design selection factor of at least 70 percent of the maximum number of points allowable under this factor to be considered for funding.

(i) Colonia Area Planning Activities. In order to qualify for the Colonia Area Planning activities, the county applicant must have a Colonia Comprehensive Plan in place that prioritizes problems and colonias for future action. The targeted colonia must be included in the Colonia Comprehensive Plan. An eligible county may submit an application for eligible planning activities that are targeted to one or more colonia areas. Eligible activities include:

(I) Payment of the cost of planning community development (including water and sewage facilities) and housing activities;

(II) costs for the provision of information and technical assistance to residents of the area in which the activities are located and to appropriate nonprofit organizations and public agencies acting on behalf of the residents; and

(III) costs for preliminary surveys and analyses of market needs, preliminary site engineering and architectural services, site options, applications, mortgage commitments, legal services, and obtaining construction loans.

(IV) for any colonia in close proximity to a city, a plan that if implemented could lead to annexation of the colonia by the city.

(ii) Colonia Comprehensive Planning Activities. To be eligible for these funds, a county must be located within 150 miles of the Texas-Mexico border. The applicant's countywide comprehensive plan will provide a general assessment of the colonias in the county, but will include enough detail for accurate profiles of the county's colonia areas. The prepared comprehensive plan must include the following information and general planning elements:

(I) Verification of the number of dwellings, number of lots, number of occupied lots, and the number of persons residing in each county colonia;

(II) Mapping of the locations of each county colonia;

(III) Demographic and economic information on colonia residents;

(IV) The physical environment in each colonia including land use and conditions, soil types, and flood prone areas;

(V) An inventory of the existing infrastructure (water, sewer, streets, drainage) in each colonia and the infrastructure needs in each colonia including projected infrastructure costs;

(VI) The condition of the existing housing stock in each colonia and projected housing costs;

(VII) A ranking system for colonias that will enable counties to prioritize colonia improvements rationally and systematically plan and implement short-range and long-range strategies to address colonia needs;

(VIII) Goals and Objectives;

(IX) Five-year capital improvement program.

(X) An assessment of the effect of the Model Subdivision Rules established pursuant to §16.343 of the Water Code and enforcement actions throughout the county; and

(XI) For any colonia in close proximity to a city, a plan that if implemented could lead to annexation of the colonia by the city.

(2) Colonia Economically Distressed Areas Program (CEDAP) Legislative Set-aside. The allocation is distributed on an as-needed basis. Eligible applicants may submit an application that will provide assistance to colonia residents that cannot afford the cost of residential service lines, hookups [~~service connections~~], and plumbing improvements associated with being connected to a TWDB EDAP-funded water and sewer system improvement project. An application cannot be submitted until the construction of the TWDB EDAP-funded water or sewer system begins. In accordance with Rider 7 of the General Appropriations Act, 81st Legislature, eligible [~~Eligible~~] program costs are residential service lines, hookups, and plumbing improvements associated with being connected to a water supply or sewer service system, any part of which is financed under the Texas Water Development Board's Economically Distressed Areas Program. If there are an insufficient number of TWDB EDAP projects ready for Colonia Economically Distressed Areas Program (CEDAP) funding, the CEDAP funds may be transferred as appropriate. [~~include water distribution lines and sewer collection lines providing connection to water and sewer lines installed through the Texas Water Development Board's Economically Distressed Areas Program (when approved by the TxCDBG), taps and meters (when approved by the TxCDBG), yard service lines, service connections, plumbing improvements, and connection fees, and other eligible approved costs associated with connecting an income-eligible family's housing unit to the TWDB improvements.~~] An applicant may not have an existing CEDAP contract open in excess of 48 months and still be eligible for a new CEDAP award.

(3) Colonia Self-Help Centers Legislative Set-aside. The colonia self-help centers fund is allocated on an annual basis to counties included in Chapter 2306, Subchapter Z, §2306.582, Texas Government Code, and/or counties designated as economically distressed areas under Chapter 17, Texas Water Code. TDHCA has established self-help centers in Cameron County, El Paso County, Hidalgo County, Starr County, and Webb County. If deemed necessary and appropriate, TDHCA may establish self-help centers in other counties (self-help centers have been established in Maverick County and Val Verde County) as long as the site is located in a county that is designated as an economically distressed area under the Texas Water Development Board Economically Distressed Areas Program, the county is eligible to receive EDAP funds, and the colonias served by the center are located within 150 miles of the Texas-Mexico border.

(d) Selection procedures.

(1) On or before the application deadline, each eligible county may submit one application for the colonia construction component, colonia area planning activities, and colonia comprehensive planning activities. Eligible applicants for the colonia EDAP fund may submit one application after construction begins on the water or sewer system financed by the Texas Water Development Board's Economically Distressed Areas Program.

(2) Upon receipt of an application, the Department [~~Office~~] staff performs an initial review to determine whether the application is complete and whether all proposed activities are eligible for funding. The results of this initial review are provided to the applicant. If not subject to disqualification, the applicant may correct any deficiencies identified within ten calendar days of the date of the staff's notification.

(3) Each regional review committee may, at its option, review and comment on a colonia fund proposal from a jurisdiction within its state planning region. These comments will become part of the application file, provided such comments are received by the Department [~~Office~~] prior to scoring of the applications.

(4) The Department [~~Office~~] then scores the colonia construction component, colonia area planning activities, and colonia comprehensive planning activities applications to determine rankings. Scores on the selection factors are derived from standardized data from the Census Bureau, other federal or state sources, and from information provided by the applicant. For colonia EDAP fund applications, the Department [~~Office~~] evaluates information in each application and other factors before the completion of a final technical review of each application.

(5) Following a final technical review, the Department [~~Office~~] staff presents the funding recommendations for the 2011 [~~2009~~] and 2012 [~~2010~~] colonia fund and colonia EDAP fund to the executive director of the Department who [~~Office. In consultation with the executive director and TxCDBG staff, the state review committee reviews and~~] approves grant applications and associated funding awards of eligible counties and municipalities.

(6) Upon announcement of the 2011 [~~2009~~] and 2012 [~~2010~~] contract awards, the Department [~~Office~~] staff works with recipients to execute the contract agreements. While the award must be based on the information provided in the application, the Department [~~Office~~] may negotiate any element of the contract with the recipient as long as the contract amount is not increased and the level of benefits described in the application is not decreased. The level of benefits may be negotiated only when the project is partially funded.

(e) Selection criteria (colonia fund). The following is an outline of the selection criteria used by the Department [~~Office~~] for scoring colonia fund applications (colonia construction component, colonia area planning activities, and colonia comprehensive planning activities).

(1) Colonia construction component (430 total points maximum).

(A) Community distress (total--35 points). All community distress factor scores are based on the unincorporated population of the applicant. An applicant that has 125% or more of the average of all applicants in the competition of the rate on any community distress factor, except per capita income, receives the maximum number of points available for that factor. An applicant with less than 125% of the average of all applicants in the competition on a factor will receive a proportionate share of the maximum points available for that factor. An applicant that has 75% or less of the average of all applicants in the competition on the per capita income factor will receive the maximum number of points available for that factor. An applicant with greater than 75% of the average of all applicants in the competition on the per capita income factor will receive a proportionate share of the maximum points available for that factor.

(i) Percentage of persons living in poverty--15 points

(ii) Per capita income--10 points

(iii) Percentage of housing units without complete plumbing--5 points

(iv) Unemployment rate--5 points

(B) Benefit to low and moderate income persons (total--30 points). A formula is used to determine the percentage of TxCDBG funds benefiting low to moderate income persons. The percentage of

low to moderate income persons benefiting from each construction, acquisition, and engineering activity is multiplied by the TxCDBG funds requested for each corresponding construction, acquisition, and engineering activity. Those calculations determine the amount of TxCDBG benefiting low to moderate income person for each of those activities. Then, the funds benefiting low to moderate income persons for each of those activities are added together and divided by the TxCDBG funds requested minus the TxCDBG funds requested for administration to determine the percentage of TxCDBG funds benefiting low to moderate income persons. Points are then awarded in accordance with the following scale:

(i) 100% to 90% of funds benefiting low to moderate income persons--30 points

(ii) 89.99% to 80% of funds benefiting low to moderate income persons--25 points

(iii) 79.99% to 70% of funds benefiting low to moderate income persons--20 points

(iv) 69.99% to 60% of funds benefiting low to moderate income persons--15 points

(v) Below 60% of funds benefiting low to moderate income persons--5 points

(C) Project priorities (total--195 points). When necessary, a weighted average is used to assign scores to applications which include activities in the different project priority scoring levels. Using as a base figure the TxCDBG funds requested minus the TxCDBG funds requested for engineering and administration, a percentage of the total TxCDBG construction dollars for each activity is calculated. The percentage of the total TxCDBG construction dollars for each activity is then multiplied by the appropriate project priorities point level. The sum of the calculations determines the composite project priorities score. The different project priority scoring levels are:

(i) activities (service lines, service connections, and/or plumbing improvements) providing access to water and/or sewer systems funded through the Texas Water Development Board Economically Distressed Area program--195 points

(ii) first time public water service activities (including yard service lines)--145 points

(iii) first time public sewer service activities (including yard service lines)--145 points

(iv) installation of approved residential on-site wastewater disposal systems for providing first time service--145 points

(v) installation of approved residential on-site wastewater disposal systems for failing systems that cause health issues--140 points

(vi) housing activities--140 points

(vii) first time water and/or sewer service through a privately-owned for profit utility--135 points

(viii) expansion or improvement of existing water and/or sewer service--120 points

(ix) street paving and drainage activities--95 [~~75~~] points

(x) all other eligible activities--20 points

(D) Matching funds (total--20 points). An applicant's matching share may consist of one or more of the following contributions: cash; in-kind services or equipment use; materials or supplies; or land. An applicant's match is considered only if the contributions are used in the same target areas for activities directly related to the activities proposed in its application; if the applicant demonstrates that its matching share has been specifically designated for use in the activities proposed in its application; and if the applicant has used an acceptable and reasonable method of valuation. The population category under which county applications are scored is dependent upon the project type and the beneficiary population served. If the project is for activities in the unincorporated area of the county with a target area of beneficiaries, the population category is based on the unincorporated residents for the entire county. For county applications addressing water and sewer improvements in unincorporated areas, the population category is based on the actual number of beneficiaries to be served by the project activities. The population category under which multi-jurisdiction applications are scored is based on the combined populations of the applicants according to the 2000 Census. Applications that include a housing rehabilitation and/or affordable new permanent housing activity for low- and moderate-income persons as a part of a multi-activity application do not have to provide any matching funds for the housing activity. This exception is for housing activities only. The TxCDBG does not consider sewer or water service lines and connections as housing activities. The TxCDBG also does not consider on-site wastewater disposal systems as housing activities. Demolition/clearance and code enforcement, when done in the same target area in conjunction with a housing rehabilitation activity, is counted as part of the housing activity. When demolition/clearance and code enforcement are proposed activities, but are not part of a housing rehabilitation activity, then the demolition/clearance and code enforcement are not considered as housing activities. Any additional activities, other than related housing activities, are scored based on the percentage of match provided for the additional activities.

(i) Applicants with populations equal to or less than 1,500 according to the 2000 census:

(I) match equal to or greater than 5.0% of grant request--20 points;

(II) match at least 2.0% but less than 5.0% of grant request--10 points;

(III) match less than 2.0% of grant request--0 points.

(ii) Applicants with populations equal to or less than 3,000 but over 1,500 according to the 2000 census:

(I) match equal to or greater than 10% of grant request--20 points;

(II) match at least 2.5% but less than 10% of grant request--10 points;

(III) match less than 2.5% of grant request--0 points.

(iii) Applicants with populations equal to or less than 5,000 but over 3,000 according to the 2000 census:

(I) match equal to or greater than 15% of grant request--20 points;

(II) match at least 3.5% but less than 15% of grant request--10 points;

(III) match less than 3.5% of grant request--0 points.

(iv) Applicants with populations over 5,000 according to the 2000 census:

(I) match equal to or greater than 20% of grant request--20 points;

(II) match at least 5.0% but less than 20% of grant request--10 points;

(III) match less than 5.0% of grant request--0 points.

(E) Project design (total--140 points). Each application is scored based on how the proposed project resolves the identified need and the severity of need within the applying jurisdiction. A more detailed description on the assignment of points under the project design scoring is included in the application guide for this fund and in subparagraph (F) of this paragraph. Each application is scored by a committee composed of TxCDBG staff using the following information submitted in the application:

(i) the severity of need within the colonia area(s) and how the proposed project resolves the identified need (additional consideration is given to water activities addressing impacts from drought conditions);

(ii) the TxCDBG cost per low to moderate income beneficiary;

(iii) the applicant's past efforts, especially the applicant's most recent efforts, to address water, sewer, and housing needs in colonia areas through applications submitted under the TxCDBG community development fund or through community development block grant entitlement funds;

(iv) the projected water and/or sewer rates after completion of the project based on 3,000 gallons, 5,000 gallons, and 10,000 gallons of usage;

(v) the ability of the applicant to utilize the grant funds in a timely manner;

(vi) the availability of grant funds to the applicant for project financing from other sources;

(vii) whether the applicant, or the service provider, has waived the payment of water or sewer service assessments, capital recovery fees, and other access fees for the proposed low and moderate income project beneficiaries;

(viii) whether the applicant's proposed use of TxCDBG funds is to provide water or sewer connections/yardlines and/or plumbing improvements that provide access to water/sewer systems financed through the Texas Water Development Board Economically Distressed Areas Program;

(ix) whether the applicant has already met its basic water and wastewater needs if the application is for activities other than water or wastewater;

(x) whether the project has provided for future funding necessary to sustain the project;

(xi) whether the applicant has provided any local matching funds for administrative, engineering, or construction activities;

(xii) the applicant's past performance on previously awarded TxCDBG contracts; and

(xiii) proximity of project site to entitlement cities or metropolitan statistical areas.

(F) Project design scoring guidelines. Project design scores are assigned by Department [~~Office~~] staff using guidelines that first consider the severity of the need for each application activity and how the project resolves the need described in the application. The severity of need and resolution of the need determine the maximum project design score that can be assigned to an application. After the maximum project design score has been established, points are then deducted from this maximum score through the evaluation of the other project design evaluation factors until the maximum score and the point deductions from that maximum score determine the final assigned project design score. When necessary, a weighted average is used to set the maximum project design score to applications that include activities in the different severity of the need/project resolution maximum scoring levels. Using as a base figure the TxCDBG funds requested minus the TxCDBG funds requested for engineering and administration, a percentage of the total TxCDBG construction dollars for each activity is calculated. The percentage of the total TxCDBG construction dollars for each activity is then multiplied by the appropriate maximum project design point level. The sum of the calculations determines the maximum project design score that the applicant can be assigned before points are deducted based on the evaluation of the other project design factors.

(i) Maximum project design score that can be assigned based on the severity of the need and resolution of the problem.

(I) Activities providing first-time public sewer service to the area--maximum score 140 points.

(II) Activities providing first-time public water service to the area--maximum score 140 points.

(III) Installation of approved residential on-site wastewater disposal systems providing first-time sewer service--maximum score 140 points.

(IV) Installation of approved residential on-site wastewater disposal systems for failing systems that cause health issues--maximum score 130 points.

(V) Housing rehabilitation and eligible new housing construction--maximum score 130 points.

(VI) Water activities addressing and resolving water supply shortage from drought conditions--maximum score 130 points.

(VII) Water or sewer activities expanding or improving existing water or sewer system--maximum score 125 points.

(VIII) Street paving activities providing first time surface pavement to the area--maximum score 100 points.

(IX) Installation of designed drainage structures providing first time designed drainage system to the area--maximum score 100 points.

(X) Reconstruction of streets with existing surface pavement--maximum score 90 points.

(XI) Installation of improvements or drainage structures to a designed drainage system--maximum score 90 points.

(XII) All other eligible activities--maximum score 80 points.

(ii) TxCDBG cost per low to moderate income beneficiary. The total amount of TxCDBG funds requested by the applicant is divided by the total number of low to moderate income persons benefiting from the application activities to determine the TxCDBG cost per beneficiary.

(I) Cost per low to moderate income beneficiary is equal to or less than $2,000. Deduct zero points from the set maximum project design score.

(II) Cost per low to moderate income beneficiary is greater than $2,000 but equal to or less than $4,000. Deduct 1 point from the set maximum project design score.

(III) Cost per low to moderate income beneficiary is greater than $4,000 but equal to or less than $6,000. Deduct 2 points from the set maximum project design score.

(IV) Cost per low to moderate income beneficiary is greater than $6,000 but equal to or less than $8,000. Deduct 3 points from the set maximum project design score.

(V) Cost per low to moderate income beneficiary is greater than $8,000 but equal to or less than $10,000. Deduct 4 points from the set maximum project design score.

(VI) Cost per low to moderate income beneficiary is greater than $10,000 but equal to or less than $11,000. Deduct 5 points from the set maximum project design score.

(VII) Cost per low to moderate income beneficiary is greater than $11,000 but equal to or less than $13,000. Deduct 10 points from the set maximum project design score.

(VIII) Cost per low to moderate income beneficiary is greater than $13,000 but equal to or less than $15,000. Deduct 15 points from the set maximum project design score.

(IX) Cost per low to moderate income beneficiary is greater than $15,000 but equal to or less than $17,000. Deduct 20 points from the set maximum project design score.

(X) Cost per low to moderate income beneficiary is greater than $17,000 but equal to or less than $19,000. Deduct 30 points from the set maximum project design score.

(XI) Cost per low to moderate income beneficiary is greater than $19,000. Deduct 40 points from the set maximum project design score.

(iii) The applicant's past efforts, especially the applicant's most recent efforts, to address water, sewer, and housing needs in colonia areas through applications submitted under the TxCDBG community development fund or through community development block grant entitlement funds.

(I) The nonentitlement county submitted an application under the TxCDBG community development fund 2009/2010 [~~2005/2006~~] biennial competition that was not addressing water, sewer, and housing needs in colonia areas. Deduct 3 points from the set maximum project design score.

(II) The nonentitlement county submitted an application under the TxCDBG community development fund 2007/2008 [~~2003/2004~~] biennial competition that was not addressing water, sewer, and housing needs in colonia areas. Deduct 3 points from the set maximum project design score.

(III) The entitlement county did not use 2009 [~~2005~~] CDBG entitlement funds to address water, sewer, and housing needs in colonia areas. Deduct 3 points from the set maximum project design score.

(IV) The entitlement county did not use 2008 [~~2004~~] CDBG entitlement funds to address water, sewer, and housing needs in colonia areas. Deduct 3 points from the set maximum project design score.

(iv) The projected water and/or sewer rates after completion of the project based on 3,000 gallons, 5,000 gallons, and 10,000 gallons of usage.

(I) The projected water and/or sewer rates may be too high for the application beneficiaries. Deduct 1 point from the set maximum project design score.

(II) The projected water and/or sewer rates are too low to discourage water conservation by the application beneficiaries. Deduct 1 point from the set maximum project design score.

(v) The ability of the applicant to utilize the grant funds in a timely manner.

(I) The application includes the acquisition of real property, easements or rights-of-way. Deduct 1 point from the set maximum project design score.

(II) The application includes matching funds that have not been secured by the applicant. Deduct 1 point from the set maximum project design score.

(III) The proposed application target area is not located in an area where a service provider already has the certificate of convenience and necessity (CCN) needed to provide service to the application beneficiaries. Deduct 1 point from the set maximum project design score.

(vi) The availability of grant funds to the applicant for project financing from other sources. Grant funds for any activity included in the application are available from another source. Deduct 1 point from the set maximum project design score.

(vii) The applicant, or the service provider, has not waived the payment of water or sewer service assessments, capital recovery fees, and other access fees for the proposed low and moderate income project beneficiaries.

(I) Assessments and fees budgeted in the application are equal to or less that $100 per low and moderate income household. Deduct 2 points from the set maximum project design score.

(II) Assessments and fees budgeted in the application are greater than $100 but equal to or less that $200 per low and moderate income household. Deduct 4 points from the set maximum project design score.

(III) Assessments and fees budgeted in the application are greater than $200 but equal to or less that $300 per low and moderate income household. Deduct 6 points from the set maximum project design score.

(IV) Assessments and fees budgeted in the application are greater than $300 but equal to or less that $500 per low and moderate income household. Deduct 8 points from the set maximum project design score.

(V) Assessments and fees budgeted in the application are greater than $500 per low and moderate income household. Deduct 10 points from the set maximum project design score.

(viii) Applicant's proposed use of TxCDBG funds does not provide water or sewer connections/yardlines and/or plumbing improvements that provide access to water/sewer systems financed through the Texas Water Development Board Economically Distressed Areas Program. Deduct 2 points from the set maximum project design score.

(ix) The application is for activities other than water or wastewater and the applicant has not already met its basic water and wastewater needs. Deduct 3 points from the set maximum project design score.

(x) The applicant has not documented that future funding necessary to sustain the project is available. Deduct 3 points from the set maximum project design score.

(G) Past performance. An applicant receives from zero to ten points based on the applicant's past performance on previously awarded TxCDBG contracts. The applicant's score will primarily be based on an assessment of the applicant's performance on the applicant's two most recent TxCDBG contracts that have reached the end of the original contract period stipulated in the contract. TxCDBG staff may also assess the applicant's performance on existing TxCDBG contracts that have not reached the end of the original contract period. An applicant that has never received a TxCDBG grant award will automatically receive these points. TxCDBG staff will assess the applicant's performance on TxCDBG contracts up to the application deadline date. The applicant's performance on TxCDBG contracts after the application deadline date will not be evaluated in this assessment. The evaluation of an applicant's past performance may include, but is not necessarily limited to the following:

(i) The applicant's completion of the previous contract activities within the original contract period.

(ii) The applicant's submission of the required close-out documents within the period prescribed for such submission.

(iii) The applicant's timely response to monitoring findings on previous TxCDBG contracts especially any instances when the monitoring findings included disallowed costs.

(iv) The applicant's timely response to audit findings on previous TxCDBG contracts.

(v) The applicant's submission of all contract reporting requirements such as quarterly progress reports, certificates of expenditures, and project completion reports.

(H) Colonia Construction Component Marginal Applicant. The marginal applicant is the applicant whose score is high enough for partial funding of the applicant's original grant request. If the marginal amount available to this applicant is equal to or more than the Colonia Construction Component grant minimum of $75,000, the marginal applicant may scale down the scope of the original project design, and accept the marginal amount, if the reduced project is still feasible. In the event that the marginal amount remaining in the Colonia Construction Component allocation is less than $75,000, then the remaining funds will be used to either fund a Colonia Planning Fund application or will be reallocated to other established TxCDBG fund categories.

(2) Colonia area planning component (340 Total Points Maximum). The following is an outline of the selection criteria used by the Department [~~Office~~] for scoring applications for eligible planning activities under this fund. Three hundred forty points are available.

(A) Community distress (total--up to 35 points). All community distress factor scores are based on the unincorporated population of the applicant. An applicant that has 125% or more of the average of all applicants in the competition of the rate on any community distress factor, except per capita income, receives the maximum number of points available for that factor. An applicant with less than 125% of the average of all applicants in the competition on a factor will receive a proportionate share of the maximum points available for that factor. An applicant that has 75% or less of the average of all applicants in the competition on the per capita income factor will receive the maximum number of points available for that factor. An applicant with greater than 75% of the average of all applicants in the competition on the per capita income factor will receive a proportionate share of the maximum points available for that factor.

(i) Percentage of persons living in poverty--15 points

(ii) Per capita income--10 points

(iii) Percentage of housing units without complete plumbing--5 points

(iv) Unemployment Rate--5 points

(B) Benefit to low and moderate income persons (total--30 points). Points are awarded based on the low and moderate income percentage for all of the colonia areas where project activities are located according to the following scale:

(i) 100% to 90% of funds benefiting low to moderate income persons--30 points

(ii) 89.99% to 80% of funds benefiting low to moderate income persons--25 points

(iii) 79.99% to 70% of funds benefiting low to moderate income persons--20 points

(iv) 69.99% to 60% of funds benefiting low to moderate income persons--15 points

(v) Below 60% of funds benefiting low to moderate income persons--5 points

(C) Project design (total--255 points). Each application is scored based on how the proposed planning effort resolves the identified need and the severity of need within the applying jurisdiction. A colonia planning fund application must receive a minimum score for the project design selection factor of at least 70 percent of the maximum number of points available under this factor to be considered for funding. A more detailed description on the assignment of points under the project design scoring is included in the application guide for this fund. Each application is scored by TxCDBG staff using the following information submitted in the application:

(i) Evidence of severity of need as described in originally received application (total--up to 10 points).

(ii) Applicant provides documentation that proposed colonia(s) is/are ranked high that is, within the top five colonias in its "comprehensive plan" as submitted to the TxCDBG (up to 30 points)

(iii) all target area colonia(s) not platted (up to 20 points)

(iv) all target area colonia(s) with no water (up to 20 points)

(v) all target area colonia(s) with no wastewater (up to 20 points)

(vi) all or some target area colonia(s) are partially platted or platted but not recorded (up to 10 points)

(vii) target area colonia(s) partial water (up to 10 points)

(viii) target area colonia(s) partial sewer (up to 10 points)

(ix) Population (total--10 points). The change in county population from 1990 and current HUD estimate is between:

(I) greater than 5% but less than or equal to 10% (2 points)

(II) greater than 10% but less than or equal to 15% (4 points)

(III) greater than 15% but less than or equal to 20% (6 points)

(IV) greater than 20% but less than or equal to 25% (8 points)

(V) greater than 25% (10 points)

(x) Needs are clearly identified in original application by priority through a community needs assessment (total--up to 5 points).

(xi) Evidence provided in the original application of citizen input or known citizen involvement in addressing need (total--up to 15 points).

(xii) Evidence provided in the original application that the public hearings to solicit input on needs were performed as described in the application guide (total--up to 28 points).

(xiii) Proposed planning efforts as described in the application are clear, concise and reasonable (total--up to 20 points).

(xiv) The description of planning activity in the original application:

(I) Originally submitted TABLE 1 requests eligible activities (3 points);

(II) Originally submitted TABLE 1 proposes an inventory, analysis and plan or an eligible activity not previously funded through the Colonia Fund (3 points);

(III) Originally submitted TABLE 1 addresses identified needs (3 points);

(IV) Originally submitted TABLE 1 activities match Table 2 planning elements (3 points);

(V) Originally submitted TABLE 1 describes or indicates an implementable strategy, for example, a capital improvements plan or other method (3 points).

(xv) All proposed activities will be conducted on a colonia-wide basis (10 points).

(xvi) The extent to which any previous planning efforts for colonia areas have been accomplished. Applicant was a previous recipient of Colonia Planning Funds and through implementation of previously funded activities a colonia has been eliminated from colonia status (water, wastewater and housing needs have been provided for). Evidence such as a resolution of the commissioner's court that county has eliminated a colonia from the original colonia list in the comprehensive study or the Office of the Attorney General (OAG) list thus indicating that the county is organized to implement the plan or would ensure that the plan is implemented. Points will be awarded) if applicant is a previous recipient of a Colonia Comprehensive Planning Fund award and certifies completion of all of a colonia's needs since the colonia's problems were last studied (25 points).

(xvii) TxCDBG cost per low to moderate income beneficiary (total--15 points):

(I) the TxCDBG cost per low to moderate income beneficiary is at least 50 percent below the median cost per beneficiary of all eligible applicants (15 points); or

(II) the TxCDBG cost per low to moderate income beneficiary is at or below the median cost per beneficiary of all eligible applicants (10 points); or

(III) the TxCDBG cost per low to moderate income beneficiary is below 150 percent of the median cost per beneficiary of all eligible applicants (7 points); or

(IV) the TxCDBG cost per low to moderate income beneficiary is 150 percent or greater than the median cost per beneficiary of all eligible applicants (5 points).

(xviii) the availability of grant funds to the applicant for project financing from other sources. The area would be eligible for funding under the Texas Water Development Board's Economically Distressed Areas Program (EDAP) or other programs as described in the original application (total--6 points).

(xix) the applicant's past performance on prior TxCDBG contracts. An applicant can receive from zero to twelve points based on the applicant's past performance on previously awarded TxCDBG contracts. The applicant's score will be primarily based on our assessment of the applicant's performance on the applicant's two most recent TxCDBG contracts that have reached the end of the original contract period stipulated in the contract. The TxCDBG may also assess the applicant's performance on existing TxCDBG contracts that have not reached the end of the original contract period. Applicants that have never received a TxCDBG grant award will automatically receive these points. The TxCDBG will assess the applicant's performance on TxCDBG contracts up to the application deadline date. The applicant's performance after the application deadline date will not be evaluated in this assessment. The evaluation of an applicant's past performance may include, but is not necessarily limited to the following:

(I) The applicant's completion of the previous two most recent contracts contract activities within the original contract period (up to 3 points).

(II) The applicant's submission of the required close-out documents for aforementioned contracts within the period prescribed for such submission (up to 3 points).

(III) The applicant's timely response to monitoring findings on previous TxCDBG contracts especially any instances when the monitoring findings included disallowed costs (up to 3 points).

(IV) The applicant's timely response to audit findings on previous TxCDBG contracts (up to 3 points).

(D) Matching funds (total--20 points). The population category under which county applications are scored is based on the actual number of beneficiaries to be served by the colonia planning activities.

(i) Applicants with populations equal to or less than 1,500 according to the 2000 census:

(I) match equal to or greater than 5.0% of grant request--20 points;

(II) match at least 2.0% but less than 5.0% of grant request--10 points;

(III) match less than 2.0% of grant request--0 points.

(ii) Applicants with populations equal to or less than 3,000 but over 1,500 according to the 2000 census:

(I) match equal to or greater than 10% of grant request--20 points;

(II) match at least 2.5% but less than 10% of grant request--10 points;

(III) match less than 2.5% of grant request--0 points.

(iii) Applicants with populations equal to or less than 5,000 but over 3,000 according to the 2000 census:

(I) match equal to or greater than 15% of grant request--20 points;

(II) match at least 3.5% but less than 15% of grant request--10 points;

(III) match less than 3.5% of grant request--0 points.

(iv) Applicants with populations over 5,000 according to the 2000 census:

(I) match equal to or greater than 20% of grant request--20 points;

(II) match at least 5.0% but less than 20% of grant request--10 points;

(III) match less than 5.0% of grant request--0 points.

(E) The marginal applicant is the applicant whose score is high enough for partial funding of the applicant's original grant request. The marginal applicant may scale down the scope of the original project design, and accept the marginal amount, if the reduced project is still feasible. Any unobligated funds remaining in the Colonia Area Planning allocation will be reallocated to either fund additional Colonia Comprehensive Planning applications, Colonia Construction Component applications, or will be reallocated to other established TxCDBG fund categories.

(3) Colonia construction component (200 Total Points Maximum). The following is an outline of the selection criteria used by the Department [~~Office~~] for scoring applications for eligible planning activities under this fund. Two hundred points are available.

(A) Community distress (total--25 points). All community distress factor scores are based on the unincorporated population of the applicant. An applicant that has 125% or more of the average of all applicants in the competition of the rate on any community distress factor, except per capita income, receives the maximum number of points available for that factor. An applicant with less than 125% of the average of all applicants in the competition on a factor will receive a proportionate share of the maximum points available for that factor. An applicant that has 75% or less of the average of all applicants in the competition on the per capita income factor will receive the maximum number of points available for that factor. An applicant with greater than 75% of the average of all applicants in the competition on the per capita income factor will receive a proportionate share of the maximum points available for that factor.

(i) Percentage of persons living in poverty--10 points

(ii) Per capita income--5 points

(iii) Percentage of housing units without complete plumbing--5 points

(iv) Unemployment Rate--5 points

(B) Project design (total--175 points). A colonia planning fund application must receive a minimum score for the project design selection factor of at least 70 percent of the maximum number of points available under this factor to be considered for funding. A more detailed description on the assignment of points under the project design scoring is included in the application guide for this fund. Each application is scored by the Department [~~Office~~] staff using the following information submitted in the application:

(i) the severity of need for the comprehensive colonia planning effort and how effectively the proposed comprehensive planning effort will result in a useful assessment of colonia populations, locations, infrastructure conditions, housing conditions, and the development of short-term and long-term strategies to resolve the identified needs;

(I) Evidence of severity of need as described in originally received application (total--100 points).

(II) Population (total--10 points). The change in county population from 1990 to current HUD estimate is between:

(-a-) greater than 2% but less than or equal to 4% (2 points).

(-b-) greater than 4% but less than or equal to 6% (4 points).

(-c-) greater than 6% but less than or equal to 8% (6 points).

(-d-) greater than 8% but less than or equal to 10% (8 points).

(-e-) greater than 10% (10 points).

(III) Needs are clearly identified in original application by priority through a community needs assessment (total--2 points);

(IV) Evidence provided in the original application of citizen input or known citizen involvement in addressing need (total--2 points);

(V) Evidence provided in the original application that the public hearings to solicit input on needs were performed as described in the application guide (total--18 points);

(VI) Proposed planning efforts as described in the application are clear, concise and reasonable (total--2 points).

(VII) Proposed planning efforts as described in the application match the needs in the target area (total--2 points).

(VIII) Evidence in the application that the county is organized to implement the plan or would ensure that the plan is implemented (total--2 points).

(IX) The description of planning activity in the original application:

(-a-) Describes eligible activities (total--1 point).

(-b-) Describes understanding of plan process (total--1 point).

(-c-) Addresses identified needs (total--1 point).

(-d-) Appears to result in solution to problems (total--1 point).

(-e-) Indicates a strategy that can be implemented (total--1 point).

(X) Considering the applicant's probable capability, the Colonia Questionnaire in the original application indicates an attempt to control problems and the original submission was complete (total--3 points).

(ii) the extent to which any previous planning efforts for colonia areas have been implemented (total--5 points). Applicant was a previous recipient of Colonia Planning Funds and some implementation of previously funded activities or special or extenuating cir-

cumstances prohibiting implementation exist. Points will be awarded if applicant is not a previous recipient of a Colonia Planning Fund award. Points will not be awarded if applicant did not implement previously funded activities and no special or extenuating circumstances prohibiting implementation existed;

(iii) whether the applicant provides any local matching funds for project activities. (total--12 points).

(I) At least 20% of TxCDBG requested amount match--12 points.

(II) At least 15% of TxCDBG requested amount but less than 20% match--9 points.

(III) At least 10% of TxCDBG requested amount but less than 15% match--6 points.

(IV) At least 5% of TxCDBG requested amount but less than 10% match--3 points.

(V) Under 5% of TxCDBG requested amount match--0 points.

(iv) the applicant's past performance on previously awarded TxCDBG contracts. An applicant can receive from zero to twelve points based on the applicant's past performance on previously awarded TxCDBG contracts. The applicant's score will be primarily based on our assessment of the applicant's performance on the applicant's two most recent TxCDBG contracts that have reached the end of the original contract period stipulated in the contract. The TxCDBG may also assess the applicant's performance on existing TxCDBG contracts that have not reached the end of the original contract period. Applicants that have never received a TxCDBG grant award will automatically receive these points. The TxCDBG will assess the applicant's performance on TxCDBG contracts up to the application deadline date. The applicant's performance after the application deadline date will not be evaluated in this assessment. The evaluation of an applicant's past performance will include, but is not necessarily limited to the following:

(I) The applicant's completion of the previous contract, two most recent TxCDBG contracts contract activities within the original contract period (up to 3 points).

(II) The applicant's submission of the required close-out documents for aforementioned contracts within the period prescribed for such submission (up to 3 points).

(III) The applicant's timely response to monitoring findings on previous TxCDBG contracts especially any instances when the monitoring findings included disallowed costs (up to 3 points).

(IV) The applicant's timely response to audit findings on previous TxCDBG contracts (up to 3 points).

(f) Program guidelines (colonia self-help centers legislative set-aside). The colonia self-help centers legislative set-aside is administered by the Texas Department of Housing and Community Affairs (TDHCA) under an interagency agreement with the Department [~~Office~~]. The following is an outline of the administrative requirements and eligible activities under this fund.

(1) The geographic area served by each colonia self-help center shall be determined by the Department [~~Office~~] or by the TDHCA. Five colonias located in each established colonia self-help center service area shall be designated to receive concentrated attention from the center. Each colonia self-help center shall set a goal to improve the living conditions of the residents located in the colonias designated for concentrated attention within a two-year period set under the contract terms. The Department [~~Office~~] and the TDHCA have the authority to make changes to the colonias designated for this concentrated attention.

(2) The Department's [~~Office's~~] grant contract for each colonia self-help center is awarded and executed with the county where the colonia self-help center is located. Each county executes a subcontract agreement with a non-profit community action agency or a public housing authority.

(3) A colonia advisory committee is established and not fewer than five persons who are residents of colonias are selected from the candidates submitted by local nonprofit organizations and the commissioners court of a county where a self-help center is located. One committee member shall be appointed to represent each of the counties in which a colonia self-help center is located. Each committee member must be a resident of a colonia located in the county the member represents but may not be a board member, contractor, or employee of or have any ownership interest in an entity that is awarded a contract through the TxCDBG. The advisory committee shall advise the Department [~~Office~~] and the TDHCA regarding:

(A) the needs of colonia residents;

(B) appropriate and effective programs that are proposed or are operated through the centers; and

(C) activities that may be undertaken through the centers to better serve the needs of colonia residents.

(4) The purpose of each colonia self-help center is to assist low income and very low income individuals and families living in colonias located in the center's designated service area to finance, refinance, construct, improve or maintain a safe, suitable home in the designated service area or in another suitable area. Each self-help center may serve low income and very low income individuals and families by:

(A) providing assistance in obtaining loans or grants to build a home;

(B) teaching construction skills necessary to repair or build a home;

(C) providing model home plans;

(D) operating a program to rent or provide tools for home construction and improvement for the benefit of property owners in colonias who are building or repairing a residence or installing necessary residential infrastructure;

(E) helping to obtain, construct, assess, or improve the service and utility infrastructure designed to service residences in a colonia, including potable water, wastewater disposal, drainage, streets and utilities;

(F) surveying or platting residential property that an individual purchased without the benefit of a legal survey, plat, or record;

(G) providing credit and debt counseling related to home purchase and finance;

(H) applying for grants and loans to provide housing and other needed community improvements;

(I) monthly programs to educate individuals and families on their rights and responsibilities as property owners;

(J) providing other eligible services that the self-help center, with the Department's [~~Office's~~] approval, determines are necessary to assist colonia residents in improving their physical living con-

ditions, including help in obtaining suitable alternative housing outside of a colonia's area;

(K) providing assistance in obtaining loans or grants to enable an individual or family to acquire fee simple title to property that originally was purchased under a contract for a deed, contract for sale, or other executory contract; and

(L) providing access to computers, the internet, and computer training.

(5) A self-help center may not provide grants, financing, or mortgage loan services to purchase, build, rehabilitate, or finance construction or improvements to a home in a colonia if water service and suitable wastewater disposal are not available.

(g) Selection criteria (colonia EDAP fund). The following is an outline of the application information evaluated by a committee composed of the Department's [~~Office's~~] staff.

(1) The proposed use of the colonia EDAP funds including the eligibility of the proposed activities and the effective use of the funds to provide water or sewer connections/yard lines to water/sewer systems funded through the Texas Water Development Board Economically Distressed Area Program.

(2) The ability of the applicant to utilize the grant funds in a timely manner.

(3) The availability of grant funds to the applicant for project financing from other sources.

(4) The applicant's past performance on previously awarded TxCDBG contracts.

(5) Cost per beneficiary.

(6) Proximity of project site to entitlement cities or metropolitan statistical areas.

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 6, 2010.

TRD-201006887
Charles S. (Charlie) Stone
Executive Director
Texas Department of Rural Affairs
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 936-6734

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 108. PROFESSIONAL CONDUCT
SUBCHAPTER C. ANESTHESIA AND ANESTHETIC AGENTS

22 TAC §§108.30 - 108.35

(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 State Board of Dental Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The State Board of Dental Examiners (SBDE) proposes the repeal of Chapter 108, Subchapter C, relating to Anesthesia and Anesthetic Agents. Subchapter C is comprised of §108.30, relating to Effective Date, §108.31, relating to Definitions, §108.32, relating to Minimum Standard of Care, Anesthesia, §108.33, relating to Sedation/Anesthesia Permit, §108.34, relating to Permit Requirements and Clinical Provisions, and §108.35, relating to Authority to Demonstrate Anesthesia. The repeal is proposed so that the SBDE may publish revised anesthesia and sedation rules. The proposed new rules are published in the Proposed Rules section of this issue of the *Texas Register.*

Ms. Sherri Sanders Meek, Executive Director, has determined that for each year of the first five years the repeal is in effect, the public benefit anticipated will be protection of the public through updated sedation and anesthesia rules.

Ms. Meek has also determined that for each year of the first five years the repeal is in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the repeal. There is no anticipated economic impact on individuals or small or micro-businesses required to comply with the repeal as proposed.

Comments on the repeal may be submitted to Carey A. Olney, staff attorney, State Board of Dental Examiners, 333 Guadalupe Street, Tower 3, Suite 800, Austin, Texas 78701 (by mail), (512) 463-7452 (by fax), or *carey.olney@tsbde.state.tx.us* (by email). To be considered, comments must be in writing and received by the State Board of Dental Examiners no later than 30 days from the date that the section is published in the *Texas Register.*

The repeal is proposed under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The repeal affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

§108.30. Effective Date.

§108.31. Definitions.

§108.32. Minimum Standard of Care, Anesthesia.

§108.33. Sedation/Anesthesia Permit.

§108.34. Permit Requirements and Clinical Provisions.

§108.35. Authority to Demonstrate Anesthesia.

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 1, 2010.

TRD-201006833
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 110. ENTERAL CONSCIOUS SEDATION

22 TAC §§110.1 - 110.4

(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 State Board of Dental Examiners or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The State Board of Dental Examiners (SBDE) proposes the repeal of Chapter 110, relating to Enteral Conscious Sedation. Chapter 110 is comprised of §110.1, relating to Definitions, §110.2, relating to Permit, §110.3, relating to Permit Requirements and Clinical Provisions, and §110.4, relating to Effective Date. The repeal is proposed so that the SBDE may publish revised anesthesia and sedation rules. The proposed new rules are published in the Proposed Rules section of this issue of the *Texas Register.*

Ms. Sherri Sanders Meek, Executive Director, has determined that for each year of the first five years the repeal is in effect, the public benefit anticipated will be protection of the public through updated sedation and anesthesia rules.

Ms. Meek has also determined that for each year of the first five years the repeal is in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the repeal. There is no anticipated economic impact on individuals or small or micro-businesses required to comply with the repeal as proposed.

Comments on the repeal may be submitted to Carey A. Olney, staff attorney, State Board of Dental Examiners, 333 Guadalupe Street, Tower 3, Suite 800, Austin, Texas 78701 (by mail), (512) 463-7452 (by fax), or *carey.olney@tsbde.state.tx.us* (by email). To be considered, comments must be in writing and received by the State Board of Dental Examiners no later than 30 days from the date that the section is published in the *Texas Register.*

The repeal is proposed under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The repeal affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

§110.1. Definitions.

§110.2. Permit.

§110.3. Permit Requirements and Clinical Provisions.

§110.4. Effective Date.

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 1, 2010.

TRD-201006834
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 110. SEDATION AND ANESTHESIA

22 TAC §§110.1 - 110.9

The State Board of Dental Examiners (SBDE) proposes new §110.1, relating to Definitions, §110.2, relating to Sedation/Anesthesia Permit, §110.3, relating to Nitrous Oxide/Oxygen Inhalation Sedation, §110.4, relating to Minimal Sedation, §110.5, relating to Moderate Sedation, §110.6, relating to Deep Sedation or General Anesthesia, §110.7, relating to Portability, §110.8, relating to Provisional Anesthesia and Portability Permits, and §110.9, relating to Anesthesia Permit Renewal.

Ms. Sherri Sanders Meek, Executive Director, has determined that for each year of the first five years the new sections are in effect, the public benefit anticipated as a result of enforcing the new sections will be protection of the public through updated sedation and anesthesia rules.

The SBDE's Anesthesia Rules Ad-Hoc Committee was convened to update the agency's sedation and anesthesia rules based on sedation guidelines adopted by the American Dental Association (ADA) House of Delegates in 2007. The committee met on August 27, 2009, November 19, 2009, April 15, 2010, and August 19, 2010. The committee was chaired by Tamela L. Gough, DDS, and its members included William L. Purifoy, DDS; James W. Chancellor, DDS; William Birdwell, DDS; Maxwell Finn, DDS, MD; and Arthur Troilo, JD.

The new sections developed by the committee (new Chapter 110, Sedation and Anesthesia) consolidate sedation and anesthesia rules previously found in §§108.30 - 108.35 and Chapter 110, Enteral Sedation. The most significant change in the revisions is to the levels of anesthesia and sedation permitting. The permitting process emphasizes the level of sedation of the patient rather than the route of administration of the medication. The new sections establish five levels of anesthesia and sedation permits beyond the standard dental license: Nitrous Oxide/Oxygen Inhalation Sedation; Level 1: Minimal Sedation; Level 2: Moderate Sedation (enteral sedation); Level 3: Moderate Sedation (parenteral sedation); and Level 4: Deep Sedation or General Anesthesia.

Most levels of permitting will change in name only. Licensed dentists who lack sedation permits may continue to utilize local anesthetic and prescribe minor tranquilizers for anxiolysis. A licensed dentist who holds an active Nitrous Oxide/Oxygen Inhalation Conscious Sedation permit, Parenteral Sedation permit, or Deep Sedation or General Anesthesia permit on or before the effective date of the new sections will have his or her permit automatically reclassified as a Nitrous Oxide/Oxygen Inhalation Sedation permit, Level 3 permit, and Level 4 permit respectively on the effective date.

A licensed dentist who holds an active Enteral Sedation permit on or before the effective date will have his or her permit automatically reclassified as a Level 1 (Minimal Sedation) permit. Dentists in this category may continue to administer Enteral Sedation as permitted by the current rules until January 1, 2013. A dentist who holds an active Enteral Sedation permit on or before June 1, 2011 who desires to administer Level 2 (Moderate - Enteral) sedation after January 1, 2013 must submit an application for a Level 2 permit prior to January 1, 2013. A Level 1 permit allows a dentist to use a single medication or a single medication

in combination with nitrous oxide to achieve sedation. The sedation provided under this permit may only result in a minimally depressed level of consciousness for the patient. A Level 2 permit will be required to utilize two or more medications to achieve sedation or to achieve a moderate level of sedation.

In addition to changes in the permitting process, the new Chapter 110 revises education requirements for future permit holders and revises clinical guidelines and continuing education requirements for current permit holders. The new chapter takes effect on June 1, 2011.

The ADA's Guidelines may be accessed at:

www.ada.org/sections/about/pdfs/anesthesia_guidelines.pdf,

www.ada.org/sections/professionalresources/pdfs/anxiety_guidelines.pdf, and

www.ada.org/sections/about/pdfs/statements_anesthesia.pdf.

Ms. Meek has also determined that for each year of the first five years the new sections are in effect, there will be no fiscal implications for local or state government as a result of enforcing or administering the sections. There is no anticipated economic impact on individuals or small or micro-businesses required to comply with the sections as proposed.

Comments on the proposals may be submitted to Carey A. Olney, staff attorney, State Board of Dental Examiners, 333 Guadalupe Street, Tower 3, Suite 800, Austin, Texas 78701 (by mail), (512) 463-7452 (by fax), or *carey.olney@tsbde.state.tx.us* (by email). To be considered, comments must be in writing and received by the State Board of Dental Examiners no later than 30 days from the date that the sections are published in the *Texas Register.*

The new sections are proposed under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The proposal affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

§110.1. Definitions.

Unless the context clearly indicates otherwise, the following words and terms shall have the following meaning when used in this chapter.

(1) Analgesia--the diminution or elimination of pain.

(2) Behavioral management--the use of pharmacological or psychological techniques, singly or in combination, to modify behavior to a level that dental treatment can be performed effectively and efficiently.

(3) Board/Agency--the Texas State Board of Dental Examiners, also known as the State Board of Dental Examiners, and, for brevity, the Dental Board, the Agency, or the Board.

(4) Child/children--a patient twelve (12) years of age or younger.

(5) Competent--displaying special skill or knowledge derived from training and experience.

(6) Deep sedation--a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

(7) Direct supervision--the dentist responsible for the sedation/anesthesia procedure shall be physically present in the facility and shall be continuously aware of the patient's physical status and well-being.

(8) Enteral--any technique of administration of sedation in which the agent is absorbed through the gastrointestinal (GI) tract or oral mucosa (i.e., oral, rectal, sublingual).

(9) Facility--the location where a permit holder practices dentistry and provides anesthesia/sedation services.

(10) Facility inspection--an on-site inspection to determine if a facility where the applicant proposes to provide anesthesia/sedation is supplied, equipped, staffed and maintained in a condition to support provision of anesthesia/sedation services that meet the minimum standard of care.

(11) General anesthesia--a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

(12) Immediately available--on-site in the facility and available for immediate use.

(13) Incremental dosing--administration of multiple doses of a drug until a desired effect is reached, but not to exceed the maximum recommended dose (MRD).

(14) Local anesthesia--the elimination of sensation, especially pain, in one part of the body by the topical application or regional injection of a drug.

(15) Maximum recommended dose (applies to minimal sedation)--FDA maximum recommended dose (MRD) of a drug, as printed in FDA-approved labeling for unmonitored home use.

(16) Minimal sedation--a minimally depressed level of consciousness, produced by a pharmacological method, which retains the patient's ability to independently and continuously maintain an airway and respond normally to tactile stimulation and verbal command. Although cognitive function and coordination may be modestly impaired, ventilatory and cardiovascular functions are unaffected. Medication administered for the purpose of minimal sedation shall not exceed the maximum doses recommended by the drug manufacturer. Nitrous oxide/oxygen may be used in combination with a single enteral drug in minimal sedation. During longer periods of minimal sedation in which the total amount of time of the procedures exceeds the effective duration of the sedative effect of the drug used, the supplemental dose of the sedative shall not exceed total safe dosage levels based on the effective half-life of the drug used. The total aggregate dose must not exceed one and one-half times the MRD on the day of treatment. The use of prescribed, previsit sedatives for children aged twelve (12) or younger should be avoided due to the risk of unobserved respiratory obstruction during the transport by untrained individuals.

(17) Moderate sedation--drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. A Level 2 permit is required for moderate sedation limited to enteral routes of administration. A Level 3 permit is required for moderate sedation including parenteral routes of administration. In accordance with this particular definition, the drugs or techniques used shall carry

a margin of safety wide enough to render unintended loss of consciousness unlikely. Repeated dosing of an agent before the effects of previous dosing can be fully appreciated may result in a greater alteration of the state of consciousness than is the intent of the dentist. A patient whose only response is reflex withdrawal from a painful stimulus is not considered to be in a state of moderate sedation.

(18) Parenteral--the administration of pharmacological agents intravenously, intraosseously, intramuscularly, subcutaneously, submucosally, intranasally, or transdermally.

(19) Patient Physical Status Classification:

(A) ASA--American Society of Anesthesiologists

(B) ASA I--a normal health patient

(C) ASA II--a patient with mild systemic disease

(D) ASA III--a patient with severe systemic disease

(E) ASA IV--a patient with severe systemic disease that is a constant threat to life

(F) ASA V--a moribund patient who is not expected to survive without the operation

(G) ASA VI--a declared brain-dead patient whose organs are being removed for donor purposes

(H) E--emergency operation of any variety (used to modify ASA I - ASA VI).

(20) Portability--the ability of a permit holder to provide permitted anesthesia services in a location other than a facility or satellite facility.

(21) Protective reflexes--includes the ability to swallow and cough effectively.

(22) Satellite facility--an additional office or offices owned or operated by the permit holder, or owned or operated by a professional organization through which the permit holder practices dentistry, or a licensed hospital facility.

(23) Supplemental dosing (applies to minimal sedation)--during minimal sedation, supplemental dosing is a single additional dose of the initial dose of the initial drug that may be necessary for prolonged procedures. The supplemental dose should not exceed one-half of the initial dose and should not be administered until the dentist has determined the clinical half-life of the initial dosing has passed. The aggregate dose must not exceed one and one-half times the MRD on the day of treatment.

(24) Time-oriented anesthesia record--documentation at appropriate time intervals of drugs, doses, and physiologic data obtained during patient monitoring. Physiologic data for moderate sedation, deep sedation and general anesthesia must be taken and recorded at required intervals unless patient cooperation interferes or prohibits compliance.

(25) Titration (applies to moderate sedation)--administration of incremental doses of a drug until the desired effect is reached. Knowledge of each drug's time of onset, peak response and duration of action is essential to avoid over-sedation. When the intent is moderate sedation, one must know whether the previous dose has taken full effect before administering an additional drug increment.

§110.2. Sedation/Anesthesia Permit.

(a) A dentist licensed under Chapter 101 of this title shall obtain an anesthesia permit for the following anesthesia procedures used for the purpose of performing dentistry:

(1) Nitrous Oxide/Oxygen inhalation sedation;

(2) Level 1: Minimal sedation;

(3) Level 2: Moderate sedation limited to enteral routes of administration;

(4) Level 3: Moderate sedation which includes parenteral routes of administration; or

(5) Level 4: Deep sedation or general anesthesia.

(b) A dentist licensed to practice in Texas who desires to administer nitrous oxide/oxygen inhalation sedation or Level 1, Level 2, Level 3 or Level 4 sedation must obtain a permit from the State Board of Dental Examiners (Board). A permit is not required to administer Schedule II drugs prescribed for the purpose of pain control or post-operative care.

(1) A permit may be obtained by completing an application form approved by the Board.

(2) The application form must be filled out completely and appropriate fees paid.

(3) Prior to issuance of a sedation/anesthesia permit, the Board may require that the applicant undergo a facility inspection or further review of credentials. The Board may direct an Anesthesia Consultant, who has been appointed by the Board, to assist in this inspection or review. The applicant will be notified in writing if an inspection is required and provided with the name of an Anesthesia Consultant who will coordinate the inspection. The applicant must make arrangements for completion of the inspection within 180 days of the date the notice is mailed. An extension of no more than ninety (90) days may be granted if the designated Anesthesia Consultant requests one.

(4) An applicant for a sedation/anesthesia permit must be licensed by and should be in good standing with the Board. For purposes of this chapter "good standing" means that the dentist's license is not suspended, whether or not the suspension is probated. Applications from licensees who are not in good standing may not be approved.

§110.3. Nitrous Oxide/Oxygen Inhalation Sedation.

(a) Education and Professional Requirements. A dentist applying for a nitrous oxide/oxygen inhalation sedation permit shall meet one of the following educational/professional criteria:

(1) satisfactory completion of a comprehensive training program consistent with that described for nitrous oxide/oxygen inhalation sedation administration in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of fourteen (14) hours of training, including a clinical component, during which competency in inhalation sedation technique is achieved. Acceptable courses include those obtained from academic programs of instruction recognized by the ADA Commission on Dental Accreditation (CODA); or courses approved and recognized by the ADA Continuing Education Recognition Program (CERP); or courses approved and recognized by the Academy of General Dentistry (AGD) Program Approval for Continuing Education (PACE);

(2) satisfactory completion of an ADA/CODA approved or recognized pre-doctoral dental or postdoctoral dental training program which affords comprehensive training necessary to administer and manage nitrous oxide/oxygen inhalation sedation; or

(3) is a Texas licensed dentist, has a current Board-issued nitrous oxide/oxygen inhalation sedation permit, and has been using nitrous oxide/oxygen inhalation sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. Any dentist whose Board-issued nitrous oxide/oxygen inhalation seda-

tion permit is active on June 1, 2011 shall automatically continue to hold this permit.

(b) Standard of Care Requirements. A dentist performing nitrous oxide/oxygen inhalation sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of nitrous oxide/oxygen inhalation sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a nitrous oxide/oxygen inhalation sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed. This provision and similar provisions in subsequent sections address dentists and are not intended to address the scope of practice of persons licensed by any other agency.

(c) Clinical Requirements. A dentist must meet the following clinical requirements to utilize nitrous oxide/oxygen inhalation sedation:

(1) Patient Evaluation. Patients considered for nitrous oxide/oxygen inhalation sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with the patient's primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised of the risks associated with the delivery of nitrous oxide/oxygen inhalation sedation and must provide written, informed consent for the proposed sedation.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of inhalation agents prior to use on each patient.

(C) Baseline vitals must be obtained in accordance with §108.7 and §108.8 of this title.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one member of the assistant staff should be present during the administration of nitrous oxide/oxygen inhalation sedation in nonemergency situations.

(B) The inhalation equipment must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(C) If nitrous oxide and oxygen delivery equipment capable of delivering less than 30% oxygen is used, an in-line oxygen analyzer must be utilized.

(D) The equipment must have an appropriate nitrous oxide/oxygen scavenging system.

(E) The ability of the provider and/or the facility to deliver positive pressure oxygen must be maintained.

(4) Monitoring.

(A) The dentist must induce the nitrous oxide/oxygen inhalation sedation and must remain in the room with the patient during the maintenance of the sedation until pharmacologic and physiologic vital sign stability is established.

(B) After pharmacologic and physiologic vital sign stability has been established, the dentist may delegate the monitoring of the nitrous oxide/oxygen inhalation sedation to a dental auxiliary who has been certified to monitor the administration of nitrous oxide/oxygen inhalation sedation by the State Board of Dental Examiners.

(5) Documentation.

(A) Pre-operative baseline vitals must be documented.

(B) Individuals present during administration must be documented.

(C) Maximum concentration administered must be documented.

(D) The start and finish times of the inhalation agent must be documented.

(6) Recovery and Discharge.

(A) Recovery from nitrous oxide/oxygen inhalation sedation, when used alone, should be relatively quick, requiring only that the patient remain in an operatory chair as needed.

(B) Patients who have unusual reactions to nitrous oxide/oxygen inhalation sedation should be assisted and monitored either in an operatory chair or recovery room until stable for discharge.

(C) The dentist must determine that the patient is appropriately responsive prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(7) Emergency Management. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of the nitrous oxide, and providing the equipment and protocols for patient rescue. A dentist must be able to rescue patients who enter a deeper state of sedation than intended. The dentist, personnel and facility must be prepared to treat emergencies that may arise from the administration of nitrous oxide/oxygen inhalation sedation.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a nitrous oxide/oxygen inhalation sedation permit shall not intentionally administer minimal sedation, moderate sedation, deep sedation, or general anesthesia.

§110.4. Minimal Sedation.

(a) Education and Professional Requirements. A dentist applying for a Level 1 Minimal Sedation permit shall meet one of the following educational/professional criteria:

(1) satisfactory completion of training to the level of competency in minimal sedation consistent with that prescribed in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students, or a comprehensive training program in minimal sedation that satisfies the requirements described in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of sixteen (16) hours of didactic training and instruction in which competency in enteral and/or combined inhalation-enteral minimal sedation technique is demonstrated; or

(2) satisfactory completion of an advanced education program accredited by the ADA Commission on Dental Accreditation (CODA) that affords comprehensive training necessary to administer and manage minimal sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(3) is a Texas licensed dentist, has a current Board-issued enteral permit, and has been using minimal sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. Any Texas licensed dentist who was issued an enteral sedation permit before June 1, 2011 and whose enteral sedation permit was active on June 1, 2011 shall automatically have the permit reclassified as a Level 1 Minimal Sedation permit on June 1, 2011. A Texas licensed dentist whose permit is reclassified from an enteral sedation permit to a Level 1 Minimal Sedation permit on June 1, 2011 may continue to administer enteral sedation until January 1, 2013. On or before January 1, 2013, the dentist shall either provide proof that adequate education has been obtained by submitting an application for a Level 2 permit on or before that date, or shall comply with the requirements of a Level 1 permit after that date. A dentist shall always follow the standard of care and clinical requirements for the level of sedation he or she is performing.

(b) Standard of Care Requirements. A dentist performing minimal sedation shall maintain the minimum standard of care for anesthesia, and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of minimal sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a minimal sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements. A dentist must meet the following clinical requirements for utilization of minimal sedation:

(1) Patient Evaluation. Patients considered for minimal sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II), this may consist of a review of their current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated with the delivery of any sedative agents and must provide written, informed consent for the proposed sedation.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative technique prescribed.

(F) Pre-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one additional person trained in Basic Life Support (BLS) for Healthcare Providers must be present.

(B) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(C) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(D) An appropriate scavenging system must be available if gases other than oxygen or air are used.

(4) Monitoring. The dentist administering the sedation must remain in the operatory room to monitor the patient until the patient meets the criteria for discharge to the recovery area. Once the patient meets the criteria for discharge to the recovery area, the dentist may delegate monitoring to a qualified dental auxiliary. Monitoring during the administration of sedation must include:

(A) Oxygenation.

(i) Color of mucosa, skin, or blood must be evaluated continually.

(ii) Oxygen saturation monitoring by pulse-oximetry should be used when a single drug minimal sedative is used. The additional use of nitrous oxide has a greater potential to increase the patient's level of sedation to moderate sedation, and a pulse oximeter must be used.

(B) Ventilation. The dentist (or appropriately qualified individual) must observe chest excursions and must verify respirations continually.

(C) Circulation. Blood pressure and heart rate should be evaluated preprocedurally, post-procedurally and intra-procedurally as necessary.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title and must include the names and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(B) A time-oriented sedation record may be considered for documentation of all monitoring parameters.

(C) Pulse oximetry, heart rate, respiratory rate, and blood pressure are the parameters which may be documented at appropriate intervals of no more than 10 minutes.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available in the recovery area if a separate recovery area is utilized.

(B) The qualified dentist must monitor the patient during recovery until the patient is ready for discharge by the dentist. The dentist may delegate this task to an appropriately qualified dental auxiliary.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(7) Emergency Management. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist is responsible for the sedative management, adequacy of the facility and staff, diagnosis and treatment of emergencies related to the administration of minimal sedation, and providing the equipment and protocols for patient rescue. A dentist must be able to rescue patients who enter a deeper state of sedation than intended.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a minimal sedation permit shall not intentionally administer moderate sedation, deep sedation, or general anesthesia.

§110.5. Moderate Sedation.

(a) Education and Professional Requirements.

(1) A dentist applying for a Level 2 Moderate Sedation permit (limited to enteral route of administration) must satisfy at least one of the following educational/professional criteria:

(A) satisfactory completion of a comprehensive training program consistent with that described for moderate enteral sedation in the American Dental Association (ADA) Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of twenty-four (24) hours of instruction, plus management of at least ten (10) case experiences in enteral moderate sedation. These ten (10) case experiences must include at least three live clinical dental experiences managed by participants in groups of no larger than five (5). The remaining cases may include simulations and/or video presentations, but must include one experience in returning (rescuing) a patient from deep to moderate sedation; or

(B) satisfactory completion of an advanced education program accredited by the ADA Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training necessary to administer and manage enteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(C) is a Texas licensed dentist who was issued an enteral sedation permit before June 1, 2011 and whose enteral sedation permit was active on June 1, 2011. Dentists in this category shall automatically have their permit reclassified as a Level 1 Minimal Sedation permit on June 1, 2011. A Texas licensed dentist whose permit is reclassified from an enteral sedation permit to a Level 1 Minimal Sedation permit on June 1, 2011 may continue to administer enteral sedation until January 1, 2013. On or before January 1, 2013, the dentist shall either provide proof that adequate education has been obtained by submitting an application for a Level 2 permit on or before that date, or shall comply with the requirements of a Level 1 permit after that date. A dentist shall always follow the standard of care and clinical requirements for the level of sedation he or she is performing.

(2) A dentist applying for a Level 3 Moderate Sedation permit (inclusive of parenteral routes of administration) must satisfy at least one of the following educational/professional criteria:

(A) satisfactory completion of a comprehensive training program consistent with that described for parenteral moderate sedation in the ADA Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students. This includes a minimum of sixty (60) hours of didactic training and instruction and satisfactory management of a minimum of twenty (20) dental patients, under supervision, using intravenous sedation; or

(B) satisfactory completion of an advanced education program accredited by the ADA/CODA that affords comprehensive and appropriate training necessary to administer and manage parenteral moderate sedation, commensurate with the ADA's Guidelines for Teaching Pain Control and Sedation to Dentists and Dental Students; or

(C) satisfactory completion of an internship or residency which included intravenous moderate sedation training equivalent to that defined in this subsection; or

(D) is a Texas licensed dentist who had a current parenteral sedation permit issued by the Board and has been using parenteral sedation in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. A Texas licensed dentist whose Board-issued permit to perform parenteral sedation is active on June 1, 2011 shall automatically have the permit reclassified as a Level 3 Moderate Sedation (inclusive of parenteral routes of administration) permit.

(3) A dentist applying for a Level 2 or 3 Moderate Sedation permit must satisfy the following emergency management certification criteria:

(A) Licensees holding moderate sedation permits shall document:

(i) Current (as indicated by the provider), successful completion of Basic Life Support (BLS) for Healthcare Providers; AND

(ii) Current (as indicated by the provider), successful completion of an Advanced Cardiac Life Support (ACLS) course, OR current (as indicated by the provider), successful completion of a

Pediatric Advanced Life Support (PALS) course, OR successful completion of a Board approved two-day anesthesia emergency course.

(B) Licensees holding Level 2 or Level 3 Moderate Sedation permits who provide anesthesia services to children (age twelve (12) or younger) must document current, successful completion of a PALS course.

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care as outlined in §108.7 of this title and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous personal supervision auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of moderate sedation;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a moderate sedation procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements.

(1) Patient Evaluation. Patients considered for moderate sedation must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this should consist of at least a review of the patient's current medical history and medication use. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated with the delivery of any sedative agents and must provide written, informed consent for the proposed sedation. The informed consent must be specific to the procedure being performed and must specify that the risks related to the procedure include cardiac arrest, brain injury, and death.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative technique prescribed.

(F) Pre-procedure verbal or written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(3) Personnel and Equipment Requirements.

(A) In addition to the dentist, at least one additional person trained in Basic Life Support (BLS) for Healthcare Providers must be present.

(B) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(C) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(i) a functioning device that prohibits the delivery of less than 30% oxygen; or

(ii) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(D) An appropriate scavenging system must be available if gases other than oxygen or air are used.

(E) The equipment necessary to establish intravenous access must be available.

(4) Monitoring. The dentist administering moderate sedation must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for recovery. When active treatment concludes and the patient recovers to a minimally sedated level, the dentist may delegate a qualified dental auxiliary to remain with the patient and continue to monitor the patient until he/she is discharged from the facility. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

(A) Consciousness. Level of consciousness (e.g., responsiveness to verbal command) must be continually assessed.

(B) Oxygenation.

(i) Color of mucosa, skin, or blood must be evaluated continually.

(ii) Oxygen saturation must be evaluated by pulse-oximetry continuously.

(C) Ventilation.

(i) Chest excursions must be continually observed.

(ii) Ventilation must be continually evaluated. This can be accomplished by auscultation of breath sounds, monitoring end-tidal CO2 or by verbal communication with the patient.

(D) Circulation.

(i) Blood pressure and heart rate must be continually evaluated.

(ii) Continuous EKG monitoring of patients sedated under moderate parenteral sedation is required.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title.

(B) A written time-oriented anesthetic record must be maintained and must include the names and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(C) Pulse-oximetry, heart rate, respiratory rate, and blood pressure must be continually monitored and documented at appropriate intervals of no more than ten (10) minutes.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

(B) While the patient is in the recovery area, the dentist or qualified clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory for discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(E) If a reversal agent is administered before discharge criteria have been met, the patient must be monitored until recovery is assured.

(7) Emergency Management.

(A) The dentist is responsible for the sedation management, adequacy of the facility and staff, diagnosis and treatment of emergencies associated with the administration of moderate sedation, and providing the equipment and protocols for patient rescue. This includes immediate access to pharmacologic antagonists and equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

(B) Advanced airway equipment and resuscitation medications must be available.

(C) A defibrillator should be available when ASA I and II patients are sedated under moderate sedation. A defibrillator must be available when ASA III and IV patients are sedated under moderate sedation.

(D) Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. If a patient enters a deeper level of sedation than the dentist is qualified to provide, the dentist must stop the dental procedure until the patient returns to the intended level of sedation. The dentist administering moderate sedation must be able to recover patients who enter a deeper state of sedation than intended.

(8) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(d) A dentist who holds a moderate sedation permit shall not intentionally administer deep sedation or general anesthesia.

§110.6. Deep Sedation or General Anesthesia.

(a) Education and Professional Requirements.

(1) A dentist applying for a permit to administer deep sedation or general anesthesia must satisfy one of the following criteria:

(A) satisfactory completion of an advanced education program accredited by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) that affords comprehensive and appropriate training necessary to administer and manage deep sedation or general anesthesia; or

(B) is a Texas licensed dentist who holds a current permit to administer deep sedation or general anesthesia issued by the Board and who has been using deep sedation or general anesthesia in a competent manner immediately prior to the implementation of this chapter on June 1, 2011. A Texas licensed dentist whose Board-issued permit to perform deep sedation or general anesthesia is active on June 1, 2011 shall automatically have the permit reclassified as a Level 4 Deep Sedation or General Anesthesia permit.

(2) A dentist applying for a permit to administer deep sedation or general anesthesia must satisfy the following emergency management certification criteria:

(A) Licensees holding deep sedation or general anesthesia permits shall document:

(i) Current (as indicated by the provider), successful completion of Basic Life Support (BLS) for Healthcare Providers; AND

(ii) Current (as indicated by the provider), successful completion of an Advanced Cardiac Life Support (ACLS) course, OR current (as indicated by the provider), successful completion of a Pediatric Advanced Life Support (PALS) course, OR successful completion of a Board approved two-day anesthesia emergency course.

(B) Licensees holding deep sedation or general anesthesia permits who provide anesthesia services to children (age twelve (12) or younger) must document current, successful completion of a PALS course.

(b) Standard of Care Requirements. A dentist must maintain the minimum standard of care for the administration of anesthesia as outlined in §108.7 of this title and in addition shall:

(1) adhere to the clinical requirements as detailed in this section;

(2) maintain under continuous direct supervision a minimum of two qualified dental auxiliary personnel who shall be capable of reasonably assisting in procedures, problems, and emergencies incident to the use of deep sedation and/or general anesthesia;

(3) maintain current certification in Basic Life Support (BLS) for Healthcare Providers for the assistant staff by having them pass a course that includes a written examination and a hands-on demonstration of skills; and

(4) not supervise a Certified Registered Nurse Anesthetist (CRNA) performing a deep sedation/general anesthesia procedure unless the dentist holds a permit issued by the Board for the sedation procedure being performed.

(c) Clinical Requirements.

(1) Patient Evaluation. Patients considered for deep sedation or general anesthesia must be suitably evaluated prior to the start of any sedative procedure. In healthy or medically stable individuals (ASA I, II) this must consist of at least a review of their current medical history, medication use, and NPO status. However, patients with significant medical considerations (ASA III, IV) may require consultation with their primary care physician or consulting medical specialist.

(2) Pre-Procedure Preparation and Informed Consent.

(A) The patient, parent, guardian, or care-giver must be advised regarding the procedure associated with the delivery of any sedative or anesthetic agents and must provide written, informed consent for the proposed deep sedation or general anesthesia procedure. The informed consent must be specific to the deep sedation and/or general anesthesia procedure being performed and must specify that the risks related to the procedure include cardiac arrest, brain injury, and death.

(B) The dentist shall determine that an adequate oxygen supply is available and evaluate equipment for proper operation and delivery of adequate oxygen under positive pressure.

(C) Baseline vital signs must be obtained in accordance with §108.7 and §108.8 of this title.

(D) A focused physical evaluation must be performed as deemed appropriate.

(E) Pre-procedure dietary restrictions must be considered based on the sedative/anesthetic technique prescribed.

(F) Pre-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver.

(G) An intravenous line, which is secured throughout the procedure, must be established except as provided in paragraph (7) of this subsection, regarding Pediatric and Special Needs Patients.

(3) Personnel and Equipment Requirements.

(A) Personnel.

(i) A minimum of three (3) individuals must be present during the procedure:

(I) a dentist qualified to administer the deep sedation or general anesthesia who is currently certified in ACLS and/or PALS; and

(II) two additional individuals who have current certification of successfully completing a course in Basic Life Support (BLS) for Healthcare Providers.

(ii) When the same individual responsible for administering the deep sedation or general anesthesia is performing the dental procedure, the dentist must delegate patient monitoring to a qualified individual.

(B) Equipment.

(i) A positive-pressure oxygen delivery system suitable for the patient being treated must be immediately available.

(ii) When inhalation equipment is used, it must have a fail-safe system that is appropriately checked and calibrated. The equipment must also have either:

(I) a functioning device that prohibits the delivery of less than 30% oxygen; or

(II) an appropriately calibrated and functioning in-line oxygen analyzer with audible alarm.

(iii) An appropriate scavenging system must be available if gases other than oxygen are used.

(iv) The equipment necessary to establish intravenous access must be available.

(v) Equipment and drugs necessary to provide advanced airway management and advanced cardiac life support must be immediately available.

(vi) If volatile anesthetic agents are utilized, an inspired agent analysis monitor and capnograph should be considered.

(vii) Emergency medications and a defibrillator must be immediately available.

(4) Monitoring. A qualified dentist administering deep sedation or general anesthesia must remain in the operatory room to monitor the patient continuously until the patient meets the criteria for discharge to the recovery area. The dentist must not leave the facility until the patient meets the criteria for discharge and is discharged from the facility. Monitoring must include:

(A) Oxygenation.

(i) Color of mucosa, skin, or blood must be continually evaluated.

(ii) Oxygenation saturation must be evaluated continuously by pulse oximetry.

(B) Ventilation.

(i) Intubated patient: End-tidal CO2 must be continuously monitored and evaluated.

(ii) Non-intubated patient: Breath sounds via auscultation and/or end-tidal CO2 must be continually monitored and evaluated.

(iii) Respiration rate must be continually monitored and evaluated.

(C) Circulation.

(i) Heart rate and rhythm via EKG and pulse rate via pulse oximetry must be evaluated throughout the procedure.

(ii) Blood pressure must be continually monitored.

(D) Temperature.

(i) A device capable of measuring body temperature must be readily available during the administration of deep sedation or general anesthesia.

(ii) The equipment to continuously monitor body temperature should be available and must be performed whenever triggering agents associated with malignant hyperthermia are administered.

(5) Documentation.

(A) Documentation must be made in accordance with §108.7 and §108.8 of this title and must include the names, times and dosages of all drugs administered and the names of individuals present during administration of the drugs.

(B) A written time-oriented anesthetic record must be maintained.

(C) Pulse oximetry and end-tidal CO2 measurements (if taken with an intubated patient), heart rate, respiratory rate, and blood pressure must be continually recorded at five (5) minute intervals.

(6) Recovery and Discharge.

(A) Oxygen and suction equipment must be immediately available if a separate recovery area is utilized.

(B) The dentist or clinical staff must continually monitor the patient's blood pressure, heart rate, oxygenation, and level of consciousness.

(C) The dentist must determine and document that the patient's level of consciousness, oxygenation, ventilation, and circulation are satisfactory prior to discharge. The dentist shall not leave the facility until the patient meets the criteria for discharge and is discharged from the facility.

(D) Post-procedure verbal and written instructions must be given to the patient, parent, escort, guardian, or care-giver. Post-procedure, patients should be accompanied by an adult caregiver for an appropriate period of recovery.

(7) Special Situations.

(A) Special Needs Patients. Because many dental patients undergoing deep sedation or general anesthesia are mentally and/or physically challenged, it is not always possible to have a comprehensive physical examination or appropriate laboratory tests prior to administering care. When these situations occur, the dentist

responsible for administering the deep sedation or general anesthesia shall document the reasons preventing the pre-procedure management.

(B) Management of Children. For children twelve (12) years of age and under, the dentist should observe the American Academy of Pediatrics/American Academy of Pediatric Dentists Guidelines for Monitoring and Management of Pediatric Patients During and After Sedation for Diagnostic and Therapeutic Procedures.

(8) Emergency Management.

(A) The dentist is responsible for the sedation management, adequacy of the facility and staff, diagnosis and treatment of emergencies associated with the administration of deep sedation or general anesthesia, and providing the equipment and protocols for patient rescue. This includes immediate access to pharmacologic antagonists and equipment for establishing a patent airway and providing positive pressure ventilation with oxygen.

(B) Advanced airway equipment, emergency medications and a defibrillator must be immediately available.

(C) Appropriate pharmacologic agents must be immediately available if known triggering agents of malignant hyperthermia are part of the anesthesia plan.

§110.7. Portability.

(a) A sedation/anesthesia permit is valid for the dentist's facility, if any, as well as any satellite facility.

(b) A Texas licensed dentist who holds the Board-issued privilege of portability on or before June 1, 2011 will automatically continue to hold that privilege provided the dentist complies with the renewal requirements of this section.

(c) Portability of a sedation/anesthesia permit will be granted to a dentist who, after June 1, 2011, applies for portability, if the dentist:

(1) holds a Level 4 Deep Sedation/General Anesthesia permit;

(2) holds a Level 3 Moderate Parenteral Sedation permit and the permit was granted based on education received in conjunction with the completion of a oral and maxillofacial specialty education program or a dental anesthesia program; or

(3) holds a Level 3 Moderate Parenteral Sedation permit and if:

(A) the training for the permit was obtained on the basis of completion of any of the following American Dental Association (ADA) Commission on Dental Accreditation (CODA) recognized or approved programs:

(i) a specialty program;

(ii) a general practice residency;

(iii) an advanced education in general dentistry program; or

(iv) a continuing education program. Dentists seeking a portability privilege designation based on this method of education shall also successfully complete no less than sixty (60) hours of didactic instruction and manage no less than twenty (20) dental patients by the intravenous route of administration; and

(B) the applicant provides proof of administration of no less than thirty (30) cases of personal administration of Level 3 sedation on patients in a primary or satellite practice location within the six (6) month period preceding the application for portability, but following the issuance of the sedation permit. Acceptable documentation shall include, but not be limited to, patient records demonstrating the applicant's anesthetic technique, as well as provision of services by the applicant within the minimum standard of care.

(d) A dentist providing anesthesia services utilizing a portability permit remains responsible for providing these services in strict compliance with all applicable laws and rules. The dentist shall ascertain that the location is supplied, equipped, staffed, and maintained in a condition to support provision of anesthesia services that meet the standard of care.

(e) Any applicant whose request for portability status is not granted on the basis of the application will be provided an opportunity for hearing pursuant to Texas Government Code, Chapter 2001 et seq.

§110.8. Provisional Anesthesia and Portability Permits.

(a) The Board may elect to issue a temporary sedation/anesthesia and/or portability permit that will expire on a stated date. A full sedation/anesthesia or portability permit may be issued after the dentist has complied with requests of the Board which may include, but shall not be limited to, review of the dentist's anesthetic technique, facility inspection, and/or review of patient records to ascertain that the minimum standard of care is being met. If a full permit is not issued, the temporary permit will expire on the stated date.

(b) A dentist licensed by the Board who is enrolled and approaching graduation in a specialty or General Practice Residency/Advanced Education in General Dentistry (GPR/AEGD) program as detailed in this chapter may, upon approval of the Board or its designees, obtain a provisional permit from the Board to administer moderate parenteral sedation and/or deep sedation and general anesthesia. A dentist licensed by the Board who holds a Level IV permit issued by the Board may, upon approval of the Board or its designees, obtain a provisional permit from the Board to provide anesthesia on a portable basis. To qualify for a provisional permit the applicant must:

(1) meet all requirements under this chapter;

(2) have a letter submitted on the applicant's behalf:

(A) on the letterhead of the school administering the program;

(B) signed by the director of the program;

(C) specifying the specific training completed; and

(D) confirming imminent graduation as a result of successful completion of all requirements in the program.

(3) For the purposes of this chapter, "completion" means the successful conclusion of all requirements of the program in question, but not including the formal graduation process.

(4) Any provisional permit issued under this section shall remain in effect until the next-scheduled regular Board meeting, at which time the Board will consider ratifying the provisional permit.

(5) On ratification of a provisional permit, the status of the permit will change to that of a regular permit under this section.

§110.9. Anesthesia Permit Renewal.

(a) The Board shall renew an anesthesia/sedation permit annually if required fees are paid and the required emergency management training and continuing education requirements are satisfied. The Board shall not renew an anesthesia/sedation permit if, after notice and opportunity for hearing, the Board finds the permit holder has provided, or is likely to provide, anesthesia/sedation services in a manner that does not meet the minimum standard of care. If a hearing is held, the Board shall consider factors including patient complaints, morbidity, mortality, and anesthesia consultant recommendations.

(b) Fees. Annual dental license renewal certificates shall include the annual permit renewal, except as provided for in this section. The licensee shall be assessed an annual renewal fee in accordance with the fee schedule in Chapter 102 of this title.

(c) Continuing Education.

(1) A dentist seeking to renew a minimal sedation, moderate sedation, or deep sedation/general anesthesia permit must complete the following hours of continuing education bi-annually on the administration of or medical emergencies associated with the permitted level of sedation:

(A) Level 1: Minimal Sedation - six (6) hours

(B) Levels 2 and 3: Moderate Sedation - eight (8) hours

(C) Level 4: Deep Sedation/General Anesthesia - twelve (12) hours

(2) The continuing education requirements under this section shall be in addition to any additional courses required for licensure. Advanced Cardiac Life Support (ACLS) course, Pediatric Advanced Life Support (PALS) course, or a Board-approved two day emergency course may be used to fulfill the continuing education requirement when not being taken for renewal of the permit.

(3) Continuing education courses must meet the provider endorsement requirements of §104.2 of this title.

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 1, 2010.

TRD-201006835
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6400

♦ ♦ ♦

PART 6. TEXAS BOARD OF PROFESSIONAL ENGINEERS

CHAPTER 133. LICENSING
SUBCHAPTER C. PROFESSIONAL ENGINEER LICENSE APPLICATION REQUIREMENTS

22 TAC §133.27

The Texas Board of Professional Engineers (Board) proposes amendments to §133.27 related to Application for Temporary License for Engineers Currently Licensed Outside the United States.

The proposed change to §133.27 modifies the requirements for Temporary License applicants from Canada based on the signed Mutual Recognition Agreement between the TBPE and Engineers Canada. The requirements for applicants from Canada will be the same as those in the current rule for applicants from Australia.

David Howell, P.E., Director of Licensing for the Board, has determined that for the first five-year period the proposed amendments are in effect there is no adverse fiscal impact for the state and local government as a result of enforcing or administering the section as amended. There is no additional cost to licensees or other individuals. There is no adverse fiscal impact to the estimated 1,000 small or 6,400 micro businesses regulated by the Board. A Regulatory Flexibility Analysis is not needed because there is no adverse economic effect to small or micro businesses.

Mr. Howell also has determined that for the first five years the proposed amendments are in effect, the public benefit anticipated as a result of enforcing the proposed amendments is an improvement in the flexibility of the licensure processes and the ability to issue temporary licenses to qualified engineers.

Any comments or request for a public hearing may be submitted no later than 30 days after the publication of this notice to David Howell, P.E., Director of Licensing, Texas Board of Professional Engineers, 1917 IH-35 South, Austin, Texas 78741 or faxed to his attention at (512) 440-0417.

The amendments are proposed pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and bylaws consistent with the Act as necessary for the performance of its duties, the governance of its own proceedings, and the regulation of the practice of engineering in this state and §1001.310, regarding Temporary or Provisional Licenses.

No other statutes, articles or codes are affected by the proposed amendment.

§133.27. Application for Temporary License for Engineers Currently Licensed Outside the United States.

(a) Pursuant to §1001.311 of the Act, a temporary license may be issued under this section for applicants who:

(1) are citizens of Australia, Canada or the United Mexican States;

(2) are seeking to perform engineering work in Texas for three years or less;

(3) are currently licensed or registered in good standing with Engineers Australia or at least one of the jurisdictions of Canada or the United Mexican States; and

(4) meet the following experience requirements:

(A) Applicant currently registered in Australia or Canada shall have at least seven years of creditable engineering experience, three of which must be practicing as a registered or chartered engineer with Engineers Australia or Engineers Canada, as evaluated by the board under §133.43 of this chapter (relating to Experience Evaluation).

(B) Applicant currently licensed in [~~Canada or~~] United Mexican States shall:

(i) meet the educational requirements of §1001.302(a)(1)(A) of the Act and have 12 or more years of creditable engineering experience, as evaluated by the board under §133.43 of this chapter; or

(ii) meet the educational requirements of §1001.302(a)(1)(B) of the Act and have 16 or more years of creditable engineering experience, as evaluated by the board under §133.43 of this chapter.

(b) - (c) (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 November 30, 2010.

TRD-201006782
Lance Kinney, P.E.
Executive Director
Texas Board of Professional Engineers
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 440-7723

♦ ♦ ♦

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 97. COMMUNICABLE DISEASES
SUBCHAPTER A. CONTROL OF COMMUNICABLE DISEASES

25 TAC §97.11, §97.14

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §97.11 concerning notification of emergency medical personnel, and others of possible exposure to methicillin-resistant *Staphylococcus aureus* (MRSA), and §97.14 concerning a program for reporting MRSA, a bacteria primarily associated with skin and soft tissue infections.

BACKGROUND AND PURPOSE

The amendments to §97.11 are necessary to comply with Government Code, §607.102, which was added by the 81st Legislature to add MRSA to diseases requiring notification of emergency medical personnel and others under certain circumstances. The amendments to §97.14 are necessary to comply with Chapter 369 (House Bill 1362), 81st Legislature, Regular Session, 2009, which amends Health and Safety Code, §81.0445, and requires the department to conduct a pilot program for reporting MRSA. A health authority that demonstrates an interest and possesses the resources to conduct the program will manage the pilot program.

The department is required to select a local health authority to administer the program established by §97.14. The program would require: (1) all clinical reference and hospital laboratories within the area served by the local health authority to report all persons with MRSA infections; (2) an evaluation of the cost and feasibility of adding MRSA infections to the reportable disease list; (3) the collection of data and analysis of findings regarding the prevalence of MRSA infections; and (4) compiling and making available to the public a summary of the program. Not later than September 1, 2011, the department shall submit to the Legislature a report concerning the effectiveness of the program.

SECTION-BY-SECTION SUMMARY

The amendment to §97.11(b) changes the list of diseases, to include MRSA, that require a hospital to notify a first responder of exposure to the disease, when the hospital believes an exposure to the disease has occurred. The amendment to §97.14(c) identifies that the MRSA pilot program will be conducted by health authorities serving Angelina, Fort Bend and McLennan counties. The amendment to §97.14(e) establishes the time period, March 1, 2011 through March 31, 2011 for reporting MRSA infection by laboratories and physicians in the three counties. The amendment to §97.14(f) revises the expiration date of the rule from September 1, 2009 to September 1, 2011.

FISCAL NOTE

Ms. Janna Zumbrun, Director, Infectious Disease Prevention Section, has determined that for each year of the first five years that §97.11 will be in effect, there will be fiscal implications to state government or local governments as a result of enforcing or administering the sections as proposed.

Subsection 97.11(b)(5) adds one disease to a long list of existing diseases that require notification of first responders. Department staff estimate that there will be five or less such exposure incidents per year that would be detected and require notification. Fiscal costs to state and local government agencies would be related to the role of the health authorities and agency directors in notifying emergency medical services persons or fire fighters of a possible exposure. The time a health authority would need to communicate to the agency director that an employee, an emergency medical service person or fire fighter was exposed would require less than 10 minutes. The time that the agency director, typically the fire department chief, that an employee, emergency medical service person or fire fighter was exposed and of agency policy to address the exposure would require an estimated 15 minutes. The average annual salary of eight known health authorities is $152,841 or $73.84 per hour assuming 2,080 working hours annually (52 weeks times 40 hours). The cost for a health authority to communicate an exposure incident to the agency directors that employs an emergency medical service person or fire fighter would be the amount of $12.31.

The United States Bureau of Labor Statistics in the Occupational Outlook Handbook, 2010-2011 Edition, reported that fire department chief's annual salary ranges from $78,672 to $104,780 or $37.81 to $50.38 per hour assuming 2,080 working hours annually. The estimated cost for a fire department chief to notify an employee that the person was exposed would range from $9.46 to $12.60. Under Health and Safety Code, §81.048, the hospital is only required to notify the local health authority when they have reason to believe an exposure to the disease has occurred. It does not require that the hospital test for the disease or perform any other medical procedure.

Section 97.14, and the statute that supports it, expires in September 2011. There are fiscal implications for the three local health authorities that have agreed to conduct the reporting program noted in §97.14. These authorities, Angelina County and Cities Health District, Fort Bend County Health and Human Services and the Waco-McLennan County Public Health District are aware of the resources necessary to successfully complete the program. The fiscal cost to the department to comply with Health and Safety Code, §81.0445, primarily relates to the cost of preparing the summary report. This fiscal cost is considered minor.

SMALL BUSINESS AND MICRO-BUSINESS IMPACT ANALYSIS

Ms. Zumbrun has also determined that there is no adverse economic effect on small businesses and micro-businesses to com-

ply with amended §97.11 and §97.14 as proposed. Hospitals that would report possible MRSA exposure incidents to the local health authority to comply with §97.11 are typically not small businesses or micro-businesses. Hospital and reference laboratories that would report a MRSA infection to the local health authorities in Angelina, Fort Bend and McLennan counties to comply with §97.14 are typically not small businesses or micro-businesses. There is no anticipated negative impact on local employment.

ECONOMIC IMPACT STATEMENT

The amendment to §97.11 will require hospital staff to notify local health authorities when a first responder was exposed to a patient who had a MRSA infection. Department staff estimate that there will be less than five such exposure incidents per year that would be detected and require notification. The most common method for making this report would be by telephone and would probably be done by hospital staff typically a registered nurse. Department staff estimate the hospital staff would take approximately five minutes to make such an incident report. Staff believe nurses in the hospitals are the primary reporters. Nurses earn an average of $34 per hour. A single report would cost a business the amount of $2.83. The estimated total cost to make incident reports and disease notifications would be the amount of $14.15. Similar costs would be incurred by the local health authority in notifying the director of the appropriate department or entity that employs the first responder, and by such director to the employee affected.

To implement §97.14, it is estimated that 337 MRSA infections will be reported during March 2011 in Angelina, Fort Bend and McLennan counties. Most of the reports will be made by hospital and clinical laboratories. Some physician offices may also make reports. Laboratory and office staff will need to telephone, fax or mail laboratory reports to the local health department. There is some minimal cost in making the reports. Health district staff estimate that a person takes approximately five minutes to make a disease report. From their experiences, health district staff believe nurses in the hospitals and medical offices are the primary reporters. Nurses earn an average of $34 per hour. A single report would cost a business the amount of $2.83. The estimated total cost to make 337 disease reports during March 2011 would be $953.71.

REGULATORY FLEXIBILITY ANALYSIS

The amendment to §97.11 is required because of the legislative mandate in Government Code, §607.102, that exposure to this disease be treated as exposure to other diseases under Health and Safety Code, §81.048. The amendment of this rule is the only feasible method of complying with this mandate.

To comply with Health and Safety Code, §81.0445, the department considered several methods to determine the incidence of methicillin-resistant *Staphylococcus aureus* in the county populations, and minimize the impacts on small businesses. The department considered reducing the number of participating pilot sites, but each of the participating three local health authorities expressed a strong desire to participate, and reducing the number of participants would reduce the epidemiologic advantage of comparing disease prevalence in sites with different geographic and demographic characteristics. The department also considered taking reports only from laboratories, but many laboratories that will diagnose MRSA in participating counties will be located outside of the counties. Therefore, the only method of achieving complete or near-complete reporting is to require reports from physician offices and laboratories.

PUBLIC BENEFIT

Ms. Zumbrun has determined that the public will benefit from adoption of the proposed amendment to §97.11 because first responders will be more promptly notified of exposure to a potentially treatable disease. Amendments to §97.14 require reporting of MRSA infections for a one month period in three counties. The public and the local health department staff will have a clearer understanding and knowledge of the occurrence of MRSA infections within a community. This knowledge will assist health departments in controlling MRSA infections.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk 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 a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed amendments do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted to Jeff Taylor, Manager, Emerging and Acute Infectious Disease Branch, Infectious Disease Control Unit, Prevention and Preparedness Services Division, Department of State Health Services, Mail Code 1960, P.O. Box 149347, Austin, Texas 78714-9347 or by email to Jeff.Taylor@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the *Texas Register.*

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the proposed rules have been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The amendments are authorized by Health and Safety Code, §81.004, which gives the commissioner of the department general statewide responsibility for the administration of the Communicable Disease Act and authorizes the adoption of rules necessary for its effective administration and implementation; Health and Safety Code, §81.0445, which requires the Executive Commissioner of the Health and Human Services Commission to develop rules to establish a pilot program to research and implement procedures for reporting cases of MRSA; Health and Safety Code, §81.048, which requires the department to designate the diseases requiring notification under that section; and Government Code, §531.0055, and Health and Safety Code, §1001.075, which authorize the Executive Commissioner of the

Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of the Health and Safety Code, Chapter 1001.

The amendments affect the Health and Safety Code, Chapters 81 and 1001; and Government Code, Chapter 531.

§97.11. Notification of Emergency Medical Personnel, Fire Fighters, Peace Officers, Detention Officers, County Jailers, or Other Persons Providing Emergency Care of Possible Exposure to a Disease.

(a) (No change.)

(b) Disease and criteria which constitute exposure. The following diseases and conditions constitute a possible exposure to the disease for the purposes of the Act, §81.048:

(1) - (2) (No change.)

(3) acquired immune deficiency syndrome (AIDS); anthrax; brucellosis; dengue; ehrlichiosis; hepatitis, viral; human immunodeficiency virus (HIV) infection; malaria; plague; syphilis; tularemia; typhus; any viral hemorrhagic fever; and yellow fever, if there has been a needlestick or other penetrating puncture of the skin with a used needle or other contaminated item; a splatter or aerosol into the eye, nose, or mouth; or any significant contamination of an open wound or non-intact skin with blood or body fluids; [~~and~~]

(4) amebiasis; campylobacteriosis; cholera; cryptosporidiosis; Escherichia coli O157:H7 infection; hepatitis A; salmonellosis, including typhoid fever; shigellosis; and Vibrio infections, if fecal material is ingested; and[~~.~~]

(5) Methicillin-resistant *Staphylococcus aureus* (MRSA) wounds, skin infections or soft tissue infections, if there has been contact of non-intact skin to these infections or drainage from these infections.

(c) Notification processes. The following notification processes shall apply when possible exposures to notifiable conditions occur.

(1) (No change.)

(2) For possible exposures to any of the diseases listed in subsection (b)(2) - (5) [~~(4)~~] of this section, the emergency medical service employee, peace officer, detention officer, county jailer, or fire fighter shall provide a medical professional at the hospital with notice, preferably written, of the circumstances of the possible exposure. Once the hospital has knowledge of a possible exposure, then notice shall be given as follows.

(A) - (D) (No change.)

(d) (No change.)

§97.14. Methicillin-resistant Staphylococcus aureus (MRSA) reporting.

(a) - (b) (No change.)

(c) Where to report. The pilot program is being conducted in Angelina, Fort Bend and McLennan [~~Bexar, Brazos, Potter and Randall~~] counties only. These jurisdictions meet the requirements of Health and Safety Code, §81.0445(b).

(1) An administrative officer of a clinical or hospital laboratory or physicians located in Angelina [~~Bexar~~] County shall report MRSA to the [~~Bexar County~~] Health Authority appointed by the Angelina County and Cities Health District.

(2) An administrative officer of a clinical or hospital laboratory or physicians located in Fort Bend [~~Potter County or Randall~~] County shall report MRSA to the Fort Bend County Health Authority [~~appointed by the Amarillo Bi-City-County Public Health District~~].

(3) An administrative officer of a clinical or hospital laboratory or physicians located in McLennan [~~Brazos~~] County shall report MRSA to the [~~Brazos County~~] Health Authority appointed by the Waco-McLennan County Public Health District.

(4) (No change.)

(d) (No change.)

(e) When to report. Any clinical specimen collected on March 1, 2011 [~~2009~~] through March 31, 2011 [~~2009~~] that is positive for methicillin-resistant *Staphylococcus aureus* shall be reported within seven calendar days of identification.

(f) This section expires September 1, 2011 [~~2009~~].

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 6, 2010.

TRD-201006885
Lisa Hernandez
General Counsel
Department of State Health Services
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 458-7111 x6972

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 34. STATE FIRE MARSHAL

The Texas Department of Insurance (Department) proposes amendments to §§34.507, 34.510, 34.515, 34.601 - 3.607, 34.610 - 34.616, 34.625, 34.707, 34.711, 34.714, 34.808, 34.810, and 34.817, and new §§34.627 - 34.630, concerning fire extinguisher, fire alarm, fire sprinkler, and fireworks regulations. These amendments and new sections are necessary to: (i) implement House Bill (HB) 2118, 80th Legislature, Regular Session, effective September 1, 2007, which established the licensee category of residential fire alarm technician and requires the Commissioner of Insurance (Commissioner) to adopt new requirements relating to the license; (ii) specify requirements relating to the Fire Detection and Alarm Devices Advisory Council established by the Insurance Code §6002.101; (iii) make changes necessary to licensing structures and procedures for the State Fire Marshal Office's (SFMO) upcoming implementation of the State Insurance Regulators Connection (SIRCON) licensing computer software program; (iv) adopt fire alarm application and renewal forms by reference; (v) delete unnecessary requirements; (vi) correct substantive and non-substantive errors; (vii) update obsolete statutory references; (viii) update fee payment procedures to reflect current practice; (ix) update adopted minimum standards; and (x) make other changes deemed necessary by the Department to improve and clarify the State Fire Marshal's Office rules and effectively enforce its statutory obligations.

1. HB 2118.

The Insurance Code Chapter 6002 (formerly Article 5.43-2) outlines the Department's duties and authority relating to the regulation of the planning, certifying, leasing, selling, servicing, installing, monitoring, and maintaining of fire detection and fire alarm devices and systems. HB 2118 amended the Insurance Code Article §5.43-2 to add a new licensing category for residential fire alarm technicians. At the time of HB 2118's enactment, the Texas Legislature was in the process of recodifying the Insurance Code Article 5.43-2. Portions of Article 5.43-2 were repealed and recodified as the Insurance Code Chapter 6002 in the nonsubstantive Insurance Code revision contained in HB 2636, 80th Legislature, Regular Session, 2007. The remaining portions of Article 5.43-2, including changes made by HB 2118 relating to the new licensing category of residential fire alarm technicians, were repealed and recodified as the Insurance Code Chapter 6002 in the nonsubstantive Insurance Code revision contained in SB 1969, 81st Legislature, Regular Session, 2009.

HB 2118 specified that a residential fire alarm technician must obtain a license issued by the Department; that the amount of the initial fee for the license may not exceed $50, and that the amount of the annual license renewal fee may not exceed $50. The bill specified that an applicant for the residential fire alarm technician license must provide with the required license application evidence of the applicant's successful completion of the required instruction from a training school approved by the State Fire Marshal. The bill specified that the training curriculum for a residential fire alarm technician course shall consist of at least eight hours of instruction on installing, servicing, and maintaining single-family and two-family residential fire alarm systems as defined by the National Fire Protection Association Standard Number 72.

Amendments to existing sections of Subchapter F, Fire Alarm Rules, are necessary to implement HB 2118. Proposed amendments to §34.606 add definitions for the terms *approval, instructor, and training school.* Proposed amendments to §34.611 add licensing categories for: (i) instructor approvals to provide training at residential fire alarm technician training schools; (ii) residential fire alarm technicians; and (iii) training school approvals for course training necessary to obtain a residential fire alarm technician license. Proposed new §34.611(b)(2) also requires that an instructor carry the instructor's approval while providing training in an approved training school on the installing, certifying, inspecting, and servicing of fire alarm or detection systems in single-family or two-family residences. A proposed amendment to redesignated §34.611(d) requires that a change in the licensee's name, mailing address, or a new or additional registered firm employing the licensee requires a revised license. The amendment deletes existing language specifying licensee notification requirements. Proposed new §34.611(e) specifies that a registered firm must submit notification of any licensee employment, termination, or resignation within 14 days of its occurrence. The title to §34.611(f) is changed from "Restrictions" to "Restrictions on Licensees and Registered Firms." Proposed new §34.611(g) specifies that approvals are not transferable. Proposed new §34.611(h) requires that a change in the instructor's name or mailing address requires a revised approval. Proposed amendments to §34.613 specify requirements for the residential fire alarm technician licenses, instructor and training school approvals. Proposed new §34.613(c)(2)(B) specifies that the State Fire Marshal shall approve or deny the application for approval for a training school within 60 days following receipt of the necessary application materials and outlines the procedure for resubmitting a denied application. Amendments to §34.614 specify fees relating to the residential fire alarm technician license and training school and instructor approvals. Two new sections are also necessary to implement HB 2118. Proposed new §34.627 specifies the requirements for residential fire alarm technician course instructors and training schools. Proposed new §34.628 specifies the requirements relating to the residential fire alarm technician course.

2. Fire Detection and Alarm Device Advisory Council.

The Insurance Code §6002.101 establishes the Fire Detection and Alarm Devices Advisory Council (Alarm Advisory Council). Proposed new §34.629 is necessary to specify the composition, duties, operating procedures, and duration of the Advisory Council.

3. SIRCON Implementation.

The SFMO will begin using State Insurance Regulators Connection (SIRCON) licensing computer software program later in 2010. Because SIRCON program features and capabilities vary from the current SFMO licensing software, procedural changes are necessary for full SIRCON implementation. Current SFMO software allows a registered firm to list numerous employees under its certificate on file with the SFMO. SIRCON offers many technological advantages and will increase uniformity in licensing processes. However, SIRCON does not have the capability to list numerous employees under a single firm certificate. The Insurance Code §6002.154 requires that each firm registered under Chapter 6002 (registered firm) employ at least one employee who is a fire alarm technician, residential fire alarm superintendent, or fire alarm planning superintendent. Therefore, to satisfy and verify compliance with this statutory requirement, the SFMO has proposed that firms submit notice of their *designated employee.* Proposed new §34.606(7) defines *designated employee.* A proposed amendment to §34.610(b) adds new language which requires that a registered firm must specify its designated employee in its initial or renewal application for a certificate of registration. The proposed amendment also requires that any change in the designated employee must be submitted in writing to the SFMO within 14 days of its occurrence and that an individual may not serve as a designated employee for more than one registered firm. To implement SIRCON and to achieve a more orderly administration of the licensing process, it is also necessary to align the certificate of registration expiration dates of registered firms' branch offices with its main office as required in proposed new §34.610(i). This requires two steps: (i) an initial alignment of expiration dates for branch offices in existence as of the effective date of the rule; and (ii) a prospective requirement that the certificate of registration for branch offices opened after the effective date of the rule will expire on the same date as the main office. Changes implementing the initial alignment of expiration dates for branch offices in existence as of the effective date of the rule are made in proposed new §34.510(m) for fire extinguisher firms and in new proposed §34.610(i) for alarm firms. Changes implementing the prospective requirement that a certificate of registration for a branch office expires on the same date as the main office are made in §34.510(g) for fire extinguisher firms and in proposed new §34.610(f) for fire alarm firms. In accordance with the Insurance Code §6002.201(c) for registered extinguisher firms and the Insurance Code §6001.201(b) for registered alarm firms, the proposed rule specifies that fees for renewals of certificates of registration for registered firms will be prorated accordingly. However, as specified in the proposal,

the initial fees for the establishment of a branch office are not prorated. As a result of the alignment of the branch offices' certificates of registration expiration dates to the main office's date, it is also necessary to simultaneously make changes to the late fee structure for fire alarm and fire extinguisher firms. Because the certificates of registration for all of a registered firms' locations will expire on the same day, it is necessary to specify how late fees will be calculated. Proposed amendments to §34.515(b)(1)(C) and (D) specify that for extinguisher firms, renewal late fees (expired 1 day to 90 days) are $225 plus $50 for each branch office held by the firm, and that the renewal late fee (expired 91 days to two years) is $450 plus $100 for each branch office operated by the firm. Existing subparagraphs (G) and (H) are proposed to be deleted because these provisions are incorporated into amendments to subparagraphs (C) and (D). Proposed amended §34.614 specifies that for fire alarm firms, late fees for renewals between one and 90 days late are $125 plus $37.50 for each branch office held by the firm. In addition, proposed amended §34.614 specifies that late fees for renewals between 91 days and two years late are $500 plus $150 for each branch office held by the firm.

4. Adoption of Fire Alarm Forms by Reference.

New §34.630 adopts by reference the following eight fire alarm application and renewal forms: (i) the License Application for Individuals For All Types of Fire Alarm Licenses, Form Number SF032, which contains instructions for completion of the form and requires information to be provided regarding the applicant and the applicant's employer; (ii) the Renewal Application For Fire Alarm Individual License, Form Number SF094, which contains instructions for completion of the form; information regarding late fees; and requires information to be provided regarding the renewing applicant; (iii) the Instructor Approval Application, Form Number SF247, which contains instructions for completion of the form and requires information to be provided regarding the applicant; (iv) the Renewal Application For Instructor Approval, Form Number SF255, which contains instructions for completion of the form and requires information to be provided regarding the applicant; (v) the Training School Approval Application, Form Number SF246, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule; (vi) the Renewal Application for Training School Approval, Form Number SF254, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule; (vii) the Fire Alarm Certificate of Registration Application, Form Number SF031, which contains instructions for completion of the form; provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant; and (viii) the Renewal Application For Fire Alarm Certificate of Registration, Form Number SF084, which contains instructions for completion of the form and requires information to be provided regarding the applicant. The proposal specifies that the adopted forms are available at the department's website at www.tdi.state.tx.us. All of the proposed forms are part of this proposal and are available for public review and comment.

5. Deletion of Unnecessary Requirements.

The Department proposes deletion of several requirements because they have found that the requirements are not useful or beneficial to the public. Section 34.510(g) requires that a fire extinguisher firm post each certificate conspicuously for public view at the business location. Section 34.610(b) requires that fire alarm companies post their certificate of registration conspicuously for public view at their business location. Section 34.611(b) requires that wall licenses must be posted conspicuously for public view at a fire alarm firm's business location. Section 34.711(b) in Subchapter G, Fire Sprinkler Rules, requires that responsible managing employee wall licenses be posted conspicuously for public view at a fire sprinkler firm's business location. These requirements were adopted so that the public would be able to verify a firm's current licensure. However, it is the Department's position that these license posting requirements do not achieve this effect because customers very infrequently visit a firm location in person. In practice, registered firms conduct their business at the customer's location. Additionally, pursuant to §34.611(c), alarm licensees are required to carry a pocket license for identification while engaged in the business activities regulated under the subchapter. Similarly, §34.711(c) requires sprinkler responsible managing employees to carry a pocket license while engaged in the activities of a responsible managing employee. Therefore, the Department proposes deletion of these license posting requirements. The requirement for a licensee to carry a pocket license is moved from existing §34.611(c) to amended §34.611(b) and the subsequent subsections are redesignated accordingly. The Department also proposes deletion of the requirement in §34.810 that upon change of certain information requiring a revised fireworks license, the old document be surrendered to the SFMO. Similarly, §34.711 requires fire sprinkler licensees to surrender their licenses upon the change of certain information. The Department's position is that the requirement to surrender obsolete documents to the SFMO is unnecessary. The surrender requirement was initially adopted in April 1984 to prevent the unauthorized use of a licensee's license by an unauthorized user. However, since the adoption of the surrender requirement the SFMO has not encountered a single instance of the unauthorized use of another's licensing document by an unauthorized user. Further, the Department's position is that in cases in which a licensee changes their information and is subsequently unable to locate their existing license for surrender, it is an undue and unreasonable hardship to deny a new license. Therefore, the proposed amendments delete the surrender requirement for fire sprinkler responsible managing employees in redesignated §34.711(d) and for fireworks licensees in §34.810(e).

6. Correction of Substantive and Non-substantive Errors.

The proposed amendments replace use of the word "chapter" with "subchapter" for consistency and to conform to current Department rule style. Replacements of the word "chapter" with "subchapter" have been made in §§34.601 - 34.605, 34.607, 34.613, and 34.616. A proposed amendment to §34.601 adds the word "the" before the phrase "Insurance Code" for consistency and to conform to current Department style. Proposed amendments change the phrase "Office of the State Fire Marshal" to "State Fire Marshal's Office" for consistency and to conform to current Department style in §34.605 and §34.707. The phrase "state fire marshal's office" is changed to "State Fire Marshal's Office" for consistency and to conform to current Department style in §34.507 and §34.607(a). A proposed amendment to §34.613 replaces the phrase "State Fire Marshal's office" with "State Fire Marshal's Office" for consistency and to conform to current Department style. Sections 34.808 and 34.817 of the Storage and Sale of Fireworks rule incorrectly require that a su-

pervisor responsible for a retail fireworks site be 16 years or older. These requirements are inconsistent with the Occupations Code §2154.254, which specifies that a person 16 years of age or older but younger than 18 years of age may be employed to sell fireworks at a retail sales location only if the person is accompanied by another person 18 years of age or older. Proposed amendments to §34.808 and §34.817 change the minimum age of a supervisor at a retail fireworks site from age 16 to 18, in accordance with the Occupations Code §2154.254.

7. Updating of Obsolete Statutory References.

The proposed rule updates numerous obsolete statutory references. These changes are nonsubstantive and are made to reflect the Texas Legislature's ongoing recodification of the Insurance Code. Portions of Article 5.43-2 were repealed and recodified as the Insurance Code Chapter 6002 in the nonsubstantive Insurance Code revision contained in HB 2636, 80th Legislature, 2007. The remaining portions of Article 5.43-2 were repealed and recodified as the Insurance Code Chapter 6002 in the nonsubstantive Insurance Code revision contained in SB 1969, 81st Legislature, 2009. Article 5.43-1 was repealed and recodified as the Insurance Code Chapter 6001 in the nonsubstantive Insurance Code revision contained in HB 2636, 80th Legislature, 2007. Article 5.43-3 was repealed and recodified as the Insurance Code Chapter 6003 in the nonsubstantive Insurance Code revision contained in HB 2636, 80th Legislature, 2007. References to the Insurance Code Article 5.43-2 are replaced with references to the Insurance Code Chapter 6002 in the following sections: §§34.601, 34.606(14), 34.607, 34.613(a)(1) and (2), 34.613(d) and (e), 34.615, 34.616(b)(1), and 34.625(a) and (c). A reference in §34.604 to the Insurance Code Article 5.43-2 §3 is replaced with a reference to the Insurance Code §6002.155. A reference in §34.606(9) to the Insurance Code Article 5.43-2 is replaced with a reference to the Insurance Code §6002.002. A reference in §34.611(f)(3) to the Insurance Code Article 5.43-2 §3b is replaced with a reference to the Insurance Code §6002.155. A reference in §34.612 to the Insurance Code Article 5.43-2 §10b is replaced with a reference to the Insurance Code 6002.302. A reference in redesignated §34.614(e) to the Insurance Code Article 5.43-2 §5C(c) is replaced with a reference to the Insurance Code §6002.203(g). References in §34.616(a)(1) and (2) to the Insurance Code Article 5.43-2, §3(b)(10) are replaced with references to the Insurance Code §6002.155(10). A reference in §34.616(b)(3) to the Insurance Code Article 5.43-1 is replaced with a reference to the Insurance Code Chapter 6001. A reference in §34.616(b)(3) to the Insurance Code Article 5.43-3 is replaced with a reference to the Insurance Code Chapter 6003. A reference in §34.616(c)(2)(B) to the Insurance Code Article 5.43-2 §9 is replaced with a reference to the Insurance Code §6002.251, and the phrase "Insurance Code Article 5.43-2, so long as" is deleted. A proposed amendment to §34.613(a)(2) updates an obsolete statutory citation to the Assumed Business or Professional Name Act, formerly codified in the Business and Commerce Code Chapter 36. The Business and Commerce Code Chapter 36 was repealed in the nonsubstantive Business and Commerce Code revision, Acts 2007, 80th Legislature, Chapter 885, §2.47, effective April 1, 2009. The Business and Commerce Code Chapter 36 was re-adopted as the Business and Commerce Code Chapter 71 in the same nonsubstantive Business and Commerce Code revision.

8. Updating of Fee Payment Procedures to Reflect Current Practice.

The proposal amends the section specifying fee payment procedures in three subchapters to reflect current procedure and possible future changes in online payment options: Subchapter E, Fire Extinguisher and Installation (§34.515); Subchapter F, Fire Alarm Rules (§34.614), and; Subchapter G, Fire Sprinkler Rules (§34.714). The amendment to each of these sections is substantively identical. The amendments to fee payment procedure sections specify that except for fees that must be paid to testing authorities, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if a license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. The Texas OnLine Project is the common electronic infrastructure established by the Government Code §2054.252 for state agencies and local governments, including licensing entities. The proposed new language specifies that should the Department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. The amendments eliminate cash as an acceptable payment method to reflect current Department policy. Effective August 1, 2009, the Department no longer accepts cash payments for fees, assessments, fines, or debts. A statement of this policy is posted at the Department's cashier's office. The proposed amendment to the fee payment procedure for fire alarm licensees specifies in §34.614 that the renewal fee is subject to the exceptions specified in proposed amended §34.610(i) (relating to Certificate of Registration) for the initial alignment of the expiration and renewal dates of existing branches.

9. Updating Adopted Minimum Standards.

Fire Extinguisher Standards

Proposed amendments to §34.507 update numerous National Fire Protection Association (NFPA) minimum standards relating to fire extinguisher systems. Requiring recent safety standards relating to fire extinguisher devices is necessary to protect the health and safety of the public. Proposed amendments to §34.507 make the following replacements: (i) NFPA 10-2002, Standard for Portable Fire Extinguishers, with NFPA 10-2010, Standard for Portable Fire Extinguishers; (ii) NFPA 11-2002, Standard for Low-Expansion Foam and Combined Agent Systems, and NFPA 11A-1999, Standard for Medium- and High-Expansion Foam Systems, with NFPA 11-2010, Standard for Low-, Medium-, and High-Expansion Foam and Combined Agent Systems; (iii) NFPA 12-2000, Standard on Carbon Dioxide Extinguishing Systems with NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems; (iv) NFPA 12A-2004, Standard on Halon 1301 Fire Extinguishing Systems with NFPA 12A-2009, Standard on Halon 1301 Fire Extinguishing Systems; (v) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (vi) NFPA 16-2003, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; (vii) NFPA 17-2002, Standard for Dry Chemical Extinguishing Systems with NFPA 17-2009, Standard for Dry Chemical Extinguishing Systems; (viii) NFPA 17A-2002, Standard for Wet Chemical Extinguishing Systems with NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems; (ix) NFPA 18-1995, Standard on Wetting Agents with NFPA 18-2006, Standard on Wetting Agents; (x) NFPA 25-2002, Standard

for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems; (xi) NFPA 96-2001, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations with NFPA 96-2008, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations; and (xii) NFPA 2001-2004, Standard on Clean Agent Fire Extinguishing Systems with NFPA 2001-2008, Standard on Clean Agent Fire Extinguishing Systems.

The updated fire extinguisher standards make the following changes from the currently adopted standards. NFPA 10-2010, Standard for Portable Fire Extinguishers, expands the list of obsolete fire extinguishers to be removed from service; and now includes pressurized water fire extinguishers manufactured prior to 1971, any extinguisher that needs to be inverted to operate, any stored pressure extinguisher manufactured prior to 1955, any extinguishers with 4B, 6B, 8B, 12B, and 16B fire ratings, and stored-pressure water extinguishers with fiberglass shells (pre-1976). The updated standard requires that dry chemical stored-pressure extinguishers manufactured prior to October 1984 shall be removed from service at the next six year maintenance interval or the next hydro test, whichever comes first, and establishes new intervals for the internal examination of certain extinguishers. NFPA 11-2010, Standard for Low-, Medium-, and High-Expansion Foam and Combined Agent Systems incorporates requirements previously found in NFPA 11A, Standard for Medium- and High-Expansion Foam and adds a new chapter to address compressed air foam systems. The updated standard revises some chapters to accommodate the incorporation of medium- and high-expansion foam systems previously regulated by NFPA 11A. Updated NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems is revised to add an emphasis on safety and match current NFPA standard formatting. The updated standard includes requirements relating to updated warning signs, evacuation procedures, and provisions prohibiting the use of total flooding systems in most normally occupied areas. NFPA 12A-2009, Standard on Halon 1301 Fire Extinguishing Systems, is revised to address testing and recharging of Halon 1301 cylinders and amends portions to conform to current standards of regulatory bodies such as the United States Department of Transportation. NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection, incorporates welding requirements for pipe and fittings and coordinating requirements for fire department connections with NFPA 13, Standard for the Installation of Sprinkler Systems 2010 Edition. NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems, is revised to coordinate definitions and requirements for fire department connections and underground pipe with those of other NFPA standards. The updated standard also adds more specific proportioning system testing methods. NFPA 17-2009, Standard for Dry Chemical Extinguishing Systems, updates requirements for installing and servicing technicians, and requires that technicians have a certification document. NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems, provides clarification on inspection, service, and maintenance requirements and updated requirements for servicing personnel; makes changes regarding the necessary replacement and tagging procedure for parts discovered to be defective during system maintenance, and the subsequent notification process upon repair; and requires system flushing after any system actuation. NFPA 18-2006, Standard on Wetting Agents, clarifies the definition of wetting agents and their use on specific types of fires. The updated standard specifies specific packaging requirements and inspection, testing, and maintenance requirements for systems using wetting agents. NFPA 25-2008, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, refines testing frequencies for water flow alarm devices; clarifies the requirements regarding the servicing of water mist systems and the test methods for microbiologically influenced corrosion. The updated standard makes additional clarifications regarding the evaluation of annual pump test data. NFPA 96-2008, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, adds requirements for downdraft appliance ventilation and clarifies requirements for cleaning and maintaining exhaust systems and diagrams detailing new arrangements for hoods with integrated supply air. The updated standard also provides clarification of the requirements for field-applied and factory-built grease duct enclosures and recognizes new technologies for venting, such as ultraviolet hoods and ventilating ceilings. NFPA 2001-2008, Standard on Clean Agent Fire Extinguishing Systems, has been revised to specify requirements for local application systems and to specify protective standards relating to clean agent systems. The updated standard includes details on pressures and pressure reliefs and discharges.

Fire Alarm Standards

Proposed amendments to §34.607 update numerous NFPA minimum standards relating to fire alarm, fire detection, or supervisory services or systems. Requiring recent safety standards relating to fire alarm and fire detection devices is necessary to protect the health and safety of the public. The proposed amendments make the following replacements: (i) NFPA 11-2002, Standard for Low-Expansion Foam and NFPA 11A-1999, Standard for Medium- and High-Expansion Foam Systems with NFPA 11-2005, Standard for Low-, Medium-, and High-Expansion Foam; (ii) NFPA 12-2000, Standard on Carbon Dioxide Extinguishing Systems with NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems; (iii) NFPA 12A-2004, Standard on Halon 1301 Fire Extinguishing Systems with NFPA 12A-2009, Standard on Halon 1301 Fire Extinguishing Systems; (iv) NFPA 13-2002, Standard for the Installation of Sprinkler Systems with NFPA 13-2007, Standard for the Installation of Sprinkler Systems; (v) NFPA 13D-2002, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes with NFPA 13D-2007, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes; (vi) NFPA 13R-2002, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height with NFPA 13R-2007, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height; (vii) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (viii) NFPA 16-2003, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems. (ix) NFPA 17-2002, Standard for Dry Chemical Extinguishing Systems with NFPA 17-2009, Standard for Dry Chemical Extinguishing Systems; (x) NFPA 17A-2002, Standard for Wet Chemical Extinguishing Systems with NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems; (xi) NFPA 25-2002, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing and Maintenance

of Water-Based Fire Protection Systems; (xii) NFPA 70-2005, National Electrical Code with NFPA 70-2008, National Electrical Code; (xiii) NFPA 72-2002, National Fire Alarm Code with NFPA 72-2007, National Fire Alarm Code; (xiv) NFPA 90A-2002, Standard for the Installation of Air Conditioning and Ventilating Systems with NFPA 90A-2009, Standard for the Installation of Air Conditioning and Ventilating Systems; (xv) NFPA 101-2003, Code for Safety to Life from Fire in Buildings and Structures (Life Safety Code) with NFPA 101-2009, Life Safety Code; and (xvi) NFPA 2001-2004, Standard on Clean Agent Fire Extinguisher Systems, with NFPA 2001-2008, Standard on Clean Agent Fire Extinguisher Systems. Proposed amendments to §34.607(b) delete the following Codes as acceptable alternative model code sets: (i) the Uniform Building Code-1991 and later editions, and the Uniform Fire Code-1991 and later editions; (ii) the SBCCI Building Code-1991 and later editions, and; (iii) the SBCCI Fire Code-1991 and later editions; and the BOCA Building Code-1991 and later editions, and the BOCA Fire Code-1991 and later editions. The deletion of these codes is necessary because they are superseded by the Local Government Code §§214.212 and 214.216. The Local Government Code §214.212 specifies that the International Residential Code, as it existed on May 1, 2001, is adopted as the municipal residential building code in Texas. The Local Government Code §214.216 specifies that the International Building Code, as it existed on May 1, 2003, is adopted as the municipal commercial building code in Texas. Due to the deletion of existing paragraphs (1) - (3), paragraphs (4) - (6) are proposed to be redesignated as paragraphs (1) - (3). Proposed amendments to §34.607(b)(3) also update the NFPA Building Construction and Safety Code 2003 with the NFPA Building Construction and Safety Code 2009 and replaces the NFPA 1 Uniform Fire Code 2003 with the NFPA 1 Uniform Fire Code 2009.

The specific changes made by the following standards updated in the fire alarm subchapter are described in detail in the portion of the proposal specifying the updated fire extinguisher standards: NFPA 11-2010, Standard for Low-, Medium-, and High-Expansion Foam and Combined Agent Systems; NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems; NFPA 12A-2009, Standard on Halon 1301 Fire Extinguishing Systems; NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; NFPA 17-2009, Standard for Dry Chemical Extinguishing Systems; NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems; NFPA 25-2008, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems; and NFPA 2001-2008, Standard on Clean Agent Fire Extinguisher Systems. Changes made by updated standards in the fire alarm subchapter that are not updated and described in the fire extinguisher subchapter are as follows. NFPA 13-2007, Standard for the Installation of Sprinkler Systems, added definitions relating to private water supply terms; clarified the requirements of Ordinary Hazard Group 1 and Group 2 Occupancies where storage is present; revised requirements relating to trapeze hangers and bracing criteria; re-organized the requirements relating to storage according to storage size, type, material, and commodity; specifies new requirements for listed expansion chambers; clarifies ceiling pocket rules; and clarifies the formulas used in calculating large antifreeze systems. NFPA 13D-2007, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes, includes new spacing and obstruction rules addressing sloped ceilings, ceiling pockets, ceiling fans, and kitchen cabinets; specifies installation, design, and acceptance requirements for pumps; clarifies the acceptability of insulation as a method of freeze protection and the acceptability of wells as a water source; specifies new requirements for listed dry pipe or preaction residential sprinkler systems, as well as clarified requirements for multipurpose combined and networked sprinkler systems; and adopts specific obstruction rules for residential sprinklers. NFPA 13R-2007, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height; includes spacing and obstruction rules addressing sloped ceilings, ceiling pockets, ceiling fans, and kitchen cabinets; clarifies the requirements for utilizing quick-response sprinklers within NFPA 13R regulations; adds new requirements addressing architectural features within dwelling units; and clarifies the requirements covering closets, including obstructions within closets and protection of mechanical closets. NFPA 70-2008, National Electrical Code, NFPA 70-2008, National Electrical Code, requires that fire alarm system conductors use raceways or cable trays that contain electrical conductors with only electrical services; allows cable ties as a supporting means; adds requirements for certain power sources to be supplied by an individual branch circuit; and specifies requirements for certain conductors and cables. NFPA 72-2007, National Fire Alarm Code, addresses mass notification systems; revises sections addressing protection of fire alarm control units, personnel qualification, heat detector response time, smoke detector spacing, smoke detection in ducts, detectors that use multiple sensing inputs, video image smoke and flame detection, synchronization of visible notification appliances, exit marking audible notification appliances, tactile notification appliances, different types of protected premises fire alarm system, and in-building enhancement systems for firefighter radio communications. The updated standard also includes changes to the requirements for smoke alarms in residential applications, revisions to require additional smoke alarms for larger dwelling units, and revisions to allow voice messages to be included as a part of the smoke alarm notification signal. The updated standard also revises the Record of Completion Form and provides examples of filled-out forms. NFPA 90A-2009, Standard for the Installation of Air Conditioning and Ventilating Systems, recognizes new criteria in the types, quantities, and permitted use of various materials in plenum spaces. The updated standard specifies required material such as plenum cable, the type of cable, and the test protocols to determine the fire and smoke characteristics of the cable and wiring components. NFPA 101-2009, the Life Safety Code, makes the following changes: (i) new provisions relating to air traffic control towers, electrically controlled egress doors, certain horizontal sliding doors, elevator lobby access door locking, door inspection and maintenance, emergency evacuations and escape devices and systems, the placement and usage of alcohol-based hand sanitizer in educational and day care settings, and door locking in settings where occupants need specialized protection; (ii) standardizes the usage of certain technical terms, including stories *in height, finished ground level, grade plane, basement, and level of exit discharge*; (iii) revises the situations in which public address systems are acceptable for occupant alarm notification; and (iv) amends provisions relating to fire curtains, patient sleeping room windows in health care settings, and sprinkler requirements in high-rise health care settings. Obsolete building codes are also deleted to conform with the Local Government Code §214.212 and §214.216. The Local Government Code §214.212(a) specifies that to protect the public health, safety, and welfare, the International Residential

Code, as it existed on May 1, 2001, is adopted as a municipal residential building code in this state. The Local Government Code §214.212(b) specifies that the International Residential Code applies to all construction, alteration, remodeling, enlargement, and repair of residential structures in a municipality. The Local Government Code §214.216 specifies that to protect the public health, safety, and welfare, the International Building Code, as it existed on May 1, 2003, is adopted as a municipal commercial building code in this state. The updated standards remove as acceptable building codes (1) the Uniform Building Code-1991 and later editions, and the Uniform Fire Code-1991 and later editions; (2) the Southern Building Code Congress International (SBCCI) Building Code-1991 and later editions; and (3) the Building Officials Code Administrators Building Code-1991 and later editions, and the BOCA Fire Code-1991 and later editions.

Fire Sprinkler Standards

Proposed amended §34.707 updates numerous NFPA minimum standards relating to fire sprinklers and related fire safety issues. Requiring updated safety standards relating to fire sprinklers and related fire safety issues is necessary to protect the health and safety of the public. Proposed amended §34.707 makes the following replacements: (i) NFPA 13-2002, Standard for the Installation of Sprinkler Systems with NFPA 13-2010, Standard for the Installation of Sprinkler Systems; (ii) NFPA 25-1998, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems; (iii) NFPA 13D-2002, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes with NFPA 13D-2010, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes; (iv) NFPA 13R-2002, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height with NFPA 13R-2010, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height; (v) NFPA 14-2000, Standard for the Installation of Standpipe, Private Hydrant and Hose Systems with NFPA 14-2010, Standard for the Installation of Standpipe, Private Hydrant and Hose Systems; (vi) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (vii) NFPA 16-1999, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; (viii) NFPA 20-1999, Standard for the Installation of Stationary Pumps for Fire Protection with NFPA 20-2008, Standard for the Installation of Stationary Pumps for Fire Protection; (ix) NFPA 22-1998, Standard for Water Tanks for Private Fire Protection with NFPA 22-2008, Standard for Water Tanks for Private Fire Protection; (x) NFPA 24-2002, Standard for the installation of Private Fire Service Mains and Their Appurtenances with NFPA 24-2010, Standard for the Installation of Private Fire Service Mains and Their Appurtenances; (xi) NFPA 30-2000, Flammable and Combustible Liquids Code with NFPA 30-2008, Flammable and Combustible Liquids Code; (xii) NFPA 30B-2002, Code for the Manufacture and Storage of Aerosol Products with NFPA 30B-2011, Code for the Manufacture and Storage of Aerosol Products; (xiii) NFPA 307-2000, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves with NFPA 307-2011, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves; (xiv) NFPA 214-2000, Standard on Water-Cooling Towers with NFPA 214-2005, Standard on Water-Cooling Towers; and (xv) NFPA 409-2001, Standard on Aircraft Hangars with NFPA 409-2004, Standard on Aircraft Hangars.

The specific changes made by the following standards updated in the fire sprinkler subchapter are described in the portion of the proposal specifying the updated fire extinguisher standards: NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; and NFPA 25-2008, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. The specific changes made by the following standards updated in the fire sprinkler subchapter are described in the portion of the proposal specifying the updated fire alarm standards: NFPA 13-2007, Standard for the Installation of Sprinkler Systems; NFPA 13D-2007, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes; and NFPA 13R-2007, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height. The changes made by the standards updated in the fire sprinkler subchapter not updated and described in either the fire extinguisher subchapter are as follows. NFPA 14-2010, Standard for the Installation of Standpipe, Private Hydrant and Hose Systems, includes guidance on the use of pressure-regulating devices and roof outlets for standpipe systems; permits express mains supplying higher zone standpipes to be designed with pressures in excess of 350 psi; revises the requirements for standpipe system zones; deletes the requirements for pipe schedule design requires all standpipe systems to be hydraulically calculated; deletes the requirement to balance hydraulic junction points; and adds new requirements to address standpipe systems risers that terminate at different floor levels. NFPA 20-2008, Standard for the Installation of Stationary Pumps for Fire Protection, updates the standard to conform with the latest edition of the *Manual of Style for NFPA Technical Committee Documents*; adds provisions addressing the use of fire pump drivers using variable speed pressure limiting control; adds acceptance test criteria for replacement of critical path components of a fire pump installation; refines requirements for variable speed drives were refined; adds requirements for break tanks and component replacement testing tables; and adds requirements on fire pumps for high-rise buildings and for pumps arranged in series. NFPA 22-2008, Standard for Water Tanks for Private Fire Protection; addresses the use of fiberglass-reinforced plastic tanks and consolidates the requirements relating to acceptance test requirements into a single new chapter. NFPA 24-2010, Standard for the Installation of Private Fire Service Mains and Their Appurtenances, establishes leakage test criteria; updates requirements for thrust blocks and restrained joints; and adds additional specifications for recommended practice for fire flow testing and for hydrant marking; revises provisions for location and identification of fire department connections, valves controlling water supply, and protection of fire. NFPA 30-2008, Flammable and Combustible Liquids Code makes changes in separation distance requirements for protected aboveground tanks and tanks in vaults; adds requirements for shop-fabricated aboveground tanks with abnormally long vertical piping for fill or vent lines; adds maximum allowable storage container sizes; adds fire protection design criteria for unsaturated polyester resins; adds fire protection design criteria using high-expansion foam systems for protection of liquids in 1-gallon plastic containers; revises spacing requirements and construction requirements for process buildings; adds

requirements for insulated piping for recirculating heat transfer systems; prohibits permanent interconnections between fire water systems and process water systems; adds new corrosion protection requirements for nonmetallic tanks; clarifies the requirements for construction of vaults; adds requirements for fire-resistant tanks; revises the maximum capacity for secondary containment-type tanks storing certain liquids; adds requirements for periodic testing, maintenance, inspection, and repair of aboveground storage tanks have been added; revises overfill prevention requirements so that they apply to all tanks larger than 1320 gallons of capacity; adds requirements for marine piping systems; and expands the fire protection design criteria for inside storage areas to include additional varieties of containers and cartons. NFPA 30B-2011, Code for the Manufacture and Storage of Aerosol Products, clarifies the requirements for aisle widths in storage facilities and revises the definition of aerosol container to allow the use of certain plastic aerosol containers. NFPA 307-2011, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves, has been revised in accordance with the *Manual of Style for NFPA Technical Committee Documents;* amends fire protection requirements for certain marine terminal buildings; revises the definition for hazardous materials; adds requirements for wood and unprotected substructures, and piles and stiffening members of piers and wharves; and permits the use of corrosion-resistant types of pipes, fitting, hangers, or listed protective corrosion-resistant coatings on fixed extinguishing system components that are subject to corrosion in a marine environment. NFPA 214-2005, Standard on Water-Cooling Towers, adds requirements for pilot line detectors. NFPA 409-2004, adds requirements for paint hangars.

10. Other Necessary Changes.

The proposal makes other necessary changes to improve the clarity and consistency of the sections. A proposed amendment to §34.605 replaces a reference to "provisions of the statutes" with a reference to "the Insurance Code Chapter 6002." A proposed amendment to §34.606(9) replaces the phrase "A person" with the phrase "An individual." A proposed amendment to §34.606(13) deletes the phrase "As used in the Texas Insurance Code, Article 5.43-2 §9(c), means a" before the definition of local *authority having jurisdiction.* The word "Texas" preceding the phrase "Insurance Code" is deleted from proposed amended §34.607(a). The title to §34.611 is proposed to be changed from "Licenses" to "Licenses and Approvals" to reflect the revised content of that section. The title to proposed amended §34.611(b) is changed from "Pocket license" to "Pocket License and Approval" for the same reason. The title to proposed amended §34.611(c) is changed from "Duplicate license" to "Duplicate License" and the title to redesignated §34.611(d) is changed from "Revised licenses" to "Licensee Responsibilities Relating to Revised Licenses" to reflect the content of that section. The title to §34.612 is changed from "Alteration of Certificates or Licenses" to "Alteration of Certificates, Licenses, or Approvals" to reflect the addition of approvals. The text of §34.612 is also amended to include the category of approvals. The title to §34.613(a) is changed from "Certificates of registration" to "Approvals and Certificates of Registration." Section 34.613(a)(5) is amended to change "Insurance required." to "Insurance is required as follows:". The phrase "these sections" is replaced with the phrase "this subchapter" in §34.613(a)(5)(A). Section §34.613(a)(7) is amended to add a sentence specifying that a fire alarm licensee serving in a monitoring capacity for a firm applying for a certificate of registration may not serve in that capacity for a registered firm other than the firm applying for the certificate of registration. Section 34.613(a)(7) is also amended to add the phrase "as adopted in §34.607 of this subchapter (relating to Adopted Standards)" after a reference to the NFPA 72. The title to §34.613(b) is proposed to be changed from "Fire alarm licenses" to "Fire Alarm Licenses" and the title to redesignated §34.613(d) is proposed to be changed from "Renewal applications." to "Renewal Applications." for consistency. A proposed amendment to redesignated §34.613(d)(1) adds instructor and training school approvals to the list of potential renewal application categories. A proposed amendment to redesignated §34.613(e) replaces the title "Complete applications." with "Complete Applications.", adds instructor and training school approvals to the list of complete applications required, and replaces a reference to the "department" with a reference to the "State Fire Marshal's Office." An amendment to the title of §34.616(a) changes "Residential alarms (single station)." to "Residential Alarms (Single Station)." Proposed amendments to §34.616(b)(1) and (2) add the category of residential fire alarm technicians to the listing of licensees subject to those sections and specify that all supervised work must be overseen by a licensee with the appropriate licensure for the work overseen. A proposed amendment to §34.616(b)(1) specifies that the installation of all fire detection and alarm devices must be performed by or under the direct on-site supervision of an appropriate licensee for the work performed. The requirement that the supervision be "on-site" was added for consistency with the Insurance Code §6002.154(d-1) which requires that supervision be "on-site." A proposed amendment to §34.616(b)(4) adds the phrase "planning and" before the word "installation" to clarify that the planning of fire alarm devices must be completed in accordance with the minimum standards adopted in §34.607. The title to §34.616(c) is proposed to be changed from "Monitoring requirements." to "Monitoring Requirements." for consistency. The requirements relating to monitoring services and registered firms in proposed amended §34.616(c)(2)(A) are changed to reflect that the registration must occur under the Insurance Code Chapter 6002. Proposed amended §34.625(a) adds the word "the" before the phrase "Insurance Code" and proposed amended §34.625(c) adds the word "the" before the phrase "Government Code." A proposed amendment to §34.810(e) requires that licensees submit written notification within 14 days of a change in the licensee's name, business location, residence, or mailing address. This change is necessary so that the SFMO may be informed in a timely manner of changes relating to licensees and is consistent with the other licensee notice requirements under Chapter 34.

Subchapter E. Fire Extinguisher and Installation

Proposed amendments to §34.507 update minimum safety standards adopted pursuant to the Texas Insurance Code §6001.052. The proposed amendments update numerous National Fire Protection Association (NFPA) minimum standards relating to fire extinguisher systems. The following replacements are made: (i) NFPA 10-2002, Standard for Portable Fire Extinguishers and its specified exceptions, with NFPA 10-2010, Standard for Portable Fire Extinguishers; (ii) NFPA 11-2002, Standard for Low-Expansion Foam and Combined Agent Systems, and NFPA 11A-1999, Standard for Medium- and High-Expansion Foam Systems, with NFPA 11-2010, Standard for Low-, Medium-, and High-Expansion Foam and Combined Agent Systems; (iii) NFPA 12-2000, Standard on Carbon Dioxide Extinguishing Systems with NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems; (iv) NFPA 12A-2004, Standard on Halon 1301 Fire Extinguishing Systems with NFPA

12A-2009, Standard on Halon 1301 Fire Extinguishing Systems; (v) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (vi) NFPA 16-2003, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; (vii) NFPA 17-2002, Standard for Dry Chemical Extinguishing Systems and its specified exceptions with NFPA 27-2009, Standard for Dry Chemical Extinguishing Systems; (viii) NFPA 17A-2002, Standard for Wet Chemical Extinguishing Systems and its specified exceptions with NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems; (ix) NFPA 18-1995, Standard on Wetting Agents with NFPA 18-2006, Standard on Wetting Agents; (x) NFPA 25-2002, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems; (xi) NFPA 96-2001, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations with NFPA 96-2008 and its specified exceptions, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations; and (xii) NFPA 2001-2004, Standard on Clean Agent Fire Extinguishing Systems with NFPA 2001-2008, Standard on Clean Agent Fire Extinguishing Systems.

Proposed new language added to §34.510(g) specifies the initial fees and expiration date for an extinguisher branch office certificate of registration. The subsection specifies that the initial fee for a branch office certificate of registration is $100 and is not prorated. The amended subsection also specifies that branch office certificates of registration expire and renew on the same date as the certificate of registration for the registered firm's main office. The proposed amendment also deletes the requirement that each certificate shall be posted conspicuously for public view at the business location.

Proposed new §34.510(m) specifies the procedure for the initial alignment of the expiration and renewal dates of existing extinguisher branch offices. The subsection specifies that for branch offices in existence as of the effective date of this rule, branch office certificates of registration shall expire and renew on the same date as the certificate of registration issued to the main office for that firm. The subsection specifies that all fees associated with the initial alignment of expiration and renewal dates for branch office certificates of registration shall be prorated accordingly.

A proposed amendment to §34.515(a) sets out the fee payment procedure for fire extinguisher licensees and specifies that except for fees that must be paid to testing authorities, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. The proposed new language in the subsection specifies that should the Department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. Another proposed amendment to §34.515(a) eliminates cash as an acceptable payment method. A proposed amendment deletes the language in §34.515(b) relating to fee payment procedure and redesignates the remaining subsections. Proposed amendments to redesignated §34.515(b)(1)(C) and (D) specify the new late fee structure for branch offices and provides that the renewal late fee for certificates of registration expired 1 day to 90 days is $225 plus $50 for each branch office operated by the registered firm and that the renewal late fee for certificates of registration expired from 91 days to two years is $450 plus $100 for each branch officer operated by the registered firm. Existing subparagraphs (G) and (H) are proposed to be deleted because these provisions are incorporated in amendments to subparagraphs (C) and (D).

Subchapter F. Fire Alarm Rules

Proposed amendments to §34.601 replace the word "chapter" with "subchapter;" add the word "the" before the phrase "Insurance Code;" and replace a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002.

A proposed amendment to §34.602 replaces the word "chapter" with the word "subchapter."

A proposed amendment to §34.603 replaces the word "chapter" with the word "subchapter."

Proposed amendments to §34.604 replace a reference to the Insurance Code Article 5.43-2 §3 with a reference to the Insurance Code §6002.155 and replace the word "chapter" with the word "subchapter."

A proposed amendment to §34.605 replaces the phrase "provisions of the statutes" with the phrase "the Insurance Code Chapter 6002." The proposed amendments replace the word "chapter" with the word "subchapter" and the phrase "Office of the State Fire Marshal" with the phrase "State Fire Marshal's Office." Proposed new §34.606(1) adds a definition for *approval,* which is defined as the document issued by the State Fire Marshal's Office to an individual or entity acknowledging that the individual or entity meets the requirements to perform the functions of an approved instructor or approved training school under the Insurance Code Chapter 6002 and Subchapter F. The remaining paragraphs in the section are proposed to be redesignated. Proposed new §34.606(7) defines *designated employee* as an individual specified by a registered firm as a full-time employee and a licensee under Subchapter F. Proposed amendments to §34.606(9) replace the phrase "a person" with the phrase "an individual" and replace a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code §6002.002. Proposed new §34.606(12) defines *instructor* as an individual approved under the Insurance Code Chapter 6002 and Subchapter F to provide training in installing, servicing, inspecting, and certifying fire alarm or detection systems in single-family or two-family residences. A proposed amendment to §34.606(13) amends the definition of *local authority having jurisdiction* to delete the phrase "As used in the Texas Insurance Code, Article 5.43-2, §9(c), means a." A proposed amendment to §34.606(14) replaces a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002. Proposed new §34.606(22) defines *training school* as an entity that is approved under the Insurance Code Chapter 6002 and Subchapter F to provide approved training in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences by approved instructors for the purpose of meeting the training requirements of an applicant for a residential fire alarm technician license issued under the applicable statutes and the subchapter.

A proposed amendment to §34.607(a) replaces the word "chapter" with the word "subchapter" and replaces a reference to the Insurance Code Article 5.43-2 with a reference to the

Insurance Code Chapter 6002. Another proposed amendment to §34.607(a) deletes the word "Texas" before the phrase "Insurance Code" and replaces the phrase "state fire marshal's office" with the phrase "State Fire Marshal's Office." The adopted standards specified in §34.607(a)(1) - (17) are updated to reflect current standards. Proposed amendments to §34.607(a) replace (i) NFPA 11-2002, Standards for Low-Expansion Foam and NFPA 11A-1999, Standard for Medium- and High-Expansion Foam Systems with NFPA 11-2005, Standard for Low-, Medium-, and High-Expansion Foam; (ii) replace NFPA 12-2000, Standard on Carbon Dioxide Extinguishing Systems, with NFPA 12-2008, Standard on Carbon Dioxide Extinguishing Systems; (iii) NFPA 12A-2004, Standard on Halon 1301 Fire Extinguishing Systems, with NFPA 12A-2009, Standard on Halon 1301 Fire Extinguishing Systems; (iv) NFPA 13-2002, Standard for the Installation of Sprinkler Systems, with NFPA 13-2007, Standard for the Installation of Sprinkler Systems; (v) NFPA 13D-2002, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwelling and Manufactured Homes, with NFPA 13D-2007, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwelling and Manufactured Homes; (vi) NFPA 13R-2002, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height with NFPA 13R-2007, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and including Four Stories in Height; (vii) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (viii) NFPA 16-2003, Standard for the Installation of Foam-Water Sprinkler and Foam Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; (ix) NFPA 17A-2002, Standard for Dry Chemical Extinguishing Systems with NFPA 17-2009, Standard for Dry Chemical Extinguishing Systems; (x) NFPA 17A-2002, Standard for Wet Chemical Extinguishing Systems with NFPA 17A-2009, Standard for Wet Chemical Extinguishing Systems; (xi) NFPA 25-2002, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems; (xii) NFPA 70-2005, National Electrical Code with NFPA 70-2008, National Electrical Code; (xiii) replace NFPA 72-2002, National Fire Alarm Code with NFPA 72-2007, National Fire Alarm Code; (xiv) NFPA 90A-2002, Standard for the Installation of Air Conditioning and Ventilating Systems with NFPA 90A-2009, Standard for the Installation of Air Conditioning and Ventilating Systems; (xv) NFPA 101-2003, Life Safety Code with NFPA 101-2009, Life Safety Code; (xvi) NFPA 2001-2004, Standard on Clean Agent Fire Extinguisher Systems with NFPA 2001-2008, Standard on Clean Agent Fire Extinguisher Systems. Proposed §34.607(b) is amended to delete the following alternative acceptable model code sets: the Uniform Building Code 1991 and later editions, and the Uniform Fire Code 1991 and later editions; the SBCCI Building Code 1991 and later editions, and the SBCCI Fire Code 1991 and later editions; or the BOCA Building Code 1991 and later editions, and the BOCA Fire Code 1991 and later editions. Proposed §34.607(b) replaces NFPA 5000, Building Construction and Safety Code-2003 with NFPA 5000, Building Construction and Safety Code-2009. Proposed §34.607(b) replaces the NFPA 1 Uniform Fire Code 2003 with the NFPA 1 Uniform Fire Code 2009.

A proposed amendment to §34.610(b) deletes the requirement that each certificate of registration must be posted conspicuously for public view at a registered firm's business location and adds new language specifying that in an application or renewal for a certificate of registration, each registered firm must specify one full-time employee holding a license under the subchapter as the firm's designated employee. The proposed new subsection also specifies that any change in the designated employee under this section must be submitted in writing to the State Fire Marshal's Office within 14 days of its occurrence, and that an individual may not serve as a designated employee for more than one registered firm. Proposed new §34.610(f) specifies that the initial fee for a branch office certificate of registration is $150 and is not prorated. The subsection also specifies that branch office certificates of registration expire and renew on the same date as the certificate of registration for the registered firm's main office. Subsections (f) and (g) are proposed to be redesignated as (g) and (h). Proposed new §34.610(i) specifies that for branch offices in existence as of the effective date of the rule, branch officer certificates of registration shall expire and renew on the same date as the certificate of registration issued to the main office for that firm. The new subsection also specifies that all fees associated with the initial alignment of expiration and renewal dates for the branch office certificate of registration shall be prorated accordingly.

A proposed amendment to §34.611(a) adds new language which states that the licenses specified in §34.611(a)(1) - (8) are issued by the State Fire Marshal's Office in accordance with the Insurance Code Chapter 6002 and Subchapter F, and specifies that, as required by the Insurance Code Chapter 6002, only licensed or approved entities may engage in specific functions. Proposed new §34.611(a)(3) adds an approval category for instructors, and specifies that the approval is for providing training at an approved training school in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences. Paragraphs (3) - (5) are proposed to be redesignated as paragraphs (4) - (6). Proposed new §34.611(a)(7) adds a license for residential fire alarm technicians and specifies that the license is for installing, certifying, inspecting, and servicing, but not planning, fire alarm or fire detection devices and systems in single-family or two-family residences. Proposed new §34.611(a)(8) adds an approval for training schools, and specifies that the approval is for conducting required training necessary for obtaining a residential fire alarm technician license. An amendment to §34.611(b) deletes the requirement that wall licenses must be posted conspicuously for public view at a registered firm's business location. The remaining subsections are proposed to be redesignated. Proposed new §34.611(b)(2) specifies that an instructor must carry their approval while providing training in an approved training school on the installing, certifying, inspecting and servicing of fire alarm or detection systems in single-family or two-family residences. Proposed amendments to redesignated §34.611(d) set out licensee responsibilities relating to revised licenses, specifying that a change in the licensee's name, licensee's mailing address, or a new or additional registered firm employee the licensee requires a revised license. Proposed new §34.611(e) specifies registered firms' responsibilities relating to licensees and specifies that a registered firm must submit notification of any licensee employment, termination, or resignation within 14 days of its occurrence. A proposed amendment to §34.611(f) changes the name of the subsection from "Restrictions" to "Restrictions on Licensees and Registered Firms." Proposed new §34.611(g) specifies that approvals are not transferable. Proposed new §34.611(h) requires that a change in the instructor's name or mailing address requires a revised approval.

A proposed amendment to §34.612 specifies that the alteration of an approval renders it invalid and may be the basis for disciplinary action. Another amendment replaces a reference to the Insurance Code Article 5.43-2, §10(b) with a reference to the Insurance Code §6002.302.

Section 34.613(a)(1) is amended to add *approvals* to the list that must be submitted on the forms adopted by reference in §34.630 of the subchapter and be accompanied by all necessary fees, documents, and information. Other amendments replace (i) a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002; (ii) the phrase "the sections of this chapter" with the phrase "this subchapter"; and (iii) the phrase "State Fire Marshal's office" with the phrase "State Fire Marshal's Office." A proposed amendment to §34.613(a)(2) replaces a reference to the Business and Commerce Code Chapter 36 with a reference to the Business and Commerce Code Chapter 71. Another proposed amendment replaces a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002. Another proposed amendment replaces the phrase "the sections of this chapter" with the phrase "this subchapter." Proposed §34.613(a)(5) replaces the phrase "Insurance required." with the phrase "Insurance is required as follows:". The phrase "State Fire Marshal's office" is replaced with the phrase "State Fire Marshal's Office" in proposed §34.613(a)(5)(A) and (B). A proposed amendment to §34.613(a)(7) adds a sentence specifying that a fire alarm licensee designated by a monitoring company as its employee may not serve in a similar capacity for another company. Section 34.613(a)(7) is also amended to replace the phrase "adopted NFPA 72" with the phrase "NFPA 72 as adopted in §34.607 of this subchapter (relating to Adopted Standards)." New proposed §34.613(b)(7) specifies that an applicant for a residential fire alarm technician license must provide evidence of the applicant's successful completion of the required residential fire alarm technician training course from a training school approved by the State Fire Marshal's Office. Proposed new §34.613(c) specifies the requirements for instructor and training school approvals. Proposed new §34.613(c)(1) specifies that an applicant for approval as an instructor must hold a current fire alarm planning superintendent's license issued by the State Fire Marshal's Office; submit a completed Instructor Approval Application, Form No. SF247, signed by the applicant, that is accompanied by all fees; and furnish written documentation of a minimum of three years of experience in fire alarm installation, service, or monitoring of fire alarm systems, unless the applicant has held a fire alarm planning superintendent's license for three or more years. Proposed new §34.613(c)(2) specifies the requirements for training school approvals. Proposed new §34.613(c)(2) specifies that an applicant for approval of a training school must submit a completed Training School Approval Application, Form No. SF 246, signed by the applicant, the sole proprietor, each partner of a partnership, or by an officer of a corporation or organization as applicable; accompanied by a detailed outline of the proposed subjects to be taught at the training school and the number and location of all training courses to be held within one year following approval of the application; and accompanied by all required fees. Proposed new §34.613(c)(2) also specifies that after review of the application for approval for a training school, the State Fire Marshal shall approve or deny the application within 60 days following receipt of the materials, and requires that a letter of denial shall state the specific reasons for the denial and that an applicant that is denied approval may reapply at any time within 180 days, in accordance with §34.613(e), by submitting a completed application that includes the changes necessary to address the specific reason for denial. Existing subsections (c) and (d) are proposed to be redesignated as subsections (d) and (e). Proposed redesignated §34.613(d) is amended to specify that in order to be complete, renewal applications for instructor approvals and training school approvals must be submitted on forms adopted by reference in §34.630 of the subchapter and be accompanied by all necessary fees. The proposed amendment replaces a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002. An amendment to redesignated §34.613(e) specifies that the application form for an instructor approval and training school approval must be accompanied by the required fee and must, within 180 days of receipt by the State Fire Marshal's Office of the initial application, be complete and accompanied by all other required information, or a new application must be submitted including all applicable fees. Other proposed amendments to §34.613(e) replace a reference to "the department" with a reference to "the State Fire Marshal's Office" and replace a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002.

Proposed amendments to §34.614 outlines the fee payment procedure. Proposed §34.614(a) specifies that except for fees that must be paid to testing authorities, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. The proposed new language in the section specifies that should the Department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. Another proposed amendment to §34.614(a) eliminates cash as an acceptable payment method. Existing text in §34.614(b) is proposed to be deleted and the text of existing subsection (c) is moved to (b). The remaining subsections are proposed to be redesignated. Proposed redesignated §34.614(c) specifies that the renewal fee for a certificate of registration remains valid for two years and is subject to the exceptions specified in §34.610(i) (relating to Certificate of Registration) for the initial alignment of the expiration and renewal dates of existing branches. Proposed redesignated §34.614(c) also amends the late fee structure to reflect the alignment of main office and branch certificate of registration expirations. Section 34.614(c)(1)(C) specifies that the renewal late fee for expirations of one to 90 days is $125 plus $37.50 for each branch office operated by the registered firm and §34.614(c)(1)(D) that the renewal late fee for expirations of 91 days to two years is $500 plus $150 for each branch office operated by the registered firm. Existing subparagraphs (G) and (H) are proposed to be deleted because these provisions are incorporated in amendments to subparagraphs (C) and (D). Proposed new §34.614(c)(4) specifies the fee structure for the new residential fire alarm technician license. The proposed fees are as follows: initial fee (for one year)--$50; renewal fee (for two years)--$100; renewal late fee (expired one day to 90 days)--$12.50; and renewal late fee (expired 91 days to two years)--$50. Proposed new §34.614(c)(5) specifies the fee structure for the new training school approval. The proposed fees are: initial fee (for one year)--$500; and renewal fee (for one year)--$500. Proposed new §34.614(c)(6) specifies the fee structure for the new instructor approval. The proposed fees are: initial fee (for one year)--$50; and renewal fee (for one year)--$50. Proposed redesignated §34.614(e) re-

places a reference to the Insurance Code Article 5.43-2 §5C(c) with a reference to the Insurance Code §6002.203(g).

A proposed amendment to §34.615 replaces a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002.

Proposed amendments to §34.616(a)(1) and (2) replace references to the Insurance Code Article 5.43-2, §3(b)(10) with references to the Insurance Code §6002.155(10). Proposed amendments to §34.616(a)(2) replace a reference to Article 5.43-2 with a reference to the Insurance Code Chapter 6002 and replace the word "chapter" with the word "subchapter." Proposed amendments to §34.616(b)(1) replace a reference to the Insurance Code Article 5.43-2 with a reference to the Insurance Code Chapter 6002, and add the phrase "on-site" to the requirement that certain work be performed under the direct supervision of a licensee. Proposed amendments to §34.616(b)(1) and (2) add residential fire alarm technicians among the listed licensees and specify that the licensee supervising the work must oversee work permitted by the licensee. A proposed amendment to §34.616(b)(2) also specifies that the licensee attaching a label must be licensed under the ACR number of the primary registered firm. A proposed amendment to §34.616(b)(3) replaces the phrase "the licensing requirements of the appropriate Insurance Code, Article 5.43-1 or 5.43-3, must be satisfied" with the phrase "the licensing requirements of Insurance Code Chapters 6001 and 6003 must be satisfied, as appropriate." A proposed amendment to §34.616(b)(4) specifies that the planning and installation of fire detection or fire alarm devices or systems, including monitoring equipment, must be in accordance with standards adopted in §34.607 (relating to Adopted Standards) except when the planning and installation complies with a more recent edition of an adopted standard or a Tentative Interim Amendment published as effective by the NFPA. Proposed amendments to amended §34.616(c) add a reference to the Insurance Code Chapter 6002 and replace the phrase "licensing requirements of Insurance Code Article 5.43-2, so long as" with the phrase "licensing requirements of that chapter; and" and also replace a reference to the Insurance Code Article 5.43-2 §9 with a reference to the Insurance Code §6002.251.

Proposed amendments to §34.625(a) and (c) replace references to the Insurance Code Article 5.43-2 with references to the Insurance Code Chapter 6002.

Proposed new §34.627 specifies the requirements for instructors and training schools. Proposed new §34.627(a) specifies that all training provided by an instructor must be conducted through an approved training school and that the instructor must teach the subjects in the outline of the training course submitted by the training school and approved by the State Fire Marshal's Office. Proposed new §34.627(b) specifies training schools must only use instructors who hold an approval issued by the State Fire Marshal's Office to provide training in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences. The subsection also specifies that the entity responsible for the training school must obtain approval of the outline of each residential fire alarm technician training course from the State Fire Marshal's Office before conducting a class. Proposed new §34.627(b) specifies that the entity responsible for the training school may not be a firm registered through the State Fire Marshal's Office or an affiliate of a registered firm. The subsection specifies that a training school may not provide training for a residential fire alarm technician license without being approved by the State Fire Marshal, and that training school approvals are not transferable and apply only to the entity specified as the responsible entity on the application for approval. The subsection specifies that the training school may not change the entity responsible for the training school without first applying for and receiving a new approval. Proposed §34.627(b) further specifies that the training school must conduct two or more classes, open to the public, within 125 miles of each county in the state that has a population in excess of 500,000 people according to the last decennial census, within each calendar year from the date the approval is issued. Proposed new §34.627(c) specifies that any individual or entity that provides general training or instruction relating to fire alarm or detection systems, but whose training is not specific to fulfill a requirement to obtain a license, is not required to have an approval.

Proposed new §34.628 specifies the requirements for the residential fire alarm technician training course. The section specifies that the training curriculum for a residential fire alarm technician training course shall consist of at least eight hours of instruction on installing, servicing, and maintaining single-family and two-family residential fire alarm systems as defined by National Fire Protection Association Standard No. 72. The section specifies that the training curriculum for a residential fire alarm technician training course must include the following minimum instruction time for the following subjects: (i) one hour of instruction on the Insurance Code Chapter 6002 and the Fire Alarm Rules; (ii) one hour of instruction pertaining to the equipment, system, and other hardware relating to household fire alarms; (iii) one hour of instruction on the National Electric Code, NFPA 70; (iv) four and one-half hours of total combined instruction on NFPA 72; NFPA 101, the Life Safety Code; and the International Residential Code for One- and Two-Family Dwellings; and (v) one-half hour of instruction on the monitoring of household fire alarm systems.

Proposed new §34.629(a) states that the purpose of the new section is to specify the purpose, member composition, member terms, and reporting requirements of the Fire Detection and Alarm Devices Advisory Council and states that the Fire Detection and Alarm Devices Advisory Council will be referred to as the Fire Alarm Advisory Council. Proposed new §34.629(b) specifies that the purpose of the Fire Alarm Advisory Council is to review rules implementing the Insurance Code Chapter 6002, and, as necessary, recommend rule amendments to the commissioner. Proposed new §34.629(c) specifies that the Fire Alarm Advisory Council shall be composed of seven members, as follows: three individuals who are employed by a registered firm in the fire protection industry and who have at least three years experience in the sale, installation, maintenance, or manufacture of fire alarm or fire detection devices; two individuals who are experienced in the engineering of fire prevention services or members of a fire protection association; one individual who is an experienced fire prevention officer employed by a municipality or county; and one individual who is employed by a registered firm and has at least three years experience in the operation of a central fire alarm monitoring station. Proposed new §34.629(d) specifies that the Fire Alarm Advisory Council members shall serve at the will of the Commissioner and that the Commissioner shall replace any member who resigns from the advisory council or whose membership is otherwise terminated. Proposed new §34.629(e) specifies that after completing review of proposed rules implementing the Insurance Code Chapter 6002 and developing recommendations relating to the rules, the Fire Alarm

Advisory Council shall submit a report of its findings and recommendations to the Commissioner. Proposed new §34.629(f) specifies that the advisory council is established to operate for four years from the effective date of its adoption unless abolished earlier or extended to a later date by the Commissioner, in accordance with §2110.008 of the Government Code.

Proposed new §34.630 adopts by reference application and renewal forms necessary under the subchapter. Proposed new §34.630(a) adopts by reference the License Application for Individuals For All Types of Fire Alarm Licenses, Form Number SF032, which contains instructions for completion of the form and requires information to be provided regarding the applicant and the applicant's employer. Proposed new §34.630(b) adopts by reference the Renewal Application For Fire Alarm Individual License, Form Number SF094, which contains instructions for completion of the form; information regarding late fees; and requires information to be provided regarding the renewing applicant. Proposed new §34.630(c) adopts by reference the Instructor Approval Application, Form Number SF247, which contains instructions for completion of the form and requires information to be provided regarding the applicant. Proposed new §34.630(d) adopts by reference the Renewal Application For Instructor Approval, Form Number SF255, which contains instructions for completion of the form and requires information to be provided regarding the applicant. Proposed new §34.630(e) adopts by reference the Training School Approval Application, Form Number SF246, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule. Proposed new §34.630(f) adopts by reference the Renewal Application for Training School Approval, Form Number SF254, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule. Proposed new §34.630(g) adopts by reference the Fire Alarm Certificate of Registration Application, Form Number SF031, which contains instructions for completion of the form; provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant. Proposed new §34.630(h) adopts by reference the Renewal Application For Fire Alarm Certificate of Registration, Form Number SF084, which contains instructions for completion of the form and requires information to be provided regarding the applicant. Proposed new §34.630(i) specifies that the forms adopted by reference in the proposed new section are available at the Department's website.

Subchapter G. Fire Sprinkler Rules

Proposed amendments to §34.707 update minimum safety standards adopted pursuant to the Texas Insurance Code §6003.052. The proposed amendments update numerous National Fire Protection Association (NFPA) minimum standards relating to fire sprinklers and related fire safety issues and make the following replacements: (i) NFPA 13-2002, Standard for the Installation of Sprinkler Systems with NFPA 13-2010, Standard for the Installation of Sprinkler Systems; (ii) NFPA 25-1998, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems with NFPA 25-2008, Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems; (iii) NFPA 13D-2002, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes with NFPA 13D-2010, Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes; (iv) NFPA 13R-2002, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height with NFPA 13R-2010, Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height; (v) NFPA 14-2000, Standard for the Installation of Standpipe, Private Hydrant and Hose Systems with NFPA 14-2010, Standard for the Installation of Standpipe, Private Hydrant and Hose Systems; (vi) NFPA 15-2001, Standard for Water Spray Fixed Systems for Fire Protection with NFPA 15-2007, Standard for Water Spray Fixed Systems for Fire Protection; (vii) NFPA 16-1999, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems with NFPA 16-2007, Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems; (viii) NFPA 20-1999, Standard for the Installation of Stationary Pumps for Fire Protection with NFPA 20-2008, Standard for the Installation of Stationary Pumps for Fire Protection; (ix) NFPA 22-1998, Standard for Water Tanks for Private Fire Protection with NFPA 22-2008, Standard for Water Tanks for Private Fire Protection; (x) NFPA 24-2002, Standard for the installation of Private Fire Service Mains and Their Appurtenances with NFPA 24-2010, Standard for the Installation of Private Fire Service Mains and Their Appurtenances; (xi) NFPA 30-2000, Flammable and Combustible Liquids Code with NFPA 30-2008, Flammable and Combustible Liquids Code; (xii) NFPA 30B-2002, Code for the Manufacture and Storage of Aerosol Products with NFPA 30B-2011, Code for the Manufacture and Storage of Aerosol Products; (xiii) NFPA 307-2000, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves with NFPA 307-2011, Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves; (xiv) NFPA 214-2000, Standard on Water-Cooling Towers with NFPA 214-2005, Standard on Water-Cooling Towers; and (xv) NFPA 409-2001, Standard on Aircraft Hangars with NFPA 409-2004, Standard on Aircraft Hangars.

A proposed amendment to redesignated §34.711(d) deletes the requirement that licenses requiring changes must be surrendered to the State Fire Marshal within 14 days of the change requiring the revision. The proposed amendment specifies that the licensee must submit written notification of the necessary change within 14 days of the change accompanied by the required fee.

A proposed amendment to §34.714(a) specifies the fee payment procedure for fire sprinkler licensees. Proposed §34.714(a) specifies that except for fees that must be paid to testing authorities, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. The proposed new language in the subsection specifies that should the Department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. Another proposed amendment to §34.714(a) eliminates cash as an acceptable payment method. A proposed amendment to §34.714(b) deletes language relating to fee payment procedure. The remaining subsections in the section are proposed to be redesignated.

Subchapter H. Storage and Sale of Fireworks

A proposed amendment to §34.808(41) changes the definition of supervisor to mean a person 18 years or older who is responsible for the retail fireworks site during operating hours.

A proposed amendment to §34.810(e) deletes the requirement that documents requiring changes must be surrendered to the State Fire Marshal within 30 days of the change, with written notification of the necessary change and adds language specifying that licensees must submit written notification within 14 days of a change of a licensee's name, business location, residence, or mailing address.

A proposed amendment to §34.817(a) changes the age of the supervisor that must be on duty during all phases of retail operation from 16 years of age or older to 18 years of age or older.

FISCAL NOTE. Paul Maldonado, State Fire Marshal, has determined that for each year of the first five years the proposed amendments and new rules are in effect, although the proposed new rules will decrease licensing fees collected by the Department, because of the Department's self-leveling method of finance there will be no fiscal implications to state or local government as a result of the enforcement and administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

The proposed new rules will result in a decrease in the amount of licensing fees collected by the Department. It is anticipated that the rule proposal will decrease licensing costs for alarm, extinguisher, and sprinkler licensees that work for more than one employer. The existing licensing structure requires licensees working for more than one employer: to (1) notify the State Fire Marshal's Office of additional employers upon initial employment and pay a $20 licensing fee ($35 for sprinkler licensees) for each additional employer, and; (2) upon subsequent renewal, pay the $20 ($35 for sprinkler licensees) licensing fee for each additional employer. Under the new proposed licensing structure, licensees will still be required to provide notification of additional employers upon initial employment, accompanied with the required licensing fee per each additional employer. However, under the new proposed licensing structure, this fee will be a one-time cost to update the licensee's records and will not be required subsequently upon renewal. Therefore, the proposed licensing structure will decrease costs upon renewal for alarm, extinguisher, and sprinkler licensees by $20 (or $35 for sprinkler licensees) for each additional employer they work for on a biennial basis. Based on an analysis of existing alarm, extinguisher, and sprinkler licensing records, the anticipated annual decrease in licensing fees collected is approximately $6,560. This estimate was calculated by adding the dollar amounts derived from duplicate alarm licenses (518 duplicate licenses x $20 = $10,360), duplicate extinguisher licenses (110 duplicates x $20 = $2,200), and duplicate sprinkler licenses (16 duplicates x $35 = $560) for a total of $13,120. Because the renewal cycle for these licenses is set for 24 months, this amount was halved to calculate the annual decrease in licensing fees of $6,560. However, because of the Department's self-leveling method of financing, this will not result in any fiscal impact or change in operating revenue to the Department.

The Department's funding comes from a self-leveling method of finance comprised primarily of maintenance taxes, fees and assessments collected from licensees. The same procedure applies to State Fire Marshal operations. Any decrease in licensing fees collected would be offset by a corresponding increase in the amount of maintenance fees collected from its licensees. Therefore, due to the nature of the Department's self-leveling funding, the proposal will not result in any fiscal impact to the Department or any other entity within state or local government.

PUBLIC BENEFIT/COST NOTE. Mr. Maldonado also has determined that for each year of the first five years the proposal is in effect, there is an anticipated public benefit of more orderly administration of the licensing process and increased clarity in regulatory requirements, as well as potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits while mitigating costs. Additionally, as discussed in the Fiscal Note portion of this proposal, it is anticipated that the rule proposal will decrease licensing costs for alarm, extinguisher, and sprinkler licensees that work for more than one employer. The existing licensing structure requires licensees working for more than one employer to: (i) notify SFMO of additional employers upon initial employment and pay a $20 licensing fee ($35 for sprinkler) for each additional employer; and (ii) upon subsequent renewal, pay the $20 licensing fee ($35 for sprinkler) for each additional employer. Under the new proposed licensing structure, licensees will still be required to provide notification of additional employers upon initial employment, accompanied with a $20 or $35 licensing fee per each additional employer. Upon changing employers, the new employer must pay the new licensing fee; the old employer will not be required to pay the fee for that licensee. However, under the new proposed licensing structure, this fee will be a one-time cost to update the licensee's records and will not be required subsequently upon renewal. Therefore, the proposed licensing structure will decrease costs upon renewal for alarm and extinguisher licensees by $20 and $35 for sprinkler licenses for each additional employer they work for on a biennial basis.

The alignment of expiration dates for certificates of registration for main and branch offices will streamline and simplify the licensing process for registered firms and the State Fire Marshal's Office by designating a single expiration date for the firm, rather than numerous expiration dates. Therefore, the requirements relating to the alignment of expiration dates for certificates of registration will allow for the more orderly and efficient administration of licensing procedures. However, the requirements in the proposal will result in some costs to alarm and extinguisher firms. The anticipated cost elements for alarm and extinguisher firms include: (i) costs relating to the initial alignment of the expiration and renewal dates for existing branches; (ii) costs relating to the alignment of the expiration and renewal dates for branches established after the effective date of the rule; (iii) costs relating to the changes in late fee structures, and; (iv) costs relating to the fees for residential fire alarm technician licenses, training school approvals, and instructor approvals.

1. Costs Relating to the Initial Alignment of the Expiration and Renewal Dates for Existing Branches. Proposed §34.610(i) specifies that the certificate of registration for fire alarm branch offices and fire extinguisher branch offices in existence as of the effective date of the rule will expire and renew on the same date as the certificate of registration issued to the main office for that firm. However, any fees associated with this requirement will be offset by the prorating of fees. The Insurance Code §6002.201(c) specifies that the Commissioner by rule may adopt a system under which fire alarm and detection device registration certificates and licenses expire on various dates during the year, and that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate

or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid. In accordance with the Insurance Code §6002.201(c), proposed amended §34.610(i) specifies that all fees associated with the initial alignment of expiration and renewal dates for the branch office certificate of registration shall be prorated accordingly. Similarly, the Insurance Code §6001.201(c) has a similar provision for fire extinguisher licensees. Section 6001.201(c) specifies that the Commissioner by rule may adopt a system under which registration certificates, licenses, and permits relating to fire extinguishers expire on various dates during the year. The section specifies that for the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid. In accordance with the Insurance Code §6001.201(c), proposed amended §34.510 specifies that all fees associated with the initial alignment of expiration and renewal dates for extinguisher branch officer certificates of registration shall be prorated accordingly. Therefore, because fees will be prorated accordingly for extinguisher and alarm licensees, the requirement that branch office certificates of registration expire and renew on the same date as the registered firm's main office certificate of registration is not anticipated to result in additional costs.

2. Costs Relating to the Alignment of the Expiration and Renewal Dates for Branches Established After the Effective Date of the Rule. The proposal's requirement that the certificate of registration for alarm and extinguisher branch offices established after the effective date of the rule expire and renew on the same date is expected to result in additional costs. This will be a one-time cost incurred by firms establishing branch offices. The cost will be incurred for each branch office opened after the effective date of the rule. Although the initial fee cost will always remain the same, the amount of time that the initial certificate of registration will remain valid will vary based on when the branch office is established in relation to when the firm's main office certificate of registration expires and renews. For example, the certificate of registration for a branch office (costing $150 for alarm branch offices and $100 for extinguisher branch offices) that opens during the same month as the main office's certificate of registration expires will expire a full year later. However, the certificate of registration for a branch office that opens a month before the certificate of registration for the main office expires will also expire one month after it is paid for. The initial fees for a certificate of registration for a branch office will not be prorated. Therefore, although the initial fee for a branch office certificate of registration will remain the same in all instances, the rule proposal will represent an additional cost because the proposal changes the amount of time that the initial certificate of registration remains valid. This one-time cost will be up to $150 for each alarm branch offices and up to $100 for each extinguisher branch office opened after the effective date of the rule. Registered firms will be able to offset these costs to the extent that they are able to open branch offices in a time frame corresponding to the expiration and renewal date for the certificate of registration for their main office

3. Costs Relating to the Changes in Late Fee Structures. Because the proposal requires the alignment of the expiration and renewal dates for certificates of registration for alarm and extinguisher main and branch offices, it is necessary to specify the manner in which late fees will be calculated. The proposal requires that late fees will consist of the specified late fee for the main office plus the specified late fee for each branch office the registered firm operates. This change in methodology will not result in any additional cost for a registered firm that operates only a single main office. The change in late fee structure will represent an additional cost to registered firms that operate branch offices. The potential additional cost depends on the number of branch offices operated by the registered firm. The proposal's change in late fee structure will result in an increased cost for a registered firm of $37.50 (expired one to 90 days) or $150 (expired 91 days to two years) for each alarm branch office and $50 (expired one to 90 days) or $100 (expired 91 days to two years) for each extinguisher branch office operated by the registered firm. However, this analysis assumes that absent the proposed change in late fee structure, a registered firm would not have been late in renewing the certificates of registration for any of their respective branch offices. To the extent that a registered firm would have not timely renewed branch office certificates of registration, the proposal represents no additional costs. The actual costs of the late fees for each branch office have not been changed by the proposal.

4. Costs Relating to the Fees for Residential Fire Alarm Technician Licenses, Training School Approvals, and Instructor Approvals. The rule specifies the following fees for residential fire alarm technician licenses: initial fee (for one year)--$50; renewal fee (for two years)--$500; renewal late fee (expired one to 90 days)--$12.50; and renewal late fee (expired 91 days to two years)--$50. The rule specifies the training school approval initial fee (for one year) is $500 and the renewal fee (for one year) is also $500. The rule specifies that the instructor approval initial fee (for one year) is $50 and the renewal fee (for one year) is also $50. However, the initial and renewal fees are specified by the Insurance Code §6002.054, and the renewal late fees are specified by the Insurance Code §6002.203. Therefore, because these fees are required by statute, they are not attributable to the proposed rule.

All of the analyses in this cost note are equally applicable to and do not vary for small or micro businesses. However, as noted in the cost note, certain costs will be incurred on the basis of the number of branch offices by a registered firm. These costs will not be incurred by small or micro businesses to the extent that small or micro registered firms do not operate branch officers or operate fewer branch offices.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. The Government Code §2006.002(c) requires that if a proposed rule may have an economic impact on small businesses, state agencies must prepare as part of the rulemaking process an economic impact statement that assesses the potential impact of the proposed rule on small businesses and a regulatory flexibility analysis that considers alternative methods of achieving the purpose of the rule. The Government Code §2006.001(2) defines "small business" as a legal entity, including a corporation, partnership, or sole proprietorship, that is formed for the purpose of making a profit, is independently owned and operated, and has fewer than 100 employees or less than $6 million in annual gross receipts. The Government Code §2006.001(1) defines "micro business" similarly to "small business" but specifies that such a business may not have more than 20 employees. The Government Code §2006.002(f) requires a state agency to adopt provisions concerning micro businesses that are uniform with those

provisions outlined in the Government Code §2006.002(b) - (d) for small businesses.

As required by the Government Code §2006.002(c), the Department has determined that the proposal may have an adverse economic effect on approximately 1,230 to 1,530 small or microbusinesses that are required to comply with the proposed rules. Although the Department is aware that the large majority of fire alarm and fire extinguisher firms are small or micro businesses, the Department does not have precise information regarding the number of small or micro alarm or extinguisher registered firms. However, for the purpose of this estimate, the Department assumes that between 850 to 1,050 of the 1,199 registered alarm firms and between 380 and 480 of the 535 registered extinguisher firms are small or microbusinesses. This information is based on data collected from registered firms upon certificate of registration renewal regarding the number of individuals employed by the firm; the firm's annual gross receipts and whether the firm is independently owned and operated. The cost of compliance with the proposal will not vary between large businesses and small or microbusinesses, and the Department's cost analysis and resulting estimated costs for insurers in the Public Benefit/Cost Note portion of this proposal is equally applicable to small or microbusinesses. However, as noted in the Public Benefit/Cost Note portion of this proposal, because the costs attributable to the rule result from a registered firm's operation of branch offices, it is anticipated that the proposal is less likely to have a cost impact on small or micro businesses because such businesses are less likely to operate branch offices.

In accordance with the Government Code §2006.002(c-1), the Department has determined that even though the proposal may have an adverse economic effect on small or microbusinesses that are required to comply with the proposal, the proposal does not require a regulatory flexibility analysis that is mandated by §2006.002(c)(2) of the Government Code. Section 2006.002(c)(2) requires that a state agency, before adopting a rule that may have an adverse economic effect on small businesses, prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory flexibility analysis ". . . consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses." Therefore, an agency is not required to consider alternatives that, while possibly minimizing adverse impacts on small and microbusinesses, would not be protective of the health, safety, and environmental and economic welfare of the state.

The purpose of this proposal's requirements relating to licensing procedure is to facilitate the SFMO's efficient and orderly administration of the licensing, oversight, and regulation of the fire alarm and fire extinguisher industries. The efficient and orderly regulation of the fire alarm and fire extinguisher industries is necessary to protect the health and safety of the citizens of Texas. Therefore, the Department has determined in accordance with §2006.002(c-1) of the Government Code, that because the proposal substantially contributes to the health and safety of Texas citizens by facilitating the orderly administration of the licensing process for the fire extinguisher and fire alarm industries, there are no regulatory alternatives to the changes in the licensing process in this proposal that will sufficiently protect the health and safety of Texas citizens who are using the services of small or micro fire extinguisher or fire alarm firms.

TAKINGS IMPACT ASSESSMENT. The Department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on January 18, 2011, to Gene C. Jarmon, 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 State Fire Marshal Paul Maldonado, State Fire Marshal's Office, Mail Code 112-FM, Texas Department of Insurance, P.O. Box 149221, Austin, Texas 78714-9221. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk before the close of the public comment period. If a hearing is held, written and oral comments presented at the hearing will be considered.

SUBCHAPTER E. FIRE EXTINGUISHER AND INSTALLATION

28 TAC §§34.507, 34.510, 34.515

STATUTORY AUTHORITY.

The sections are proposed under the Government Code §417.004 and §417.005; the Occupations Code §2154.052; and the Insurance Code §§6001.051, 6001.052, 6001.201, 6002.051, 6002.052, 6002.201, 6003.051, 6003.052, 6003.054, 6003.201, and 36.001.

The Government Code §417.004 specifies that the Commissioner of Insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection. The Government Code §417.005 specifies that the Commissioner of Insurance may, after consulting with the State Fire Marshal, adopt necessary rules to guide the State Fire Marshal in the investigation of arson, fire, and suspected arson and in the performance of other duties for the Commissioner of Insurance. The Occupations Code §2154.052(b) specifies that the Commissioner shall adopt and the State Fire Marshal shall administer rules the Commissioner considers necessary for the protection, safety, and preservation of life and property, including rules regulating: (i) the issuance of licenses and permits to persons engaged in manufacturing, selling, storing, possessing, or transporting fireworks in this state; (ii) the conduct of public fireworks displays; and (iii) the safe storage of Fireworks 1.3G and Fireworks 1.4G. The Occupations Code §2154.052(c) specifies that the Commissioner shall adopt rules for applications for licenses and permits. The Insurance Code §6001.051(a) specifies that the Department shall administer the Insurance Code Chapter 6001. The Insurance Code §6001.051(b) specifies that the Commissioner may issue rules the Commissioner considers necessary to administer Chapter 6001 through the State Fire Marshal. The Insurance Code §6001.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards published by the National Fire Protection Association; recognized by federal law or regulation; published by any nationally recognized standards-making organization; or contained in the manufacturer's installation manuals. The Insurance Code §6001.052(b) specifies that the Commissioner shall adopt and administer rules determined essentially necessary for the protection and preservation of life

and property regarding: (i) registration of firms engaged in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems or hydrostatic testing of fire extinguisher cylinders; (ii) the examination and licensing of individuals to install or service portable fire extinguishers and plan, certify, install, or service fixed fire extinguisher systems; and (iii) requirements for installing or servicing portable fire extinguishers and planning, certifying, installing, or servicing fixed fire extinguisher systems. The Insurance Code §6001.052(c) specifies that the Commissioner by rule shall prescribe requirements for applications and qualifications for licenses, permits, and certificates issued under this chapter. The Insurance Code §6001.201(c) specifies (i) that the Commissioner by rule may adopt a system under which registration certificates, licenses, and permits expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid; and (iii) that on each subsequent renewal, the total renewal fee is payable. The Insurance Code §6002.051(a) specifies that the Department shall administer Chapter 6002. The Insurance Code §6002.051(b) specifies that the Commissioner may adopt rules as necessary to administer Chapter 6002, including rules the Commissioner considers necessary to administer Chapter 6002 through the State Fire Marshal. The Insurance Code §6002.052(a) specifies that in adopting necessary rules, the Commissioner may use: (i) recognized standards, such as, but not limited to standards of the National Fire Protection Association; standards recognized by federal law or regulation; or standards published by a nationally recognized standards-making organization; (ii) the National Electrical Code; or (iii) information provided by individual manufacturers. The Insurance Code §6002.052(b) specifies that under rules adopted under §6002.051, the Department may create specialized licenses or registration certificates for an organization or individual engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining fire alarm or fire detection devices or systems, and that the rules must establish appropriate training and qualification standards for each kind of license and certificate. The Insurance Code §6002.052(c) specifies that the Commissioner shall also adopt standards applicable to fire alarm devices, equipment, or systems regulated under this chapter, and that in adopting standards, the Commissioner may allow the operation of a fire alarm monitoring station that relies on fire alarm devices or equipment approved or listed by a nationally recognized testing laboratory without regard to whether the monitoring station is approved or listed by a nationally recognized testing laboratory if the operator of the station demonstrates that the station operating standards are substantially equivalent to those required to be approved or listed. The Insurance Code §6002.201(b) specifies that: (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and (iii) that the total renewal fee is payable on renewal on the new expiration date. The Insurance Code §6003.051(a) specifies that the Department shall administer Chapter 6003. The Insurance Code §6003.051(b) specifies that the Commissioner may issues rules necessary to administer Chapter 6003 through the State Fire Marshal. The Insurance Code §6003.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards adopted by federal law or regulation; standards published by a nationally recognized standards-making organization; or standards developed by individual manufacturers. The Insurance Code §6003.054(a) specifies that the Commissioner may delegate authority to exercise all or part of the Commissioner's functions, powers, and duties under Chapter 6003, including the issuance of licenses and registration certificates, to the State Fire Marshal Section 6003.054(a) further specifies that the State Fire Marshal shall implement the rules adopted by the commissioner for the protection and preservation of life and property in controlling: (i) the registration of an individual or an organization engaged in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; and (ii) the requirements for the plan, sale, installation, maintenance, or servicing of fire protection sprinkler systems by determining the criteria and qualifications for registration certificate and license holders; evaluating the qualifications of an applicant for a registration certificate to engage in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; conducting examinations and evaluating the qualifications of a license applicant; and issuing registration certificates and licenses to qualified applicants. The Insurance Code §6003.201(c) specifies that (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and that (iii) on renewal on the new expiration date, the total renewal fee is payable. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE.

The following statutes are affected by this proposal: Insurance Code §§6002.054, 6002.101, 6002.102, 6002.151 - 6002.156, 6002.158, 6002.201, 6002.301 - 6002.303, 6003.051, 6003.052, 6003.153 and 6003.155

Government Code §417.010

Occupations Code §§2154.051, 2154.052, 2154.254.

§34.507. Adopted Standards.

The commissioner adopts by reference in their entirety, except as noted, the following copyrighted standards and recommendations in this subchapter. If a standard refers to a provision in a specific edition of another standard, the provision is applicable only if it does not conflict with the adopted standard shown in this section. The standards are published by and available from the National Fire Protection Association, Inc., (NFPA), Batterymarch Park, Quincy, Massachusetts 02269. A copy of the standards shall be kept available for public inspection in the State Fire Marshal's Office [~~state fire marshal's office~~].

(1) NFPA 10-2010 [~~10-2002~~], Standard for Portable Fire Extinguishers.[~~, except that the date, June 30, 1998, in paragraph 4.3.2.1 shall be deleted and the following date substituted: "January 1, 2006."~~]

(2) NFPA 11-2010 [~~11-2002~~], Standard for Low-, Medium-, and High- [~~Low~~] Expansion Foam and Combined Agent Systems.

[~~(3) NFPA 11A-1999, Standard for Medium and High Expansion Foam Systems.~~]

(3) [~~(4)~~] NFPA 12-2008 [~~12-2000~~], Standard on Carbon Dioxide Extinguishing Systems.

(4) [~~(5)~~] NFPA 12A-2009 [~~12A-2004~~], Standard on Halon 1301 Fire Extinguishing Systems.

(5) [~~(6)~~] NFPA 15-2007 [~~15-2001~~], Standard for Water Spray Fixed Systems for Fire Protection.

(6) [~~(7)~~] NFPA 16-2007 [~~16-2003~~], Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems.

(7) [~~(8)~~] NFPA 17-2009 [~~17-2002~~], Standard for Dry Chemical Extinguishing Systems[~~, except that paragraph 9.3.2 in conjunction with 1.3.2 shall only apply to new or modified installations after July 1, 1996, in accordance with §34.517(f) of this subchapter (relating to Installation and Service)~~].

(8) [~~(9)~~] NFPA 17A-2009 [~~17A-2002~~], Standard for Wet Chemical Extinguishing Systems[~~, except that paragraph 5.1.1 in conjunction with 1.4.1 shall only apply to new or modified installations after July 1, 1996, in accordance with §34.517(f) of this subchapter~~].

(9) [~~(10)~~] NFPA 1Q8-2006 [~~18-1995~~], Standard on Wetting Agents.

(10) [~~(11)~~] NFPA 25-2008 [~~25-2002~~], Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.

(11) [~~(12)~~] NFPA 9Q6-2008 [~~96-2001~~], Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations[~~, except that paragraph 7-2.2 shall only apply to new or modified installations after July 1, 1996, in accordance with §34.517(f) of this subchapter~~].

(12) [~~(13)~~] NFPA 2Q001-2008 [~~2001-2004~~], Standard on Clean Agent Fire Extinguishing Systems.

§34.510. Certificates of Registration.

(a) - (f) (No change.)

(g) Branch Office Initial Certificate of Registration Fees and Expiration Dates. The initial fee for a branch office certificate of registration is $100 and is not prorated. Branch office certificates of registration expire and renew on the same date as the certificate of registration for the registered firm's main office. [~~Posting. Each certificate shall be posted conspicuously for public view at the business location.~~]

(h) - (l) (No change.)

(m) Initial Alignment of the Expiration and Renewal Dates of Existing Branches. For branch offices in existence as of the effective date of this rule, branch office certificates of registration shall expire and renew on the same date as the certificate of registration issued to the main office for that firm. All fees associated with the initial alignment of expiration and renewal dates for the branch office certificate of registration shall be prorated accordingly.

§34.515. Fees.

(a) Except for fees specified in subsection (d) of this section, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. Should the department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. [~~Every fee payable to the department and required in accordance with the provisions of the Insurance Code, Article 5.43-1, and this subchapter must be paid by cash, money order, or check. Money orders and checks must be made payable to the Texas Department of Insurance.~~] Except for overpayments resulting from mistakes of law or fact, all fees are non-refundable.

[~~(b) Fees payable to the department must be paid at the Office of the State Fire Marshal in Austin, or mailed to an address specified by the state fire marshal.~~]

(b) [~~(c)~~] Fees are as follows.

(1) Certificates of registration:

(A) initial fee--$450;

(B) renewal fee (for two years)--$600;

(C) renewal late fee (expired 1 day to 90 days)--$225 plus $50 for each branch office operated by the registered firm;

(D) renewal late fee (expired 91 days to two years)--$450 plus $100 for each branch office operated by the registered firm;

(E) branch office initial fee--$100;

(F) branch office renewal fee (for two years)--$200.[~~;~~]

[~~(G) branch office late fee (expired 1 day to 90 days)--$50;~~]

[~~(H) branch office late fee (expired 91 days to two years)--$100.~~]

(2) Certificate of registration (Type C):

(A) initial fee--$250;

(B) renewal fee (for two years)--$300;

(C) renewal late fee (expired 1 day to 90 days)--$125;

(D) renewal late fee (expired 91 days to two years)--$250.

(3) Fire extinguisher license (Type A, B, R and K):

(A) initial fee--$70;

(B) renewal fee (for two years)--$100;

(C) renewal late fee (expired 1 day to 90 days)--$35;

(D) renewal late fee (expired 91 days to two years)--$70.

(4) Fire extinguisher license (Type PL):

(A) initial fee--$70;

(B) renewal fee (for two years)--$100;

(C) renewal late fee (expired 1 day to 90 days)--$35;

(D) renewal late fee (expired 91 days to two years)--$70.

(5) Apprentice permit fee--$30.

(6) Duplicate or revised certificates, licenses, permits, or other requested changes to certificates, licenses, or permits--$20.

(7) Initial test fee (if administered by the SFMO)--$20.

(8) Retest fee (if administered by the SFMO)--$20.

(c) [~~(d)~~] Fees for tests administered by an outsource testing service are payable to the testing service in the amount and manner required by the testing service.

(d) [~~(e)~~] Late fees are required of all certificate or license holders who fail to submit complete renewal applications before the expiration of the certificate or license.

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 November 29, 2010.

TRD-201006769
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER F. FIRE ALARM RULES

28 TAC §§34.601 - 34.607, 34.610 - 34.616, 34.625, 34.627 - 34.630

STATUTORY AUTHORITY.

The sections are proposed under the Government Code §417.004 and §417.005; the Occupations Code §2154.052; and the Insurance Code §§6001.051, 6001.052, 6001.201, 6002.051, 6002.052, 6002.201, 6003.051, 6003.052, 6003.054, 6003.201, and 36.001.

The Government Code §417.004 specifies that the Commissioner of Insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection. The Government Code §417.005 specifies that the Commissioner of Insurance may, after consulting with the State Fire Marshal, adopt necessary rules to guide the State Fire Marshal in the investigation of arson, fire, and suspected arson and in the performance of other duties for the Commissioner of Insurance. The Occupations Code §2154.052(b) specifies that the Commissioner shall adopt and the State Fire Marshal shall administer rules the Commissioner considers necessary for the protection, safety, and preservation of life and property, including rules regulating: (i) the issuance of licenses and permits to persons engaged in manufacturing, selling, storing, possessing, or transporting fireworks in this state; (ii) the conduct of public fireworks displays; and (iii) the safe storage of Fireworks 1.3G and Fireworks 1.4G. The Occupations Code §2154.052(c) specifies that the Commissioner shall adopt rules for applications for licenses and permits. The Insurance Code §6001.051(a) specifies that the Department shall administer the Insurance Code Chapter 6001. The Insurance Code §6001.051(b) specifies that the Commissioner may issue rules the Commissioner considers necessary to administer Chapter 6001 through the State Fire Marshal. The Insurance Code §6001.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards published by the National Fire Protection Association; recognized by federal law or regulation; published by any nationally recognized standards-making organization; or contained in the manufacturer's installation manuals. The Insurance Code §6001.052(b) specifies that the Commissioner shall adopt and administer rules determined essentially necessary for the protection and preservation of life and property regarding: (i) registration of firms engaged in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems or hydrostatic testing of fire extinguisher cylinders; (ii) the examination and licensing of individuals to install or service portable fire extinguishers and plan, certify, install, or service fixed fire extinguisher systems; and (iii) requirements for installing or servicing portable fire extinguishers and planning, certifying, installing, or servicing fixed fire extinguisher systems. The Insurance Code §6001.052(c) specifies that the Commissioner by rule shall prescribe requirements for applications and qualifications for licenses, permits, and certificates issued under this chapter. The Insurance Code §6001.201(c) specifies (i) that the Commissioner by rule may adopt a system under which registration certificates, licenses, and permits expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid; and (iii) that on each subsequent renewal, the total renewal fee is payable. The Insurance Code §6002.051(a) specifies that the Department shall administer Chapter 6002. The Insurance Code §6002.051(b) specifies that the Commissioner may adopt rules as necessary to administer Chapter 6002, including rules the Commissioner considers necessary to administer Chapter 6002 through the State Fire Marshal. The Insurance Code §6002.052(a) specifies that in adopting necessary rules, the Commissioner may use: (i) recognized standards, such as, but not limited to standards of the National Fire Protection Association; standards recognized by federal law or regulation; or standards published by a nationally recognized standards-making organization; (ii) the National Electrical Code; or (iii) information provided by individual manufacturers. The Insurance Code §6002.052(b) specifies that under rules adopted under Section 6002.051, the Department may create specialized licenses or registration certificates for an organization or individual engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining fire alarm or fire detection devices or systems, and that the rules must establish appropriate training and qualification standards for each kind of license and certificate. The Insurance Code §6002.052(c) specifies that the Commissioner shall also adopt standards applicable to fire alarm devices, equipment, or systems regulated under this chapter, and that in adopting standards, the Commissioner may allow the operation of a fire alarm monitoring station that relies on fire alarm devices or equipment approved or listed by a nationally recognized testing laboratory without regard to whether the monitoring station is approved or listed by a nationally recognized testing laboratory if the operator of the station demonstrates that the station operating standards are substantially equivalent to those required to be approved or listed. The Insurance Code §6002.201(b) specifies that: (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on

various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and (iii) that the total renewal fee is payable on renewal on the new expiration date. The Insurance Code §6003.051(a) specifies that the Department shall administer Chapter 6003. The Insurance Code §6003.051(b) specifies that the Commissioner may issues rules necessary to administer Chapter 6003 through the State Fire Marshal. The Insurance Code §6003.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards adopted by federal law or regulation; standards published by a nationally recognized standards-making organization; or standards developed by individual manufacturers. The Insurance Code §6003.054(a) specifies that the Commissioner may delegate authority to exercise all or part of the Commissioner's functions, powers, and duties under Chapter 6003, including the issuance of licenses and registration certificates, to the State Fire Marshal Section 6003.054(a) further specifies that the State Fire Marshal shall implement the rules adopted by the commissioner for the protection and preservation of life and property in controlling: (i) the registration of an individual or an organization engaged in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; and (ii) the requirements for the plan, sale, installation, maintenance, or servicing of fire protection sprinkler systems by determining the criteria and qualifications for registration certificate and license holders; evaluating the qualifications of an applicant for a registration certificate to engage in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; conducting examinations and evaluating the qualifications of a license applicant; and issuing registration certificates and licenses to qualified applicants. The Insurance Code §6003.201(c) specifies that (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and that (iii) on renewal on the new expiration date, the total renewal fee is payable. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE.

The following statutes are affected by this proposal: Insurance Code §6002.054, §§6002.101 - 6002.102, §§6002.151 - 6002.156, §6002.158, §6002.201, §§6002.301 - 6002.303, §§6003.051 - 6003.052, §6003.153 and 6003.155

Government Code §417.010

Occupations Code §§2154.051 - §2154.052, §2154.254

§34.601. Purpose.

The purpose of this subchapter [~~chapter~~] is to administer through the state fire marshal the law set forth in the Insurance Code Chapter 6002[~~, Article 5.43-2~~] regarding inspecting, planning, certifying, leasing, selling, servicing, testing, installing, monitoring, and maintaining fire alarm or fire detection devices and systems in the interest of safeguarding lives and property.

§34.602. Title.

The sections of this subchapter [~~chapter~~] shall be known as and may be cited as the Fire Alarm Rules.

§34.603. Applicability of Sections.

The sections of this subchapter [~~chapter~~] shall apply to persons and organizations engaged in the business of inspecting, planning, certifying, leasing, selling, servicing, testing, installing, monitoring, and maintaining fire alarm or fire detection devices and systems, and not to the general public.

§34.604. Exceptions.

The exceptions of the Insurance Code §6002.155 [~~, Article 5.43-2, §3,~~] are applicable to the sections of this subchapter [~~chapter~~].

§34.605. Notices.

Notice by the state fire marshal, as required by the Insurance Code Chapter 6002 [~~provisions of the statutes~~] or of this subchapter [~~chapter~~], may be given by personal service or mail, postage prepaid, addressed to the person to be notified at the last known address of the person's residence or business as it appears on the records in the [~~Office of the~~] State Fire Marshal's Office [~~Marshal~~].

§34.606. Definitions.

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

(1) Approval--The document issued by the State Fire Marshal's Office to an individual or entity acknowledging that the individual or entity meets the requirements to perform the functions of an approved instructor or approved training school under this subchapter and the Insurance Code Chapter 6002.

(2) [~~(1)~~] Business--Inspecting, planning, certifying, leasing, selling, servicing, testing, installing, monitoring, or maintaining of fire alarm or fire detection devices and systems.

(3) [~~(2)~~] Certificate--The certificate of registration issued by the state fire marshal.

(4) [~~(3)~~] Certify--To attest to the proper planning or servicing, installing, or maintaining of fire detection and fire alarm devices and systems, including monitoring equipment, by attaching a completed installation/service record label and completing an installation certificate form or other additional form required by a governmental authority.

(5) [~~(4)~~] Commissioner--The commissioner of insurance.

(6) [~~(5)~~] Department--The Texas Department of Insurance.

(7) Designated employee--An individual specified by a registered firm as a full-time employee and a licensee under this subchapter.

(8) [~~(6)~~] Direct supervision--The control of work, excluding the installation of conduit, raceways, junction boxes, back boxes, or similar electrical enclosures, as it is being performed on fire detection or fire alarm devices and systems by a licensed fire alarm technician or a licensed fire alarm planning superintendent.

(9) [~~(7)~~] Firm--An individual [~~A person~~] or an organization, as defined in the Insurance Code §6002.002[~~, Article 5.43-2~~].

(10) [~~(8)~~] Full-time--The number of hours that represents the regular, normal, or standard amount of time per week each employee of the firm devotes to work-related activities.

(11) [~~(9)~~] Full-time employment--An employee is considered to work on a full-time basis if the employee works per week at least the average number of hours worked per week by all other employees of the firm.

(12) Instructor--An individual approved under the Insurance Code Chapter 6002 and this subchapter to provide training in installing, servicing, inspecting, and certifying fire alarm or detection systems in single-family or two-family residences.

(13) [~~(10)~~] Local authority having jurisdiction--A [~~As used in the Texas Insurance Code, Article 5.43-2, §9(c), means a~~] fire chief, fire marshal, or other designated official having statutory authority.

(14) [~~(11)~~] Monitoring equipment--Equipment used to transmit and receive fire alarm, trouble, and supervisory signals from protected premises to a firm registered to monitor or one exempt from licensing by the Insurance Code Chapter 6002[~~, Article 5.43-2~~].

(15) [~~(12)~~] NFPA--National Fire Protection Association, a nationally recognized standards-making organization.

(16) [~~(13)~~] NICET--National Institute for Certification in Engineering Technologies.

(17) [~~(14)~~] Outsource testing service--The testing service selected by the state fire marshal to administer certain designated qualifying tests for licenses under this subchapter.

(18) [~~(15)~~] Plan--To lay out, detail, draw, calculate, devise, or arrange an assembly of fire alarm or detection devices, equipment, and appurtenances, including monitoring equipment, in accordance with standards adopted in this subchapter.

(19) [~~(16)~~] Primary registered firm--The registered fire alarm company with the responsibility for the fire alarm system certification.

(20) [~~(17)~~] Repair--To restore to proper operating condition.

(21) [~~(18)~~] Test--The act of subjecting a fire detection or alarm device or system, including monitoring equipment, to any procedure required by applicable standards or manufacturers' recommendations to determine whether it is properly installed or operates correctly.

(22) Training school--An entity that is approved under the Insurance Code Chapter 6002 and this subchapter to provide approved training in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences by approved instructors for the purpose of meeting the training requirements of an applicant for a residential fire alarm technician license issued under the applicable statutes and this subchapter.

§34.607. Adopted Standards.

(a) The commissioner adopts by reference those sections of the following copyrighted minimum standards, recommendations, and appendices concerning fire alarm, fire detection, or supervisory services or systems, except to the extent they are at variance to sections of this subchapter [~~chapter~~], the [~~Texas~~] Insurance Code Chapter 6002[~~, Article 5.43-2~~], or other state statutes. The standards are published by and are available from the National Fire Protection Association, Quincy, Massachusetts. A copy of the standards shall be kept available for public inspection at the State Fire Marshal's Office [~~state fire marshal's office~~].

(1) NFPA 11-2005 [~~11-2002~~], Standard for Low-, Medium-, and High Expansion Foam.

[~~(2) NFPA 11A-1999, Standard for Medium- and High-Expansion Foam Systems.~~]

(2) [~~(3)~~] NFPA 12-2008 [~~12-2000~~], Standard on Carbon Dioxide Extinguishing Systems.

(3) [~~(4)~~] NFPA 12A-2009 [~~12A-2004~~], Standard on Halon 1301 Fire Extinguishing Systems.

(4) [~~(5)~~] NFPA 13-2007 [~~13-2002~~], Standard for the Installation of Sprinkler Systems.

(5) [~~(6)~~] NFPA 13D-2007 [~~13D-2002~~], Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes.

(6) [~~(7)~~] NFPA 13R-2007 [~~13R-2002~~], Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height.

(7) [~~(8)~~] NFPA 15-2007 [~~15-2001~~], Standard for Water Spray Fixed Systems for Fire Protection.

(8) [~~(9)~~] NFPA 16-2007 [~~16-2003~~], Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems.

(9) [~~(10)~~] NFPA 17-2009 [~~17-2002~~], Standard for Dry Chemical Extinguishing Systems.

(10) [~~(11)~~] NFPA 17A-2009 [~~17A-2002~~], Standard for Wet Chemical Extinguishing Systems.

(11) [~~(12)~~] NFPA 25-2008 [~~25-2002~~], Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems.

(12) [~~(13)~~] NFPA 70-2008 [~~70-2005~~], National Electrical Code.

(13) [~~(14)~~] NFPA 72-2007 [~~72-2002~~], National Fire Alarm Code.

(14) [~~(15)~~] NFPA 90A-2009 [~~90A-2002~~], Standard for the Installation of Air Conditioning and Ventilating Systems.

(15) [~~(16)~~] NFPA 101®-2009 [~~101®-2003~~], or later editions, Code for Safety to Life from Fire in Buildings and Structures (Life Safety Code)®, or a local jurisdiction may adopt one set of the model codes listed in subsection (b) of this section in lieu of NFPA 101.

(16) [~~(17)~~] UL 827 October 1, 1996, Standard for Central Station Alarm Services.

(17) [~~(18)~~] NFPA 2001-2008 [~~2001-2004~~], Standard on Clean Agent Fire Extinguisher Systems.

(b) The acceptable alternative model code sets are:

[~~(1) the Uniform Building Code-1991 and later editions, and the Uniform Fire Code-1991 and later editions; or~~]

[~~(2) the SBCCI Building Code-1991 and later editions, and the SBCCI Fire Code-1991 and later editions; or~~]

[~~(3) the BOCA Building Code-1991 and later editions, and the BOCA Fire Code-1991 and later editions; or~~]

(1) [~~(4)~~] the International Building Code®-2003 or later editions, and the International Fire Code-2003 or later editions; or

(2) [~~(5)~~] the International Residential Code® for One- and Two-Family Dwellings-2003 or later editions; or

(3) [~~(6)~~] NFPA 5000 [~~5000™~~], Building Construction and Safety Code-2009 [~~Code™ 2003~~] or later editions, and NFPA 1 Uniform Fire Code 2009 [~~Code™ 2003~~] or later editions.

§34.610. Certificate of Registration.

(a) (No change.)

(b) Designated Employee. Each registered firm must specify one full-time employee holding a license under this subchapter as the firm's designated employee on their Fire Alarm Certificate of Registration Application, Form No. SF031, and on their Renewal Application for Fire Alarm Certificate of Registration, Form No. SF084. Any change in the designated employee under this section must be submitted in writing to the State Fire Marshal's Office within 14 days of its occurrence. An individual may not serve as a designated employee for more than one registered firm. [~~Posting. Each certificate must be posted conspicuously for public view at the business location.~~]

(c) - (e) (No change.)

(f) Branch Office Initial Certificate of Registration Fees and Expiration Dates. The initial fee for a branch office certificate of registration is $150 and is not prorated. Branch office certificates of registration expire and renew on the same date as the certificate of registration for the registered firm's main office.

(g) [~~(f)~~] Duplicate certificates. A duplicate certificate must be obtained from the state fire marshal to replace a lost or destroyed certificate. The certificate holder must submit written notification of the loss or destruction without delay, accompanied by the required fee.

(h) [~~(g)~~] Revised certificates. The change of a firm's name, location, or mailing address requires a revised certificate. Within 14 days after the change requiring the revision, the certificate holder must submit written notification of the necessary change accompanied by the required fee.

(i) Initial Alignment of the Expiration and Renewal Dates of Existing Branches. For branch offices in existence as of the effective date of this rule, branch office certificates of registration shall expire and renew on the same date as the certificate of registration issued to the main office for that firm. All fees associated with the initial alignment of expiration and renewal dates for the branch office certificate of registration shall be prorated accordingly.

§34.611. Licenses and Approvals.

(a) Types of Licenses and Approvals. The following licenses and approvals are issued by the State Fire Marshal's Office in accordance with the Insurance Code Chapter 6002 and this subchapter. As required by the Insurance Code Chapter 6002, an individual or entity must be licensed or approved in order to lawfully perform the functions for which the license or approval is issued. [~~licenses.~~]

(1) - (2) (No change.)

(3) Instructor approval--For providing training at an approved training school in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences.

(4) [~~(3)~~] Residential fire alarm superintendent single station license--For planning, installing, certifying, inspecting, testing, servicing, and maintaining to single station smoke or heat detectors which are not a part of or connected to any other detection device or system in single-family or two-family residences.

(5) [~~(4)~~] Residential fire alarm superintendent license--For planning, installing, certifying, inspecting, testing, servicing, monitoring, and maintaining fire alarm or fire detection devices and systems in single-family or two-family residences.

(6) [~~(5)~~] Fire alarm planning superintendent license--For planning, installing, certifying, inspecting, testing, servicing, monitoring, and maintaining fire alarm or fire detection devices.

(7) Residential fire alarm technician license--For installing, certifying, inspecting, and servicing, but not planning, fire alarm or fire detection devices and systems in single-family or two-family residences.

(8) Training school approval--For conducting required training necessary for obtaining a residential fire alarm technician license.

[~~(b) Posting. Wall licenses must be posted conspicuously for public view at the firm's business location.~~]

(b) [~~(c)~~] Pocket License and Approval. [~~license.~~]

(1) A licensee must carry a pocket license for identification while engaged in the activities of the business.

(2) An instructor must carry the instructor's approval while providing training in an approved training school on the installing, certifying, inspecting, and servicing of fire alarm or detection systems in single-family or two-family residences.

(c) [~~(d)~~] Duplicate License [~~license~~]. A duplicate license must be obtained from the state fire marshal to replace a lost or destroyed license. The license holder or registered firm must submit written notification of the loss or destruction without delay, accompanied by the required fee.

(d) [~~(e)~~] Licensee Responsibilities Relating to Revised Licenses [~~licenses~~]. A change in the licensee's name, the licensee's mailing address, or a new or additional registered firm employing the licensee requires a revised license. [~~The change of a licensee's registered firm or mailing address requires a revised license.~~] Within 14 days after the change requiring the revision, the license holder [~~or registered firm~~] must submit written notification of the necessary change accompanied by the required fee.

(e) Registered Firms' Responsibilities Relating to Licensees. A registered firm must submit notification of any licensee employment, termination, or resignation within 14 days of its occurrence.

(f) Restrictions on Licensees and Registered Firms.

(1) A licensee must not engage in any act of the business unless employed by or as an agent of a registered firm.

(2) A registered firm must notify the state fire marshal within 14 days after termination of employment of a licensee.

(3) Each person who engages in the activities of the business must have the appropriate license issued by the state fire marshal unless excepted from the licensing provisions by the Insurance Code §6002.155[~~, Article 5.43-2, §3(b)~~].

(g) Restrictions on Approval Holders. Approvals are not transferable.

(h) Responsibilities Relating to Revised Approvals. A change in an instructor's name or mailing address requires a revised approval. The change in the mailing address of a fire alarm training school requires a revised approval. Within 14 days after the change requiring the revision, the approval holder must submit written notification of the necessary change accompanied by the required fee.

§34.612. Alteration of Certificates, [~~or~~] Licenses, or Approvals.

The alteration of certificates, [~~or~~] licenses, or approvals renders them invalid and is the basis for administrative action pursuant to the Insurance Code §6002.302[~~, Article 5.43-2, §10(b)~~].

§34.613. Applications.

(a) Approvals and Certificates of Registration [~~registration~~].

(1) Applications for approvals, certificates, and branch office certificates must be submitted on the forms adopted by reference in §34.630 of this subchapter (relating to Application and Renewal Forms) [~~provided by the state fire marshal~~] and be accompanied by all fees, documents, and information required by the Insurance Code Chapter 6002[~~, Article 5.43-2,~~] and [~~the sections of~~] this subchapter [~~chapter~~]. An application will not be deemed complete until all required forms, fees, and documents have been received in the State Fire Marshal's Office [~~office~~].

(2) Applications must be signed by the sole proprietor, or by each partner of a partnership, or by an officer of a corporation. For applicants using an assumed name, the application must also be accompanied by evidence of compliance with the Assumed Business or Professional Name Act, Texas Business and Commerce Code[~~,~~] Chapter 71 [~~36~~]. The application must also include written authorization by the applicant permitting the state fire marshal or his representative to enter, examine, and inspect any premises, building, room, or establishment used by the applicant while engaged in the business to determine compliance with the provisions of the Insurance Code Chapter 6002[~~, Article 5.43-2,~~] and [~~the sections of~~] this subchapter [~~chapter~~].

(3) - (4) (No change.)

(5) Insurance is required as follows:[~~,~~]

(A) The state fire marshal will not issue a certificate of registration under this subchapter [~~these sections~~] unless the applicant files with the State Fire Marshal's Office [~~office~~] evidence of an acceptable general liability insurance policy.

(B) Each registered firm must maintain in force and on file in the State Fire Marshal's Office [~~office~~] a certificate of insurance identifying the insured and the exact nature of the business insured. In identifying the named insured, the certificate of insurance must include either an assumed name or the name of the corporation, partners, if any, or sole proprietor, if applicable.

(6) (No change.)

(7) Applicants for a certificate of registration who engage in monitoring must provide the specific business location(s) where monitoring will take place and the name and license number of the fire alarm licensee(s) at each business location. A fire alarm licensee may not serve in this capacity for a registered firm other than the firm applying for a certificate of registration. In addition, the applicants must provide evidence of listing or certification as a central station by a testing laboratory approved by the commissioner and a statement that the monitoring service is in compliance with [~~adopted~~] NFPA 72 as adopted in §34.607 of this subchapter (relating to Adopted Standards).

(8) (No change.)

(b) Fire Alarm Licenses [~~alarm licenses~~].

(1) - (6) (No change.)

(7) An applicant for a residential fire alarm technician license must provide evidence of the applicant's successful completion of the required residential fire alarm technician training course from a training school approved by the State Fire Marshal's Office.

(c) Instructor and Training School Approvals.

(1) Instructor approvals. An applicant for approval as an instructor must:

(A) hold a current fire alarm planning superintendent's license issued by the State Fire Marshal's Office;

(B) submit a completed Instructor Approval Application, Form No. SF247, signed by the applicant, that is accompanied by all fees; and

(C) furnish written documentation of a minimum of three years of experience in fire alarm installation, service, or monitoring of fire alarm systems, unless the applicant has held a fire alarm planning superintendent's license for three or more years.

(2) Training school approvals.

(A) An applicant for approval of a training school must submit a completed Training School Approval Application, Form No. SF 246, to the State Fire Marshal's Office. To be complete, the application must be:

(i) signed by the applicant, the sole proprietor, by each partner of a partnership, or by an officer of a corporation or organization as applicable;

(ii) accompanied by a detailed outline of the proposed subjects to be taught at the training school and the number and location of all training courses to be held within one year following approval of the application; and

(iii) accompanied by all required fees.

(B) After review of the application for approval for a training school, the state fire marshal shall approve or deny the application within 60 days following receipt of the materials. A letter of denial shall state the specific reasons for the denial. An applicant that is denied approval may reapply at any time by submitting a completed application that includes the changes necessary to address the specific reasons for denial.

(d) [~~(c)~~] Renewal Applications [~~applications~~].

(1) In order to be complete, renewal applications for certificates, [~~and~~] licenses, instructor approvals, and training school approvals must be submitted on the forms adopted by reference in §34.630 of this subchapter [~~provided by the state fire marshal~~] and be accompanied by all fees, documents, and information required by the Insurance Code Chapter 6002[~~, Article 5.43-2,~~] and this subchapter. A complete renewal application deposited with the United States Postal Service is deemed to be timely filed, regardless of actual date of delivery, when its envelope bears a postmark date which is before the expiration of the certificate or license being renewed.

(2) A licensee with an unexpired license who is not employed by a registered firm at the time of the licensee's renewal may renew that license; however, the licensee may not engage in any activity for which the license was granted until the licensee is employed and qualified by a registered firm.

(e) [~~(d)~~] Complete Applications [~~applications~~]. The application form for a license, [~~or~~] registration, instructor approval, and training school approval must be accompanied by the required fee and must, within 180 days of receipt by the State Fire Marshal's Office [~~department~~] of the initial application, be complete and accompanied by all other information required by the Insurance Code Chapter 6002 [~~Article 5.43-2~~] and this subchapter, or a new application must be submitted including all applicable fees.

§34.614. Fees.

(a) Except for fees specified in subsection (c) of this section, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Author-

ity. Should the department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. [~~Every fee payable to the department and required in accordance with the provisions of the Insurance Code, Article 5.43-2, and this subchapter must be paid by cash, money order, or check. Money orders and checks must be made payable to the Texas Department of Insurance.~~] Except for overpayments resulting from mistakes of law or fact, all fees are non-refundable.

[~~(b) Fees payable to the department must be paid at the Office of the State Fire Marshal in Austin, Texas, or mailed to an address specified by the state fire marshal.~~]

(b) [~~(c)~~] Fees for tests administered by an outsource testing service are payable to the testing service in the amount and manner required by the testing service.

(c) [~~(d)~~] Fees are as follows:

(1) Certificates of registration:

(A) Initial fee--$500;

(B) renewal fee (for two years, subject to the exceptions specified in §34.610(i) of this subchapter (relating to Certificate of Registration) for the initial alignment of the expiration and renewal dates of existing branches)--$1,000;

(C) renewal late fee (expired 1 day to 90 days)--$125 plus $37.50 for each branch office operated by the registered firm;

(D) renewal late fee (expired 91 days to two years)--$500 plus $150 for each branch office operated by the registered firm;

(E) branch office initial fee--$150;

(F) branch office renewal fee (for two years)--$300;

[~~(G) branch office late fee (expired 1 day to 90 days)--$37.50;~~]

[~~(H) branch office late fee (expired 91 days to two years)--$150;~~]

(2) Certificates of registration--Single Station:

(A) initial fee--$250;

(B) renewal fee (for two years)--$500;

(C) renewal late fee (expired 1 day to 90 days)--$62.50;

(D) renewal late fee (expired 91 days to two years)--$250;

(E) branch office initial fee--None;

(F) branch office renewal fee (for two years)-None;

(3) Fire Alarm licenses (Fire alarm technician license, Fire alarm monitoring technician license, Residential fire alarm superintendent (single station) license; Residential fire alarm superintendent license, Fire alarm planning superintendent license);

(A) initial fee--$120;

(B) renewal fee (for two years)--$200;

(C) renewal late fee (expired 1 day to 90 days)--$30;

(D) renewal late fee (expired 91 days to two years)--$120;

(4) Residential fire alarm technician licenses:

(A) initial fee (for one year)--$50;

(B) renewal fee (for two years)--$100;

(C) renewal late fee (expired 1 day to 90 days)--$12.50;

(D) renewal late fee (expired 91 days to two years)--$50;

(5) Training school approval:

(A) initial fee (for one year)--$500;

(B) renewal fee (for one year)--$500;

(6) Instructor approval:

(A) initial fee (for one year)--$50;

(B) renewal fee (for one year)--$50;

(7) [~~(4)~~] Duplicate or revised certificate or license or other requested changes to certificates, approvals, or licenses--$20;

(8) [~~(5)~~] Initial test fee (if administered by the State Fire Marshal's Office)--$20;

(9) [~~(6)~~] Retest fee (if administered by the State Fire Marshal's Office)--$20.

(d) [~~(e)~~] All fees are forfeited if the applicant does not appear for the scheduled test.

(e) [~~(f)~~] Late fees are required of all certificate or license holders who fail to submit complete renewal applications before the expiration of the certificate or license except as provided in the Insurance Code §6002.203(g)[~~, Article 5.43-2, §5C(c)~~].

(f) [~~(g)~~] Fees for certificates and licenses which have been expired for less than two years include both renewal and late fees.

§34.615. Test.

(a) Each applicant for a license must pass the appropriate tests. Tests may be supplemented by practical tests or demonstrations necessary to determine the applicant's knowledge and ability.

(1) The license test will include a section on this subchapter and the Insurance Code Chapter 6002 [~~, Article 5.43-2,~~] and a technical qualifying test to be conducted by:

(A) - (C) (No change.)

(2) (No change.)

(b) - (e) (No change.)

§34.616. Sales, Installation, and Service.

(a) Residential Alarms (Single Station) [~~alarms (single station)~~].

(1) Registered firms may employ persons exempt from the licensing provisions of the Insurance Code §6002.155(10)[~~, Article 5.43-2, §3(b)(10),~~] to sell, install, and service residential, single station alarms. Exempted persons must be under the supervision of a residential fire alarm superintendent (single station), residential fire alarm superintendent, or fire alarm planning superintendent.

(2) Each registered firm that employs persons exempt from licensing provisions of the Insurance Code §6002.155(10)[~~, Article 5.43-2, §3(b)(10),~~] is required to maintain documentation to include lesson plans and annual test results demonstrating competency of said employees regarding the provisions of the Insurance Code Chapter 6002 [~~Article 5.43-2~~], adopted standards, and this subchapter [~~chapter~~] applicable to single station devices.

(b) Fire detection and fire alarm devices or systems other than residential single station.

(1) The installation of all fire detection and fire alarm devices or systems, including monitoring equipment, subject to the Insurance Code Chapter 6002[, ~~Article 5.43-2~~] must be performed by or under the direct on-site supervision of a licensed fire alarm technician, residential fire alarm technician, residential fire alarm superintendent, or a fire alarm planning superintendent, for the work permitted by the license. The certifying licensee must be licensed under the ACR number of the primary registered firm and must be present for the final acceptance test prior to certification.

(2) The maintenance or servicing of all fire detection and fire alarm devices or systems must be performed by or under the direct on-site supervision of a licensed fire alarm technician, residential fire alarm technician, residential fire alarm superintendent or a fire alarm planning superintendent, for the work permitted by the license. The licensee attaching a label must be licensed under the ACR number of the primary registered firm.

(3) If the installation or servicing of a fire alarm system also includes installation or servicing of any part of a fire protection sprinkler system and/or a fire extinguisher system other than inspection and testing of detection or supervisory devices, the licensing requirements of the [~~appropriate~~] Insurance Code Chapters 6001 and 6003[, ~~Article 5.43-1 or 5.43-3,~~] must be satisfied, as appropriate.

(4) The planning and installation [~~Installation~~] of fire detection or fire alarm devices or systems, including monitoring equipment, must be in accordance with standards adopted in §34.607 of this title (relating to Adopted Standards) except when the planning and installation complies with a more recent edition of an adopted standard or a Tentative Interim Amendment published as effective by the NFPA.

(5) - (6) (No change.)

(c) Monitoring Requirements [~~requirements~~].

(1) (No change.)

(2) A registered firm may not connect a fire alarm system to a monitoring service unless:

(A) the monitoring service is registered under the Insurance Code Chapter 6002 or is exempt from the licensing requirements of that chapter; and [~~Insurance Code Article 5.43-2, so long as~~]

(B) the monitoring equipment being used is in compliance with the Insurance Code §6002.251 [~~Article 5.43-2, §9~~].

(3) - (6) (No change.)

§34.625. Enforcement.

(a) The state fire marshal, or the state fire marshal's representative, may conduct investigations of registered firms to determine compliance with the Insurance Code Chapter 6002 [~~Article 5.43-2~~] and this subchapter. An investigation may be initiated on the written complaint of any party or by the department on its own motion.

(b) (No change.)

(c) The failure to comply with the provisions of this subchapter and the provisions of Insurance Code Chapter 6002 [~~Article 5.43-2~~] by certificate holders or licensees may subject them, as provided in the Government Code §417.010, to administrative action including, but not limited to, suspension, revocation, or refusal to issue or renew a license or a certificate of registration or issuance of a cease and desist order and/or administrative penalty and/or order for restitution to persons harmed.

§34.627. Requirements for Instructors and Training Schools.

(a) An instructor must comply with the following requirements:

(1) All training provided by an instructor must be conducted through an approved training school.

(2) The instructor must teach the subjects in the outline of the training course submitted by the training school and approved by the State Fire Marshal's Office.

(b) A training school must comply with the following requirements:

(1) The training school must only use instructors who hold an approval issued by the State Fire Marshal's Office to provide the training in installing, certifying, inspecting, and servicing fire alarm or detection systems in single-family or two-family residences.

(2) The entity responsible for the training school must obtain approval of the outline of each residential fire alarm technician training course from the State Fire Marshal's Office before conducting a class.

(3) The entity responsible for the training school may not be a firm registered through the State Fire Marshal's Office or an affiliate of a registered firm.

(4) A training school may not provide training for a residential fire alarm technician license without being approved by the State Fire Marshal. Training school approvals are not transferable and apply only to the entity specified as the responsible entity on the completed Training School Approval Application, Form No. SF246. The training school may not change the entity responsible for the training school without first applying for and receiving a new approval.

(5) The training school must conduct two or more classes, open to the public, within 125 miles of each county in the state that has a population in excess of 500,000 people according to the last decennial census, within each calendar year from the date the approval is issued.

(c) Any individual or entity that provides general training or instruction relating to fire alarm or detection systems not specific to fulfill a requirement to obtain a license is not required to have an approval.

§34.628. Requirements for Residential Fire Alarm Technician Training Course.

The training curriculum for a residential fire alarm technician training course shall consist of at least eight hours of instruction on installing, servicing, and maintaining single-family and two-family residential fire alarm systems as defined by National Fire Protection Association Standard No. 72. The training curriculum for a residential fire alarm technician training course must include the following minimum instruction time for the following subjects:

(1) one hour of instruction on the Insurance Code Chapter 6002 and the Fire Alarm Rules;

(2) one hour of instruction pertaining to the equipment, system, and other hardware relating to household fire alarms;

(3) one hour of instruction on the National Electric Code, NFPA 70;

(4) four and one-half hours of total combined instruction on:

(A) NFPA 72;

(B) NFPA 101, the Life Safety Code; and

(C) the International Residential Code for One- and Two-Family Dwellings; and

(5) one-half hour of instruction on the monitoring of household fire alarm systems.

§34.629. Advisory Council.

(a) The purpose of this section is to specify the purpose, member composition, member terms, and reporting requirements of the Fire Detection and Alarm Devices Advisory Council. The Fire Detection and Alarm Devices Advisory Council shall be referred to in this subchapter as the Fire Alarm Advisory Council.

(b) The purpose of the Fire Alarm Advisory Council is to:

(1) review rules implementing the Insurance Code Chapter 6002; and

(2) as necessary, recommend rule amendments to the commissioner.

(c) The Fire Alarm Advisory Council shall be composed of seven members, as follows:

(1) three individuals who are employed by a registered firm in the fire protection industry and who have at least three years experience in the sale, installation, maintenance, or manufacture of fire alarm or fire detection devices;

(2) two individuals who are:

(A) experienced in the engineering of fire prevention services; or

(B) members of a fire protection association;

(3) one individual who is an experienced fire prevention officer employed by a municipality or county; and

(4) one individual who:

(A) is employed by a registered firm; and

(B) has at least three years experience in the operation of a central fire alarm monitoring station.

(d) The Fire Alarm Advisory Council members shall serve at the will of the commissioner. The commissioner shall replace any member who resigns from the advisory council or whose membership is otherwise terminated.

(e) After completing review of proposed rules implementing the Insurance Code Chapter 6002 and developing recommendations relating to the rules, the Fire Alarm Advisory Council shall submit a report of its findings and recommendations to the commissioner.

(f) Duration. The advisory council is established to operate for four years from the effective date of the adoption of this section unless abolished earlier or extended to a later date by the commissioner of insurance. Such abolishment or extension shall be by amendment of this section as required by the Government Code §2110.008.

§34.630. Application and Renewal Forms.

(a) The commissioner adopts by reference the License Application for Individuals For All Types of Fire Alarm Licenses, Form Number SF032, which contains instructions for completion of the form and requires information to be provided regarding the applicant and the applicant's employer.

(b) The commissioner adopts by reference the Renewal Application For Fire Alarm Individual License, Form Number SF094, which contains instructions for completion of the form; information regarding late fees; and requires information to be provided regarding the renewing applicant.

(c) The commissioner adopts by reference the Instructor Approval Application, Form Number SF247, which contains instructions for completion of the form and requires information to be provided regarding the applicant.

(d) The commissioner adopts by reference the Renewal Application For Instructor Approval, Form Number SF255, which contains instructions for completion of the form and requires information to be provided regarding the applicant.

(e) The commissioner adopts by reference the Training School Approval Application, Form Number SF246, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule.

(f) The commissioner adopts by reference the Renewal Application for Training School Approval, Form Number SF246, which contains instructions for completion of the form, provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant and course location and schedule.

(g) The commissioner adopts by reference the Fire Alarm Certificate of Registration Application, Form Number SF031, which contains instructions for completion of the form; provides information regarding necessary filing documents pursuant to business entity type, and requires information to be provided regarding the applicant.

(h) The commissioner adopts by reference the Renewal Application For Fire Alarm Certificate of Registration, Form Number SF031, which contains instructions for completion of the form and requires information to be provided regarding the applicant.

(i) The forms adopted by reference in this section are available at the department's website at www.tdi.state.tx.us.

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 November 29, 2010.

TRD-201006770
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER G. FIRE SPRINKLER RULES

28 TAC §§34.707, 34.711, 34.714

STATUTORY AUTHORITY.

The sections are proposed under the Government Code §417.004 and §417.005; the Occupations Code §2154.052; and the Insurance Code §§6001.051, 6001.052, 6001.201, 6002.051, 6002.052, 6002.201, 6003.051, 6003.052, 6003.054, 6003.201, and 36.001.

The Government Code §417.004 specifies that the Commissioner of Insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection. The Government Code §417.005 specifies that the Commissioner of Insurance may, after consulting with the State Fire Marshal, adopt necessary rules to guide the State Fire Marshal in the investigation of arson, fire, and suspected arson and in the performance of other duties for the Commissioner of

Insurance. The Occupations Code §2154.052(b) specifies that the Commissioner shall adopt and the State Fire Marshal shall administer rules the Commissioner considers necessary for the protection, safety, and preservation of life and property, including rules regulating: (i) the issuance of licenses and permits to persons engaged in manufacturing, selling, storing, possessing, or transporting fireworks in this state; (ii) the conduct of public fireworks displays; and (iii) the safe storage of Fireworks 1.3G and Fireworks 1.4G. The Occupations Code §2154.052(c) specifies that the Commissioner shall adopt rules for applications for licenses and permits. The Insurance Code §6001.051(a) specifies that the Department shall administer the Insurance Code Chapter 6001. The Insurance Code §6001.051(b) specifies that the Commissioner may issue rules the Commissioner considers necessary to administer Chapter 6001 through the State Fire Marshal. The Insurance Code §6001.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards published by the National Fire Protection Association; recognized by federal law or regulation; published by any nationally recognized standards-making organization; or contained in the manufacturer's installation manuals. The Insurance Code §6001.052(b) specifies that the Commissioner shall adopt and administer rules determined essentially necessary for the protection and preservation of life and property regarding: (i) registration of firms engaged in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems or hydrostatic testing of fire extinguisher cylinders; (ii) the examination and licensing of individuals to install or service portable fire extinguishers and plan, certify, install, or service fixed fire extinguisher systems; and (iii) requirements for installing or servicing portable fire extinguishers and planning, certifying, installing, or servicing fixed fire extinguisher systems. The Insurance Code §6001.052(c) specifies that the Commissioner by rule shall prescribe requirements for applications and qualifications for licenses, permits, and certificates issued under this chapter. The Insurance Code §6001.201(c) specifies (i) that the Commissioner by rule may adopt a system under which registration certificates, licenses, and permits expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid; and (iii) that on each subsequent renewal, the total renewal fee is payable. The Insurance Code §6002.051(a) specifies that the Department shall administer Chapter 6002. The Insurance Code §6002.051(b) specifies that the Commissioner may adopt rules as necessary to administer Chapter 6002, including rules the Commissioner considers necessary to administer Chapter 6002 through the State Fire Marshal. The Insurance Code §6002.052(a) specifies that in adopting necessary rules, the Commissioner may use: (i) recognized standards, such as, but not limited to standards of the National Fire Protection Association; standards recognized by federal law or regulation; or standards published by a nationally recognized standards-making organization; (ii) the National Electrical Code; or (iii) information provided by individual manufacturers. The Insurance Code §6002.052(b) specifies that under rules adopted under Section 6002.051, the Department may create specialized licenses or registration certificates for an organization or individual engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining fire alarm or fire detection devices or systems, and that the rules must establish appropriate training and qualification standards for each kind of license and certificate. The Insurance Code §6002.052(c) specifies that the Commissioner shall also adopt standards applicable to fire alarm devices, equipment, or systems regulated under this chapter, and that in adopting standards, the Commissioner may allow the operation of a fire alarm monitoring station that relies on fire alarm devices or equipment approved or listed by a nationally recognized testing laboratory without regard to whether the monitoring station is approved or listed by a nationally recognized testing laboratory if the operator of the station demonstrates that the station operating standards are substantially equivalent to those required to be approved or listed. The Insurance Code §6002.201(b) specifies that: (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and (iii) that the total renewal fee is payable on renewal on the new expiration date. The Insurance Code §6003.051(a) specifies that the Department shall administer Chapter 6003. The Insurance Code §6003.051(b) specifies that the Commissioner may issues rules necessary to administer Chapter 6003 through the State Fire Marshal. The Insurance Code §6003.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards adopted by federal law or regulation; standards published by a nationally recognized standards-making organization; or standards developed by individual manufacturers. The Insurance Code §6003.054(a) specifies that the Commissioner may delegate authority to exercise all or part of the Commissioner's functions, powers, and duties under Chapter 6003, including the issuance of licenses and registration certificates, to the State Fire Marshal Section 6003.054(a) further specifies that the State Fire Marshal shall implement the rules adopted by the commissioner for the protection and preservation of life and property in controlling: (i) the registration of an individual or an organization engaged in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; and (ii) the requirements for the plan, sale, installation, maintenance, or servicing of fire protection sprinkler systems by determining the criteria and qualifications for registration certificate and license holders; evaluating the qualifications of an applicant for a registration certificate to engage in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; conducting examinations and evaluating the qualifications of a license applicant; and issuing registration certificates and licenses to qualified applicants. The Insurance Code §6003.201(c) specifies that (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and that (iii) on renewal on the new expiration date, the total renewal

fee is payable. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE.

The following statutes are affected by this proposal: Insurance Code §§6002.054, 6002.101, 6002.102, 6002.151 - 6002.156, 6002.158, 6002.201, 6002.301 - 6002.303, 6003.051, 6003.052, 6003.153 and 6003.155

Government Code §417.010

Occupations Code §§2154.051, 2154.052, 2154.254

§34.707. Adopted Standards.

The Commissioner adopts by reference in their entirety the following copyrighted standards and recommended practices published by and available from the National Fire Protection Association, Inc. (NFPA), Batterymarch Park, Quincy, Massachusetts 02269. A copy of the standards shall be kept available for public inspection in [~~the Office of~~] the State Fire Marshal's Office [~~Marshal~~].

(1) NFPA 13-2010 [~~13-2002~~], Standard for the Installation of Sprinkler Systems;

(2) NFPA 25-2008 [~~25-1998~~], Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems;

(3) NFPA 13D-2010 [~~13D-2002~~], Standard for the Installation of Sprinkler Systems in One- and Two-Family Dwellings and Manufactured Homes;

(4) NFPA 13R-2010 [~~13R-2002~~], Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height;

(5) NFPA 14-2010 [~~14-2000~~], Standard for the Installation of Standpipe, Private Hydrant and Hose Systems;

(6) NFPA 15-2007 [~~15-2001~~], Standard for Water Spray Fixed Systems for Fire Protection;

(7) NFPA 16-2007 [~~16-1999~~], Standard for the Installation of Foam-Water Sprinkler and Foam-Water Spray Systems;

(8) NFPA 20-2008 [~~20-1999~~], Standard for the Installation of Stationary Pumps for Fire Protection;

(9) NFPA 22-2008 [~~22-1998~~], Standard for Water Tanks for Private Fire Protection;

(10) NFPA 24-2010 [~~24-2002~~], Standard for the installation of Private Fire Service Mains and Their Appurtenances;

(11) NFPA 30-2008 [~~30-2000~~], Flammable and Combustible Liquids Code;

(12) NFPA 30B-2011 [~~30B-2002~~], Code for the Manufacture and Storage of Aerosol Products;

(13) NFPA 307-2011 [~~307-2000~~], Standard for the Construction and Fire Protection of Marine Terminals, Piers, and Wharves;

(14) NFPA 214-2005 [~~214-2000~~], Standard on Water-Cooling Towers; and

(15) NFPA 409-2004 [~~409-2001~~], Standard on Aircraft Hangars.

§34.711. Responsible Managing Employee (RME) License.

(a) (No change.)

[~~(b) Posting. Wall licenses shall be posted conspicuously for public view at the firm's business location.~~]

(b) [~~(c)~~] Pocket License [~~license~~]. An RME must carry a pocket license for identification while engaged in the activities of an RME.

(c) [~~(d)~~] Duplicate License [~~license~~]. A duplicate license must be obtained from the state fire marshal to replace a lost or destroyed license. The license holder must submit written notification of the loss or destruction without delay, accompanied by the required fee.

(d) [~~(e)~~] Revised Licenses [~~licenses~~]. The change of licensee's employer, home address, or mailing address requires a revised license. [~~Licenses requiring changes must be surrendered to the state fire marshal within 14 days after the change requiring the revision.~~] The license holder must submit written notification of the necessary change within 14 days of the change [~~with the surrendered license,~~] accompanied by the required fee.

(e) [~~(f)~~] Restrictions.

(1) A licensee shall not engage in any act of the business unless employed by a registered firm.

(2) A registered firm must notify the state marshal within 14 days after termination of employment of an RME.

(3) A license is neither temporarily nor permanently transferable from one person to another.

(f) [~~(g)~~] Types.

(1) RME-General--A license issued to an individual who is designated by a registered firm to assure that any fire protection sprinkler system, as planned, installed, maintained, or serviced, meets the standards provided by law.

(2) RME-Dwelling--A license issued to an individual who is designated by a registered firm to assure that the fire protection sprinkler system for a one- and two-family dwelling, as planned, installed, maintained, or serviced, meets the standards provided by law.

(3) RME-Underground Fire Main--A license issued to an individual who is designated by a registered firm to assure that the underground fire main for a fire protection sprinkler system, as installed, maintained, or serviced, meets the standards provided by law.

(4) RME-General Inspector--A license issued to an individual who is designated by a registered firm to perform the inspection, test and maintenance service for a fire protection sprinkler system in accordance with the standards adopted in this subchapter.

§34.714. Fees.

(a) Except for fees specified in subsection (b) of this section, all fees payable shall be submitted by check or money order made payable to the Texas Department of Insurance or the State Fire Marshal's Office, or if the license is renewable over the internet, where the renewal application is to be submitted under the Texas OnLine Project, in which case fees shall be submitted as directed by the Texas OnLine Authority. Should the department authorize other online or electronic original applications or other transactions, persons shall submit fees with the transaction as directed by the department or the Texas OnLine Authority. [~~Every fee payable to the department and required in accordance with the provisions of the Insurance Code, Article 5.43-3, and this subchapter must be paid by cash, money order, or check. Money orders and checks must be made payable to the Texas Department of Insurance.~~] Except for overpayments resulting from mistakes of law or fact, all fees are nonrefundable and non-transferable.

[~~(b) Fees payable to the department shall be paid at the Office of the State Fire Marshal in Austin or mailed to an address specified by the state fire marshal.~~]

(b) [~~(c)~~] Fees for tests administered by an outsource testing service are payable to the testing service in the amount and manner required by the testing service.

(c) [~~(d)~~] Fees are as follows:

(1) Certificates of registration:

(A) all initial applications shall include an application fee of--$50;

(B) initial fee--$900;

(C) renewal fee (for two years)--$1,800;

(D) renewal late fee (expired 1 day to 90 days)--$450;

(E) renewal late fee (expired 91 days to two years)--$900;

(2) Certificates of registration--(Dwelling or Underground fire main):

(A) all initial applications shall include an application fee of--$50;

(B) initial fee--$300;

(C) renewal fee (for two years)--$600;

(D) renewal late fee (expired 1 day to 90 days)--$150;

(E) renewal late fee (expired 91 days to two years)--$300;

(3) Responsible managing employee license (General):

(A) initial fee--$200;

(B) renewal fee (for two years)--$350;

(C) renewal late fee (expired 1 day to 90 days)--$100;

(D) renewal late fee (expired 91 days to two years)--$200;

(4) Responsible managing employee licenses (Dwelling, or Underground fire main):

(A) initial fee--$150;

(B) renewal fee (for two years)--$200;

(C) renewal late fee (expired 1 day to 90 days)--$75;

(D) renewal late fee (expired 91 days to two years)--$150;

(5) Responsible managing employee license (General Inspector):

(A) initial fee--$50;

(B) renewal fee (for two years)--$100;

(C) renewal late fee (expired 1 day to 90 days)--$25;

(D) renewal late fee (expired 91 days to two years)--$50;

(6) Duplicate or revised certificate or license or other requested changes to certificates or licenses--$35;

(7) Test fee (if administered by the State Fire Marshal's Office)--$50.

(d) [~~(e)~~] Late fees are required of all certificate or license holders who fail to submit renewal applications before their expiration dates.

(e) [~~(f)~~] A license or registration shall expire at 12:00 midnight on the date printed on the license or registration. A renewal application and fee for license or registration must be postmarked on or before the date of expiration to be accepted as timely. If a renewal application is not complete but there has been no lapse in the required insurance, the applicant shall have 30 days from the time the applicant is notified by the State Fire Marshal's Office of the deficiencies in the renewal application to submit any additional requirement. If an applicant fails to respond and correct all deficiencies in a renewal application within the 30-day period, a late fee may be charged.

(f) [~~(g)~~] Holders of certificates and licenses which have been expired for less than two years cannot be issued new certificates or licenses.

(g) [~~(h)~~] Fees for certificates and licenses which have been expired for less than two years include both renewal and late fees.

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 November 29, 2010.

TRD-201006771
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER H. STORAGE AND SALE OF FIREWORKS

28 TAC §§34.808, 34.810, 34.817

STATUTORY AUTHORITY.

The sections are proposed under the Government Code §417.004 and §417.005; the Occupations Code §2154.052; and the Insurance Code §§6001.051, 6001.052, 6001.201, 6002.051, 6002.052, 6002.201, 6003.051, 6003.052, 6003.054, 6003.201, and 36.001.

The Government Code §417.004 specifies that the Commissioner of Insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection. The Government Code §417.005 specifies that the Commissioner of Insurance may, after consulting with the State Fire Marshal, adopt necessary rules to guide the State Fire Marshal in the investigation of arson, fire, and suspected arson and in the performance of other duties for the Commissioner of Insurance. The Occupations Code §2154.052(b) specifies that the Commissioner shall adopt and the State Fire Marshal shall administer rules the Commissioner considers necessary for the protection, safety, and preservation of life and property, including rules regulating: (i) the issuance of licenses and permits to persons engaged in manufacturing, selling, storing, possessing, or transporting fireworks in this state; (ii) the conduct of public fireworks displays; and (iii) the safe storage of Fireworks 1.3G and Fireworks 1.4G. The Occupations Code §2154.052(c) spec-

ifies that the Commissioner shall adopt rules for applications for licenses and permits. The Insurance Code §6001.051(a) specifies that the Department shall administer the Insurance Code Chapter 6001. The Insurance Code §6001.051(b) specifies that the Commissioner may issue rules the Commissioner considers necessary to administer Chapter 6001 through the State Fire Marshal. The Insurance Code §6001.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards published by the National Fire Protection Association; recognized by federal law or regulation; published by any nationally recognized standards-making organization; or contained in the manufacturer's installation manuals. The Insurance Code §6001.052(b) specifies that the Commissioner shall adopt and administer rules determined essentially necessary for the protection and preservation of life and property regarding: (i) registration of firms engaged in the business of installing or servicing portable fire extinguishers or planning, certifying, installing, or servicing fixed fire extinguisher systems or hydrostatic testing of fire extinguisher cylinders; (ii) the examination and licensing of individuals to install or service portable fire extinguishers and plan, certify, install, or service fixed fire extinguisher systems; and (iii) requirements for installing or servicing portable fire extinguishers and planning, certifying, installing, or servicing fixed fire extinguisher systems. The Insurance Code §6001.052(c) specifies that the Commissioner by rule shall prescribe requirements for applications and qualifications for licenses, permits, and certificates issued under this chapter. The Insurance Code §6001.201(c) specifies (i) that the Commissioner by rule may adopt a system under which registration certificates, licenses, and permits expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate, license, or permit is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate, license, or permit pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate, license, or permit is valid; and (iii) that on each subsequent renewal, the total renewal fee is payable. The Insurance Code §6002.051(a) specifies that the Department shall administer Chapter 6002. The Insurance Code §6002.051(b) specifies that the Commissioner may adopt rules as necessary to administer Chapter 6002, including rules the Commissioner considers necessary to administer Chapter 6002 through the State Fire Marshal. The Insurance Code §6002.052(a) specifies that in adopting necessary rules, the Commissioner may use: (i) recognized standards, such as, but not limited to standards of the National Fire Protection Association; standards recognized by federal law or regulation; or standards published by a nationally recognized standards-making organization; (ii) the National Electrical Code; or (iii) information provided by individual manufacturers. The Insurance Code §6002.052(b) specifies that under rules adopted under Section 6002.051, the Department may create specialized licenses or registration certificates for an organization or individual engaged in the business of planning, certifying, leasing, selling, servicing, installing, monitoring, or maintaining fire alarm or fire detection devices or systems, and that the rules must establish appropriate training and qualification standards for each kind of license and certificate. The Insurance Code §6002.052(c) specifies that the Commissioner shall also adopt standards applicable to fire alarm devices, equipment, or systems regulated under this chapter, and that in adopting standards, the Commissioner may allow the operation of a fire alarm monitoring station that relies on fire alarm devices or equipment approved or listed by a nationally recognized testing laboratory without regard to whether the monitoring station is approved or listed by a nationally recognized testing laboratory if the operator of the station demonstrates that the station operating standards are substantially equivalent to those required to be approved or listed. The Insurance Code §6002.201(b) specifies that: (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and (iii) that the total renewal fee is payable on renewal on the new expiration date. The Insurance Code §6003.051(a) specifies that the Department shall administer Chapter 6003. The Insurance Code §6003.051(b) specifies that the Commissioner may issues rules necessary to administer Chapter 6003 through the State Fire Marshal. The Insurance Code §6003.052(a) specifies that in adopting necessary rules, the Commissioner may use recognized standards, including standards adopted by federal law or regulation; standards published by a nationally recognized standards-making organization; or standards developed by individual manufacturers. The Insurance Code §6003.054(a) specifies that the Commissioner may delegate authority to exercise all or part of the Commissioner's functions, powers, and duties under Chapter 6003, including the issuance of licenses and registration certificates, to the State Fire Marshal Section 6003.054(a) further specifies that the State Fire Marshal shall implement the rules adopted by the commissioner for the protection and preservation of life and property in controlling: (i) the registration of an individual or an organization engaged in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; and (ii) the requirements for the plan, sale, installation, maintenance, or servicing of fire protection sprinkler systems by determining the criteria and qualifications for registration certificate and license holders; evaluating the qualifications of an applicant for a registration certificate to engage in the business of planning, selling, installing, maintaining, or servicing fire protection sprinkler systems; conducting examinations and evaluating the qualifications of a license applicant; and issuing registration certificates and licenses to qualified applicants. The Insurance Code §6003.201(c) specifies that (i) the Commissioner by rule may adopt a system under which registration certificates and licenses expire on various dates during the year; (ii) that for the year in which an expiration date of a registration certificate or license is less than one year from its issuance or anniversary date, the fee shall be prorated on a monthly basis so that each holder of a registration certificate or license pays only that portion of the renewal fee that is allocable to the number of months during which the registration certificate or license is valid; and that (iii) on renewal on the new expiration date, the total renewal fee is payable. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE.

The following statutes are affected by this proposal: Insurance Code §§6002.054, 6002.101, 6002.102, 6002.151 - 6002.156,

6002.158, 6002.201, 6002.301 - 6002.303, 6003.051, 6003.052, 6003.153 and 6003.155

Government Code §417.010

Occupations Code §§2154.051 - §2154.052, §2154.254

§34.808. Definitions.

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

(1) - (40) (No change.)

(41) Supervisor--A person 18 [~~16~~] years or older who is responsible for the retail fireworks site during operating hours.

(42) (No change.)

§34.810. Requirements, Licensees.

(a) - (d) (No change.)

(e) The change of a licensee's name, business location, residence, or mailing address requires a revised license document. Licensees must submit written notification within 14 days of the change. [~~Documents requiring changes must be surrendered to the state fire marshal within 30 days after the change, with written notification of the necessary change.~~]

§34.817. Retail Sales General Requirements.

(a) A supervisor, 18 [~~16~~] years of age or older, shall be on duty during all phases of operation. It shall be the responsibility of the permit holder as well as the supervisor to comply with or require compliance with the fireworks rules.

(b) - (q) (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 November 29, 2010.

TRD-201006772
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Earliest possible date of adoption: January 16, 2011
For further information, please call: (512) 463-6327

♦ ♦ ♦

WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 22. EXAMINING BOARDS

PART 22. TEXAS STATE BOARD OF PUBLIC ACCOUNTANCY

CHAPTER 511. ELIGIBILITY

SUBCHAPTER C. EDUCATIONAL REQUIREMENTS

22 TAC §511.51

The Texas State Board of Public Accountancy withdraws the proposed new §511.51 which appeared in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9036).

Filed with the Office of the Secretary of State on December 2, 2010.

TRD-201006839
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: December 2, 2010
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §511.52

The Texas State Board of Public Accountancy withdraws the proposed amendments to §511.52 which appeared in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9037).

Filed with the Office of the Secretary of State on December 2, 2010.

TRD-201006841
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: December 2, 2010
For further information, please call: (512) 305-7842

♦ ♦ ♦

22 TAC §511.57

The Texas State Board of Public Accountancy withdraws the proposed amendments to §511.57 which appeared in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9038).

Filed with the Office of the Secretary of State on December 2, 2010.

TRD-201006840
J. Randel (Jerry) Hill
General Counsel
Texas State Board of Public Accountancy
Effective date: December 2, 2010
For further information, please call: (512) 305-7842

♦ ♦ ♦

ADOPTED RULES

Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 392. PROCUREMENTS BY HEALTH AND HUMAN SERVICES COMMISSION

SUBCHAPTER J. HISTORICALLY UNDERUTILIZED BUSINESSES

1 TAC §392.100

The Texas Health and Human Services Commission (HHSC) adopts the amendment to §392.100, concerning the Historically Underutilized Business (HUB) program, without changes to the proposed text as published in the October 1, 2010, issue of the *Texas Register* (35 TexReg 8847) and will not be republished.

Background and Justification

Pursuant to §2161.003 of the Texas Government Code, state agencies are required to adopt the Texas Comptroller of Public Accounts (CPA) rules governing the use of HUBs for construction projects and purchases of goods and services paid for with state-appropriated funds. Section 392.100 currently adopts obsolete rules of the Texas Building and Procurement Commission (TBPC). TBPC was the governing authority for the statewide HUB program until the 80th Texas Legislature, in House Bill 3560, moved that authority to the CPA. The amendment is adopted to ensure that HHSC's rule reflects the correct governing authority and rule citation for the statewide HUB program.

Comments

HHSC received no comments regarding adoption of the amendment.

Legal Authority

The amendment is adopted under Texas Government Code, §531.0055, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties; and under Texas Government Code §2161.003, which directs state agencies to adopt the CPA's rules under 34 TAC Chapter 20, Subchapter B, relating to the Historically Underutilized Business 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 3, 2010.

TRD-201006870
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Effective date: December 23, 2010
Proposal publication date: October 1, 2010
For further information, please call: (512) 424-6900

♦ ♦ ♦

TITLE 10. COMMUNITY DEVELOPMENT

PART 1. TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

CHAPTER 5. COMMUNITY AFFAIRS PROGRAMS

SUBCHAPTER H. SECTION 8 HOUSING CHOICE VOUCHER PROGRAM

10 TAC §5.801

The Texas Department of Housing and Community Affairs (the "Department") adopts amendments to 10 TAC Chapter 5, Subchapter H, §5.801, Project Access Initiative, with changes to the proposed text as published in the August 6, 2010, issue of the *Texas Register* (35 TexReg 6744).

Project Access was originally a housing voucher pilot program developed by HUD and the U.S. Department of Health and Human Services (HHS). The goal of the pilot program was to assist low-income nonelderly persons with disabilities to transition from institutions into the community by providing access to affordable housing and necessary supportive services. The Department applied for the pilot program and received thirty-five Section 8 housing vouchers from HUD in 2001. After the expiration of the HUD pilot program in 2003, the Department elected to continue the program in recognition of housing need and expressed public interest and has continued to operate the program since that time with periodic increases in the number of Project Access vouchers.

Currently, the Department works closely with the Texas Department of Aging and Disability Services in outreach and identification of program participants. The number of Project Access vouchers administered by the Department increased from fifty to sixty in January 2010. The Public Housing Agency (PHA) Plan approved by the Board of Directors on June 28, 2010 outlines an increase for the 2011 Annual PHA Plan from sixty to one hundred

vouchers. The Department is awaiting approval of the PHA Plan from HUD by end of 2010.

Original changes to the rule included an administrative correction that reinserts two definitions for the Project Access Program, including the definition of an At-Risk Applicant. In addition, the Department had received feedback from the Disability Advisory Workgroup and the Promoting Independence Advisory Committee that some portion of the Project Access vouchers, which historically have been utilized for only non-elderly, should be made available to serve persons with disabilities at or over the age of 62. In tandem with the increase in vouchers from 60 to 100 in the PHA Plan, the Department is using this opportunity to designate that 20 percent of Project Access vouchers be reserved for persons at or over the age of 62, due to the great need for affordable housing among this aging population transitioning out of institutions.

The public comment period was from August 6, 2010 through September 6, 2010. The Department received no comments on the proposed amendments.

The final rule includes one amendment from the proposed draft rule that clarifies that 20 percent of vouchers will be reserved for those "at or" over the age of 62, not just over the age of 62, as well as other minor administrative changes. Fifty-seven percent of the nursing facility population that chooses to relocate back into the community is over the age of 60, according to the Texas Department of Aging and Disability Services. With this rule change, 80 percent of the vouchers will continue to be reserved for those under the age of 62, the population historically served by the Project Access program.

The Board approved the final order adopting the amended sections on November 10, 2010.

The amendments are adopted pursuant to the authority Chapter 2306 of the Texas Government Code, which provides the Department with the authority to adopt rules governing the administration of the Department and its programs.

§5.801. Project Access Initiative.

(a) Purpose. Project Access is a program that utilizes federal Section 8 Housing Choice Vouchers administered by the Department to assist low-income persons with disabilities in transitioning from institutions into the community by providing access to affordable housing.

(b) Definitions.

(1) Section 8--The United States Department of Housing and Urban Development Section 8 Housing Choice Voucher Program administered by the Texas Department of Housing and Community Affairs (the "Department").

(2) At-Risk Applicant--Applicant that meets the criteria in subparagraphs (A) and (B) of this paragraph:

(A) current recipient of Tenant-Based Rental Assistance from the Department's HOME Investments Partnership Program; and

(B) within one-hundred-twenty (120) days prior to expiration of assistance.

(c) Regulations Governing Program. All Section 8 Program rules and regulations apply to the program.

(d) Program Design. Twenty percent of Project Access Vouchers will be reserved for persons meeting the Project Access eligibility criteria at or over the age of sixty-two (62) at the time of voucher issuance and eighty percent will be reserved for persons meeting the eligibility criteria under the age of sixty-two (62) at the time of voucher issuance. The number of Project Access Vouchers that correlate with the 20%/80% division will be determined each year in the Departmental Annual Public Housing Agency (PHA) Plan.

(e) Project Access Eligibility Criteria. A Project Access voucher recipient must meet all Section 8 eligibility criteria as well as meet all of the eligibility criteria in paragraphs (1) and (2) of this subsection:

(1) have a permanent disability as defined in §223 of the Social Security Code or be determined to have a physical, mental, or emotional disability that is expected to be of long-continued and indefinite duration that impedes one's ability to live independently;

(2) meet one of the criteria in subparagraphs (A) and (B) of this paragraph:

(A) be an At-Risk Applicant and a previous resident of a nursing facility, intermediate care facility, or board and care facility as defined by the U.S. Department of Housing and Urban Development (HUD); or

(B) be a current resident of a nursing facility, intermediate care facility, or board and care facility at the time of voucher issuance as defined by HUD.

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 2, 2010.

TRD-201006856
Michael Gerber
Executive Director
Texas Department of Housing and Community Affairs
Effective date: December 22, 2010
Proposal publication date: August 6, 2010
For further information, please call: (512) 475-3916

♦ ♦ ♦

TITLE 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 5. CARBON DIOXIDE (CO2)

The Railroad Commission of Texas (Commission) adopts new Chapter 5, relating to Carbon Dioxide (CO_2), to implement Senate Bill (SB) 1387, 81st Legislature (Regular Session, 2009), which was effective September 1, 2009. SB 1387 amended the Texas Water Code and the Texas Natural Resources Code to provide for the implementation of projects involving the capture, injection, sequestration, or geologic storage of carbon dioxide (CO_2). Sections 5.101, 5.102, 5.201, and 5.208 are adopted without changes; §5.204 is adopted without changes to the text but with a modification to the font requirements in the required notices; and §§5.202, 5.203, 5.205, 5.206, and 5.207 are adopted with changes to the versions published in the October 15, 2010, issue of the *Texas Register* (35 TexReg 9177).

The purpose of the proposed rules is to protect underground sources of drinking water while promoting the capture and storage of anthropogenic CO_2. In a prior rulemaking action, the

Commission proposed new Chapter 5, relating to Carbon Dioxide, which was published in the March 26, 2010, issue of the *Texas Register* (35 TexReg 2446). The Commission received numerous and extensive comments on that proposal. Because of the changes that the Commission made to the rules as originally proposed, the Commission withdrew the prior proposal and published the revised proposal in the October 15, 2010, issue of the *Texas Register* (35 TexReg 9177).

SB 1387 delegates to the Commission jurisdiction over the injection of anthropogenic CO_2 into productive formations and saline formations directly above and below the productive formations for the purpose of geological storage. The bill establishes an Anthropogenic Carbon Dioxide Storage Trust Fund to include fees established by the Commission for implementation. The bill also authorizes the Commission to issue a permit if the Commission finds that injection and geologic storage of anthropogenic CO_2 will not endanger or injure any oil, gas, or other mineral formation; that with proper safeguards, both ground and surface fresh water can be adequately protected from CO_2 migration or displaced formation fluids; that the injection of CO_2 will not endanger or injure human health and safety; that the reservoir into which the CO_2 is injected is suitable for or capable of being made suitable for protecting against the escape or migration of CO_2 from the reservoir; and that the permit applicant meets all of the other statutory and regulatory requirements for the issuance of the permit.

SB 1387 requires the Commission to adopt rules and procedures, including rules for geologic site characterization; area of review and corrective action; well construction; operation; mechanical integrity testing; plugging; monitoring; post-injection site care and site closure; long-term stewardship of the geologic storage; enforcement; and the collection and administration of fees and penalties to cover the cost of permitting, monitoring, inspection, enforcement, and implementation associated with the program. SB 1387 requires coordination between the Commission and the Texas Commission on Environmental Quality (TCEQ) to ensure the regulation of CO_2 storage in Texas is being performed in an economically and environmentally sound manner. SB 1387 also requires that the permit applicant obtain and submit to the Commission a letter from the Executive Director of the TCEQ certifying that underground fresh water supplies will not be injured by the permitted activity.

SB 1387 also requires the Commission, TCEQ, and the University of Texas Bureau of Economic Geology (BEG) to conduct a study of, and report back to the legislature on, the appropriate agency to regulate the long-term storage of CO_2 into non-oil, gas, or geothermal producing geologic formations. SB 1387 further requires the Texas General Land Office (GLO), in conjunction with the Commission, TCEQ, and BEG, to develop recommendations for managing geologic storage of CO_2 on state-owned lands, including an assessment of storage capacity and new legal and regulatory frameworks that might be necessary. The agencies have prepared a joint report, which will be delivered to the Legislature as required on December 1, 2010. SB 1387 clearly states that the storage operator owns the anthropogenic CO_2 in a geologic storage facility and authorizes the Commission to regulate the withdrawal of any stored CO_2. Finally, SB 1387 requires the Commission's rules to be consistent with the regulations of the United States Environmental Protection Agency (EPA) and contemplates that the Commission will seek enforcement primacy from the EPA for the program.

On July 25, 2008, EPA proposed requirements for underground injection of CO_2 for geologic storage under the authority of the federal Safe Drinking Water Act (SDWA). The goal of the proposed regulations is to protect underground sources of drinking water (USDWs) while promoting carbon capture and storage. EPA proposed to create a new class of injection well, designated as Class VI. EPA used as the beginning framework the program for Class I hazardous injection wells, then added requirements to address the unique nature of CO_2 injection for geologic storage, relative buoyancy of CO_2, corrosivity in the presence of water, potential presence of impurities in the CO_2 stream, mobility within subsurface formations, and the large injection volumes expected. EPA's proposed rules would establish technical criteria for geologic site characterization; area of review and corrective action; well construction and operation; mechanical integrity testing and monitoring; monitoring of the CO_2 plume and pressure front; groundwater monitoring; well plugging; extended post-injection site care; long-term financial assurance to ensure proper site care and closure; and site closure. The administrator of EPA signed these rules on November 22, 2010. The rules will be effective 30 days from the date of publication in the *Federal Register.*

As noted, SB 1387 contemplates that the Commission will seek enforcement authority (primacy) for the Underground Injection Control (UIC) program for geologic storage of anthropogenic CO_2 and the associated injection wells. Section 1425 of the federal SDWA allows states seeking primacy for Class II wells to demonstrate that their existing standards are effective in preventing endangerment of USDWs. These programs must include requirements for permitting, enforcement, inspection, monitoring, record-keeping, and reporting that demonstrate the effectiveness of their requirements. However, under Section 1422 of the federal SDWA, states applying to EPA for primary enforcement responsibility to administer the UIC program (primacy) must show that the state programs meet EPA's minimum federal requirements for UIC programs, including construction, operating, monitoring and testing, reporting, and closure requirements for well owners or operators.

Absent some action from Congress, states will be required to apply for primacy for the UIC program for geologic storage of CO_2 under Section 1422 of the federal SDWA. Therefore, the state's program must be at least as stringent as EPA's program. Where states do not seek this responsibility or fail to demonstrate that they meet EPA's minimum requirements, EPA is required to implement a UIC program for the state.

COMMENTS

With respect to the revised proposal published in the *Texas Register* on October 15, 2010 (35 TexReg 9177), the Commission received comments from the Clean Coal Technology Foundation of Texas (the Foundation) and Denbury Onshore, LLC (Denbury). Neither stated support or opposition to the proposed rules in their entirety, but offered suggestions for revisions to some of the rule provisions.

The Foundation commented that it strongly supports the Commission's efforts to implement SB 1387 to provide regulatory certainty and strong environmental protection of Texas' natural resources and expressed appreciation of the Commission's support in furthering the goal of making carbon capture and storage a Texas success story. The Commission appreciates this comment.

Denbury commented that many of the technical provisions presume all geologic storage sites and operations require the same generic activities, which provisions ignore practical differences between geologic sites and operations as well as probable advancements in industry technology or available information. Denbury stated that these distinct requirements belong in guidelines or as options on the forms to be filed by an applicant to provide flexibility to both the Commission and the industry in recognition of differences in geologic storage sites and operations as well as providing the possibility of using advances in technological tools. In this light, Denbury had several comments.

Denbury commented that §5.201(b), as proposed, contains a provision authorizing a "determination" to be made by the director that an injection well involved in enhanced recovery that is simultaneously being operated as a geologic storage facility may not truly be a Class II injection well. Further, upon this determination, an operator has only two choices: shut in the well or apply for a permit under Subchapter B. There is no provision for a third alternative that would allow an operator to demonstrate to the Commission that injection may be occurring for the purpose of pressure buildup in a portion of the reservoir and EOR is truly occurring simultaneously. The Commission needs to consider one alternative or the other for inclusion in the rule to provide for proper agency procedure under the Administrative Procedure Act.

The Commission does not agree with this comment. Proposed §5.201(b) states that, if the director determines that an injection well regulated under §3.46 should be regulated under this subchapter because the injection well is no longer being used for the primary purpose of enhanced recovery operations, the director must notify the operator of that determination and allow the operator at least 30 days (clarified from the March 2010 originally proposed "reasonable time") to respond to the determination and to file an application under this subchapter or cease operation of the well. Because the rule provides the operator with the ability to respond to such a determination, the rule is consistent with the Administrative Procedure Act. The Commission makes no change in response to this comment.

Denbury commented that, although it appreciates recognition of the Securities and Exchange Commission restrictions included in proposed §5.202(c)(1), it recommended that notice of the permit transfer should be 45 days prior to transfer "of operations." The Commission agrees with this comment and has made this clarifying change.

In addition, Denbury recommended that the Commission clarify whether "plans required by §5.203 or §5.206" are intended to cover only the corrective action plan or every activity plan that is submitted as part of the application process. Sections 5.203 and 5.206 relate to application requirements and permit standards, respectively; therefore, "plans required by §5.203 or §5.206" refers to any plan required by either of those sections. The Commission makes no change in response to this comment.

Denbury commented that the Commission should accept suggested changes recommended by the Texas Oil and Gas Association (TXOGA) in its comment on the original proposal of new §5.203(c)(2)(A) that would limit the geologic and topographic maps and cross sections required to be submitted to those indicating the vertical and lateral limits of the lowermost USDW and in USDWs in the immediate vicinity of the proposed injection well. In that comment, TXOGA had recommended that the Commission revise §5.203(c)(2)(A) to clarify language relating to maps and stratigraphic cross sections. TXOGA stated that, as long as the applicant proposes to inject CO_2 below the lowermost underground source of drinking water (USDW), it is not necessary to require maps and stratigraphic cross sections for the entire extent of those USDWs above the lowermost USDW. TXOGA further stated that, although mapping and stratigraphic cross sections in the immediate vicinity of the proposed injection locations should be required, data regarding all USDWs in the area of review will be costly and difficult to collect; and the usefulness of such data is unclear.

The Commission does not agree with this comment. Proper review of the application must include a review of data on all USDWs in the area of review. In addition, the requirement is consistent with the requirement in EPA's regulations, as signed by EPA Administrator Lisa Jackson on November 22, 2010, and is appropriate for the anticipated scale of a geologic storage facility. The Commission makes no change in response to this comment.

Denbury recommended that the Commission delete or further clarify language regarding the analytical results in proposed §5.203(c)(2)(F). Denbury stated that, because formation testing is a drilling or post-completion operation, the requirement to provide analytical results as part of the application package cannot be met. The Commission disagrees with this comment. Information regarding the chemical and physical characteristics of the formation(s) into which injection will occur is necessary for modeling of the area of review. However, the Commission adopts some changes in §5.203(c)(2)(F) to clarify that the operator must submit a description of the formation testing program used and the analytical results used to determine the chemical and physical characteristics of the injection zone and the confining zone.

Denbury recommended the following change to proposed §5.203(f)(2)(C): "The operator must verify that proposed operational injection pressure does not exceed the fracture pressures for the injection and confining zone." Denbury stated that in order to "determine" that the fracture pressure as originally drafted, the fracture pressure would actually have to be exceeded. The Commission agrees in part with this comment. The EPA rules, as signed by Administrator Jackson on November 22, 2010, require that, at a minimum, the owner or operator must "determine or calculate" the fracture pressure of the injection and confining zones. However, fracture pressure changes with pore pressure increase as the reservoir fills up. Therefore, the Commission adopts clarifying wording to require that the owner or operator "determine *or calculate"* the fracture pressures. The Commission also adopts additional clarifying language stating that, if the fracture pressures are calculated, the Commission will limit the injection pressure to 90% of that calculated limit to ensure that the permitted injection pressure does not exceed the fracture pressures.

Denbury commented that the requirements in proposed §5.203(j)(2)(C), relating to corrosion monitoring, are too specific and fail to take into account prior well construction and the nature of carbon dioxide when injected. Denbury recommended that the Commission provide operators with more flexibility by limiting this requirement to well components that contact water-saturated carbon dioxide streams and state that this requirement is waived when the carbon dioxide stream is dehydrated to meet pipeline specifications. The Commission disagrees with this comment. Although Texas statutes define the standards for "pipeline quality" natural gas, there are no defined standards for "pipeline quality" CO_2. Dehydration of the

CO_2 stream prior to injection may be sufficient to protect the tubing and packer of the injection well from corrosion; however, the CO_2 stream is "re-hydrated" once it contacts the formations. Thus, any exposed cement and casing strings in the injection well would likely be vulnerable to corrosion from exposure to acidic fluids. Also, casing and cement in other wells down gradient of the injection wells may be exposed to corrosive properties of the re-hydrated injectate. The Commission makes no change in response to this comment.

Denbury commented that proposed §5.203(k)(2)(D) is not necessary because the wellbore will be flushed prior to plugging and most cements used for well plugging are sufficiently compatible with carbon dioxide. The Commission finds no reason to delete the language if operators already plan to flush wellbores prior to plugging and use cements that are compatible with the CO_2 stream and formation fluids. The Commission makes no change in response to this comment.

The Foundation recommended that the Commission remove references to "fresh water" from proposed §5.203(o) when describing the "letter from the Texas Commission on Environmental Quality" requirement. Because the letter is adequately described in §27.046 of the Texas Water Code, the Commission agrees with this comment and has made the recommended clarifying change.

The Foundation commented that the Commission should allow operators of carbon dioxide injection facilities to use insurance, trust funds, corporate guarantees, and other financial assurance mechanisms to satisfy the financial assurance requirements in §5.205. In support of this comment, the Foundation stated that such forms are routinely available under other federal environmental programs and stated that the Texas Commission on Environmental Quality's rules at 30 TAC §37.241 (relating to Insurance) provide for the use of insurance as a financial assurance mechanisms for closure, post-closure, and corrective action activities.

The Commission agrees with the comment that additional options should be available. Both EPA's and the Commission's proposed rules would require that operators demonstrate financial responsibility and maintain financial assurance for activities related to operating, maintaining, monitoring, and closing geologic storage facilities. The rule proposed by EPA on July 25, 2008, specifies only a general duty to obtain financial assurance acceptable to the Director, but did not designate any specific financial assurance mechanism to be used. The rules signed by EPA Administrator Jackson on November 22, 2010, included several options for financial assurance, as well as criteria for appropriate financial security. EPA also advised that it will be providing additional guidance on financial assurance at a later date.

The Commission finds that revising the rule to allow additional forms of financial assurance is not within the scope of the notice of proposed rulemaking and therefore would be a major revision requiring republication of §5.205 to allow comment by interested persons. The Commission adopts the financial assurance provisions in §5.205 without changes to the proposed version, partly in the interest of timely adoption of rules to implement SB 1387, and partly because the various potential additional forms of financial assurance have not been fully evaluated in terms of either their compliance with EPA's rules or the nature and extent of the financial risk to the state. Some financial assurance instruments are not appropriate for all geologic storage activities. The appropriateness of the instrument is tied to the financial risk to the state. Section 5.205 requires financial assurance for the following geologic storage activities: corrective action, post-injection site care and monitoring, site closure (including injection well plugging), and emergency and remedial response. Trust funds, letters of credit, and surety bonds may be appropriate for corrective action. Trust funds may be appropriate for post-injection site care and site closure. Insurance may be appropriate for unforeseen circumstances, such as emergency response and remedial action. The Commission makes no change in response to this comment at this time, but will consider future amendments to allow additional mechanisms for financial assurance in the near future. The Commission welcomes comments from interested persons regarding the various forms of financial assurance and specifically whether certain forms of financial assurance are appropriate to mitigate particular risks to the state.

Denbury commented that the amount of financial assurance required in proposed §5.205(c) should be limited to the maximum amount necessary to perform post-injection monitoring, post-injection site care and closure of the geologic storage facility as was succinctly set forth in SB 1387, and should not have been expanded to cover additional activities of corrective action, emergency response, and remedial action. In the proposal preamble, the Commission stated that the financial assurance requirements establish the requirements of SB 1387. SB 1387 distinctly requires only that the operator maintain financial assurance to ensure that an abandoned injection well is properly plugged and that funds are available for plugging, post-injection site care, and closure of an injection well. Increasing the amount of financial assurance beyond that set forth in the statute will create an additional unnecessary expense for operators.

The Commission does not agree with this comment. Post-injection site care and closure of the geologic storage facility could include the need for corrective action, emergency response, and remedial action. The Commission makes no change in response to this comment.

Denbury commented that, although it appreciated the changes made to proposed §5.203(a) regarding the use of licensed professionals if required under Chapter 1001 of the Occupations Code, relating to Texas Engineering Practices Act or Chapter 1002 relating to Texas Geoscientists Practices Act, this clarification should also be made in proposed §5.205(c)(2)(C)(ii). The Commission agrees with this comment and has made the recommended clarifying change.

The Foundation commented that the Commission's provision for reducing the amount of required financial assurance should not be limited to the financial assurance required for post-injection monitoring in proposed §5.205(c)(4). The Foundation stated that, although it appreciates that the Commission included a provision to allow for the reduction of the amount of financial assurance as the projects progress, the provision is too narrow because it applies only to that portion of the financial assurance required for post-injection monitoring. The Foundation stated that this provision should be broadened to allow for the reduction of financial assurance required for corrective action as the facility nears closure and that the rules could use the performance standards or benchmarks included in the rules that must be met before the facility can be closed after cessation of injection as milestones for the reduction. The Commission agrees with this comment and has made the recommended change.

Denbury commented that proposed §5.206(j) fails to include any obligation of time for review by, or even a response from, the Commission to a request for closure, which could result in indefinite continued unnecessary and expensive monitoring and

reporting after a site is ready for permanent closure. Denbury and others previously suggested a 180-day period for the Commission to respond to such a request, either with approval for closure or denial. Denbury recommended that the Commission reconsider adding a definite time period to this section to minimize the economic impact on, and aid in the business planning of, a geologic storage facility operator seeking permanent closure for its facility.

The Commission notes that Denbury and others originally recommended, in comments filed on the initial proposal published in March 2010, that the Commission revise §5.206(j)(3) to provide for automatic authorization of site closure 180 days after monitor wells are plugged or properly managed unless the director affirmatively acts to extend the post-injection site care period. In joint comments, the Texas Carbon Capture and Storage Association and the Environmental Defense fund had recommended that the Commission revise §5.206(j)(5), as originally proposed, to provide for a certificate of closure and to place time limits on the Commission to provide written notification of the decision to the operator: *"(5) Certificate of storage facility closure. Within 60 days of a determination by the director that the operator has made demonstrations required in subsection (j)(3) the director shall provide written notification of his decision to the operator."* The Commission disagrees with these comments. While such an automatic authorization might be appropriate in the case of a relatively minor activity, the Commission declines to provide for an automatic authorization for closure of a geologic storage facility. In addition, because of the expected complexities of some geologic storage facilities and declining staffing, the Commission declines at this time to commit to performing this review within a set time period. The Commission commits to working as efficiently as possible to provide operators with a determination regarding closure of a geologic storage facility in a timely manner.

The Foundation commented that the Commission should clarify that filing a certificate with a land plat delineating the storage area is an acceptable form of notice under §5.206(k), which states that the operator must record a notation on the deed to the facility property "or any other document that is normally examined during a title search that will in perpetuity" to provide certain information to a potential purchaser of the property. The Foundation appreciates that the Commission has provided for a notice mechanism other than the filing of a notation on every deed. The Foundation seeks clarification from the Commission that the filing of a certificate with a land plat delineating the storage area and setting further the information required under the regulation, is the type of document that would be acceptable to the Commission in meeting the requirements of this section. It is the intent of the Commission that the applicant submit a document that is acceptable to the county clerk for filing in the official public records of the county. The document must delineate the storage area and set forth the information required under the regulation. In addition, the document must contain the complete legal description of the affected property. The document may be a certificate with a land plat if that is acceptable to the county clerk for filing in the official public records of the county and the document contains the complete legal description of the affected property. The Commission's concern is that the document be in the official public record so that abstract companies or title insurance companies will find it in a title search. The Commission adopts §5.206(k) with clarifying changes.

Denbury commented that it appreciates the changes to proposed §5.207(a)(2)(D)(iii) creating an exception to submitting a recalculated area of review as part of the annual report if the operator submits a statement signed by an appropriate company official; however, proposed §5.207(a)(2)(D)(vi) is burdensome and unnecessary. Denbury stated that proposed §5.207(a)(2)(D)(vi) appears to decimate the new exception by providing a means for the Commission to second-guess the analysis performed by the operator in applying for the exception. The rule already describes when the area of review and other plans must be updated and it is sufficient for an operator to submit a statement as part of the annual report confirming that data supports the area of review and plans on file with the Commission without going into the unnecessary detail now required.

The Commission agrees that the language in §5.207(a)(2)(D)(vi) should be clarified as follows: "(vi) The operator must maintain and update required plans in accordance with the provision of this *subchapter."* However, the Commission disagrees that the clause has an impact on a permittee's ability to determine whether updates are warranted by material change in the monitoring and operational data, or in the evaluation of these data. In addition, the information described in the clause clarifies the type of information needed by the permittee and the Commission to determine whether updates are warranted. The Commission makes no additional change in response to this comment.

Denbury further commented that in proposed §5.207(a)(2)(D)(vi)(III), which allows the director to require revision whenever the director deems necessary, it is not clear on what basis the director would make such a determination. The language grants the director undefined discretionary authority on a decision to update these plans, which in Denbury's view is best left to the operator who will continually be reviewing the appropriate data and determining whether a change in any of the plans is warranted by the data reviewed. The Commission disagrees with this comment. The language appropriately allows a permittee to determine whether updates, including reevaluation of the area of review, are necessary based on the permittee's review and evaluation of pertinent data. Further, the language also appropriately allows the Commission to require updates if the Commission disagrees with that interpretation.

ADOPTION

The Commission adopts new Chapter 5, relating to Carbon Dioxide (CO_2). The Commission adopts new Subchapter A, relating to General Provisions, and §5.101, relating to Purpose. The purpose of the new chapter is to implement the portion of the state program for geologic storage of anthropogenic CO_2 over which the Commission has jurisdiction consistent with state and federal law related to protection of underground sources of drinking water (USDWs) and sequestration of CO_2.

The Commission adopts new §5.102, relating to Definitions. Many of the terms defined in this section are the same as or consistent with definitions of the same terms that are ubiquitous in the underground injection control program. These include definitions of "area of review," "confining zone," "corrective action," "enhanced recovery operation," "fracture pressure," "injection zone," "mechanical integrity," "pressure front," "transmissive fault or fracture," "well stimulation," and "workover." The Commission has modified a few of these definitions as necessary for geologic sequestration.

The Commission defines the term "underground source of drinking water," a term used in the federal UIC program. Heretofore, the Commission has used the terms "fresh water" and "usable quality water" because they are used in the Texas statutes relating to underground injection. However, as noted before, use

of the term "underground sources of drinking water" in the Commission's rules will make it easier for the EPA to approve any request for enforcement primacy. The Commission proposes to define "underground source of drinking water" as an aquifer or its portion which is not an exempt aquifer as defined in 40 Code of Federal Regulations §146.4 and which supplies any public water system, or contains a sufficient quantity of ground water to supply a public water system and currently supplies drinking water for human consumption or contains fewer than 10,000 mg/l total dissolved solids.

The Commission defines other terms necessary to regulation of geologic storage of anthropogenic CO_2. The Commission defines the term "anthropogenic CO_2," slightly differently from the definition in Texas Water Code, §27.002, as added by SB 1387. The Commission defines the terms "geologic storage," "geologic storage facility or storage facility," and "reservoir" as those terms are defined in Texas Water Code, §27.002, as added by SB 1387. Definitions for the terms "CO_2 plume," "CO_2 stream," "post-injection facility care," and "facility closure" are modifications of the definitions of those terms as adopted by EPA.

The Commission adopts new Subchapter B, relating to Geologic Storage and Associated Injection of Anthropogenic Carbon Dioxide (CO_2). The Commission adopts new §5.201, relating to Applicability and Compliance, which states that Subchapter B applies to the geologic storage of anthropogenic CO_2 in, and the injection of anthropogenic CO_2 into, a reservoir that is initially or may be productive of oil, gas, or geothermal resources or a saline formation directly above or below that reservoir. A reservoir that may be productive means an identifiable geologic unit that has had production in the past, which is similar to productive or previously productive reservoirs along the same or a similar trend, or potentially contains oil, gas, or geothermal resources based on analysis of geophysical and/or seismic data.

In accordance with SB 1387, §5.201(b) states that Subchapter B does not apply to the injection of fluid through the use of an injection well regulated under §3.46 of this title for the primary purpose of enhanced recovery operations from which there is reasonable expectation of more than insignificant future production volumes of oil, gas, or geothermal energy and operating pressures are no higher than reasonably necessary to produce such volumes or rates. However, the operator of an enhanced recovery project may propose simultaneously to permit the enhanced recovery project as a CO_2 geologic storage facility. There may not be much difference between injection pressures used for enhanced recovery and those for geologic storage; however, this may depend on the geology and hydrology of the storage facility and whether the operator proposes to allow the reservoir pressure to increase above the hydrostatic pressure on a long-term basis. Subsection (b) further states that, if the director determines that an injection well regulated under §3.46 of this title should be regulated under this subchapter because the injection well is no longer being used for the primary purpose of enhanced recovery operations, the director must notify the operator of such determination and allow the operator at least 30 days to respond to the determination and to file an application under this subchapter or cease operation of the well. Additionally, this subchapter does not preclude an enhanced oil recovery project operator from opting into any other regulatory program that provides credit for anthropogenic CO_2 sequestered through the enhanced recovery project.

Subsection (c) states that, if a well is authorized as or converted to an anthropogenic CO_2 injection well for geologic storage, this subchapter would apply to the well.

Subsection (d) states that, if a provision of this subchapter conflicts with any provision or term of a Commission order or permit, the provision of such order or permit controls.

Subsection (e) requires the operator of a geologic storage facility to comply with all other applicable Commission rules and orders and states that, if a provision of Subchapter B conflicts with any provision or term of a Commission order or permit, the provision of the order or permit controls.

The Commission adopts §5.202, relating to Permit Required. Subsection (a) prohibits a person from beginning to drill or to operate an anthropogenic CO_2 injection well for geologic storage or constructing or operating a geologic storage facility regulated under this subchapter without first obtaining the necessary permit(s) from the Commission. Subsection (b) outlines the requirements for amendment of an existing geologic storage facility permit. Subsection (c) sets forth the requirements for transfer of a permit for a geologic storage facility permit from one operator to another operator. The Commission adopts subsection (c)(1) with a change as previously discussed in the preamble.

Subsection (d) states that the Commission has the authority to modify, cancel, or suspend a geologic storage facility permit after notice and opportunity for hearing under specific circumstances, listed in the subsection. Subsection (d) further provides that in the event of an emergency that threatens endangerment to USDWs or to life or property, or an imminent threat of uncontrolled escape of CO_2, the director may immediately order suspension of the operation of a geologic storage facility until a final order is issued pursuant to a hearing, if any.

The Commission adopts §5.203, relating to Application Requirements. Subsection (a) establishes the general requirements for the form of a permit application, the filing requirements, and providing general information. This subsection also states that the Commission may not issue a permit before receiving a complete application. The subsection further states that all reports must be prepared by a qualified and knowledgeable person. In addition, if required by the Texas Geoscientist Practice Act or the Texas Engineering Practices Act, a professional geoscientist or professional engineer must conduct the logging, sampling, and testing, and affix the appropriate seal on the resulting reports required under this subchapter. Subsection (b) establishes the requirements for surface map and information. Subsection (c) establishes the geologic, geochemical, and hydrologic information required with an application. These requirements are consistent with EPA's requirements. The Commission adopts subsection (c)(2)(F) with a change as previously discussed in the preamble.

Subsection (d) establishes the application requirements for the area of review and corrective action. Paragraph (1) establishes the permit application requirements for the initial delineation of the area of review and the initial corrective action. Permit applicants must perform the initial delineation of the area of review using computational modeling to predict the lateral and vertical migration of the CO_2 plume, the formation fluids, and the pressure differentials required to cause movement of injected fluids or formation fluids into a USDW in the subsurface for three periods after initiation of injection: (1) five years after initiation of injection; (2) from initiation of injection to the end of the injection period proposed by the applicant; and (3) from initiation of injection to 10 years after the end of the injection period proposed by

the applicant. The Commission has determined that delineation of the probable area of review after five years from commencement of injection will provide the operator and the Commission with useful information to verify the adequacy of the methods and programs used to delineate the areas of review throughout the life of the storage facility and to make any necessary adjustments shortly after the first five years of operation.

Subsection (d) also establishes the application requirements for identification of penetrations and table of wells and establishes the application requirements for any necessary corrective action. The applicant must include in the table of wells all penetrations that are known or reasonably discoverable through specialized knowledge or experience. Examples of such specialized knowledge or experience may include reviews of federal, state and local government records, interviews with past and present owners, operators and occupants, reviews of historical information (including aerial photographs, chain of title documents, and land use records), and visual inspections of the facility and adjoining properties. Subsection (d) further requires that the applicant submit an area of review and corrective action plan, and details what that plan must include. The requirements in this subsection are consistent with those in EPA's regulation.

Subsection (e) establishes the requirements for construction of anthropogenic CO_2 injection wells. These requirements are consistent with the requirements for Class II injection wells, with the addition of one requirement included in EPA's rules, *i.e.,* verification of the integrity and location of the cement using technology capable of radial evaluation of cement quality and identification of the location of channels to ensure that underground sources of drinking water will not be endangered. Existing wells that have been associated with injection of CO_2 for the purpose of enhanced recovery may be exempt from provisions of these casing and cementing requirements if the applicant demonstrates that the well construction meets the general performance criteria. Subsection (e) also establishes the requirements for the well construction information that must be submitted with a permit application, including a well construction plan and a well stimulation plan. Such information is necessary to allow the director to determine whether the wells will be constructed to prevent endangerment of USDWs and will isolate the injected fluids to the storage reservoir.

Subsection (f), relating to logging, sampling, and testing, establishes the logging, sampling and testing results to be submitted with the application sufficient to determine the depth, thickness, porosity, permeability, and lithology of, and the geochemistry of any formation fluids in, all relevant geologic formations. Subsection (f) also requires the applicant to submit a plan for logging, sampling, and testing the injection well(s), after permitting but prior to injection well operation. The plan must describe the logs, surveys, and tests to be conducted to verify the depth, thickness, porosity, permeability, and lithology of, and the salinity of any formation fluids in, the formations that are to be used for monitoring, storage, and confinement to assure conformance with the injection well construction requirements, and to establish accurate baseline data against which future measurements may be compared. The subsection further requires the applicant to submit a sampling plan. The subsection establishes the criteria and information for both plans. These requirements are a modification of the requirements in EPA's rule §146.87 for Class VI wells, except that the Commission has included more performance requirements and fewer mandates that operators perform specific tests to allow the operator to use whatever tests provide the necessary demonstration and to allow for technological advancements in testing methods. The Commission adopts subsection (f)(2)(C) with a change as previously discussed in the preamble.

Subsection (g), relating to compatibility determination, requires an applicant to submit a determination of the compatibility of the CO_2 stream with the materials to be used to construct the well; fluids in the injection zone; and minerals in both the injection and the confining zone, based on the results of the formation testing program.

Subsection (h), relating to mechanical integrity testing information, sets forth the criteria and information to be submitted in a mechanical integrity testing plan. These requirements are a modification of the requirements in EPA's rule §146.89. The requirements include an initial annulus pressure test; continuous monitoring of the injection pressure, rate, injected volumes, and pressure on the annulus between tubing and long string casing; an annual confirmation that the injected fluids are confined to the injection zone using a method approved by the director (e.g., diagnostic surveys, such as oxygen-activation logging or temperature or noise logs); and injection well testing after any workover that disturbs the seal between the tubing, packer, and casing, and at least once every five years to determine if leaks exist in the tubing, packer, or casing. The subsection further requires that the applicant submit a mechanical integrity testing plan and outlines the requirements of the plan.

Subsection (i), relating to operating information, establishes the maximum injection pressure and the requirement for an operating plan. This requirement is consistent with EPA's rules, except that it does not set the limit to 90% of the fracture pressure of the injection zone. Rather, the Commission proposes to set the maximum injection pressure to one that takes into account the risks of tensile failure and, where appropriate, geomechanical or other studies that assess the risk of tensile failure and shear failure; that with a reasonable degree of certainty will avoid initiation or propagation of fractures in the confining zone or cause otherwise non-transmissive faults transecting the confining zone to become transmissive; and that in no case may cause the movement of injection or formation fluids in a manner that endangers USDWs.

Subsection (j), relating to monitoring, sampling, and testing plan, requires the applicant to prepare and submit a plan to verify that the geologic storage facility is operating as permitted and that the injected fluids are confined to the injection zone. The subsection establishes the requirements of the plan, which are consistent with EPA's rules.

Subsection (k), relating to well plugging plan, sets forth the requirements for plugging injection and monitor wells. In accordance with §3.14 of this title, operators must plug monitor wells that penetrate the base of usable quality water and, upon abandonment, all injection wells. Operators must plug all monitoring wells that do not penetrate the base of usable quality water, in accordance with 16 TAC Chapter 76 (relating to Water Well Drillers and Water Well Plump Installers).

Subsection (l), relating to emergency and remedial response plan, requires that the applicant submit an emergency and remedial response plan that describes actions to be taken to address escape from the permitted injection interval or movement of the injection or formation fluids that may cause an endangerment to USDWs during construction, operation, closure and post-closure periods; includes a safety plan that includes emergency response procedures, provisions to provide security against unauthorized activity, and CO_2 release detection and prevention mea-

sures; and includes a description of the training and testing that will be provided to each employee at the storage facility on operational safety and emergency response procedures to the extent applicable to the employee's duties and responsibilities.

Subsection (m), relating to post-injection facility care and facility closure plan, requires that an applicant submit a plan that includes the pressure differential between pre-injection and predicted post-injection pressures in the injection zone; the predicted position of the CO_2 plume and associated pressure front at closure as demonstrated in the area of review evaluation; a description of post-injection monitoring location, methods, and proposed frequency; a proposed schedule for submitting post-injection storage facility care monitoring results to the Commission; and the estimated cost of proposed post-injection care and closure.

Subsection (n), relating to financial responsibility, requires that an applicant demonstrate that the applicant has met the financial responsibility requirements under §5.205 of this subchapter. Such requirements are consistent with Texas Water Code, §27.050, and EPA's rule §146.85.

Subsection (o), relating to letter from the TCEQ, implements the requirement in Texas Water Code, §27.046, that an applicant submit a letter from the Executive Director of the TCEQ. The Commission adopts subsection (o) with a change as previously discussed in the preamble.

Subsection (p), relating to other information, requires that an applicant submit any other information requested by the director as necessary to discharge the Commission's duties under Texas Water Code, Chapter 27, Subchapter B-1, or deemed necessary by the director to clarify, explain, and support the required attachments, consistent with Texas Water Code, §27.044, as amended by SB 1387.

The Commission adopts §5.204, relating to Notice and Hearing. Subsection §5.204(a) requires the applicant to make a complete copy of the permit application available for the public to inspect and copy by filing a copy of the application with the County Clerk at the courthouse of the county or counties where the storage facility is to be located, or if approved by the director, at another equivalent public office. In addition, the subsection requires the applicant to provide an electronic copy of the complete application to be posted on the Commission's website. The applicant must file any subsequent revision of an application with each County Clerk or other approved public office and must file at the Commission an electronic copy of the updated application at the same time the applicant files the revision at the Commission.

Subsection (b), relating to notice requirements, establishes the notice requirements for a permit application under this subchapter. Such notice is similar to the notice requirements for a gas storage facility under §3.96 of this title (relating to Underground Storage of Gas in Productive or Depleted Reservoirs), except that here the Commission proposes additional notice to surface owners, as well as mineral leaseholders and surface leaseholders adjoining the outermost boundary of the area of review.

In both subsections (a) and (b), the Commission adopts minor modifications to a portion of the text in the required notices. The sentences identifying the underground depth of the geologic storage reservoir must be in all capitals and bold font.

Subsection (c), relating to hearing requirements, is similar to the hearing requirements for an enhanced recovery injection well under §3.46 of this title. If the Commission receives a protest regarding an application for a new, or amendment of a permitted, geologic storage facility permit from a person who was notified pursuant to subsection (b) or from any other affected person within 30 days of the date of receipt of the application by the division, receipt of individual notice, or last publication of notice, whichever is later, then the applicant will be notified that the application cannot be administratively approved. The director will schedule a hearing on the application upon request of the applicant. The Commission must give notice of the hearing to all affected persons, local governments, and other persons who express, in writing, an interest in the application. After hearing, the examiner will recommend a final action by the Commission. If the Commission receives no protest regarding an application for a new, or amendment of a permitted, geologic storage facility permit from a person notified pursuant to subsection (a), or from any other affected person, the director may administratively approve the application. If the permit application for a new, or amendment of a permitted, geologic storage facility is administratively denied, a hearing will be scheduled upon written request of the applicant. After hearing, the examiner will recommend a final action by the Commission.

Section 5.205, relating to Fees and Financial Assurance, establishes three non-refundable fees: a base fee for each application to cover the Commission's costs for processing the application; an annual fee based on the number of metric tons injected into the geologic storage facility; and an annual post-injection care fee to be paid each year the operator does not inject into the geologic storage facility until the director has authorized storage facility closure. These fees are in addition to the fee required for each injection well by §3.78 of this title (relating to Fees and Financial Security Requirements). Subsection (b), relating to financial responsibility, is consistent with of the Texas Water Code, §27.050, as added by SB 1387.

Subsection (c) establishes financial assurance requirements as required by Texas Water Code, §27.073, as added by SB 1387. The operator must comply with the requirements of §3.78 of this title for all monitoring wells that penetrate the base of usable quality water and all injection wells. In addition, an applicant for a geologic storage facility must file a bond or letter of credit that is in an amount approved by the director under this subsection and that meets the requirements of this subsection as to form and issuer. The Commission must approve the bond or letter of credit before issuing a permit. The Commission adopts subsection (c)(2)(C)(ii) and (c)(4) with changes as previously discussed in the preamble.

Subsection (d), relating to notice of adverse financial conditions, requires an operator notify the Commission of adverse financial conditions that may affect the operator's ability to carry out injection well plugging, post-injection storage facility care, and storage facility closure. The subsection requires that notice of bankruptcy be filed in accordance with §3.1 of this title (relating to Organization Report; Retention of Records; Notice Requirements). The bond must provide a mechanism for the bond or surety company to give prompt notice to the Commission and the operator of any action filed alleging insolvency or bankruptcy of the surety company or the bank or alleging any violation that would result in suspension or revocation of the surety or bank's charter or license to do business. Upon the incapacity of a bank or surety company by reason of bankruptcy, insolvency, or suspension, or of revocation of its charter or license, the operator will be deemed to be without bond coverage. The Commission must issue a notice to any operator who is without bond coverage and specify a

reasonable period to replace bond coverage, not to exceed 90 days.

The Commission adopts §5.206, relating to Permit Standards. Subsection (a) establishes the general criteria for issuance of a permit. The language is consistent with Texas Water Code, §27.051(b-1), as added by SB 1387. The Commission adds requirements, such as the applicant's submission of the letter from the Executive Director of the TCEQ required by Texas Water Code, §27.046; the applicant's demonstration that the applicant has a good faith claim to the necessary and sufficient property rights for construction and operation of the geologic storage facility; the applicant's payment of the fee required in §5.205(a) of this subchapter; the director's determination that the applicant has sufficiently demonstrated financial responsibility; and the applicant submitted to the director the required financial security.

Subsection (b) requires that construction of anthropogenic CO_2 injection wells meet the criteria in §5.203(e) of this subchapter; that within 30 days after the completion or conversion of an injection well, the operator file a complete record of the well on the Commission's approved form showing the current completion; and that an operator of a geologic storage facility must notify the director and obtain the director's approval prior to conducting any well workover.

Subsection (c) establishes the requirements for operating a geologic storage facility. The subsection requires the operator to maintain and comply with the approved operating plan and adhere to certain operating criteria relating to metering, injection pressure, annulus fluid, recording devices, alarms, and automatic shut-off systems.

Subsection (d) requires that the operator maintain and comply with the approved monitoring, sampling, and testing plan to verify that the geologic storage facility is operating as permitted and that the injected fluids are confined to the injection zone.

Subsection (e) requires that the operator maintain and comply with the approved mechanical integrity testing plan submitted in accordance with §5.203(h) of this subchapter, and maintain mechanical integrity of the injection well at all times, except during periods of well workover.

Subsection (f) requires that, at the frequency specified in the approved area of review and corrective action plan or permit, or when monitoring and operational conditions warrant, the operator of a geologic storage facility must: (1) re-evaluate the area of review through computational modeling; (2) identify all wells in the re-evaluated area of review that require corrective action; (3) perform corrective action on wells requiring corrective action in the re-evaluated area of review; and (4) submit an amended area of review and corrective action plan or demonstrate to the director through monitoring data and modeling results that no change to the area of review and corrective action plan is needed.

Subsection (g) requires that the operator maintain, update as necessary, and comply with the approved emergency and remedial response plan required by §5.203(l). The subsection also states the action an operator must take if the operator obtains evidence that the injected CO_2 stream and associated pressure front may cause an endangerment to USDWs and states that the director may allow the operator to resume injection prior to remediation if the operator demonstrates that the injection operation will not endanger USDWs. These requirements are consistent with the requirements in EPA's regulations at §146.94.

Subsection (h) requires the operator to give the division the opportunity to witness all testing and logging.

Subsection (i) requires the operator to maintain and comply with the approved well plugging plan required by §5.203(k).

Subsection (j) requires the operator of an injection well to maintain and comply with the approved post-injection storage facility care and closure plan required under proposed new §5.203(m). Prior to authorization for storage facility closure, the operator must submit to the director a demonstration, based on monitoring and other site-specific data, that the CO_2 plume and pressure front have stabilized and that no additional monitoring is needed to assure that the geologic storage facility will not endanger USDWs. Subsection (j) establishes the requirements necessary for the Commission to authorize closure. These requirements are generally consistent with EPA's regulation §146.93.

Section 5.206(k) requires the operator of a geologic storage facility to record specific information in a notation on the deed to the facility property or any other document to put any potential purchaser of the property on notice of certain facts, including the fact that the land has been used to geologically store CO_2.

Subsection (l) requires that the operator retain for three years following storage facility closure certain records collected during the post-injection storage facility care period. The subsection further requires that the operator deliver those records to the director at the conclusion of the retention period and that the records be retained at the Austin Headquarters of the Commission.

Subsection (m) requires identification of each location at which geologic storage activities take place, including each injection well, by a sign that meets the requirements specified in §3.3 of this title (relating to Identification of Properties, Wells, and Tanks). In addition, each sign must include a telephone number at which the operator, or a representative of the operator, can be reached in the event of an emergency.

Subsection (n) states that, in any permit for a geologic storage facility, the director will impose terms and conditions reasonably necessary to protect USDWs, including the necessary casing. The subsection further states that the permits issued under this subchapter continue in effect until revoked, modified, or suspended by the Commission. Operators must comply with each requirement set forth in this subchapter as a condition of the permit unless specifically modified by the terms of the permit.

The Commission adopts §5.207, which establishes reporting and record-keeping requirements. The operator must file a complete record of all tests in duplicate with the district office within 30 days after the testing. In reporting the results of mechanical integrity tests to the director, the operator must include a description of the test(s) and the method(s) used. Various operating reports are due within 24 hours, within 30 days, semi-annually, annually, or on a cumulative basis. The operator must report to the district office orally as soon as practicable upon the discovery of any pressure changes or other monitoring data that indicate the presence of leaks in the well or the lack of confinement of the injected CO_2 stream to the geologic storage reservoir, and must confirm the report in writing within five working days.

Within 30 days, the operator must report the results of periodic tests for mechanical integrity; the results of any other test of the injection well conducted by the operator if required by the direc-

tor; and a description of any well workover. These reports must include summary cumulative tables of the required information.

Semi-annually, the operator must report a summary of well head pressure monitoring; changes to the physical, chemical and other relevant characteristics of the CO_2 stream from the proposed operating data; monthly average, maximum, and minimum values for injection pressure, flow rate and volume, and annular pressure; a description of any event that significantly exceeds operating parameters for annulus pressure or injection pressure as specified in the permit; a description of any event that triggers a shutdown device and the response taken; and the results of monitoring prescribed under §5.206(d).

Other information that may be obtained annually includes but is not limited to reports of corrective action performed; new wells installed and the type, location, number and information required in §5.203(e); re-calculated area of review; tons of CO_2 injected; and other information that may be required by a particular permit. Section 5.207 also prescribes the reporting formats and record retention requirements. The Commission adopts subsection (a)(2)(D)(vi) with a change as previously discussed in the preamble.

The Commission adopts §5.208, relating to Penalties, which states that violations of this subchapter may subject the operator to penalties and remedies specified in the Texas Natural Resources Code, Title 3, Texas Water Code, Chapter 27, and other statutes administered by Commission, and that the certificate of compliance for any oil, gas, or geothermal resource well may be revoked in the manner provided in §3.73 of this title (relating to Pipeline Connection; Cancellation of Certificate of Compliance; Severance) for violation of this subchapter.

SUBCHAPTER A. GENERAL PROVISIONS

16 TAC §5.101, §5.102

The Commission adopts the rules in new Chapter 5 pursuant to Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all persons owning or engaged in drilling or operating oil or gas wells in Texas and the authority to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission; Texas Natural Resources Code, Chapter 91, Subchapter R, as enacted by SB 1387, relating to authorization for multiple or alternative uses of wells; Texas Water Code, Chapter 27, Subchapter C-1, as enacted by SB 1387, which gives the Commission jurisdiction over the geologic storage of CO_2 in, and the injection of CO_2 into, a reservoir that is initially or may be productive of oil, gas, or geothermal resources or a saline formation directly above or below that reservoir; and Texas Water Code, Chapter 120, as enacted by SB 1387, which establishes the Anthropogenic Carbon Dioxide Storage Trust Fund, a special interest-bearing fund in the state treasury, to consist of fees collected by the Commission and penalties imposed under Texas Water Code, Chapter 27, Subchapter C-1, and to be used by the Commission for only certain specified activities associated with geologic storage facilities and associated anthropogenic CO_2 injection wells.

Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120, are affected by the adopted new rules.

Statutory authority: Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120.

Cross-reference to statute: Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120.

Issued in Austin, Texas, on November 30, 2010.

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 November 30, 2010.

TRD-201006798
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: December 20, 2010
Proposal publication date: October 15, 2010
For further information, please call: (512) 475-1295

♦ ♦ ♦

SUBCHAPTER B. GEOLOGIC STORAGE AND ASSOCIATED INJECTION OF ANTHROPOGENIC CARBON DIOXIDE (CO2)

16 TAC §§5.201 - 5.208

The Commission adopts the rules in new Chapter 5 pursuant to Texas Natural Resources Code, §81.051 and §81.052, which give the Commission jurisdiction over all persons owning or engaged in drilling or operating oil or gas wells in Texas and the authority to adopt all necessary rules for governing and regulating persons and their operations under the jurisdiction of the Commission; Texas Natural Resources Code, Chapter 91, Subchapter R, as enacted by SB 1387, relating to authorization for multiple or alternative uses of wells; Texas Water Code, Chapter 27, Subchapter C-1, as enacted by SB 1387, which gives the Commission jurisdiction over the geologic storage of CO_2 in, and the injection of CO_2 into, a reservoir that is initially or may be productive of oil, gas, or geothermal resources or a saline formation directly above or below that reservoir; and Texas Water Code, Chapter 120, as enacted by SB 1387, which establishes the Anthropogenic Carbon Dioxide Storage Trust Fund, a special interest-bearing fund in the state treasury, to consist of fees collected by the Commission and penalties imposed under Texas Water Code, Chapter 27, Subchapter C-1, and to be used by the Commission for only certain specified activities associated with geologic storage facilities and associated anthropogenic CO_2 injection wells.

Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120, are affected by the adopted new rules.

Statutory authority: Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120.

Cross-reference to statute: Texas Natural Resources Code, §81.051 and §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120.

Issued in Austin, Texas, on November 30, 2010.

§5.202. Permit Required.

(a) Permit required. A person may not begin drilling or operating an anthropogenic CO_2 injection well for geologic storage or constructing or operating a geologic storage facility regulated under this subchapter without first obtaining the necessary permit(s) from the Commission.

(b) Permit amendment.

(1) An operator must file an application to amend an existing geologic storage facility permit with the director:

(A) prior to expanding the areal extent of the storage reservoir;

(B) prior to increasing the permitted injection pressure;

(C) prior to adding injection wells; or

(D) at any time that conditions at the geologic storage facility materially deviate from the conditions specified in the permit or permit application.

(2) Compliance with plan amendments required by this subchapter does not necessarily constitute a material deviation in conditions requiring an amendment of the permit.

(c) Permit transfer. An operator may transfer its geologic storage facility permit to another operator if the requirements of this subsection are met. A new operator may not assume operation of the geologic storage facility without a valid permit.

(1) Notice. An applicant must submit written notice of an intended permit transfer to the director at least 45 days prior to the date the transfer of operations is proposed to take place, unless such action could trigger U. S. Securities and Exchange Commission fiduciary and insider trading restrictions and/or rules.

(A) The applicant's notice to the director must contain:

(i) the name and address of the person to whom the geologic storage facility will be sold, assigned, transferred, leased, conveyed, exchanged, or otherwise disposed;

(ii) the name and location of the geologic storage facility and a legal description of the land upon which the storage facility is situated;

(iii) the date that the sale, assignment, transfer, lease conveyance, exchange, or other disposition is proposed to become final; and

(iv) the date that the transferring operator will relinquish possession as a result of the sale, assignment, transfer, lease conveyance, exchange, or other disposition.

(B) The person acquiring a geologic storage facility, whether by purchase, transfer, assignment, lease, conveyance, exchange, or other disposition, must notify the director in writing of the acquisition as soon as it is reasonably possible but not later than five business days after the date that the acquisition of the geologic storage facility becomes final. The director may not approve the transfer of a geologic storage facility permit until the new operator provides all of the following:

(i) the name and address of the operator from which the geologic storage facility was acquired;

(ii) the name and location of the geologic storage facility and a description of the land upon which the geologic storage facility is situated;

(iii) the date that the acquisition became or will become final;

(iv) the date that possession was or will be acquired; and

(v) the financial assurance required by this subchapter.

(2) Evidence of financial responsibility. The operator acquiring the permit must provide the director with evidence of financial responsibility satisfactory to the director in accordance with §5.205 of this title (relating to Fees, Financial Responsibility, and Financial Assurance).

(3) Transfer of responsibility. An operator remains responsible for the geologic storage facility until the director approves in writing the sale, assignment, transfer, lease, conveyance, exchange, or other disposition and the person acquiring the storage facility complies with all applicable requirements.

(d) Modification, cancellation, or suspension of a geologic storage facility permit.

(1) General. The director may modify, suspend, or cancel a geologic storage facility permit after notice and opportunity for hearing under any of the following circumstances:

(A) There is a material change in conditions in the operation of the geologic storage facility, or there are material deviations from the information originally furnished to the director. A change in conditions at a facility that does not affect the ability of the facility to operate without causing an unauthorized release of CO_2 and/or formation fluids is not considered to be material;

(B) Underground sources of drinking water are likely to be endangered as a result of the continued operation of the geologic storage facility;

(C) There are substantial violations of the terms and provisions of the permit or of applicable Commission orders or regulations;

(D) The operator misrepresented material facts during the permit application or issuance process; or

(E) Fluids are escaping or are likely to escape from the injection zone.

(2) Emergency shutdown. Notwithstanding the provisions of paragraph (1) of this subsection, in the event of an emergency that threatens endangerment to underground sources of drinking water or to life or property, or an imminent threat of uncontrolled release of CO_2, the director may immediately order suspension of the operation of the geologic storage facility until a final order is issued pursuant to a hearing, if any.

§5.203. Application Requirements.

(a) General.

(1) Form and filing. Each applicant for a permit to construct and operate a geologic storage facility must file an application with the division in Austin on a form prescribed by the Commission. The applicant must file one copy of the application and all attachments with the division in an electronic format. On the same date, the appli-

cant must file one copy with the appropriate district office(s) and one copy with the Executive Director of the Texas Commission on Environmental Quality. An applicant must ensure that the application is executed by a party having knowledge of the facts entered on the form and included in the required attachments. If otherwise required under Occupations Code, Chapter 1001, relating to Texas Engineering Practices Act, or Chapter 1002, relating to Texas Geoscientists Practices Act, respectively, a licensed professional engineer or geoscientist must conduct the geologic and hydrologic evaluations required under this section and must affix the appropriate seal on the resulting reports of such evaluations.

(2) General information. On the application, the applicant must include the name, mailing address, and location of the facility for which the application is being submitted and the operator's name, address, telephone number, Commission Organization Report number, and ownership of the facility.

(3) Application completeness. The Commission may not issue a permit before receiving a complete application. A permit application is complete when the director determines that the application contains information addressing each application requirement of the regulatory program and all information necessary to initiate the final review by the director.

(4) Reports. An applicant must ensure that all descriptive reports are prepared by a qualified and knowledgeable person and include an interpretation of the results of all logs, surveys, sampling, and tests required in this subchapter. The applicant must include in the application a quality assurance and surveillance plan for all testing and monitoring, which includes, at a minimum, validation of the analytical laboratory data, calibration of field instruments, and an explanation of the sampling and data acquisition techniques.

(b) Surface map and information. Only information of public record is required to be included on this map.

(1) The applicant must file with the director a surface map delineating the proposed location(s) of injection well(s) and the boundary of the geologic storage facility for which a permit is sought and the applicable area of review.

(2) The applicant must show within the area of review on the map the number or name and the location of:

(A) all known artificial penetrations through the confining zone, including injection wells, producing wells, inactive wells, plugged wells, or dry holes;

(B) the locations of cathodic protection holes, subsurface cleanup sites, bodies of surface water, springs, surface and subsurface mines, quarries, and water wells; and

(C) other pertinent surface features, including pipelines, roads, and structures intended for human occupancy.

(3) The applicant must identify on the map any known or suspected faults expressed at the surface.

(c) Geologic, geochemical, and hydrologic information.

(1) The applicant must submit a descriptive report prepared by a knowledgeable person that includes an interpretation of the results of appropriate logs, surveys, sampling, and testing sufficient to determine the depth, thickness, porosity, permeability, and lithology of, and the geochemistry of any formation fluids in, all relevant geologic formations.

(2) The applicant must submit information on the geologic structure and reservoir properties of the proposed storage reservoir and overlying formations, including the following information:

(A) geologic and topographic maps and cross sections illustrating regional geology, hydrogeology, and the geologic structure of the area from the ground surface to the base of the injection zone within the area of review that indicate the general vertical and lateral limits of all underground sources of drinking water within the area of review, their positions relative to the storage reservoir and the direction of water movement, where known;

(B) the depth, areal extent, thickness, mineralogy, porosity, permeability, and capillary pressure of, and the geochemistry of any formation fluids in, the storage reservoir and confining zone and any other relevant geologic formations, including geology/facies changes based on field data, which may include geologic cores, outcrop data, seismic surveys, well logs, and lithologic descriptions, and the analyses of logging, sampling, and testing results used to make such determinations;

(C) the location, orientation, and properties of known or suspected transmissive faults or fractures that may transect the confining zone within the area of review and a determination that such faults or fractures would not compromise containment;

(D) the seismic history, including the presence and depth of seismic sources, and a determination that the seismicity would not compromise containment;

(E) geomechanical information on fractures, stress, ductility, rock strength, and in situ fluid pressures within the confining zone;

(F) a description of the formation testing program used and the analytical results used to determine the chemical and physical characteristics of the injection zone and the confining zone; and

(G) baseline geochemical data for subsurface formations that will be used for monitoring purposes, including all formations containing underground sources of drinking water within the area of review.

(d) Area of review and corrective action. This subsection describes the standards for the information regarding the delineation of the area of review, the identification of penetrations, and corrective action that an applicant must include in an application.

(1) Initial delineation of the area of review and initial corrective action. The applicant must delineate the area of review, identify all wells that require corrective action, and perform corrective action on those wells. Corrective action may be phased.

(A) Delineation of area of review.

(i) Using computational modeling that considers the volumes and the physical and chemical properties of the injected CO_2 stream, the physical properties of the formation into which the CO_2 stream is to be injected, and available data including data available from logging, testing, or operation of wells, the applicant must predict the lateral and vertical extent of migration for the CO_2 plume and formation fluids and the pressure differentials required to cause movement of injected fluids or formation fluids into an underground source of drinking water in the subsurface for the following time periods:

(I) five years after initiation of injection;

(II) from initiation of injection to the end of the injection period proposed by the applicant; and

(III) from initiation of injection to 10 years after the end of the injection period proposed by the applicant.

(ii) The applicant must use a computational model that:

(I) is based on geologic and reservoir engineering information collected to characterize the injection zone and the confining zone;

(II) is based on anticipated operating data, including injection pressures, rates, and total volumes over the proposed duration of injection;

(III) takes into account relevant geologic heterogeneities and data quality, and their possible impact on model predictions;

(IV) considers the physical and chemical properties of injected and formation fluids; and

(V) considers potential migration through known faults, fractures, and artificial penetrations and beyond lateral spill points.

(iii) The applicant must provide the name and a description of the model, software, the assumptions used to determine the area of review, and the equations solved.

(B) Identification and table of penetrations. The applicant must identify, compile, and submit a table listing all penetrations, including active, inactive, plugged, and unplugged wells and underground mines in the area of review that may penetrate the confining zone, that are known or reasonably discoverable through specialized knowledge or experience. The applicant must provide a description of each penetration's type, construction, date drilled or excavated, location, depth, and record of plugging and/or completion or closure. Examples of specialized knowledge or experience may include reviews of federal, state, and local government records, interviews with past and present owners, operators, and occupants, reviews of historical information (including aerial photographs, chain of title documents, and land use records), and visual inspections of the facility and adjoining properties.

(C) Corrective action. The applicant must demonstrate whether each of the wells on the table of penetrations has or has not been plugged and whether each of the underground mines (if any) on the table of penetrations has or has not been closed in a manner that prevents the movement of injected fluids or displaced formation fluids that may endanger underground sources of drinking water or allow the injected fluids or formation fluids to escape the permitted injection zone. The applicant must perform corrective action on all wells and underground mines in the area of review that are determined to need corrective action. The operator must perform corrective action using materials suitable for use with the CO_2 stream. Corrective action may be phased.

(2) Area of review and corrective action plan. As part of an application, the applicant must submit an area of review and corrective action plan that includes the following information:

(A) the method for delineating the area of review, including the model to be used, assumptions that will be made, and the site characterization data on which the model will be based;

(B) for the area of review, a description of:

(i) the minimum frequency subject to the annual certification pursuant to §5.206(f) of this title (relating to Permit Standards) at which the applicant proposes to re-evaluate the area of review during the life of the geologic storage facility;

(ii) how monitoring and operational data will be used to re- evaluate the area of review; and

(iii) the monitoring and operational conditions that would warrant a re-evaluation of the area of review prior to the next scheduled re-evaluation; and

(C) a corrective action plan that describes:

(i) how the corrective action will be conducted;

(ii) how corrective action will be adjusted if there are changes in the area of review;

(iii) if a phased corrective action is planned, how the phasing will be determined; and

(iv) how site access will be secured for future corrective action.

(e) Injection well construction.

(1) Criteria for construction of anthropogenic CO_2 injection wells. This paragraph establishes the criteria for the information about the construction and casing and cementing of, and special equipment for, anthropogenic CO_2 injection wells that an applicant must include in an application.

(A) General. The operator of a geologic storage facility must ensure that all anthropogenic CO_2 injection wells are constructed and completed in a manner that will:

(i) prevent the movement of injected CO_2 or displaced formation fluids into any unauthorized zones or into any areas where they could endanger underground sources of drinking water;

(ii) allow the use of appropriate testing devices and workover tools; and

(iii) allow continuous monitoring of the annulus space between the injection tubing and long string casing.

(B) Casing and cementing of anthropogenic CO_2 injection wells.

(i) The operator must ensure that injection wells are cased and the casing cemented in compliance with §3.13 of this title (relating to Casing, Cementing, Drilling, and Completion Requirements).

(ii) Casing, cement, cement additives, and/or other materials used in the construction of each injection well must have sufficient structural strength and must be of sufficient quality and quantity to maintain integrity over the design life of the injection well. All well materials must be suitable for use with fluids with which the well materials may be expected to come into contact and must meet or exceed test standards developed for such materials by the American Petroleum Institute, ASTM International, or comparable standards as approved by the director.

(iii) Surface casing must extend through the base of the lowermost underground source of drinking water above the injection zone and must be cemented to the surface.

(iv) Circulation of cement may be accomplished by staging. The director may approve an alternative method of cementing in cases where the cement cannot be circulated to the surface, provided the applicant can demonstrate by using logs that the cement does not allow fluid movement between the casing and the well bore.

(v) At least one long string casing, using a sufficient number of centralizers, must extend through the injection zone. The long string casing must isolate the injection zone and other intervals as necessary for the protection of underground sources of drinking water and to ensure confinement of the injected and formation fluids to the permitted injection zone using cement and/or other isolation techniques.

(vi) The applicant must verify the integrity and location of the cement using technology capable of radial evaluation of cement quality and identification of the location of channels to ensure that underground sources of drinking water will not be endangered.

(vii) The director may exempt existing wells that have been associated with injection of CO_2 for the purpose of enhanced recovery from provisions of these casing and cementing requirements if the applicant demonstrates that the well construction meets the general performance criteria in subparagraph (A) of this paragraph.

(C) Special equipment.

(i) Tubing and packer. All injection wells must inject fluids through tubing set on a mechanical packer. Packers must be set no higher than 100 feet above the top of the permitted injection interval or at a location approved by the director.

(ii) Pressure observation valve. The wellhead of each injection well must be equipped with a pressure observation valve on the tubing and each annulus of the well.

(2) Construction information. The applicant must provide the following information for each well to allow the director to determine whether the proposed well construction and completion design will meet the general performance criteria in paragraph (1) of this subsection:

(A) depth to the injection zone;

(B) hole size;

(C) size and grade of all casing and tubing strings (e.g., wall thickness, external diameter, nominal weight, length, joint specification and construction material, tubing tensile, burst, and collapse strengths);

(D) proposed injection rate (intermittent or continuous), maximum proposed surface injection pressure, and maximum proposed volume of the CO_2 stream;

(E) type of packer and packer setting depth;

(F) a description of the capability of the materials to withstand corrosion when exposed to a combination of the CO_2 stream and formation fluids;

(G) down-hole temperatures and pressures;

(H) lithology of injection and confining zones;

(I) type or grade of cement and additives;

(J) chemical composition and temperature of the CO_2 stream; and

(K) schematic drawings of the surface and subsurface construction details.

(3) Well construction plan. The applicant must submit an injection well construction plan that meets the criteria in paragraph (1) of this subsection.

(4) Well stimulation plan. The applicant must submit, as applicable, a description of the proposed well stimulation program and a determination that well stimulation will not compromise containment.

(f) Plan for logging, sampling, and testing of injection wells after permitting but before injection. The applicant must submit a plan for logging, sampling, and testing of each injection well after permitting but prior to injection well operation. The plan need not include identical logging, sampling, and testing procedures for all wells provided there is a reasonable basis for different procedures. Such plan is not necessary for existing wells being converted to anthropogenic CO_2 injection wells in accordance with this subchapter, to the extent such activities already have taken place. The plan must describe the logs, surveys, and tests to be conducted to verify the depth, thickness, porosity, permeability, and lithology of, and the salinity of any formation fluids in, the formations that are to be used for monitoring, storage, and confinement to assure conformance with the injection well construction requirements set forth in subsection (e) of this section, and to establish accurate baseline data against which future measurements may be compared. The plan must meet the following criteria and must include the following information.

(1) Logs and surveys of newly drilled and completed injection wells.

(A) During the drilling of any hole that is constructed by drilling a pilot hole that is enlarged by reaming or another method, the operator must perform deviation checks at sufficiently frequent intervals to determine the location of the borehole and to assure that vertical avenues for fluid movement in the form of diverging holes are not created during drilling.

(B) Before surface casing is installed, the operator must run appropriate logs, such as resistivity, spontaneous potential, and caliper logs.

(C) After each casing string is set and cemented, the operator must run logs, such as a cement bond log, variable density log, and a temperature log, to ensure proper cementing.

(D) Before long string casing is installed, the operator must run logs appropriate to the geology, such as resistivity, spontaneous potential, porosity, caliper, gamma ray, and fracture finder logs, to gather data necessary to verify the characterization of the geology and hydrology.

(2) Testing and determination of hydrogeologic characteristics of injection and confining zone.

(A) Prior to operation, the operator must conduct tests to verify hydrogeologic characteristics of the injection zone.

(B) The operator must perform an initial pressure falloff or other test and submit to the director a written report of the results of the test, including details of the methods used to perform the test and to interpret the results, all necessary graphs, and the testing log, to verify permeability, injectivity, and initial pressure using water or CO_2.

(C) The operator must determine or calculate the fracture pressures for the injection and confining zone. If the fracture pressures are determined through calculation, the Commission will include in any permit it might issue a limit of 90% of the calculated fracture pressure to ensure that the injection pressure does not exceed the fracture pressure.

(3) Sampling.

(A) The operator must record and submit the formation fluid temperature, pH, and conductivity, the reservoir pressure, and the static fluid level of the injection zone.

(B) The operator must submit analyses of whole cores or sidewall cores representative of the injection zone and confining zone and formation fluid samples from the injection zone. The director may accept data from cores and formation fluid samples from nearby wells or other data if the operator can demonstrate to the director that such data are representative of conditions at the proposed injection well.

(g) Compatibility determination. Based on the results of the formation testing program required by subsection (f) of this section,

the applicant must submit a determination of the compatibility of the CO_2 stream with:

(1) the materials to be used to construct the well;

(2) fluids in the injection zone; and

(3) minerals in both the injection and the confining zone.

(h) Mechanical integrity testing.

(1) Criteria. This paragraph establishes the criteria for the mechanical integrity testing plan for anthropogenic CO_2 injection wells that an applicant must include in an application.

(A) Other than during periods of well workover in which the sealed tubing-casing annulus is of necessity disassembled for maintenance or corrective procedures, the operator must maintain mechanical integrity of the injection well at all times.

(B) Before beginning injection operations and at least once every five years thereafter, the operator must demonstrate mechanical integrity for each injection well by pressure testing the tubing-casing annulus.

(C) Following an initial annulus pressure test, the operator must continuously monitor injection pressure, rate, injected volumes, and pressure on the annulus between tubing and long string casing to confirm that the injected fluids are confined to the injection zone.

(D) At least once every five years, the operator must confirm that the injected fluids are confined to the injection zone using a method approved by the director (e.g., diagnostic surveys such as oxygen-activation logging or temperature or noise logs).

(E) The operator must test injection wells after any workover that disturbs the seal between the tubing, packer, and casing in a manner that verifies mechanical integrity of the tubing and long string casing.

(F) An operator must either repair and successfully retest or plug a well that fails a mechanical integrity test.

(2) Mechanical integrity testing plan. The applicant must prepare and submit a mechanical integrity testing plan as part of a permit application. The plan must include a schedule for the performance of a series of tests at a minimum frequency of five years. The performance tests must be designed to demonstrate the internal and external mechanical integrity of each injection well. These tests may include:

(A) a pressure test with liquid or inert gas;

(B) a tracer survey such as oxygen-activation logging;

(C) a temperature or noise log;

(D) a casing inspection log; and/or

(E) any alternative method that provides equivalent or better information approved by the director.

(i) Operating information.

(1) Operating plan. The applicant must submit a plan for operating the injection wells and the geologic storage facility that complies with the criteria set forth in §5.206(c) of this title, and that outlines the steps necessary to conduct injection operations. The applicant must include the following proposed operating data in the plan:

(A) the average and maximum daily injection rates and volumes of the CO_2 stream;

(B) the average and maximum surface injection pressure;

(C) the source(s) of the CO_2 stream and the volume of CO_2 from each source; and

(D) an analysis of the chemical and physical characteristics of the CO_2 stream prior to injection.

(2) Maximum injection pressure. The director will approve a maximum injection pressure limit that:

(A) considers the risks of tensile failure and, where appropriate, geomechanical or other studies that assess the risk of tensile failure and shear failure;

(B) with a reasonable degree of certainty will avoid initiation or propagation of fractures in the confining zone or cause otherwise non-transmissive faults transecting the confining zone to become transmissive; and

(C) in no case may cause the movement of injection fluids or formation fluids in a manner that endangers underground sources of drinking water.

(j) Plan for monitoring, sampling, and testing after initiation of operation.

(1) The applicant must submit a monitoring, sampling, and testing plan for verifying that the geologic storage facility is operating as permitted and that the injected fluids are confined to the injection zone.

(2) The plan must include the following:

(A) the analysis of the CO_2 stream prior to injection with sufficient frequency to yield data representative of its chemical and physical characteristics;

(B) the installation and use of continuous recording devices to monitor injection pressure, rate, and volume, and the pressure on the annulus between the tubing and the long string casing, except during workovers;

(C) after initiation of injection, the performance on a semi- annual basis of corrosion monitoring of the well materials for loss of mass, thickness, cracking, pitting, and other signs of corrosion to ensure that the well components meet the minimum standards for material strength and performance set forth in subsection (e)(1)(A) of this section. The operator must report the results of such monitoring annually. Corrosion monitoring may be accomplished by:

(i) analyzing coupons of the well construction materials in contact with the CO_2 stream;

(ii) routing the CO_2 stream through a loop constructed with the materials used in the well and inspecting the materials in the loop; or

(iii) using an alternative method, materials, or time period approved by the director;

(D) monitoring of geochemical and geophysical changes, including:

(i) periodic sampling of the fluid temperature, pH, conductivity, reservoir pressure and static fluid level of the injection zone and monitoring for pressure changes, and for changes in geochemistry, in a permeable and porous formation near to and above the top confining zone;

(ii) periodic monitoring of the quality and geochemistry of an underground source of drinking water within the area of review and the formation fluid in a permeable and porous formation near to and above the top confining zone to detect any movement of the injected CO_2 through the confining zone into that monitored formation;

(iii) the location and number of monitoring wells justified on the basis of the area of review, injection rate and volume, geology, and the presence of artificial penetrations and other factors specific to the geologic storage facility; and

(iv) the monitoring frequency and spatial distribution of monitoring wells based on baseline geochemical data collected under subsection (c)(2) of this section and any modeling results in the area of review evaluation;

(E) tracking the extent of the CO_2 plume and the position of the pressure front by using indirect, geophysical techniques, which may include seismic, electrical, gravity, or electromagnetic surveys and/or down-hole CO_2 detection tools; and

(F) additional monitoring as the director may determine to be necessary to support, upgrade, and improve computational modeling of the area of review evaluation and to determine compliance with the requirements that the injection activity not allow the movement of fluid containing any contaminant into underground sources of drinking water and that the injected fluid remain within the permitted interval.

(k) Well plugging plan. The applicant must submit a well plugging plan for all injection wells and monitoring wells that penetrate the base of usable quality water that includes:

(1) a proposal for plugging all monitoring wells that penetrate the base of usable quality water and all injection wells upon abandonment in accordance with §3.14 of this title (relating to Plugging);

(2) proposals for activities to be undertaken prior to plugging an injection well, specifically:

(A) flushing each injection well with a buffer fluid;

(B) performing tests or measures to determine bottomhole reservoir pressure;

(C) performing final tests to assess mechanical integrity; and

(D) ensuring that the material to be used in plugging must be compatible with the CO_2 stream and the formation fluids;

(3) a proposal for giving notice of intent to plug monitoring wells that penetrate the base of usable quality water and all injection wells. The applicant's plan must ensure that:

(A) the operator notifies the director at least 60 days before plugging a well. At this time, if any changes have been made to the original well plugging plan, the operator must also provide a revised well plugging plan. At the discretion of the director, an operator may be allowed to proceed with well plugging on a shorter notice period; and

(B) the operator will file a notice of intention to plug and abandon (Form W-3A) a well with the appropriate Commission district office and the division in Austin at least five days prior to the beginning of plugging operations;

(4) a plugging report for monitoring wells that penetrate the base of usable quality water and all injection wells. The applicant's plan must ensure that within 30 days after plugging the operator will file a complete well plugging record (Form W-3) in duplicate with the appropriate district office. The operator and the person who performed the plugging operation (if other than the operator) must certify the report as accurate;

(5) a plan for plugging all monitoring wells that do not penetrate the base of usable quality water in accordance with 16 TAC Chapter 76 (relating to Water Well Drillers and Water Well Pump Installers); and

(6) a plan for certifying that all monitoring wells that do not penetrate the base of usable quality water will be plugged in accordance with 16 TAC Chapter 76.

(l) Emergency and remedial response plan. The applicant must submit an emergency and remedial response plan that:

(1) accounts for the entire area of review, regardless of whether or not corrective action in the area of review is phased;

(2) describes actions to be taken to address escape from the permitted injection interval or movement of the injection fluids or formation fluids that may cause an endangerment to underground sources of drinking water during construction, operation, closure, and post-closure periods;

(3) includes a safety plan that includes emergency response procedures, provisions to provide security against unauthorized activity, and CO_2 release detection and prevention measures; and

(4) includes a description of the training and testing that will be provided to each employee at the storage facility on operational safety and emergency response procedures to the extent applicable to the employee's duties and responsibilities. The operator must train all employees before commencing injection and storage operations at the facility. The operator must train each subsequently hired employee before that employee commences work at the storage facility. The operator must hold a safety meeting with each contractor prior to the commencement of any new contract work at a storage facility. Emergency measures specific to the contractor's work must be explained in the contractor safety meeting. Training schedules, training dates, and course outlines must be provided to Commission personnel upon request for the purpose of Commission review to determine compliance with this paragraph.

(m) Post-injection storage facility care and closure plan. The applicant must submit a post-injection storage facility care and closure plan. The plan must include:

(1) the pressure differential between pre-injection and predicted post-injection pressures in the injection zone;

(2) the predicted position of the CO_2 plume and associated pressure front at closure as demonstrated in the area of review evaluation required under subsection (d) of this section;

(3) a description of the proposed post-injection monitoring location, methods, and frequency;

(4) a proposed schedule for submitting post-injection storage facility care monitoring results to the division; and

(5) the estimated cost of proposed post-injection storage facility care and closure.

(n) Fees, financial responsibility, and financial assurance. The applicant must pay the fees, demonstrate that it has met the financial responsibility requirements, and provide the Commission with financial assurance as required under §5.205 of this title (relating to Fees, Financial Responsibility, and Financial Assurance).

(1) The applicant must demonstrate financial responsibility and resources for corrective action, injection well plugging, post-injection storage facility care and storage facility closure, and emergency and remedial response until the director has provided to the operator a written verification that the director has determined that the facility has reached the end of the post-injection storage facility care period.

(2) In determining whether the applicant is financially responsible, the director must rely on the following:

(A) the person's most recent audited annual report filed with the U. S. Securities and Exchange Commission under Section 13 or 15(d), Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)). The date of the audit may not be more than one year before the date of submission of the application to the division; and

(B) the person's most recent quarterly report filed with the U. S. Securities and Exchange Commission under Section 13 or 15(d), Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)); or

(C) if the person is not required to file such a report, the person's most recent audited financial statement. The date of the audit must not be more than one year before the date of submission of the application to the division.

(o) Letter from the Texas Commission on Environmental Quality. The applicant must submit a letter from the Executive Director of the Texas Commission on Environmental Quality in accordance with Texas Water Code, §27.046.

(p) Other information. The applicant must submit any other information requested by the director as necessary to discharge the Commission's duties under Texas Water Code, Chapter 27, Subchapter B-1, or deemed necessary by the director to clarify, explain, and support the required attachments.

§5.205. Fees, Financial Responsibility, and Financial Assurance.

(a) Fees. In addition to the fee for each injection well required by §3.78 of this title (relating to Fees and Financial Security Requirements), the following non-refundable fees must be remitted to the Commission with the application:

(1) Base application fee.

(A) The applicant must pay to the Commission an application fee of $50,000 for each permit application for a geologic storage facility.

(B) The applicant must pay to the Commission an application fee of $25,000 for each application to amend a permit for a geologic storage facility.

(2) Injection fee. The operator must pay to the Commission an annual fee of $0.025 per metric ton of CO_2 injected into the geologic storage facility.

(3) Post-injection care fee. The operator must pay to the Commission an annual fee of $50,000 each year the operator does not inject into the geologic storage facility until the director has authorized storage facility closure.

(4) The anthropogenic CO_2 storage trust fund shall be capped at $5,000,000.

(b) Financial responsibility.

(1) A person to whom a permit is issued under this subchapter must provide annually to the director evidence of financial responsibility that is satisfactory to the director. The operator must demonstrate and maintain financial responsibility and resources for corrective action, injection well plugging, post-injection storage facility care and storage facility closure, and emergency and remedial response until the director has provided written verification that the director has determined that the facility has reached the end of the post-injection storage facility care period.

(2) In determining whether the person is financially responsible, the director must rely on:

(A) the person's most recent audited annual report filed with the U. S. Securities and Exchange Commission under Section 13 or 15(d), Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)); and

(B) the person's most recent quarterly report filed with the U. S. Securities and Exchange Commission under Section 13 or 15(d), Securities Exchange Act of 1934 (15 U.S.C. Section 78m or 78o(d)); or

(C) if the person is not required to file such a report, the person's most recent audited financial statement. The date of the audit must not be more than one year before the date of submission of the application to the director.

(3) The applicant's demonstration of financial responsibility must account for the entire area of review, regardless of whether corrective action in the area of review is phased.

(c) Financial assurance.

(1) Injection and monitoring wells. The operator must comply with the requirements of §3.78 of this title for all monitoring wells that penetrate the base of usable quality water and all injection wells.

(2) Geologic storage facility.

(A) The applicant must include in an application for a geologic storage facility permit:

(i) a written estimate of the highest likely dollar amount necessary to perform post-injection monitoring and closure of the facility that shows all assumptions and calculations used to develop the estimate;

(ii) a copy of the form of the bond or letter of credit that will be filed with the Commission; and

(iii) information concerning the issuer of the bond or letter of credit including the issuer's name and address and evidence of authority to issue bonds or letters of credit in Texas.

(B) A geologic storage facility may not receive CO_2 until a bond or letter of credit in an amount approved by the director under this subsection and meeting the requirements of this subsection as to form and issuer has been filed with and approved by the director.

(C) The determination of the amount of financial assurance for a geologic storage facility is subject to the following requirements:

(i) The director must approve the dollar amount of the financial assurance. The amount of financial assurance required to be filed under this subsection must be equal to or greater than the maximum amount necessary to perform corrective action, emergency response, and remedial action, post-injection monitoring and site care, and closure of the geologic storage facility, exclusive of plugging costs for any well or wells at the facility, at any time during the permit term in accordance with all applicable state laws, Commission rules and orders, and the permit;

(ii) A qualified professional engineer licensed by the State of Texas, as required under Occupations Code, Chapter 1001, relating to Texas Engineering Practices Act, must prepare or supervise the preparation of a written estimate of the highest likely amount necessary to close the geologic storage facility. The operator must submit to the director the written estimate under seal of a qualified licensed professional engineer, as required under Occupations Code, Chapter 1001, relating to Texas Engineering Practices Act; and

(iii) The Commission may use the proceeds of financial assurance filed under this subsection to pay the costs of plugging any well or wells at the facility if the financial assurance for plugging

costs filed with the Commission is insufficient to pay for the plugging of such well or wells.

(D) Bonds and letters of credit filed in satisfaction of the financial assurance requirements for a geologic storage facility must comply with the following standards as to issuer and form.

(i) The issuer of any geologic storage facility bond filed in satisfaction of the requirements of this subsection must be a corporate surety authorized to do business in Texas. The form of bond filed under this subsection must provide that the bond be renewed and continued in effect until the conditions of the bond have been met or its release is authorized by the director.

(ii) Any letter of credit filed in satisfaction of the requirements of this subsection must be issued by and drawn on a bank authorized under state or federal law to operate in Texas. The letter of credit must be an irrevocable, standby letter of credit subject to the requirements of Texas Business and Commerce Code, §§5.101 - 5.118. The letter of credit must provide that it will be renewed and continued in effect until the conditions of the letter of credit have been met or its release is authorized by the director.

(E) The operator of a geologic storage facility must provide to the director annual written updates of the cost estimate to increase or decrease the cost estimate to account for any changes to the area of review and corrective action plan, the emergency response and remedial action plan, the injection well plugging plan, and the post-injection storage facility care and closure plan. The operator must provide to the director upon request an adjustment of the cost estimate if the director has reason to believe that the original demonstration is no longer adequate to cover the cost of injection well plugging and post-injection storage facility care and closure.

(3) The director may consider allowing the phasing in of financial assurance for only corrective action based on project-specific factors.

(4) The director may approve a reduction in the amount of financial assurance required for post-injection monitoring and/or corrective action based on project-specific monitoring results.

(d) Notice of adverse financial conditions.

(1) The operator must notify the Commission of adverse financial conditions that may affect the operator's ability to carry out injection well plugging and post-injection storage facility care and closure. An operator must file any notice of bankruptcy in accordance with §3.1(f) of this title (relating to Organization Report; Retention of Records; Notice Requirements). The operator must give such notice by certified mail.

(2) The operator filing a bond must ensure that the bond provides a mechanism for the bond or surety company to give prompt notice to the Commission and the operator of any action filed alleging insolvency or bankruptcy of the surety company or the bank or alleging any violation that would result in suspension or revocation of the surety or bank's charter or license to do business.

(3) Upon the incapacity of a bank or surety company by reason of bankruptcy, insolvency or suspension, or revocation of its charter or license, the Commission must deem the operator to be without bond coverage. The Commission must issue a notice to any operator who is without bond coverage and must specify a reasonable period to replace bond coverage, not to exceed 90 days.

§5.206. Permit Standards.

(a) General criteria. The director may issue a permit under this subchapter if the applicant demonstrates and the director finds that:

(1) the injection and geologic storage of anthropogenic CO_2 will not endanger or injure any existing or prospective oil, gas, geothermal, or other mineral resource, or cause waste as defined by Texas Natural Resources Code, §85.046(11);

(2) with proper safeguards, both underground sources of drinking water and surface water can be adequately protected from CO_2 migration or displaced formation fluids;

(3) the injection of anthropogenic CO_2 will not endanger or injure human health and safety;

(4) the reservoir into which the anthropogenic CO_2 is injected is suitable for or capable of being made suitable for protecting against the escape or migration of anthropogenic CO_2 from the storage reservoir;

(5) the geologic storage facility will be sited in an area with suitable geology, which at a minimum must include:

(A) an injection zone of sufficient areal extent, thickness, porosity, and permeability to receive the total anticipated volume of the CO_2 stream; and

(B) a confining zone(s) that is laterally continuous and free of known transecting transmissive faults or fractures over an area sufficient to contain the injected CO_2 stream and displaced formation fluids and allow injection at proposed maximum pressures and volumes without compromising the confining zone or causing the movement of fluids that endangers underground sources of drinking water;

(6) the applicant for the permit meets all of the other statutory and regulatory requirements for the issuance of the permit;

(7) the applicant has provided a letter from the Executive Director of the Texas Commission on Environmental Quality in accordance with §5.203(o) of this title (relating to Application Requirements);

(8) the applicant has provided a signed statement that the applicant has a good faith claim to the necessary and sufficient property rights for construction and operation of the geologic storage facility for at least the first five years after initiation of injection in accordance with §5.203(d)(1)(A) of this title;

(9) the applicant has paid the fees required in §5.205(a) of this title (relating to Fees, Financial Responsibility, and Financial Assurance);

(10) the director has determined that the applicant has sufficiently demonstrated financial responsibility as required in §5.205(b) of this title; and

(11) the applicant submitted to the director financial assurance in accordance with §5.205(c) of this title.

(b) Injection well construction.

(1) Construction of anthropogenic CO_2 injection wells must meet the criteria in §5.203(e) of this title.

(2) Within 30 days after the completion or conversion of an injection well subject to this subchapter, the operator must file with the division a complete record of the well on the appropriate form showing the current completion.

(3) Except in the case of an emergency repair, the operator of a geologic storage facility must notify the director at least 48 hours, and obtain the director's approval, prior to conducting any well workover that involves running tubing and setting packer(s), beginning any workover or remedial operation, or conducting any required pressure tests or surveys. In the case of an emergency repair, the operator

must notify the director of such emergency repair as soon as reasonably practical.

(c) Operating a geologic storage facility.

(1) Operating plan. The operator must maintain and comply with the approved operating plan.

(2) Operating criteria.

(A) Injection between the outermost casing protecting underground sources of drinking water and the well bore is prohibited.

(B) The total volume of CO_2 injected into the storage facility must be metered through a master meter or a series of master meters. The volume of CO_2 injected into each injection well must be metered through an individual well meter.

(C) The operator must comply with a maximum surface injection pressure limit approved by the director and specified in the permit. In approving a maximum surface injection pressure limit, the director must consider the results of well tests and, where appropriate, geomechanical or other studies that assess the risks of tensile failure and shear failure. The director must approve limits that, with a reasonable degree of certainty, will avoid initiation or propagation of fractures in the confining zone or cause otherwise non-transmissive faults or fractures transecting the confining zone to become transmissive. In no case may injection pressure cause movement of injection fluids or formation fluids in a manner that endangers underground sources of drinking water. The director may approve a plan for controlled artificial fracturing of the injection zone.

(D) The operator must fill the annulus between the tubing and the long string casing with a corrosion inhibiting fluid approved by the director.

(E) The operator must install and use continuous recording devices to monitor the injection pressure, and the rate, volume, and temperature of the CO_2 stream. The operator must monitor the pressure on the annulus between the tubing and the long string casing. The operator must continuously record, continuously monitor, or control by a preset high-low pressure sensor switch the wellhead pressure of each injection well.

(F) The operator must comply with the following requirements for alarms and automatic shut-off systems.

(i) The operator must install and use alarms and automatic shut-off systems designed to alert the operator and shut-in the well when operating parameters such as annulus pressure, injection rate or other parameters diverge from permitted ranges and/or gradients. On offshore wells, the automatic shut-off systems must be installed down-hole.

(ii) If an automatic shutdown is triggered or a loss of mechanical integrity is discovered, the operator must immediately investigate and identify as expeditiously as possible the cause. If, upon investigation, the well appears to be lacking mechanical integrity, or if monitoring otherwise indicates that the well may be lacking mechanical integrity, the operator must:

(I) immediately cease injection;

(II) take all steps reasonably necessary to determine whether there may have been a release of the injected CO_2 stream into any unauthorized zone;

(III) notify the director as soon as practicable, but within 24 hours;

(IV) restore and demonstrate mechanical integrity to the satisfaction of the director prior to resuming injection; and

(V) notify the director when injection can be expected to resume.

(d) Monitoring, sampling, and testing requirements. The operator of an anthropogenic CO_2 injection well must maintain and comply with the approved monitoring, sampling, and testing plan to verify that the geologic storage facility is operating as permitted and that the injected fluids are confined to the injection zone. The director may require additional monitoring as necessary to support, upgrade, and improve computational modeling of the area of review evaluation and to determine compliance with the requirement that the injection activity not allow movement of fluid that would endanger underground sources of drinking water.

(e) Mechanical integrity.

(1) The operator must maintain and comply with the approved mechanical integrity testing plan submitted in accordance with §5.203(j) of this title.

(2) Other than during periods of well workover in which the sealed tubing-casing annulus is of necessity disassembled for maintenance or corrective procedures, the operator must maintain mechanical integrity of the injection well at all times.

(3) The operator must either repair and successfully retest or plug a well that fails a mechanical integrity test.

(4) The director may require additional or alternative tests if the results presented by the operator do not demonstrate to the director that there is no leak in the casing, tubing, or packer or movement of fluid into or between formations containing underground sources of drinking water resulting from the injection activity.

(f) Area of review and corrective action. Notwithstanding the requirement in §5.203(d)(2)(B)(i) of this title to perform a re-evaluation of the area of review, at the frequency specified in the area of review and corrective action plan or permit, the operator of a geologic storage facility also must conduct the following whenever warranted by a material change in the monitoring and/or operational data or in the evaluation of the monitoring and operational data by the operator:

(1) a re-evaluation of the area of review by performing all of the actions specified in §5.203(d)(1)(A) - (C) of this title to delineate the area of review and identify all wells that require corrective action;

(2) identify all wells in the re-evaluated area of review that require corrective action;

(3) perform corrective action on wells requiring corrective action in the re-evaluated area of review in the same manner specified in §5.203(d)(1)(C) of this title; and

(4) submit an amended area of review and corrective action plan or demonstrate to the director through monitoring data and modeling results that no change to the area of review and corrective action plan is needed.

(g) Emergency, mitigation, and remedial response.

(1) Plan. The operator must maintain and comply with the approved emergency and remedial response plan required by §5.203(l) of this title. The operator must update the plan in accordance with §5.207(a)(2)(D)(vi) of this title (relating to Reporting and Record-Keeping). The operator must make copies of the plan available at the storage facility and at the company headquarters.

(2) Training.

(A) The operator must prepare and implement a plan to train and test each employee at the storage facility on occupational safety and emergency response procedures to the extent applicable to the employee's duties and responsibilities. The operator must make copies of the plan available at the geological storage facility. The operator must train all employees before commencing injection and storage operations at the facility. The operator must train each subsequently hired employee before that employee commences work at the storage facility.

(B) The operator must hold a safety meeting with each contractor prior to the commencement of any new contract work at a storage facility. The operator must explain emergency measures specific to the contractor's work in the contractor safety meeting.

(C) The operator must provide training schedules, training dates, and course outlines to Commission personnel upon request for the purpose of Commission review to determine compliance with this paragraph.

(3) Action. If an operator obtains evidence that the injected CO_2 stream and associated pressure front may cause an endangerment to underground sources of drinking water, the operator must:

(A) immediately cease injection;

(B) take all steps reasonably necessary to identify and characterize any release;

(C) notify the director as soon as practicable but within at least 24 hours; and

(D) implement the approved emergency and remedial response plan.

(4) Resumption of injection. The director may allow the operator to resume injection prior to remediation if the operator demonstrates that the injection operation will not endanger underground sources of drinking water.

(h) Commission witnessing of testing and logging. The operator must provide the division with the opportunity to witness all testing and logging. The operator must submit a proposed schedule of such activities to the Commission at least 30 days prior to conducting the first test and submit notice at least 48 hours in advance of any actual testing or logging. Testing and logging may not commence before the end of the 48-hour period unless authorized by the director.

(i) Well plugging. The operator of a geologic storage facility must maintain and comply with the approved well plugging plan required by §5.203(k) of this title.

(j) Post-injection storage facility care and closure.

(1) Post-injection storage facility care and closure plan.

(A) The operator of an injection well must maintain and comply with the approved post-injection storage facility care and closure plan.

(B) The operator must update the plan in accordance with §5.207(a)(2)(D)(vi) of this title.

(C) Upon cessation of injection, the operator of a geologic storage facility must either submit an amended plan or demonstrate to the director through monitoring data and modeling results that no amendment to the plan is needed.

(2) Post-injection storage facility monitoring. Following cessation of injection, the operator must continue to conduct monitoring as specified in the approved plan until the director determines that the position of the CO_2 plume and pressure front are such that the geologic storage facility will not endanger underground sources of drinking water.

(3) Prior to closure. Prior to authorization for storage facility closure, the operator must demonstrate to the director, based on monitoring, other site-specific data, and modeling that is reasonably consistent with site performance that no additional monitoring is needed to assure that the geologic storage facility will not endanger underground sources of drinking water. The operator must demonstrate, based on the current understanding of the site, including monitoring data and/or modeling, all of the following:

(A) the estimated magnitude and extent of the facility footprint (the CO_2 plume and the area of elevated pressure);

(B) that there is no leakage of either CO_2 or displaced formation fluids that will endanger underground sources of drinking water;

(C) that the injected or displaced fluids are not expected to migrate in the future in a manner that encounters a potential leakage pathway into underground sources of drinking water;

(D) that the injection wells at the site completed into or through the injection zone or confining zone will be plugged and abandoned in accordance with these requirements; and

(E) any remaining facility monitoring wells will be properly plugged or are being managed by a person and in a manner approved by the director.

(4) Notice of intent for storage facility closure. The operator must notify the director at least 120 days before storage facility closure. At the time of such notice, if the operator has made any changes to the original plan, the operator also must provide the revised plan. The director may approve a shorter notice period.

(5) Authorization for storage facility closure. No operator may initiate storage facility closure until the director has approved closure of the storage facility in writing. After the director has authorized storage facility closure, the operator must plug all wells in accordance with the approved plan required by §5.203(k) of this title.

(6) Storage facility closure report. Once the director has authorized storage facility closure, the operator must submit a storage facility closure report within 90 days that must thereafter be retained by the Commission in Austin. The report must include the following information:

(A) documentation of appropriate injection and monitoring well plugging. The operator must provide a copy of a survey plat that has been submitted to the Regional Administrator of Region 6 of the United States Environmental Protection Agency. The plat must indicate the location of the injection well relative to permanently surveyed benchmarks;

(B) documentation of appropriate notification and information to such state and local authorities as have authority over drilling activities to enable such state and local authorities to impose appropriate conditions on subsequent drilling activities that may penetrate the injection and confining zones; and

(C) records reflecting the nature, composition and volume of the CO_2 stream.

(7) Certificate of closure. Upon completion of the requirements in paragraphs (3) - (6) of this subsection, the director will issue a certificate of closure. At that time, the operator is released from the requirement in §5.205(c) of this title to maintain financial assurance.

(k) Deed notation. The operator of a geologic storage facility must record a notation on the deed to the facility property; on any other document that is normally examined during title search; or on any other document that is acceptable to the county clerk for filing in the official public records of the county that will in perpetuity provide any potential purchaser of the property the following information:

(1) a complete legal description of the affected property;

(2) that land has been used to geologically store CO_2;

(3) that the survey plat has been filed with the Commission;

(4) the address of the office of the United States Environmental Protection Agency, Region 6, to which the operator sent a copy of the survey plat; and

(5) the volume of fluid injected, the injection zone or zones into which it was injected, and the period over which injection occurred.

(l) Retention of records. The operator must retain for five years following storage facility closure records collected during the post-injection storage facility care period. The operator must deliver the records to the director at the conclusion of the retention period, and the records must thereafter be retained at the Austin headquarters of the Commission.

(m) Signs. The operator must identify each location at which geologic storage activities take place, including each injection well, by a sign that meets the requirements specified in §3.3(1), (2), and (5) of this title (relating to Identification of Properties, Wells, and Tanks). In addition, each sign must include a telephone number where the operator or a representative of the operator can be reached 24 hours a day, seven days a week in the event of an emergency.

(n) Other permit terms and conditions. In any permit for a geologic storage facility, the director must impose terms and conditions reasonably necessary to protect underground sources of drinking water. Permits issued under this subchapter continue in effect until revoked, modified, or suspended by the Commission. The operator must comply with each requirement set forth in this subchapter as a condition of the permit unless modified by the terms of the permit.

§5.207. Reporting and Record-Keeping.

(a) The operator of a geologic storage facility must provide, at a minimum, the following reports to the director and retain the following information.

(1) Test records. The operator must file a complete record of all tests in duplicate with the district office within 30 days after the testing. In conducting and evaluating the tests enumerated in this subchapter or others to be allowed by the director, the operator and the director must apply methods and standards generally accepted in the industry. When the operator reports the results of mechanical integrity tests to the director, the operator must include a description of the test(s) and the method(s) used. In making this evaluation, the director must review monitoring and other test data submitted since the previous evaluation.

(2) Operating reports. The operator also must include summary cumulative tables of the information required by the reports listed in this paragraph.

(A) Report within 24 hours. The operator must report to the appropriate district office the discovery of any significant pressure changes or other monitoring data that indicate the presence of leaks in the well or the lack of confinement of the injected gases to the geologic storage reservoir. Such report must be made orally as soon as practicable, but within 24 hours, following the discovery of the leak, and must be confirmed in writing within five working days.

(B) Report within 30 days. The operator must report:

(i) the results of periodic tests for mechanical integrity;

(ii) the results of any other test of the injection well conducted by the operator if required by the director; and

(iii) a description of any well workover.

(C) Semi-annual report. The operator must report:

(i) a summary of well head pressure monitoring;

(ii) changes to the physical, chemical, and other relevant characteristics of the CO_2 stream from the proposed operating data;

(iii) monthly average, maximum and minimum values for injection pressure, flow rate and volume, and annular pressure;

(iv) a description of any event that significantly exceeds operating parameters for annulus pressure or injection pressure as specified in the permit;

(v) a description of any event that triggers a shutdown device and the response taken; and

(vi) the results of monitoring prescribed under §5.206(d) of this title (relating to Permit Standards).

(D) Annual reports. The operator must submit an annual report detailing:

(i) corrective action performed;

(ii) new wells installed and the type, location, number, and information required in §5.203(e) of this title (relating to Application Requirements);

(iii) re-calculated area of review unless the operator submits a statement signed by an appropriate company official confirming that monitoring and operational data supports the current delineation of the area of review on file with the Commission;

(iv) the updated area for which the operator has a good faith claim to the necessary and sufficient property rights to operate the geologic storage facility;

(v) tons of CO_2 injected; and

(vi) The operator must maintain and update required plans in accordance with the provisions of this subchapter.

(I) Operators must submit an annual statement, signed by an appropriate company official, confirming that the operator has:

(-a-) reviewed the monitoring and operational data that are relevant to a decision on whether to reevaluate the area of review and the monitoring and operational data that are relevant to a decision on whether to update an approved plan required by §5.203 or §5.206 of this title; and

(-b-) determined whether any updates were warranted by material change in the monitoring and operational data or in the evaluation of the monitoring and operational data by the operator.

(II) Operators must submit either the updated plan or a summary of the modifications for each plan for which an update the operator determined to be warranted pursuant to subclause (I) of this clause. The director may require submission of copies of

any updated plans and/or additional information regarding whether or not updates of any particular plans are warranted.

(III) The director may require the revision of any required plan whenever the director determines that such a revision is necessary to comply with the requirements of this title.

(vii) other information as required by the permit.

(b) Report format. The operator must report the results of injection pressure and injection rate monitoring of each injection well on Form H-10, Annual Disposal/Injection Well Monitoring Report, and the results of mechanical integrity testing on Form H-5, Disposal/Injection Well Pressure Test Report. Operators must submit other reports in a format acceptable to the Commission. At the discretion of the director, other formats may be accepted.

(c) Record retention. The operator must retain all wellhead pressure records, metering records, and integrity test results for at least five years. The operator must retain all documentation of good faith claim to necessary and sufficient property rights to operate the geologic storage facility until the director issues the final certificate of closure in accordance with §5.206(j)(7) 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 November 30, 2010.

TRD-201006799
Mary Ross McDonald
Managing Director
Railroad Commission of Texas
Effective date: December 20, 2010
Proposal publication date: October 15, 2010
For further information, please call: (512) 475-1295

♦ ♦ ♦

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 61. SCHOOL DISTRICTS
SUBCHAPTER A. BOARD OF TRUSTEES RELATIONSHIP

19 TAC §61.1, §61.2

The State Board of Education (SBOE) adopts amendments to §61.1 and §61.2, concerning school district boards of trustees. The amendments are adopted without changes to the proposed text as published in the October 15, 2010, issue of the *Texas Register* (35 TexReg 9202) and will not be republished. Section 61.1 specifies requirements for continuing education for school board trustees. Section 61.2 addresses requirements for nominating trustees for military reservation school districts. As a result of the statutorily required four-year review of rules, the adopted amendments revise the rules to better align with statute and current practice.

The Texas Education Code (TEC), §11.159, Member Training and Orientation, requires the SBOE to provide a training course for school board trustees. Section 61.1 addresses this statutory requirement. School board trustee training under current SBOE rule includes a local school district orientation session, a basic orientation to the TEC, an annual team-building session with the local school board and the superintendent, and specified hours of continuing education based on identified needs.

The TEC, §11.352, Governance of Special-Purpose District, authorizes the SBOE to appoint a board of three, five, or seven trustees, as determined by the SBOE, for each district established under the TEC, §11.351. Additionally, it authorizes the SBOE to appoint a board of three or five trustees for each military reservation school district. Section 61.2 addresses this statutory requirement. Trustees of the boards of the Fort Sam Houston Independent School District (ISD), Lackland ISD, Randolph Field ISD, and Boys Ranch ISD are appointed by the SBOE in accordance with this rule and statute.

As a result of the statutorily required four-year review of the SBOE rules in 19 TAC Chapter 61, Subchapter A, the adopted amendments revise the rules to better align with statute and current practice regarding the dissemination of information to boards of trustees and the public and the appointment of trustees to the Boys Ranch ISD. Specifically, the following changes were made.

The adopted amendment to §61.1 revises subsection (a) to reflect that the framework for governance leadership used in structuring continuing education for board members will be posted to the Texas Education Agency (TEA) website rather than mailed to board presidents annually. The requirement of the board president to share the information with other board members and the superintendent would not change. Subsection (j) was revised to align with statute regarding the board meeting at which board training updates must be disseminated and noted in the minutes. In accordance with the TEC, §11.159(b), the amendment specifies that the announcement must be made at the last regular meeting of the board of trustees held during the calendar year. Additionally, technical edits were made to update a cross reference to statute and correct word usage.

The adopted amendment to §61.2 adds a new subsection (b) to reflect the process used to nominate for SBOE approval members of the board of trustees for Boys Ranch ISD, a special-purpose district. Existing subsection (b) was relettered as subsection (c). The section title was also amended to reflect the addition of information relating to Boys Ranch ISD. In addition, technical edits were made to correct word usage.

The SBOE approved the proposed amendments to 19 TAC Chapter 61, Subchapter A, for second reading and final adoption at the November 2010 meeting.

The adopted amendment to 19 TAC §61.1 revises the procedures for dissemination of the framework to be used in structuring continuing education for school board members and the annual public reporting of continuing education completion information for all board members. The adopted amendment to 19 TAC §61.2 establishes the process for nominating trustee candidates for Boys Ranch ISD, including information that must be provided to the TEA for each nominee.

Verification of completion of board member continuing education must continue to be maintained by the participant and participant's school district. Minutes of the board meeting in which continuing education hours obtained by each board member for the past calendar year are announced must also continue to be maintained locally and made available to local media.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

In accordance with the TEC, §7.102(f), the SBOE approved the amendments for adoption by a vote of two-thirds of its members to specify an effective date earlier than the beginning of the 2011-2012 school year in order to implement the latest policy in a timely manner. The effective date for the amendment is 20 days after filing as adopted.

No public comments were received on the proposal.

The amendments are adopted under the Texas Education Code (TEC), §11.159, which authorizes the SBOE to provide a training course for school board trustees; and TEC, §11.352(c), which authorizes the SBOE to adopt rules for the governance of a special-purpose district.

The amendments implement the Texas Education Code, §11.159 and §11.352.

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 November 30, 2010.

TRD-201006779
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 20, 2010
Proposal publication date: October 15, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 74. CURRICULUM REQUIREMENTS

SUBCHAPTER C. OTHER PROVISIONS

19 TAC §74.36

The State Board of Education (SBOE) adopts amendment to §74.36, concerning curriculum requirements. The amendment is adopted with technical changes to the proposed text as published in the June 18, 2010, issue of the *Texas Register* (35 TexReg 5139). The section establishes requirements for elective courses on the Bible's Hebrew Scriptures (Old Testament) and New Testament and their impact on the history and literature of western civilization. As a result of the statutorily required four-year review of rules, the adopted amendment updates the section to align with revised student expectations in the Texas Essential Knowledge and Skills (TEKS) for Special Topics in Social Studies and Independent Study in English.

House Bill (HB) 1287, 80th Texas Legislature, 2007, added Texas Education Code (TEC), §28.011, allowing school districts to teach an elective course on the Hebrew Scriptures (Old Testament) and the New Testament and their impact on the history and literature of Western civilization. In July 2008, the SBOE approved new 19 TAC §74.36, which allowed the elective course on the Hebrew Scriptures (Old Testament) and the New Testament to be taught using the TEKS for Special Topics in Social Studies or Independent Study in English, to be effective September 1, 2008.

The SBOE approved new TEKS for Special Topics in Social Studies in May 2010 and approved an amendment to the TEKS for Independent Study in English in March 2010. Both sets of TEKS will be implemented in the 2011-2012 school year. The adopted amendment to 19 TAC §74.36 ensures that the student expectations for the elective course on the Hebrew Scriptures (Old Testament) and the New Testament reflect approved revisions to the student expectations for Independent Study in English and Special Topics in Social Studies. The adopted amendment to 19 TAC §74.36 also includes language to begin implementation in the 2011-2012 school year.

Following SBOE approval of proposed amendment to 19 TAC §74.36 for first reading and filing authorization at the May 2010 meeting, the proposal, which includes the proposed essential knowledge and skills of a course offered under the TEC, §28.011, was submitted to the Attorney General for review. In accordance with TEC, §28.011(e), the proposal must be submitted to the Attorney General for review to ensure that the course complies with the First Amendment to the United States Constitution before the SBOE adopts the proposal.

On November 2, 2010, the Attorney General's Office responded that the proposal had been reviewed and concluded that courses taught in accordance with applicable Texas law and the proposed TEKS for the religious literature curriculum appear to be facially valid under the First Amendment.

The SBOE approved the proposed amendment to 19 TAC Chapter §74.36 for second reading and final adoption at the November 2010 meeting subsequent to receiving the November 2, 2010, response from the Attorney General's Office. The adoption includes technical edits to correct a formatting error in the introduction and to correctly cite the *Modern Language Association Style Manual (MLA).* No changes were made to the content of the course.

The adopted amendment has no new procedural and reporting implications. The adopted amendment has no new locally maintained paperwork requirements.

The Texas Education Agency determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

In accordance with the TEC, §7.102(f), the SBOE approved the amendment to §74.36 for adoption by a vote of two-thirds of its members to specify an effective date earlier than the beginning of the 2011-2012 school year. The earlier effective date will allow districts to begin preparing for implementation of revised curriculum standards. The effective date for the amendment is 20 days after filing as adopted.

No public comments were received on the proposal.

The amendment is adopted under the Texas Education Code (TEC), §7.102(c)(4), which authorizes the SBOE to establish curriculum and graduation requirements; the TEC, §28.002, which authorizes the SBOE to by rule designate subjects constituting a well-balanced curriculum to be offered by a school district; and the TEC, §28.011, which authorizes the SBOE to adopt rules, subsequent to review of the proposal by the Attorney General, identifying the essential knowledge and skills of a course on the Bible's Hebrew Scriptures (Old Testament) and New Testament

and their impact on the history and literature of Western Civilization.

The amendments implement the Texas Education Code, §§7.102(c)(4), 28.002, and 28.011.

§74.36. Requirements for Elective Courses on the Bible's Hebrew Scriptures (Old Testament) and New Testament and Their Impact on the History and Literature of Western Civilization.

(a) Pursuant to this rule, a school district may offer to students in Grade 9 or above:

(1) an elective course on the Hebrew Scriptures (Old Testament) and its impact and an elective course on the New Testament and its impact; or

(2) an elective course that combines the courses on the Hebrew Scriptures (Old Testament) and its impact and on the New Testament and its impact.

(b) The purpose of a course under this section is to:

(1) teach students knowledge of biblical content, characters, poetry, and narratives that are prerequisites to understanding contemporary society and culture, including literature, art, music, mores, oratory, and public policy; and

(2) familiarize students with, as applicable:

(A) the contents of the Hebrew Scriptures or New Testament;

(B) the history of the Hebrew Scriptures or New Testament;

(C) the literary style and structure of the Hebrew Scriptures or New Testament; and

(D) the influence of the Hebrew Scriptures or New Testament on law, history, government, literature, art, music, customs, morals, values, and culture.

(c) A course offered under this section shall follow applicable law and all federal and state guidelines in maintaining religious neutrality and accommodating the diverse religious views, traditions, and perspectives of students in their school district. A course under this section shall not endorse, favor, or promote, or disfavor or show hostility toward, any particular religion or nonreligious faith or religious perspective.

(d) A course offered under this section shall follow the Texas Essential Knowledge and Skills for Special Topics in Social Studies or the Texas Essential Knowledge and Skills for Independent Study in English as set out in this subsection until the 2011-2012 school year.

(1) Texas Essential Knowledge and Skills for Special Topics in Social Studies (One-Half Credit). The provisions of this paragraph shall be superseded by subsection (e)(1) of this section beginning with the 2011-2012 school year.

(A) General requirements. Students shall be awarded one-half unit of credit for successful completion of this course. Students may take this course with different course content for a maximum of two credits.

(B) Introduction. In Special Topics in Social Studies, an elective course comparable to the former Advanced Social Science Problems, students are provided the opportunity to apply the knowledge and skills of the social sciences to a variety of topics and issues. Students use critical-thinking skills to locate, organize, analyze, and use data collected from a variety of sources. Problem solving and decision making are important elements of the course as is the communication of information in written, oral, and visual forms.

(C) Knowledge and skills.

(i) Social studies skills. The student applies critical-thinking skills to organize and use information acquired from a variety of sources including electronic technology. The student is expected to:

(I) differentiate between, locate, and use primary and secondary sources such as computer software, databases, media and news services, biographies, interviews, and artifacts to acquire information about a selected topic in social studies;

(II) analyze information by sequencing, categorizing, identifying cause-and-effect relationships, comparing, contrasting, finding the main idea, summarizing, making generalizations and predictions, and drawing inferences and conclusions;

(III) identify points of view from the historic context surrounding an event and the frame of reference that influenced the participants;

(IV) support a point of view on a social studies issue or event;

(V) identify bias in written, oral, and visual material;

(VI) evaluate the validity of a source based on language, corroboration with other sources, and information about the author; and

(VII) use appropriate mathematical skills to interpret social studies information such as maps and graphs.

(ii) Social studies skills. The student communicates in written, oral, and visual forms. The student is expected to:

(I) use social studies terminology correctly;

(II) use standard grammar, spelling, sentence structure, and punctuation;

(III) transfer information from one medium to another, including written to visual and statistical to written or visual, using computer software as appropriate; and

(IV) create written, oral, and visual presentations of social studies information.

(iii) Social studies skills. The student uses problem-solving and decision-making skills, working independently and with others, in a variety of settings. The student is expected to:

(I) use a problem-solving process to identify a problem, gather information, list and consider options, consider advantages and disadvantages, choose and implement a solution, and evaluate the effectiveness of the solution; and

(II) use a decision-making process to identify a situation that requires a decision, gather information, identify options, predict consequences, and take action to implement a decision.

(2) Texas Essential Knowledge and Skills for Independent Study in English (One-Half to One Credit). The provisions of this paragraph shall be superseded by subsection (e)(2) of this section beginning with the 2011-2012 school year.

(A) Introduction. Students enrolled in Independent Study in English write in a variety of forms for a variety of audiences and purposes. High school students are expected to plan, draft, and complete written compositions on a regular basis, and carefully examine their papers for clarity, engaging language, and the correct

use of the conventions and mechanics of written English. Independent Study in English students are expected to write in a variety of forms including business, personal, literary, and persuasive texts for a variety of audiences and purposes. Writing is used as a tool for learning as students create, clarify, critique, and express appreciation for others' ideas and responses. Independent Study in English students evaluate their own written work as well as the work of others. Students continue to read extensively in increasingly difficult texts selected in multiple genres for a variety of purposes. When comprehension breaks down, students effectively and efficiently monitor and adjust their use of a variety of comprehension strategies. Students respond to texts through talking and writing in both traditional print and electronic formats. Students connect their knowledge of the world and the knowledge they gather from other texts with the text being read. For high school students whose first language is not English, the students' native language serves as a foundation for English language acquisition and language learning.

(B) Knowledge and skills.

(i) Writing. The student uses writing as a tool for learning and research. The student is expected to:

(I) use writing to formulate questions, refine topics, and clarify ideas;

(II) use writing to organize and support what is known and what needs to be learned about a topic;

(III) compile information from primary and secondary sources using available technology;

(IV) use writing to discover, record, review, and learn;

(V) organize notes from multiple sources, including primary and secondary sources, in useful and informing ways;

(VI) link related information and ideas from a variety of sources;

(VII) represent information in a variety of ways such as graphics, conceptual maps, and learning logs;

(VIII) compile written ideas and representations, interpret empirical data into reports, summaries, or other formats, and draw conclusions; and

(IX) use writing as a tool such as to reflect, explore, or problem solve.

(ii) Reading. The student inquires through reading and researching self-selected and assigned topics. The student is expected to:

(I) read widely to establish a specific area of interest for further study;

(II) generate relevant, interesting, and researchable questions with instructor guidance and approval;

(III) locate appropriate print and non-print information using text and technical resources, including databases;

(IV) use text organizers such as overviews, headings, and graphic features to locate and categorize information;

(V) organize and record new information in systematic ways such as notes, charts, and graphic organizers;

(VI) produce research projects and reports in various forms for audiences;

(VII) draw relevant questions for further study from the research findings or conclusions; and

(VIII) conduct a research project(s), producing an original work in print or another medium with a demonstration of advanced skill.

(iii) Viewing/representing. The student produces visual representations that communicate with others. The student is expected to:

(I) use a range of techniques in planning and creating media text; and

(II) prepare and present a research project.

(e) Beginning with school year 2011-2012, a course offered under this section shall follow the Texas Essential Knowledge and Skills for Special Topics in Social Studies, Beginning with School Year 2011-2012, or the Texas Essential Knowledge and Skills for Independent Study in English as set out in this subsection.

(1) Texas Essential Knowledge and Skills for Special Topics in Social Studies (One-Half Credit), Beginning with School Year 2011-2012. The provisions of this paragraph shall be implemented by school districts beginning with the 2011-2012 school year and at that time shall supersede subsection (d)(1) of this section.

(A) General requirements. Students shall be awarded one-half unit of credit for successful completion of this course. Students may take this course with different course content for a maximum of two credits.

(B) Introduction.

(i) In Special Topics in Social Studies, an elective course, students are provided the opportunity to develop a greater understanding of the historic, political, economic, geographic, multicultural, and social forces that have shaped their lives and the world in which they live. Students will use social science knowledge and skills to engage in rational and logical analysis of complex problems using a variety of approaches, while recognizing and appreciating diverse human perspectives.

(ii) Statements that contain the word "including" reference content that must be mastered, while those containing the phrase "such as" are intended as possible illustrative examples.

(iii) State and federal laws mandate a variety of celebrations and observances, including Celebrate Freedom Week.

(I) Each social studies class shall include, during Celebrate Freedom Week as provided under Texas Education Code, §29.907, or during another full school week as determined by the board of trustees of a school district, appropriate instruction concerning the intent, meaning, and importance of the Declaration of Independence and the U.S. Constitution, including the Bill of Rights, in their historical contexts. The study of the Declaration of Independence must include the study of the relationship of the ideas expressed in that document to subsequent American history, including the relationship of its ideas to the rich diversity of our people as a nation of immigrants, the American Revolution, the formulation of the U.S. Constitution, and the abolitionist movement, which led to the Emancipation Proclamation and the women's suffrage movement.

(II) Each school district shall require that, during Celebrate Freedom Week or other week of instruction prescribed under subclause (I) of this clause, students in Grades 3-12 study and recite the following text: "We hold these Truths to be self-evident, that all Men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the

Pursuit of Happiness--That to secure these Rights, Governments are instituted among Men, deriving their just Powers from the Consent of the Governed."

(C) Knowledge and skills.

(i) Social studies skills. The student uses problem-solving and decision-making skills, working independently and with others, in a variety of settings. The student is expected to:

(I) apply social studies methodologies encompassing a variety of research and analytical tools to explore questions or issues thoroughly and fairly to include multiple perspectives;

(II) evaluate effects of major political, economic, and social conditions on selected social studies topic;

(III) appraise a geographic perspective that considers physical and cultural processes as they affect the selected topic;

(IV) examine the role of diverse communities in the context of the selected topic;

(V) analyze ethical issues raised by the selected topic in historic, cultural, and social contexts;

(VI) depending on the topic, use a problem-solving process to identify a problem, gather information, list and consider options, consider advantages and disadvantages, choose and implement a solution, and evaluate the effectiveness of the solution; and

(VII) depending on the topic, use a decision-making process to identify a situation that requires a decision, gather information, identify options, predict consequences, and take action to implement a decision.

(ii) Social studies skills. The student applies critical-thinking skills to organize and use information acquired from a variety of sources, including electronic technology. The student is expected to:

(I) locate, analyze, organize, synthesize, evaluate, and apply information about selected topic, identifying, describing, and evaluating multiple points of view;

(II) differentiate between valid primary and secondary sources and use them appropriately to conduct research and construct arguments;

(III) read narrative texts critically and identify points of view from the historical context surrounding an event and the frame of reference that influenced the participants;

(IV) analyze information by sequencing, categorizing, identifying cause-and-effect relationships, comparing, contrasting, finding the main idea, summarizing, making generalizations and predictions, and drawing inferences and conclusions;

(V) collect visual images (photographs, paintings, political cartoons, and other media) to enhance understanding and appreciation of multiple perspectives in a social studies topic;

(VI) identify bias in written, oral, and visual material;

(VII) evaluate the validity of a source based on language, corroboration with other sources, and information about the author; and

(VIII) use appropriate mathematical skills to interpret social studies information such as maps and graphs.

(iii) Social studies skills. The student creates written, oral, and visual presentations of social studies information. The student is expected to:

(I) apply the conventions of usage and mechanics of written English;

(II) use social studies terminology correctly;

(III) use appropriate oral communication techniques;

(IV) construct a thesis that is supported by evidence;

(V) recognize and evaluate counter arguments;

(VI) use visual images (photographs, paintings, and other media) to facilitate understanding and appreciation of multiple perspectives in a social studies topic;

(VII) develop a bibliography with ideas and information attributed to source materials and authors using accepted social science formats such as *Modern Language Association Style Manual* (MLA) and *Chicago Manual of Style* (CMS) to document sources and format written materials; and

(VIII) use computer software to create written, graphic, or visual products from collected data.

(2) Texas Essential Knowledge and Skills for Independent Study in English (One-Half to One Credit). The provisions of this paragraph shall be implemented by school districts beginning with the 2011-2012 school year and at that time shall supersede subsection (d)(2) of this section.

(A) Introduction.

(i) Students enrolled in Independent Study in English will focus on a specialized area of study such as the work of a particular author or genre. Students will read and write in multiple forms for a variety of audiences and purposes. High school students are expected to plan, draft, and complete written compositions on a regular basis and carefully examine their papers for clarity, engaging language, and the correct use of the conventions and mechanics of written English.

(ii) If this course is being used to satisfy requirements for the Distinguished Achievement Program, a student research/product must be presented before a panel of professionals or approved by the student's mentor.

(iii) For high school students whose first language is not English, the students' native language serves as a foundation for English language acquisition and language learning.

(iv) Statements that contain the word "including" reference content that must be mastered, while those containing the phrase "such as" are intended as possible illustrative examples.

(v) The essential knowledge and skills as well as the student expectations for Independent Study in English are described in subparagraph (B) of this paragraph.

(B) Knowledge and skills.

(i) The student inquires through reading literature and researching self-selected and assigned topics. The student is expected to:

(I) read widely for further study;

(II) generate relevant, interesting, and researchable questions with instructor guidance and approval; and

(III) draw relevant questions for further study from the research findings or conclusions.

(ii) The student uses writing as a tool for learning and research. The student produces visual representations that communicate with others. The student is expected to:

(I) produce research projects and reports in multiple forms for a variety of audiences from primary and secondary sources using available technology;

(II) conduct a research project(s), producing an original work in print or another medium with a demonstration of advanced skill;

(III) use writing to organize and support what is known and needs to be learned about a topic, including discovering, recording, reviewing, and learning;

(IV) compile written ideas and representations; interpret information into reports, summaries, or other formats; and draw conclusions; and

(V) use writing as a tool such as to reflect, explore, or problem solve.

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 November 30, 2010.

TRD-201006780
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 20, 2010
Proposal publication date: June 18, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 97. PLANNING AND ACCOUNTABILITY
SUBCHAPTER DD. INVESTIGATIVE REPORTS, SANCTIONS, AND RECORD REVIEWS

19 TAC §§97.1031, 97.1033, 97.1035, 97.1037

The Texas Education Agency (TEA) adopts amendments to §§97.1031, 97.1033, 97.1035, and 97.1037, concerning investigative reports, sanctions, and record reviews. The amendments to §§97.1031, 97.1033, and 97.1035 are adopted without changes to the proposed text as published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9020) and will not be republished. The amendment to §97.1037 is adopted with technical changes to the proposed text as published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9020). The sections define the procedures for required on-site investigations and reports and procedures for accreditation sanctions. The adopted amendments update and clarify these procedures. The adopted amendments reflect changes in the Texas Education Code (TEC), Chapter 39, as reflected in House Bill (HB) 3, 81st Texas Legislature, Regular Session, 2009. HB 3, 81st Texas Legislature, Regular Session, 2009, enacted numerous changes to the TEC, Chapter 39, and renumbered the chapter, requiring that existing rules be revised and updated.

The rules in 19 TAC Chapter 97, Planning and Accountability, Subchapter DD, Investigative Reports, Sanctions, and Record Reviews, define the procedures for on-site investigations and reports as required by TEC, §39.058, and procedures for accreditation sanctions under TEC, Chapter 39, Subchapter E, resulting from such reports. The rules provide for notice to any person whom the report finds to have committed a violation of law, rule, or policy and provide for an informal review of such findings before they may become final.

The adopted amendments to 19 TAC Chapter 97, Subchapter DD, update and clarify existing rules in light of HB 3. Specifically, the adopted amendments establish the following.

The adopted amendment to 19 TAC §97.1031, Preliminary Investigative Report, updates statutory references in alignment with HB 3. Additionally, language in subsection (b)(3), establishing a specific deadline for requesting an informal review of preliminary investigative findings, was deleted to provide for individual consideration of an appropriate timeline in alignment with the nature of the findings.

The adopted amendment to 19 TAC §97.1033, Informal Review of Preliminary Investigative Report; Final Investigative Report, provides a minor technical update in subsection (b) in alignment with the change made to §97.1031(b)(3).

The adopted amendment to 19 TAC §97.1035, Procedures for Accreditation Sanctions, adds a reference in subsection (a) to interventions for charter violations under §100.1023. In addition, subsection (d) updates statutory references in alignment with HB 3.

The adopted amendment to 19 TAC §97.1037, Record Review of Certain Decisions, updates statutory references in alignment with HB 3. Additionally, subsection (a)(5) was deleted, as HB 3 added open-enrollment charter schools to the state's financial accountability rating system, which has a statutorily required appeals process.

In response to public comment, 19 TAC §97.1037 was modified at adoption to clarify agency intent. Specifically, 19 TAC §97.1037(e)(6) was revised to clarify that district or charter school participants in a record review are allowed to ask questions during a review, and 19 TAC §97.1037(g)(1)(A) was revised to remove an unnecessary reference to a "school district."

The adopted amendments have no new reporting implications. Changes to current procedures include the removal of a specified timeframe in 19 TAC §97.1031(b)(3) for requesting an informal review of findings to provide for individual consideration of an appropriate timeline. In addition, deletion of 19 TAC §97.1037(a)(5) removes applicability of the record review requirement to an open-enrollment charter school financial finding in lieu of a financial accountability rating in accordance with HB 3 changes that made the financial accountability rating system, and its specified appeals process, applicable to open-enrollment charter schools. The adopted amendments have no new locally maintained paperwork requirements.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 8, 2010, and ended November 8, 2010. Following is a summary of public comments received and corresponding agency responses regarding the proposed amendments to 19 TAC Chapter 97, Planning and Accountability, Subchapter DD, Investigative Reports, Sanctions, and Record Reviews.

§97.1031, Preliminary Investigative Report

Comment. Concerning proposed §97.1031(b)(3), the Texas Charter Schools Association (TCSA) commented that the removal of the 10-day deadline reference would make it possible for a charter school to have less than sufficient time to notify the TEA of its request for an informal review and could result in a school returning from a holiday to find that it had missed the window of opportunity for requesting an informal review. The TCSA requested that the 10-day rule remain and that the rule be amended to reference 10 working days instead of 10 calendar days.

Agency Response. The agency agrees in part and disagrees in part. The agency agrees that deadlines should be established taking into consideration issues such as upcoming holiday breaks and other calendar issues. However, the reference to a 10-day timeline was removed to provide flexibility to address varying situations such as critical health and safety issues that require a very short turnaround. Current agency practice is to establish a timeline in individualized district correspondence and to align the timeline to the type of findings or recommendations reflected in the correspondence. Furthermore, the agency considers upcoming holidays and other potential conflicts in establishing individualized timelines. Additionally, the agency consistently considers, and grants, as appropriate, reasonable requests for timeline extensions. Therefore, the agency has determined that removal of the 10-day timeline is necessary and appropriate and has maintained language as published as proposed.

§97.1037, Record Review of Certain Decisions

Comment. Concerning proposed §97.1037(e)(6), Region 1 Education Service Center (ESC) commented that, in the second sentence of the subsection, the word "may" should be replaced with "shall" to read, "The TEA representative shall designate a specific portion of the meeting for this purpose."

Agency Response. The agency agrees that it is appropriate to clarify rule intent as it relates to the ability of district or charter school representatives to ask questions during a record review. However, instead of adopting the specific language suggested, which would require the agency to set aside a specific portion of a record review for questions, the agency has modified §97.1037(e)(6) at adoption to clearly state in the first sentence that district participants are allowed to ask questions during a record review. The agency has maintained the language in the second sentence that allows the person conducting the record review to accept questions throughout the review or at a designated time.

Comment. Concerning proposed §97.1037(g)(1)(A), Region 1 ESC commented that the rule should be revised to clarify consequences and stated that, preferably, when a school district or charter school does not request a record review, a final order should be issued pursuant to subsection (f). Specifically, the ESC suggested that adverse action against a charter should occur only following the issuance of a final order that triggers an adverse action and should not occur solely because of the charter school's failure to request a record review. Furthermore, the ESC suggested that the words "school district" be deleted from §97.1037(g)(1)(A).

Agency Response. The agency agrees that the reference to "school district" should be deleted and has modified §97.1037(g)(1)(A) at adoption to remove the reference. In regard to the comment on adverse action, the agency notes that adverse actions are not taken solely because of the failure of a school to request a record review. The findings and recommendations leading to a proposed adverse action are detailed in preliminary agency reports and correspondence, and a record review is offered to districts and charter schools in accordance with the rule. If a record review is requested, a final order is issued after completion of the review. If a review is not requested, the preliminary findings and/or actions may become final. The agency does not agree that the decision of a district to forego a record review, or the failure of a district to request a review, should preclude the agency from taking action in response to findings and proposals reflected in a preliminary report.

The amendments are adopted under the Texas Education Code (TEC), §39.058, which authorizes the agency to adopt written procedures for conducting on-site investigations under TEC, Chapter 39, Subchapter C, and requires that the agency provide an informal review of preliminary findings after completion of an investigation; and TEC, §39.152, which authorizes the agency to establish procedures for creating an administrative record for review by the State Office of Administrative Hearings for certain decisions.

The amendments implement the Texas Education Code, §39.058 and §39.152.

§97.1037. Record Review of Certain Decisions.

(a) Applicability. This section applies only to:

(1) a notice under §97.1035 of this title (relating to Procedures for Accreditation Sanctions) proposing to order:

(A) alternative management of a school district campus or a charter school campus under Texas Education Code (TEC), §39.107;

(B) closure of a school district or an open-enrollment charter school under TEC, §§39.052, 39.102, or 39.104; or

(C) closure of a school district campus or charter school campus under TEC, §39.107;

(2) assignment under §97.1055 of this title (relating to Accreditation Status) of an accreditation status of Accredited-Warned or Accredited-Probation;

(3) assignment of a board of managers under TEC, §39.112 and §39.102, or TEC, §39.107; or

(4) request for review of an over-allocation from an open-enrollment charter school granted by the commissioner of education under §100.1041(e) of this title (relating to State Funding).

(b) Notice. Notice of a proposed order subject to this section shall be made as provided by §97.1035 of this title and this section.

(1) The notice shall attach or make reference to any Texas Education Agency (TEA) reports, final investigative reports, or other information on which the proposed order is based.

(A) Information maintained on the TEA website may be referenced by providing a general citation to the information.

(B) TEA reports previously sent to the district, charter, or campus may be referenced by providing the title and date of the report.

(C) On request, the TEA shall provide copies of, or reasonable access to, information referenced in the notice.

(2) The notice shall state the procedures for requesting a record review of the proposed order under this section, including the name and department of the TEA representative to whom a request for record review may be addressed.

(3) The notice shall set a deadline for requesting a record review, which shall not be less than ten calendar days from the date of mailing of the notice.

(c) Request. The superintendent of the district or chief operating officer of the open-enrollment charter school may request, in writing, a record review under this section.

(1) The request must be properly addressed to the TEA representative identified in the notice under subsection (b)(2) of this section, and must be received by the TEA representative on or before the deadline specified in subsection (b)(3) of this section.

(2) A timely and sufficient request for record review is a prerequisite for an appeal of the proposed order under Chapter 157, Subchapter EE, of this title (relating to Review by State Office of Administrative Hearings: Certain Accreditation Sanctions).

(d) Preliminary matters.

(1) In response to a request under subsection (c) of this section, the TEA representative shall provide written notice to the district or charter of the date, time, and place for the record review.

(A) In this written notice, the TEA representative may:

(i) set time limits for presentations on the record;

(ii) set deadlines for exchanging documents prior to the record review;

(iii) set deadlines for identifying participants who may present information or ask questions during the review; and

(iv) provide any other instructions on the conduct of the record review.

(B) The TEA representative may consider reasonable requests to reschedule the record review and associated deadlines, but shall give primary importance to the need for a speedy resolution of the matter under review.

(C) The record review should in all instances be completed on or before the expiration of 30 calendar days following receipt of the request under subsection (c) of this section.

(D) Timely completion of the record review under subsection (c) of this section is a prerequisite for an appeal of the proposed order under Chapter 157, Subchapter EE, of this title.

(2) The district or charter shall submit any written information to the TEA representative in advance of the record review. To be considered part of the record, such information must also be presented during the review.

(3) In its request for record review, or within a reasonable time thereafter, the district or charter may request that specific TEA staff members attend the record review to assist the TEA representative in reviewing the information presented.

(A) Such request shall be limited to staff directly involved in the development of the information identified in the notice under subsection (b) of this section.

(B) If reasonable and practicable, the TEA representative shall schedule the record review so as to allow the requested staff to attend.

(4) At all times prior to the record review, the district or charter is encouraged to contact the office of the TEA representative to discuss the process and to facilitate preliminary matters. However, such communications will not be recorded and will not be considered part of the record.

(5) The county-district or campus identification number of the affected entity must be included in all written correspondence on the record review, as well as the date the notice was issued under subsection (b) of this section. Correspondence relating to the review may be made part of the record.

(6) All deadlines under this section shall be calculated from the date of actual receipt. No mailbox rule applies.

(e) Record review.

(1) The TEA representative shall meet with the superintendent and/or representatives of the district or charter at the TEA headquarters in Austin, Texas, to receive oral and written information on the proposed order.

(2) The proceedings shall be recorded by audiotape or similar means. The audiotape and all written information presented during the review shall comprise the official record of the proceedings.

(3) The district or charter may have legal counsel present during the proceedings.

(4) The district or charter may present information verbally and in writing, and may rebut information presented by the TEA staff.

(5) The rules of evidence do not apply. Presentations need not follow question-and-answer format.

(6) The district or charter is allowed to ask questions of the TEA staff. The TEA representative may designate a specific portion of the meeting for this purpose.

(7) The TEA representative may ask questions of any participant directly or through the TEA staff.

(8) The TEA representative shall strictly confine presentations and questions to the matters set forth in the notice, and shall exclude information that is irrelevant, immaterial, or unduly repetitious.

(9) On request, the TEA representative shall include in the record a brief written proffer describing any information excluded under paragraph (8) of this subsection. In lieu of a written proffer, an oral statement may be recorded on a separate audiotape. If the excluded information is in writing, the document shall be identified as excluded and preserved with the record.

(10) The TEA representative may take official notice of generally recognized information within the TEA's area of specialized knowledge.

(A) Each party shall be notified either before or during the record review, or by reference in a preliminary report or otherwise, of the material officially noticed, including staff memoranda or information.

(B) Any participant may present information to rebut information that is officially noticed.

(11) The special skills and knowledge of the TEA representative and staff shall be used in evaluating all information presented during the record review.

(12) At the request of the district or charter, a record review may be conducted by telephone or similar means.

(13) A participant may present information via telephone or similar means during any record review.

(f) Final order. Following the record review, a final order will be issued. The final order may include changes or additions to the proposed order and such modifications are not subject to another record review procedure. This order may be appealed only as provided by Chapter 157, Subchapter EE, of this title.

(g) No request. If no record review is requested by the deadline specified in subsection (b)(3) of this section, a final order may be issued without record review. An order issued without record review may not be appealed under Chapter 157, Subchapter EE, of this title, or otherwise.

(1) The charter of an open-enrollment charter school is automatically:

(A) revoked, void, and of no further force or effect on the effective date of a final decision by the commissioner of education ordering the charter school closed under this subsection; and

(B) modified to remove authorization for an individual campus on the effective date of a final decision by the commissioner ordering the campus closed under this subsection.

(2) If sanctions are imposed on an open-enrollment charter school under the procedures provided by this subsection, a charter school is not entitled to an additional hearing relating to the modification, placement on probation, revocation, or denial of renewal of a charter as provided by TEC, Chapter 12, Subchapter D.

(h) Other law. Government Code, Chapter 2001, and TEC, §7.057, do not apply to a record review under this section.

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 2, 2010.

TRD-201006853
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 22, 2010
Proposal publication date: October 8, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

SUBCHAPTER EE. ACCREDITATION STATUS, STANDARDS, AND SANCTIONS

19 TAC §97.1072

The Texas Education Agency (TEA) adopts new §97.1072, concerning residential facility monitoring. The new section is adopted without changes to the proposed text as published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9022) and will not be republished. The adopted new section implements the requirements of the Texas Education Code (TEC), the Individuals with Disabilities Education Improvement Act (IDEA 2004) Amendments of 2004, and 34 Code of Federal Regulations (CFR), which require the agency to adopt and implement a comprehensive system for monitoring school district compliance with federal and state laws relating to special education. Specifically, the adoption establishes procedures for the administration of residential facility (RF) monitoring for public school districts and open-enrollment charter schools related to programs provided to students with disabilities residing in RFs. The action also adopts in rule the Residential Facility Monitoring (RFM) Manual, dated August 2010.

On April 15, 2004, the United States District Court issued a decision in the *Angel G. v. Texas Education Agency* lawsuit and found that the TEA must develop a new monitoring system to ensure that students with disabilities residing in RFs received a free, appropriate public education (FAPE). On May 17, 2004, the TEA filed a Notice of Appeal in the United States Court of Appeals for the Fifth Circuit. During the pendency of the appeal, the parties agreed to the entry of a consent decree to resolve the disputes and to achieve a common goal of developing and implementing an effective monitoring system. The consent decree was filed with the District Court on August 8, 2005, and will automatically expire on December 31, 2010, given that neither party requested that the District Court extend the term of the consent decree.

The TEA began implementing the consent decree during the 2005-2006 school year by hiring and training RF monitoring staff and developing required products and data collection systems. During the 2006-2007 school year, the TEA completed initial development of the RF monitoring system in accordance with the terms of the consent decree, and on-site RF monitoring visits under the terms of the consent decree began. For the subsequent school years of 2007-2008, 2008-2009, and 2009-2010, the TEA continued to implement the monitoring system required under the consent decree.

While the *Angel G.* consent decree will expire on December 31, 2010, the TEA has identified an ongoing need to oversee and monitor the programs provided to students with disabilities who reside in RFs. Therefore, the commissioner will, through this rule adoption, implement a system of RF monitoring after the expiration of the consent decree.

Adopted new 19 TAC §97.1072, Residential Facility Monitoring; Determinations, Investigations, and Sanctions, establishes a RFM system through which the TEA will meet its federal and state special education monitoring obligations for the RF population. The adopted new section establishes a data collection system for RFM and the general criteria used to determine which districts would be subject to RFM activities. The adopted new section also describes the graduated monitoring activities that will comprise the RFM system and possible interventions and/or sanctions that will be implemented under the system. Furthermore, the action adopts in rule an RF monitoring manual to define RF districts subject to the RFM system and establish specific criteria, standards, and procedures for implementing the RFM system.

The adopted rule action has no new reporting implications. Consistent with current procedures, districts subject to the RFM system have a continuing obligation to submit data regarding RF students with disabilities to the TEA. Districts and campuses have continued reporting obligations related to required interventions and sanctions under this action. However, the TEA will seek to reduce, to the extent possible, the data reporting

obligations previously associated with the requirements of the consent decree. The adopted rule action has no new locally maintained paperwork requirements. Districts will continue to be required to maintain documentation related to completion of required RFM intervention activities and/or implementation of any required RFM sanctions.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 8, 2010, and ended November 8, 2010. Following is a summary of public comments received and corresponding agency responses regarding the proposed new 19 TAC Chapter 97, Planning and Accountability, Subchapter EE, Accreditation Status, Standards, and Sanctions, §97.1072, Residential Facility Monitoring; Determinations, Investigations, and Sanctions.

Comment. Three special education directors, one special education counselor, one educational diagnostician, and one individual stated that the commissioner should not adopt the proposed rule. The commenters further stated that, with the expiration of the consent decree, the system of residential facility monitoring (RFM) could be maintained locally by school districts and that the monitoring, enforcement, and regulation by the TEA was unnecessary, too expensive, and not required in federal law. One special education director stated that the system has no positive impact on students, while another special education director and one special education counselor stated that the system could be eliminated without any negative impact on student achievement. One special education director further commented that the time and resources invested in RFM could be more effectively spent in monitoring "big issues" for every student in Texas, and an educational diagnostician and one individual stated that the RFM system was another costly layer of bureaucracy and that resources could be better spent to help all students. One special education director further stated that an RFM system is unfair to other students with disabilities in the state because so much time and effort is focused on students who happen to live in a residential facility (RF).

Agency Response. The agency disagrees. The TEA has monitoring and enforcement obligations as established in Texas Education Code (TEC), §29.010, and 34 Code of Federal Regulations (CFR) §300.149 and §300.600, and may not delegate its responsibility for ensuring compliance with special education program requirements to local education agencies. State and federal statute and regulations require the TEA to maintain a system of monitoring and enforcement. Furthermore, the agency has determined that, to implement a comprehensive system for monitoring school district compliance with federal and state special education requirements, it is necessary to adopt an RFM system designed to address the unique circumstances of a population of students who often have limited access to family members who can advocate for their educational needs.

Comment. One special education director stated that one of the most ridiculous aspects of the RFM system is to consider students who are incarcerated in a juvenile detention facility as students living in an RF.

Agency Response. The agency disagrees. Federal regulations at 34 CFR §300.101 and §300.102 establish the obligation of the agency to ensure a free appropriate public education (FAPE) for incarcerated youth, and students with disabilities who are incarcerated, like students living in other types of RFs, are a unique and vulnerable population of students who often have limited access to family members who can advocate for their educational needs.

Comment. Killeen Independent School District (ISD) implored the commissioner to withdraw the proposed rule and stated that it is not necessary for an RFM process to be codified in state law to ensure that students with disabilities in an RF receive a FAPE. Killeen ISD further stated that the numerous practical flaws of the process have far outweighed its theoretical benefit to students. Killeen ISD provided several examples of instances in which the district disagreed with the agency's findings or required corrective actions under the RFM system implemented under the *Angel G.* consent decree and stated that the RFM process exceeds requirements under state or federal law. Killeen ISD also stated that the proposed §97.1072(a) implies that RFM is limited to students residing in RFs but that, in reality, RFM corrective action plans (CAPs) impact students who were never in an RF. In addition, Killeen ISD stated that the proposed §97.1072(b) and (f) codify an existing process that leaves unbridled authority to agency staff to find fault with districts for very minor procedural inadequacies even though federal statute and regulations relating to other processes require a meaningful examination of whether a procedural violation impeded a child's right to a FAPE, significantly impeded a parent's opportunity to participate, or caused a deprivation of educational benefit. Killeen ISD further stated that monitoring staff have fabricated certain requirements and directly overruled admission, review, and dismissal (ARD) committee decisions in certain circumstances. Finally, Killeen ISD stated that an RFM system is burdensome, unwarranted, and unnecessary, with arbitrary and overreaching enforcement, and urged that specific limits to the authority of RFM monitors be put in place if the rule is not withdrawn in its entirety.

Agency Response. The agency agrees in part and disagrees in part. The agency agrees that certain aspects of the *Angel G.* consent decree removed discretion from the agency by requiring it to monitor and implement enforcement actions in a prescribed fashion. The agency disagrees that an RFM system to be implemented under this rule action goes beyond state or federal requirements. The TEA has monitoring and enforcement obligations as established in TEC, §29.010, and 34 CFR §300.149 and §300.600 and has the responsibility for ensuring compliance with special education program requirements. The agency has determined that, to implement a comprehensive system for monitoring school district compliance with federal and state special education requirements, it is necessary to adopt an RFM system designed to address the unique circumstances of a population of students who often have limited access to family members who can advocate for their educational needs. With regard to the comment that RFM staff have issued findings of noncompliance for minor procedural violations, the United States Department of Education has clarified that state educational agencies must identify any level of noncompliance with special education requirements and ensure correction of the noncompliance as soon as possible and in no case longer than one year from identification of the noncompliance. The agency acknowledges that certain corrective actions implemented as part of an RFM CAP can result in a district's improving its overall compliance with special education requirements for both RF and non-RF students with disabilities, which the agency considers to be a positive aspect of the RFM system. It is the agency's intent to align, to the extent possible, the monitoring activities under the RFM system

with other systems of agency monitoring and to reduce, to the extent possible, the data reporting obligations previously associated with the requirements of the consent decree. Many of the statements in the comment reflect upon implementation of the monitoring system under the consent decree, and, as such, are not directly related to the language of the rule proposal.

Comment. The Alliance Directors of Special Education (ADSE) and one special education director stated that they recognize the need for the TEA to monitor districts for compliance and offered comments and recommendations that they believe would allow for monitoring that would maintain the integrity of compliance while not being additionally burdensome to districts. The commenters noted their agreement with the need for a graduated monitoring system and recommended that the RFM system be incorporated into already-existing monitoring systems. The commenters also suggested that the RFM system be co-developed with a team of special education directors and stated that monitoring procedures should be clearly outlined, with required, regular training of monitoring staff. The commenters further recommended that all correspondence relating to the RFM system be in writing and include legal citations. The commenters stated that it was erroneous for the agency to state that there was no additional fiscal burden with the rule actions. The commenters suggested that the agency revise the language of its letter of adoption by deleting the words "seek to" related to the agency's stated intent to seek to reduce, to the extent possible, the data reporting obligations previously associated with the requirements of the consent decree.

Agency Response. The agency agrees in part and disagrees in part. The agency agrees with the need for clearly defined policies and procedures and for regular training of monitoring staff. The agency notes that the RFM Manual, which is adopted as part of this rule action, establishes a number of procedures and policies related to the RFM system. However, certain suggestions included in the comment, including the suggestion related to monitor training, deal with agency implementation activities and, therefore, go beyond the scope of the rule adoption. It is the agency's intent to align, to the extent possible, the monitoring activities under the RFM system with other agency monitoring systems and to reduce, to the extent possible, the data reporting obligations previously associated with the requirements of the consent decree. As part of this process, the agency will seek input from stakeholders. The agency does not agree that all aspects of the RFM system can be embedded in other monitoring systems given the unique circumstances surrounding the RF student population and disagrees that a change should be made to the rule adoption as it relates to the agency's stated efforts to seek to reduce data reporting obligations. In regard to the comments concerning costs, the agency acknowledges that there is a fiscal impact to the state and districts for reporting requirements and compliance activities related to RFM; however, the fiscal impact statement specifically notes that the rule action assigns no additional fiscal burden beyond what already is imposed by law or the previous consent decree.

Comment. An attorney from Schwartz & Eichelbaum and two special education directors stated that the commissioner should not adopt the proposed rule. Specifically, the commenters stated that the rule imposes costly burdens on districts without a commensurate benefit to students and that the system mostly has identified errors that are very minor in nature and unrelated to the quality of education for students. The commenters further stated that the state is not required to continue these practices after the consent decree expires and that the rule allows a certain segment of agency staff to keep their jobs. The commenters also stated that enforcement of RFM standards has been arbitrary at times and that agency staff has provided little assistance to districts and education service centers (ESCs). The special education directors stated that ESC directors find the system onerous and of no benefit to students. The commenters stated that there already are safeguards in place to protect students with disabilities and that the system is not consistent with smaller government. The special education directors further commented that *Angel G.* was caused by the agency not doing their job and, as a result, local districts are being punished.

Agency Response. The agency disagrees. The TEA has monitoring and enforcement obligations as established in TEC, §29.010, and 34 CFR §300.149 and §300.600 and has the responsibility for ensuring compliance with special education program requirements. The agency has determined that, to implement a comprehensive system for monitoring school district compliance with federal and state special education requirements, it is necessary to adopt an RFM system designed to address the unique circumstances of a population of students who often have limited access to family members who can advocate for their educational needs. The agency disagrees that it has provided little assistance to districts and ESCs and notes that it remains committed to ongoing dialogue and assistance as the RFM system is revised and implemented. In response to the comments that most of the errors found in the RFM process have been minor, the agency disagrees and notes that it has consistently identified noncompliance in substantive areas such as properly constituted ARD committee meetings, least restrictive environment, highly qualified and certified staff, and individualized education program (IEP) implementation. While the *Angel G.* consent decree resulted from an adverse court decision, the current effort to create an RFM system that is aligned, to the extent possible, with other agency monitoring systems is a direct response to the agency's obligation to address the needs of a unique and vulnerable student population.

Comment. The Texas Charter Schools Association (TCSA) shared certain observations and asked a number of questions that it suggested be addressed in the final rule and RFM Manual. In regard to §97.1072(c), the TCSA asked what critical indicators will be used to determine which RF districts will be subject to RFM activities and what specific enrollment numbers or percentages will trigger an RFM activity. The TCSA further inquired as to whether the term "districts" as referenced in the rule applies to open-enrollment charter schools. The TCSA stated that any performance comparisons should be made only to the performance of other entities that serve the same grade levels, similarly sized student populations, and populations that have the same or nearly the same mobility rates. The TCSA further inquired regarding how the agency would measure a district's longitudinal performance and stated that true longitudinal performance may be difficult to measure due to student mobility issues. In regard to §97.1072(d), the TCSA asked what was meant by the term "longitudinal intervention history" and what "other relevant factors" will fall into the category. In regard to §97.1072(h), the TCSA inquired under what legal authority the commissioner is permitted to require districts to pay for professional services assigned by the TEA and suggested that a provision be added to §97.1072(h) to require the commissioner to streamline as much as possible multiple corrective action plans or other consequences of ineffectiveness or noncompliance that affect the same charter holder.

Agency Response. The agency clarifies that reference to districts in proposed §97.1072 includes open-enrollment charter schools. The agency also clarifies that §97.1072(c) establishes general criteria for determining which districts, including open-enrollment charter schools, will be subject to RFM activities but notes that the critical indicators of student performance are more appropriately reflected in the agency's system for RFM data collection and its supporting documentation and in the RFM Manual, which is adopted in rule. The specific enrollment numbers and percentages that will trigger monitoring activities cannot be determined in isolation of the other factors and considerations listed in §97.1072(c) and, therefore, are not reflected. The agency will take under advisement the suggestion that it compare like entities in its implementation of an RFM system. The agency acknowledges that the mobility of RF students affects, in some cases, a district's and the agency's ability to track longitudinal student performance. Nevertheless, longitudinal data are available over time. In regard to the meaning of "longitudinal intervention history" in §97.1072(d), the agency notes that it will consider the performance of districts over time in the agency's systems of monitoring and general supervision and that "other relevant factors" include district information that is relevant to the agency's determination of the need to conduct RFM monitoring activities. In regard to the questions related to §97.1072(h), the agency notes its authority under TEC, §39.109, to order a district to acquire professional services. As it relates to the comment on streamlining the need for corrective action plans, the agency agrees that activities should be streamlined and consolidated to the extent possible and already has taken action to begin to address this need. The agency will continue to expand its efforts in this area; however, this suggestion deals with agency implementation activities rather than specific rule language.

The new section is adopted under the Texas Education Code, §29.010, which authorizes the agency to adopt and implement a comprehensive system for monitoring school district compliance with federal and state laws relating to special education; Title 34 Code of Federal Regulations (CFR) §300.149, which requires the agency to have in effect policies and procedures to ensure that it meets its general supervision responsibilities related to the education of children with disabilities and complies with monitoring and enforcement requirements under Part B of the Individuals with Disabilities Education Act (IDEA) and implementing regulations; and Title 34 CFR §300.600, which requires the agency to monitor the implementation and enforce the requirements of IDEA, Part B, including monitoring of local education agencies to improve educational results and functional outcomes for children with disabilities and ensure that program requirements are met.

The new section implements the Texas Education Code, §29.010, and Title 34 CFR §300.149 and §300.600.

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 2, 2010.

TRD-201006857

Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 22, 2010
Proposal publication date: October 8, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 109. BUDGETING, ACCOUNTING, AND AUDITING

SUBCHAPTER AA. COMMISSIONER'S RULES CONCERNING FINANCIAL ACCOUNTABILITY

DIVISION 2. FINANCIAL SOLVENCY

19 TAC §109.1101

The Texas Education Agency (TEA) adopts new §109.1101, concerning financial solvency. The new section is adopted with changes to the proposed text as published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9025). The adopted new section allows the commissioner to implement and administer the provisions of the Texas Education Code (TEC), §39.0822 and §39.0823, as added by Section 59 of House Bill (HB) 3, 81st Texas Legislature, 2009, which direct the TEA to develop a review process relating to financial solvency of school districts and open-enrollment charter schools and to take certain actions if the TEA's review indicates a projected deficit.

HB 3, 81st Texas Legislature, 2009, added the TEC, §39.0822 and §39.0823. Section 39.0822 requires the commissioner to adopt rules related to the financial solvency review required by that section. This review is to be developed by the TEA, in consultation with school district financial officers and public finance experts, to anticipate the future financial solvency of school districts and open-enrollment charter schools through analysis of tax and financial information and staff and student count information. Section 39.0823 requires the commissioner to assign an accredited-warned status to a school district or an open-enrollment charter school that has been required to submit a financial plan as a result of the findings of the TEA's financial solvency review if the district or charter school fails to submit, get approval for, or appropriately implement the plan.

From December 2009 through April 2010, the TEA held a series of focus groups with school district and open-enrollment charter school financial officers and public finance experts to develop the financial solvency review required by the TEC, §39.0822, and to solicit feedback on draft rule language. The adopted new 19 TAC §109.1101, which incorporates feedback from these focus groups, implements the required financial solvency review. Specifically, the adopted new rule explains the review's purpose, provides definitions, describes the data to be used in the review, explains the review process and methodology, and sets out requirements related to financial plans and consequences for failing to comply with these requirements. The adoption includes adoption as rule the document entitled "Financial Solvency Review Methodology."

In addition, Chapter 109, Subchapter AA, was renamed and organized to include the adopted new financial solvency rule. The subchapter title was changed from "Commissioner's Rules

Concerning Financial Accountability Rating System" to "Commissioner's Rules Concerning Financial Accountability."

In response to public comment, subsection (d)(3)(C) and the figure provided in subsection (d)(1) were modified at adoption to reference the financial accountability terms of "assigned and unassigned" that will go into effect with fiscal year 2010-2011 data. Also in response to public comment, subsection (g) was modified at adoption to remove the prohibition on appealing accreditation status decisions made by the commissioner in regard to the financial solvency review.

School districts and open-enrollment charter schools are required to use an electronic template to submit to the TEA first-quarter financial data for the current school year; information about district/school borrowing, administration turnover, and whether the district has recently declared financial exigency or the school has recently declared bankruptcy; and comments on any irregularities. School districts and open-enrollment charter schools that the TEA selects for additional review are required to submit interim financial reports supplemented by staff and student data. The adopted rule action has no locally maintained paperwork requirements.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 8, 2010, and ended November 8, 2010. Following is a summary of public comments received and corresponding agency responses regarding proposed new 19 TAC Chapter 109, Budgeting, Accounting, and Auditing, Subchapter AA, Commissioner's Rules Concerning Financial Accountability, Division 2, Financial Solvency, §109.1101, Financial Solvency Review.

Comment. The Texas Charter Schools Association (TCSA) commented that the agency should consider, in its statutorily required review of the first-quarter financial data specified in subsection (c)(2)(A), that these data may be skewed because of start-up costs associated with the start of the school year. The TCSA further commented that the agency should give significant weight to the Public Education Information Management System (PEIMS) financial actual data for the past two school years specified in subsection (c)(1)(B).

Agency Response. The agency agrees that significant weight should be given to the PEIMS financial actual data for the past two school years and has maintained language as published as proposed.

Comment. The TCSA commented that it supported the language in subsection (c)(2)(B), which provides for school districts and charter schools to submit comments regarding the financial information to be reviewed by the agency.

Agency Response. The agency agrees with the comment and has maintained language as published as proposed.

Comment. The Arlington Independent School District executive director of finance asked how the agency will treat fund balance in determining a district's financial solvency and, specifically, which fund balance category or categories will be considered in the financial solvency review.

Agency Response. The agency provides the following clarification. Only the unreserved undesignated general fund balance will be used in determining financial solvency, as specified in subsection (d)(3)(C) and in the figure included in subsection (d)(1) of the rule, which describes the methodology to be used in the financial solvency review. Subsection (d)(3)(C) and the figure included in subsection (d)(1) have been modified at adoption to clarify that, effective beginning with fiscal year 2010-2011 data, the term "unreserved" will be replaced by the term "assigned and unassigned" in the financial accountability system.

Comment. The TCSA commented that it had concerns about the analysis of projected revenues and expenditures for the current school year and next two school years described in subsection (d)(2)(B), stating that charter schools may not be able to project with specificity revenues and expenditures for upcoming school years. The TCSA further commented that it encouraged the agency to avoid adopting a reporting template that would require specificity or would hold charter schools accountable for meeting the schools' projections.

Agency Response. The agency disagrees that subsection (d)(2)(B) is problematic and has maintained language as published as proposed. The projections described in subsection (d)(2)(B) are projections that will be developed by the agency and not by charter schools themselves. The projections will be used only as one of several data items to develop a preliminary list, for internal agency use, of school districts or charter schools that warrant further review to determine whether they face potential financial insolvency. School districts and charter schools will not be held accountable for meeting the agency-developed projections described in subsection (d)(2)(B).

Comment. The TCSA commented that subsection (f)(4) should be modified to provide for notification of the affected school district or charter school before assignment of an Accredited-Warned status and to provide for the opportunity for the district or charter school to revise its financial plan.

Agency Response. The agency disagrees with the comment and has maintained language as published as proposed. Subsection (e)(4) already provides for notification of the affected school district or charter school and for the opportunity to modify a financial plan.

Comment. The TCSA commented that subsection (g) conflicts with the Texas Education Code (TEC), §39.151, and should be modified to allow for appeals under 19 TAC §109.1002.

Agency Response. The agency agrees with the comment in part and has modified subsection (g) to remove the prohibition on appealing accreditation status decisions.

The agency disagrees that the subsection (g) provision prohibiting the appeal of financial plan approval decisions conflicts with the TEC, §39.151, and has maintained that provision as published as proposed.

The agency clarifies that the appeal process specified in §109.1002 of this title (relating to Financial Accountability Ratings) would not apply to agency decisions provided for in §109.1101 (relating to Financial Solvency Review), as §109.1002 provides only for appeals of preliminary financial accountability ratings. Nothing in §109.1101 prevents a school district or charter school from appealing its preliminary financial accountability rating under §109.1002.

The new section is adopted under the Texas Education Code (TEC), §39.085, which authorizes the commissioner to adopt rules as necessary for the implementation and administration of financial accountability for the public school system. In adopting rules for a required financial solvency review program, TEC,

§39.0822(d), authorizes the commissioner to adopt rules to allow a district to enter estimates of critical data into the program before the district adopts its budget.

The new section implements the Texas Education Code, §§39.0822, 39.0823, and 39.085.

§109.1101. Financial Solvency Review.

(a) Purpose of financial solvency review. The purpose of the financial solvency review is to anticipate the future financial solvency of Texas public school districts and open-enrollment charter schools. The review is designed to alert school districts and open-enrollment charter schools to circumstances that could lead to financial insolvency.

(b) Definitions. The following terms, when used in this section, have the following meanings, unless the context clearly indicates otherwise.

(1) Financial solvency--When used to describe a school district or open-enrollment charter school, the condition in which a school district or open-enrollment charter school either is generally paying its debts as they become due, unless such debts are the subject of a bona fide dispute, or is able to pay its debts as they become due.

(2) Public Education Information Management System (PEIMS)--The system described by §61.1025 of this title (relating to Public Education Information Management System (PEIMS) Data and Reporting Standards).

(c) Financial solvency review data.

(1) In its financial solvency review, the Texas Education Agency (TEA) will use the following data, which are available to the TEA through existing data sources:

(A) annual financial audits for the past two school years;

(B) PEIMS financial actual data for the past two school years;

(C) PEIMS financial budget data for the current year and the past two school years;

(D) PEIMS staff data for the current year and the past two school years;

(E) PEIMS student data for the current year and the past two school years; and

(F) school district tax rate data.

(2) In its financial solvency review, the TEA will use the following additional information, which the TEA will request from school districts and open-enrollment charter schools:

(A) first-quarter school district and open-enrollment charter school financial data for the current school year; and

(B) school district and open-enrollment charter school comments.

(3) School districts and open-enrollment charter schools that the TEA selects for additional review may be required to submit other additional information as described in subsection (d)(5) of this section.

(4) School districts and open-enrollment charter schools that the TEA projects to have a general fund deficit within the next three school years will be required to submit interim financial reports supplemented by staff and student data as described in subsection (d)(5) of this section.

(d) Financial solvency review.

(1) In its financial solvency review, the TEA will use the methodology described in the document provided in this paragraph, entitled "Financial Solvency Review Methodology."
Figure: 19 TAC §109.1101(d)(1)

(2) In its financial solvency review, the TEA will analyze the following:

(A) school district and open-enrollment charter school revenues and expenditures for the past school year; and

(B) projected school district and open-enrollment charter school revenues and expenditures for the current school year and the next two school years.

(3) In analyzing the information under paragraph (2) of this subsection, the TEA may consider, for the past school year, the current school year, and the next two school years, as appropriate, the following:

(A) student-to-staff ratios relative to expenditures;

(B) average staff salaries;

(C) the rate of change in the unreserved (assigned and unassigned, effective beginning with fiscal year 2010-2011 data) general fund balance;

(D) the number of students enrolled in the district or open-enrollment charter school;

(E) the adopted tax rate of the school district;

(F) any independent audit report prepared for the school district or open-enrollment charter school; and

(G) actual school district or open-enrollment charter school financial information for the first quarter.

(4) The TEA will notify any school district or open-enrollment charter school for which the financial solvency review shows one or more of the following:

(A) a student-to-staff ratio that is significantly outside the norm;

(B) a rapid depletion of the general fund balance; or

(C) a significant discrepancy between submitted budget figures and projected revenues and expenditures.

(5) The TEA may extend the financial solvency review and require additional documentation of a school district or open-enrollment charter school that has been notified as described in paragraph (4) of this subsection following an initial review.

(A) The TEA will determine additional documentation requirements on a case-by-case basis.

(B) The TEA will use additional documentation and comments submitted by a school district or open-enrollment charter school to determine whether the school district or open-enrollment charter school is projected to have a deficit for its general fund within the next three school years.

(C) If the financial solvency review indicates a projected deficit for a school district or open-enrollment charter school general fund within the next three school years, the school district or open-enrollment charter school must submit to the TEA interim financial reports, supplemented by staff and student count data, as needed, for the TEA to evaluate the current budget status of the school district or open-enrollment charter school.

(D) If analysis and evaluation of the additional data required to be submitted under subparagraph (C) of this paragraph substantiates a projected deficit within the next three school years, the school district or open-enrollment charter school must develop and submit a financial plan to the TEA for approval.

(6) All documentation generated and gathered in the process of determining a school district's or open-enrollment charter school's financial solvency will be considered working papers and not subject to open records requests. Financial solvency documentation related to school districts and open-enrollment charter schools required to submit financial plans will be subject to open records requests as permitted by statute or rule.

(e) Financial plans.

(1) If the TEA determines that a school district or open-enrollment charter school is required to submit a financial plan, the TEA will provide written notification of this requirement to the school district or open-enrollment charter school.

(2) On receiving the notification described in paragraph (1) of this subsection, a school district or open-enrollment charter school must develop and submit to the TEA for approval a financial plan for avoiding the projected insolvency.

(3) If the TEA determines that a submitted financial plan will permit a school district or open-enrollment charter school to avoid projected insolvency, the TEA will provide written notification of its approval of the financial plan to the school district or open-enrollment charter school.

(4) If the TEA determines that a submitted financial plan will not permit a school district or open-enrollment charter school to avoid projected insolvency, the TEA will require the school district or open-enrollment charter school to modify the financial plan submitted to the TEA. The TEA will provide written notification of this requirement to the school district or open-enrollment charter school.

(5) The TEA may monitor the implementation of a financial plan or modified financial plan that is based on a financial review for a period of up to three years after TEA approval of the financial plan or modified financial plan, as applicable.

(f) Financial plans and accreditation. The commissioner of education will assign an Accredited-Warned status to a school district or open-enrollment charter school that is required to develop and submit a financial plan as provided by subsection (e) of this section if:

(1) the school district or open-enrollment charter school fails to submit a financial plan to avoid a projected deficit;

(2) the school district or open-enrollment charter school fails to get approval from the TEA for a financial plan or modified financial plan;

(3) the school district or open-enrollment charter school fails to comply with a TEA-approved financial plan; or

(4) the TEA determines in a subsequent school year, based on financial data submitted by the school district or open-enrollment charter school, that the approved plan for the school district or open-enrollment charter school is no longer sufficient or is not appropriately implemented.

(g) Decisions by commissioner final. All financial plan approval decisions made by the commissioner in regard to the financial solvency review are final and cannot be appealed.

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 2, 2010.

TRD-201006855
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 22, 2010
Proposal publication date: October 8, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 130. TEXAS ESSENTIAL KNOWLEDGE AND SKILLS FOR CAREER AND TECHNICAL EDUCATION

SUBCHAPTER O. SCIENCE, TECHNOLOGY, ENGINEERING, AND MATHEMATICS

19 TAC §130.371

The State Board of Education (SBOE) adopts amendment to §130.371, concerning Texas essential knowledge and skills (TEKS) for principles of technology. The amendment is adopted without changes to the proposed text as published in the October 15, 2010, issue of the *Texas Register* (35 TexReg 9207) and will not be republished. The section establishes the TEKS for a career and technical education (CTE) course that may be taken to earn science credit. The adopted amendment makes minor modifications to the Principles of Technology course that would satisfy the physics graduation requirement to align with end-of-course assessment requirements.

Due to requirements for end-of-course assessments for physics, minor modifications are needed to the TEKS for the new CTE Principles of Technology course adopted in July 2009 in 19 TAC §130.371. In March 2010, the SBOE adopted new 19 TAC Chapter 112, Texas Essential Knowledge and Skills for Science, Subchapter D, Other Science Courses, §112.71, Principles of Technology, to reflect the modifications needed. The adopted rule action amends the TEKS for Principles of Technology in 19 TAC Chapter 130 to align with the changes made to the Principles of Technology TEKS in 19 TAC Chapter 112.

The SBOE approved the proposed amendment to 19 TAC §130.371 for second reading and final adoption at the November 2010 meeting.

The adopted rule action has no new procedural and reporting implications. The adopted rule action has no new locally maintained paperwork requirements.

The Texas Education Agency determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

In accordance with the TEC, §7.102(f), the SBOE approved the amendments for adoption by a vote of two-thirds of its members to specify an effective date earlier than the beginning of the 2011-2012 school year. The earlier effective date will allow districts to

implement the revised standards immediately. The effective date for the amendment is 20 days after filing as adopted.

No public comments were received on the proposal.

The amendment is adopted under the Texas Education Code (TEC), §7.102(c)(4), which authorizes the SBOE to establish curriculum and graduation requirements; §28.002, which authorizes the SBOE to by rule designate subjects constituting a well-balanced curriculum and to require each district to provide instruction in the essential knowledge and skills at appropriate grade levels; and §28.025, which authorizes the SBOE to by rule determine curriculum requirements for the minimum, recommended, and advanced high school programs that are consistent with the required curriculum under §28.002.

The amendment implements the Texas Education Code, §§7.102(c)(4), 28.002, and 28.025.

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 November 30, 2010.

TRD-201006778
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 20, 2010
Proposal publication date: October 15, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 157. HEARINGS AND APPEALS
SUBCHAPTER EE. REVIEW BY STATE OFFICE OF ADMINISTRATIVE HEARINGS: CERTAIN ACCREDITATION SANCTIONS

19 TAC §§157.1151, 157.1153, 157.1155, 157.1167, 157.1169, 157.1171

The Texas Education Agency (TEA) adopts amendments to §§157.1151, 157.1153, 157.1155, 157.1167, 157.1169, and 157.1171, concerning hearings and appeals. The amendments are adopted without changes to the proposed text as published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9030) and will not be republished. The sections establish provisions relating to the review of certain accreditation sanctions by the State Office of Administrative Hearings (SOAH). The adopted amendments update and clarify provisions relating to the SOAH review of certain accreditation sanctions. The adopted amendments reflect changes in the Texas Education Code (TEC), Chapter 39, as reflected in House Bill (HB) 3, 81st Texas Legislature, Regular Session, 2009.

HB 1, 79th Texas Legislature, Third Called Session, 2006, required that an opportunity for challenging the record review of accreditation sanctions be available in specified circumstances and provided by the SOAH. The rules adopted in 19 TAC Chapter 157, Hearings and Appeals, Subchapter EE, Review by State Office of Administrative Hearings: Certain Accreditation Sanctions, implement these requirements. HB 3, 81st Texas Legislature, Regular Session, 2009, enacted numerous changes to the TEC, Chapter 39, and renumbered the chapter, requiring that existing rules be revised and updated.

The adopted amendments to 19 TAC Chapter 157, Subchapter EE, update and clarify existing rules in light of HB 3. Specifically, the adopted amendments establish the following.

The adopted amendments to 19 TAC §157.1151, Applicability, and 19 TAC §157.1153, Applicability of Other Law, update statutory references in alignment with HB 3.

The adopted amendment to 19 TAC §157.1155, Petition for Review, revises the timeline by which a petitioner may file with the TEA a petition for review. Additionally, as a result of the amendment to shorten the timeline under subsection (a), subsection (b) was revised to allow a petition for review to be amended or supplemented after the deadline for filing a petition for review.

The adopted amendment to 19 TAC §157.1167, Expedited Review, adds subsection (f), requiring an administrative law judge to issue a final order no later than May 31 immediately following a final order issued no later than March 15 under 19 TAC §97.1037(f), relating to the record review of a decision to assign an accreditation status of Not Accredited-Revoked to a district. A minor conforming amendment was made to subsection (a).

The adopted amendment to 19 TAC §157.1169, Conduct of Review During a Ratings Appeal, updates statutory references in alignment with HB 3.

The adopted amendment to 19 TAC §157.1171, Final Decision, removes a reference to a section of statute that was deleted and restructured in HB 3 and relies on other statutory references and procedures reflected in the subchapter.

The adopted amendments have no new reporting implications. Changes to current procedures include changes to timeframes related to petitions in 19 TAC §157.1155 and additional specifications related to an accreditation status final order issued by an administrative law judge in 19 TAC §157.1167. The adopted amendments have no new locally maintained paperwork requirements.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began October 8, 2010, and ended November 8, 2010. No public comments were received.

The amendments are adopted under the Texas Education Code, §39.152, which authorizes the agency to establish procedures for creating an administrative record for review by the State Office of Administrative Hearings for certain decisions.

The amendments implement the Texas Education Code, §39.152.

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 2, 2010.

TRD-201006854

Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Effective date: December 22, 2010
Proposal publication date: October 8, 2010
For further information, please call: (512) 475-1497

♦ ♦ ♦

PART 7. STATE BOARD FOR EDUCATOR CERTIFICATION

CHAPTER 228. REQUIREMENTS FOR EDUCATOR PREPARATION PROGRAMS

19 TAC §§228.2, 228.35, 228.60

The State Board for Educator Certification (SBEC) adopts amendments to §§228.2, 228.35, and 228.60, relating to requirements for educator preparation programs. The amendments to §228.2 and §228.60 are adopted without changes to the proposed text as published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8033) and will not be republished. The amendment to §228.35 is adopted with changes to the proposed text as published in the September 3, 2010, issue. The rules establish minimum standards for educator preparation programs. The adopted amendments clarify the requirements for educator preparation program coursework, training, internships, student teaching, clinical teaching, practicums, field-based experiences, and field supervision and provide that the program requirements that were in effect on the date an educator candidate was admitted to a program are the requirements applicable to that candidate.

Since the revisions to 19 TAC Chapter 228, Requirements for Educator Preparation Programs, became effective December 14, 2008, the Texas Education Agency (TEA) staff received numerous questions and comments regarding the locations, other than Texas public schools, at which an educator preparation program candidate may complete the required field-based experiences, student teaching, clinical teaching, internship, and/or practicum. The SBEC rules codified in the TAC were unclear on this subject because the rules did not specify the process or criteria for TEA approval of schools for this purpose.

The adopted amendments to 19 TAC §§228.2, 228.35, and 228.60 provide the process and criteria for an educator preparation program to seek TEA approval for the use of schools other than public schools accredited by the TEA as a site for the required candidate experience, revise the definitions and requirements for the various required experiences, revise the field supervision requirements, and revise the implementation date of the provisions in Chapter 228. These adopted amendments reflect discussions held during the March 25, 2010, and June 21, 2010, stakeholder meetings. Following is a description of the adopted changes.

§228.2. Definitions

Language in 19 TAC §228.2(4), (9), (12), (16), and (17) was amended to specify that field-based experiences, student teaching, clinical teaching, internship, and practicum may take place not only in a public school accredited by the TEA, but also in other schools approved by the TEA pursuant to procedures described in new §228.35(d)(4). Language in §228.2(16) was amended to update the definition of "practicum" to clarify that the term applies only to a supervised assignment that is a requirement for a professional certificate, rather than as a general term that might also be applied to internships, student teaching, or clinical teaching.

The definition of "clock-hours" in 19 TAC §228.2(5) was amended to clarify the relationship between clock-hours and university credit hours.

The definition of "field-based experiences" in 19 TAC §228.2(9) was amended to add specificity by incorporating standards that were previously applicable only to field-based experiences provided through video or electronic transmission. The adopted amendments also remove those standards from 19 TAC §228.35 that reference the use of video or electronic transmission for field-based experience requirements because they are redundant.

§228.35. Preparation Program Coursework and/or Training

Language in 19 TAC §228.35 was amended to align with the adopted amendments to the definitions in §228.2. The standards for use of technology to meet field-based experience requirements were deleted throughout this section since the adopted new definition in §228.2(9) applies them to all field-based experiences.

Section 228.35(a)(6) was amended to provide that experience or professional training that is substituted for educator preparation program training and/or coursework requirements may not also be counted as part of internship, clinical teaching, student teaching, or practicum requirements.

Language in 19 TAC §228.35(d)(2)(C)(i) was amended to eliminate the requirement that a Head Start program be affiliated with a public school, as long as it is affiliated with the federal Head Start program and approved by the TEA. Language was also amended in §228.35(d)(2)(C)(ii) to clarify that an internship, clinical teaching, student teaching, or practicum experience must take place in an actual school setting.

Section 228.35(d) was amended to add new paragraph (4) to provide that all Department of Defense Education Activity (DoDEA) schools, wherever located, and all schools accredited by the Texas Private School Accreditation Commission (TEPSAC) be approved as sites for field-based experiences, internship, clinical teaching, student teaching, or practicum experience. The rule also specifies the procedures and establishes criteria for obtaining TEA approval for other schools as sites for field-based experiences, internship, clinical teaching, student teaching, or practicum experience.

Language in 19 TAC §228.35(f) was amended to clarify and distinguish the field observation requirements for clinical teaching, student teaching, and practicum experiences.

Section 228.35(g) was added to clarify that coursework and training requirements are subject to the exemptions from field experiences and student teaching requirements granted by the TEC, §21.050(c).

Since published as proposed, language in §228.35(g) was revised to clarify the provisions of the exemption in TEC, §21.050(c).

§228.60. Implementation Date

Language was amended in 19 TAC §228.60 to clarify that the provisions of 19 TAC Chapter 228 that apply to an educator

preparation candidate are those that were in effect on the date the candidate was admitted to an educator preparation program.

Regarding procedural and reporting implications, an educator preparation program follows the procedures established in adopted new 19 TAC §228.35(d)(4), which includes required elements to be submitted when requesting approval for schools as sites for field-based experiences, internship, clinical teaching, student teaching, or practicum experience. The adopted amendments have no locally maintained paperwork requirements for school districts and educators.

There is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

Following the August 2010 SBEC meeting, the proposed amendments to 19 TAC §§228.2, 228.35, and 228.60 were filed with the *Texas Register* initiating the official public comment period. The following comment was received regarding the proposed amendments.

Comment: The executive director of Education Career Alternatives Program (ECAP) commented on the definition of "mentor" in 19 TAC §228.2(14). The commenter noted that an educator preparation program does not have the authority to assign a mentor. The commenter stated that the district administrator who assigned the mentor for the candidate should be the person to receive any reports from the mentor about the candidate's progress, not the educator preparation program.

Board Response: The SBEC disagreed and maintained the definition of "mentor" as specified in 19 TAC §228.2(14). The definition of a mentor states that the mentor should communicate with the educator preparation program. The definition does not make the educator preparation program responsible for ensuring that the communication takes place. The mentor supports a candidate in the educator preparation program and, therefore, should communicate with the educator preparation program.

The State Board of Education (SBOE) took no action on the review of the amendments to 19 TAC §§228.2, 228.35, and 228.60 at the November 19, 2010, SBOE meeting.

The amendments are adopted under the Texas Education Code (TEC), §21.031, which authorizes the SBEC to regulate and oversee all aspects of the certification, continuing education, and standards of conduct of public school educators, and states that in proposing rules under the TEC, Chapter 21, Subchapter B, the SBEC shall ensure that all candidates for certification or renewal of certification demonstrate the knowledge and skills necessary to improve the performance of the diverse student population of this state; §21.044, which authorizes the SBEC to propose rules establishing the training requirements a person must accomplish to obtain a certificate, enter an internship, or enter an induction-year program and specify the minimum academic qualifications required for a certificate; §21.045(a), which authorizes the SBEC to propose rules establishing standards to govern the approval and continuing accountability of all educator preparation programs based on the following information that is disaggregated with respect to sex and ethnicity: results of the certification examinations prescribed under the TEC, §21.048(a); §21.050(a), which states that a person who applies for a teaching certificate for which SBEC rules require a bachelor's degree must possess a bachelor's degree received with an academic major or interdisciplinary academic major, including reading, other than education, that is related to the curriculum as prescribed under TEC, Chapter 28, Subchapter A; §21.050(c), which states that a person who receives a bachelor's degree required for a teaching certificate on the basis of higher education coursework completed while receiving an exemption from tuition and fees under the TEC, §54.214, may not be required to participate in any field experience or internship consisting of student teaching to receive a teaching certificate; and §21.051, which authorizes the SBEC to propose rules providing flexible options for persons for any field experience or internship required for certification.

The adopted amendments implement the TEC, §§21.031; 21.044; 21.045(a); 21.050(a) and (c); and 21.051.

§228.35. Preparation Program Coursework and/or Training.

(a) Coursework and/or Training for Candidates Seeking Initial Certification.

(1) An educator preparation program shall provide coursework and/or training to ensure the educator is effective in the classroom.

(2) Professional development should be sustained, intensive, and classroom focused.

(3) An educator preparation program shall provide each candidate with a minimum of 300 clock-hours of coursework and/or training that includes the following:

(A) a minimum of 30 clock-hours of field-based experience to be completed prior to student teaching, clinical teaching, or internship. Up to 15 clock-hours of field-based experience may be provided by use of electronic transmission, or other video or technology-based method;

(B) 80 clock-hours of coursework and/or training prior to student teaching, clinical teaching, or internship; and

(C) six clock-hours of explicit test preparation that is not embedded in other curriculum elements.

(4) All coursework and/or training shall be completed prior to educator preparation program completion and standard certification.

(5) With appropriate documentation such as certificate of attendance, sign-in sheet, or other written school district verification, 50 clock-hours of training may be provided by a school district and/or campus that is an approved Texas Education Agency (TEA) continuing professional education provider.

(6) Each educator preparation program must develop and implement specific criteria and procedures that allow candidates to substitute prior or ongoing experience and/or professional training for part of the educator preparation requirements, provided that the experience or training is not also counted as a part of the internship, clinical teaching, student teaching, or practicum requirements, and is directly related to the certificate being sought.

(b) Coursework and/or Training for Professional Certification (i.e. superintendent, principal, school counselor, school librarian, educational diagnostician, reading specialist, and/or master teacher). An educator preparation program shall provide coursework and/or training to ensure that the educator is effective in the professional assignment. An educator preparation program shall provide a candidate with a minimum of 200 clock-hours of coursework and/or training that is directly aligned to the state standards for the applicable certification field.

(c) Late Hires. A late hire for a teaching position shall complete 30 clock-hours of field-based experience as well as 80 clock-hours of initial training within 90 school days of assignment. Up to 15 clock-

hours of field-based experience may be provided by use of electronic transmission, or other video or technology-based method.

(d) Educator Preparation Program Delivery. An educator preparation program shall provide evidence of on-going and relevant field-based experiences throughout the educator preparation program, as determined by the advisory committee as specified in §228.20 of this title (relating to Governance of Educator Preparation Programs), in a variety of educational settings with diverse student populations, including observation, modeling, and demonstration of effective practices to improve student learning.

(1) For initial certification, each educator preparation program shall provide field-based experiences, as defined in §228.2 of this title (relating to Definitions), for a minimum of 30 clock-hours. The field-based experiences must be completed prior to assignment in an internship, student teaching, or clinical teaching. Up to 15 clock-hours of field-based experience may be provided by use of electronic transmission, or other video or technology-based method.

(2) For initial certification, each educator preparation program shall also provide one of the following:

(A) student teaching, as defined in §228.2 of this title, for a minimum of 12 weeks;

(B) clinical teaching, as defined in §228.2 of this title, for a minimum of 12 weeks; or

(C) internship, as defined in §228.2 of this title, for a minimum of one academic year (or 180 school days) for the assignment that matches the certification field for which the individual is accepted into the educator preparation program. The individual would hold a probationary certificate and be classified as a "teacher" as reported on the campus Public Education Information Management System (PEIMS) data. An educator preparation program may permit an internship of up to 30 school days less than the minimum if due to maternity leave, military leave, illness, or late hire date.

(i) An internship, student teaching, or clinical teaching for an Early Childhood-Grade 4 and Early Childhood-Grade 6 candidate may be completed at a Head Start Program with the following stipulations:

(I) a certified teacher is available as a trained mentor;

(II) the Head Start program is affiliated with the federal Head Start program and approved by the TEA;

(III) the Head Start program teaches three and four-year-old students; and

(IV) the state's pre-kindergarten curriculum guidelines are being implemented.

(ii) An internship, student teaching, clinical teaching, or practicum experience must take place in an actual school setting rather than a distance learning lab or virtual school setting.

(3) For candidates seeking professional certification as a superintendent, principal, school counselor, school librarian, or an educational diagnostician, each educator preparation program shall provide a practicum, as defined in §228.2 of this title, for a minimum of 160 clock-hours.

(4) Subject to all the requirements of this section, the TEA may approve a school that is not a public school accredited by the TEA as a site for field-based experience, internship, student teaching, clinical teaching, and/or practicum.

(A) All Department of Defense Education Activity (DoDEA) schools, wherever located, and all schools accredited by the Texas Private School Accreditation Commission (TEPSAC) are approved by the TEA for purposes of field-based experience, internship, student teaching, clinical teaching, and/or practicum.

(B) An educator preparation program may file an application with the TEA for approval, subject to periodic review, of a public school, a private school, or a school system located within any state or territory of the United States, as a site for field-based experience, or for video or other technology-based depiction of a school setting. The application shall be in a form developed by the TEA staff and shall include, at a minimum, evidence showing that the instructional standards of the school or school system align with those of the applicable Texas Essential Knowledge and Skills (TEKS) and State Board for Educator Certification (SBEC) certification standards. To prevent unnecessary duplication of such applications, the TEA shall maintain a list of the schools, school systems, videos, and other technology-based transmissions that have been approved by the TEA for field-based experience.

(C) An educator preparation program may file an application with the TEA for approval, subject to periodic review, of a public or private school located within any state or territory of the United States, as a site for an internship, student teaching, clinical teaching, and/or practicum required by this chapter. The application shall be in a form developed by the TEA staff and shall include, at a minimum:

(i) the accreditation(s) held by the school;

(ii) a crosswalk comparison of the alignment of the instructional standards of the school with those of the applicable TEKS and SBEC certification standards;

(iii) the certification, credentials, and training of the field supervisor(s) who will supervise candidates in the school; and

(iv) the measures that will be taken by the educator preparation program to ensure that the candidate's experience will be equivalent to that of a candidate in a Texas public school accredited by the TEA.

(D) An educator preparation program may file an application with the SBEC for approval, subject to periodic review, of a public or private school located outside the United States, as a site for student teaching or clinical teaching required by this chapter. The application shall be in a form developed by the TEA staff and shall include, at a minimum, the same elements required in subparagraph (C) of this paragraph for schools located within any state or territory of the United States, with the addition of a description of the on-site program personnel and program support that will be provided and a description of the school's recognition by the U.S. State Department Office of Overseas Schools.

(e) Campus Mentors and Cooperating Teachers. In order to support a new educator and to increase teacher retention, an educator preparation program shall collaborate with the campus administrator to assign each candidate a campus mentor during his or her internship or assign a cooperating teacher during the candidate's student teaching or clinical teaching experience. The educator preparation program is responsible for providing mentor and/or cooperating teacher training that relies on scientifically-based research, but the program may allow the training to be provided by a school district, if properly documented.

(f) On-Going Educator Preparation Program Support. Supervision of each candidate shall be conducted with the structured guidance and regular ongoing support of an experienced educator who has been trained as a field supervisor. The initial contact, which may be made by telephone, email, or other electronic communication, with the assigned candidate must occur within the first three weeks of as-

signment. The field supervisor shall document instructional practices observed, provide written feedback through an interactive conference with the candidate, and provide a copy of the written feedback to the candidate's campus administrator. Informal observations and coaching shall be provided by the field supervisor as appropriate.

(1) Each observation must be at least 45 minutes in duration and must be conducted by the field supervisor.

(2) An educator preparation program must provide the first observation within the first six weeks of all assignments.

(3) For an internship, an educator preparation program must provide a minimum of two formal observations during the first semester and one formal observation during the second semester.

(4) For student teaching and clinical teaching, an educator preparation program must provide a minimum of three observations during the assignment, which is a minimum of 12 weeks.

(5) For a practicum, an educator preparation program must provide a minimum of three observations during the term of the practicum.

(g) Exemption. Under the Texas Education Code (TEC), §21.050(c), a candidate who receives a baccalaureate degree required for a teaching certificate on the basis of higher education coursework completed while receiving an exemption from tuition and fees under the TEC, §54.214, is exempt from the requirements of this chapter relating to field-based experience or internship consisting of student teaching.

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 6, 2010.

TRD-201006882

Jerel Booker

Associate Commissioner, Educator and Student Policy Initiatives, Texas Education Agency

State Board for Educator Certification

Effective date: December 26, 2010

Proposal publication date: September 3, 2010

For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 247. EDUCATORS' CODE OF ETHICS

19 TAC §247.1, §247.2

The State Board for Educator Certification (SBEC) adopts amendments to §247.1 and §247.2, relating to the educators' code of ethics standards. The amendments to §247.1 and §247.2 are adopted with changes to the proposed text as published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8038). The rules establish the purpose and scope of the educators' code of ethics and standard practices for Texas educators.

The adopted amendments to 19 TAC Chapter 247 update the educators' code of ethics to clarify and better address current issues relating to ethical and professional educator conduct. The adopted amendments result from the SBEC's rule review conducted in accordance with Texas Government Code, §2001.039. The adopted amendments reflect input received at the March 25, 2010, and June 28, 2010, stakeholder meetings, including changes adopted by the SBEC at its October 2010 meeting. Following is a description of the adopted changes.

Section 247.1 was reorganized to reflect language previously included in §247.2. Specifically, the statement of purpose currently in 19 TAC §247.2(a) was amended and moved to §247.1(b). Language currently in §247.1(a) was amended and moved as adopted new subsection (c) to provide for the enforcement of the Educators' Code of Ethics through the disciplinary proceedings provided in 19 TAC Chapter 249, Disciplinary Proceedings, Sanctions, and Contested Cases. Adopted new subsection (d) references the primary goals for such disciplinary proceedings, as provided in 19 TAC §249.5, Purpose.

Since published as proposed, changes were made to further clarify and enhance the provisions in §247.1 and §247.2, as well as in response to requests by the SBEC, public testimony given at the August 2010 meeting, and public comments received.

Since published as proposed, new subsection §247.1(e) was revised to remove the incorporation by reference to 19 TAC §249.3, Definitions, and, instead, add the definitions for words and terms used in Chapter 247 to be consistent with definitions in §249.3. The definition of "endanger" in new paragraph (8) covers only exposure of a student or minor to an "unjustified" risk. Definitions for "intentionally," "knowingly," and "minor" are included as new paragraphs (10), (11), and (12), respectively, in §247.1(e), and the definition for "negligence" is not included in §247.1(e). In addition, the phrase "worthy to instruct or to supervise the youth of this state" was defined in new paragraph (21). The section title of 19 TAC §247.1 was also amended to include "Definitions."

The adopted amendment to 19 TAC §247.2 moves current subsection (a) to §247.1, as previously described, and, as a result, current subsection (b) was reorganized accordingly. Language in paragraph (1)(A), Standard 1.1, was amended to include intentionally and recklessly, as well as knowingly deceptive practices, and to specifically cover deceptive practices regarding official policies of educator preparation programs, the Texas Education Agency, and the SBEC, as well as school districts and educational institutions. Paragraph (1)(G), Standard 1.7, was amended to strike the word "applicable." Adopted new paragraph (1)(I), Standard 1.9, prohibits threats of violence against school district employees, school board members, students, or parents of students. Adopted new paragraph (1)(J), Standard 1.10, provides that an educator shall be of good moral character and be worthy to instruct or to supervise the youth of this state. Since published as proposed, in new paragraph (1)(J), the reference to the definitions in §249.3 was deleted as it is no longer necessary and the phrase "demonstrate that he or she is fit" was replaced with the word "be" since "fit" is not a defined term.

Since published as proposed, language in adopted new paragraph (1)(K), Standard 1.11, was amended to replace the term "purposefully" with the terms "intentionally or knowingly," which are defined terms, to provide that an educator should not "intentionally or knowingly" misrepresent his or her employment history, criminal history, and/or disciplinary record when applying for subsequent employment.

Adopted new paragraph (1)(L), Standard 1.12, provides that an educator should refrain from the illegal use or distribution of controlled substances and/or abuse of prescription drugs and toxic inhalants. Adopted new paragraph (1)(M), Standard 1.13, provides that an educator should not consume alcoholic beverages

on school property or during school activities when students are present.

Since published as proposed, language in paragraph (2)(B), Standard 2.2, was amended to delete the word "recklessly." Paragraph (2)(E), Standard 2.5, was amended to update the term "sex" to "gender" and include language to address discrimination against colleagues on the basis of sexual orientation. Paragraph (2)(G), Standard 2.7, was amended to include retaliation against anyone who provides information for an SBEC disciplinary investigation or proceeding.

Language in paragraph (3)(B), Standard 3.2, was amended to include the words "intentional" and "recklessly," regarding the treatment by an educator that adversely affects or endangers a student or minor. Since published as proposed, the word "negligently" was deleted. Paragraph (3)(C), Standard 3.3, was amended to cover misrepresentations of facts regarding a student that are intentional or made with reckless disregard. Paragraph (3)(D), Standard 3.4, was amended to update the term "sex" to "gender" and include language to address discrimination against students on the basis of sexual orientation. Paragraph (3)(E), Standard 3.5, was amended to include intentionally, knowingly, or recklessly engaging in neglect or abuse of a student or minor, as well as physical mistreatment. Paragraph (3)(F), Standard 3.6, was amended to include minors, as well as students. Since published as proposed, paragraph (3)(G), Standard 3.7, was further amended to replace the phrase "student or minor" with the phrase "person under 21 years of age unless the educator is a parent or guardian of that child."

Adopted new paragraph (3)(H), Standard 3.8, provides that an educator should maintain a professional educator-student relationship with students. Since published as proposed, language was amended by adding the phrase "and boundaries based on a reasonably prudent educator standard."

Adopted new paragraph (3)(I), Standard 3.9, provides that an educator should refrain from inappropriate communication, including electronic communication, with a student or minor. Since published as proposed, language was amended by removing the words "excessive and/or" and "excessive or" since excessive is not a defined term.

The adopted amendments have no procedural and reporting implications to school districts and educators. Also, the adopted amendments have no locally maintained paperwork requirements to school districts and educators.

There is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

Following the August 2010 SBEC meeting, the proposed amendments to §247.1 and §247.2 were filed with the *Texas Register* initiating the official public comment period. The following comments were received regarding the proposed amendments.

Non-Binding Referendum

Comment: Brim, Arnett, Robinett, Conners & McCormick, P.C. (Brim Arnett); the Association of Texas Professional Educators (ATPE) and its state president; the Texas Classroom Teachers Association (TCTA); and the Texas American Federation of Teachers (Texas AFT) commented that the proposed amendments to 19 TAC Chapter 247 should be submitted to a non-binding referendum of certified educators before the proposed amendments are adopted, as was done with the 2002 amendments to Chapter 247.

Board Response: The SBEC disagreed and took action to adopt, subject to State Board of Education (SBOE) review, the amendments with changes since published as proposed.

Although initially very similar in content to the Educators' Code of Ethics developed by the former Teachers' Professional Practices Commission (TPPC), the Educators' Code of Ethics contained in 19 TAC Chapter 247 was adopted as an SBEC rule in 1998 under SBEC statutory authority; thus it is no longer the same as the TPPC Educators' Code of Ethics. In order for the TPPC to implement the Educators' Code of Ethics, the TPPC was required by statute to conduct a referendum. In contrast, the Texas Education Code (TEC), §21.041(b)(8), the statutory authority for Chapter 247, requires that the SBEC "shall propose rules that provide for the adoption, amendment, and enforcement of an educator's code of ethics." The SBEC, therefore, was never required to adopt the Educators' Code of Ethics developed by the TPPC and was never statutorily required to follow the same adoption procedure, including a non-binding referendum, conducted by the TPPC.

Public comment on the amendments to 19 TAC Chapter 247 had been actively solicited and responded to for more than six months. The statutorily required review of and/or amendments to Chapter 247 had previously been on the SBEC agenda for the February 2010, April 2010, June 2010, and August 2010 meetings. A stakeholder meeting was held March 25, 2010, to which all the teacher organization commenters were invited. Texas Education Agency (TEA) staff considered the comments made at the meeting and proposed additional changes to the amendments before placing the item on the June 2010 SBEC agenda. In order to ensure that all concerns were received and considered, the SBEC postponed consideration of the item, as recommended by the TEA staff, so that stakeholders could submit additional comments. A second stakeholder meeting was held on June 28, 2010. Additional rule text changes were made in response to comments received, and proposed amendments were presented for action at the August 2010 SBEC meeting. The SBEC took action to approve the amendments for filing as proposed, which were published in the September 3, 2010, issue of the *Texas Register.*

Further rule text changes were then made in response to public testimony received at the August 2010 meeting, requests for clarification by the SBEC at the August 2010 meeting, and public comments received. The changes were incorporated into the October 2010 SBEC agenda item presenting the amendments for adoption, subject to SBOE review. The official public comment period extended to the October 2010 meeting; all comments received up to and including those presented at that meeting were considered. As a result, further revisions were made to the amendments that were adopted, subject to SBOE review, by the SBEC.

The SBEC disagreed that the non-binding referendum that was held regarding the 2002 amendments to the Educators' Code of Ethics should be viewed as creating a precedent. When the Educators' Code of Ethics contained in 19 TAC Chapter 247 was adopted in rule in 1998, as discussed earlier, a referendum was not required and the SBEC minutes do not reflect that a referendum was held. Pursuant to TEC, §21.041(b)(8), the SBEC expressly provided in 19 TAC §247.1 that "The board may amend the ethics code in the same manner as any other formal rule." However, because the 2002 amendments represented a major

philosophical shift from the original Educators' Code of Ethics since they contained standards that were to be made expressly enforceable for the first time, the SBEC at that time voluntarily conducted a non-binding referendum. In contrast, the current amendments do not represent such a major change in the scope and applicability of 19 TAC Chapter 247. The amendments to the ethical standards set forth the SBEC's policy of protecting students and minors and further clarify and define the current standards for educators.

If the SBEC had not taken action to adopt, subject to SBOE review, the amendments to 19 TAC Chapter 247 and §249.3 at the October 2010 meeting, the proposals would have expired under the timelines of the Administrative Procedure Act. In addition, the SBEC was prohibited under the Texas Open Meetings Act, Texas Government Code, §552.041, from directing the TEA staff to conduct a referendum because the subject was not posted as part of the SBEC's agenda for the October 2010 meeting. The result, assuming that a non-binding referendum process could be adopted at the next SBEC meeting in February 2011 and that funding for such a process could be obtained, would have been that no amendments to the Educators' Code of Ethics would have become effective for another year or more. Since the teacher organizations that represent the great majority of all Texas teachers have had multiple opportunities to contribute and comment on the amendments for more than six months, the SBEC disagreed that adding a non-binding educator referendum to the already extensive SBEC rulemaking process would have been a reasonable or appropriate use of scarce government resources. While teacher organizations asserted that the SBEC would gain "teacher buy-in" to support the amendments to the Educators' Code of Ethics, this does not outweigh the cost of conducting a non-binding referendum.

§247.1. Purpose and Scope; Definitions

Comment: ATPE commented that most of the text in proposed §247.1(b) should be deleted, beginning with the phrase "and shall safeguard academic freedom...," and continuing to the end of the subsection. In the alternative, ATPE and TCTA commented that current §247.2(a) should be reinstated.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.1(b) as published as proposed. The text of §247.1(b) is almost identical to the current §247.2(a). The only differences are the addition of the phrase "good moral character" and the statement that Chapter 247 applies not only to educators but also to candidates for educator certification, which was added in response to a request by educator preparation program representatives at the stakeholder meetings.

Comment: ATPE commented that proposed §247.1(d) should be deleted since it restates §249.5.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.1(d) as published as proposed. It is important, especially for candidates for educator certification and beginning educators, that the Educators' Code of Ethics expressly state the foundation of the ethical standards.

Comment: Brim Arnett, Texas AFT, and ATPE commented that the term "good moral character," as defined in proposed §247.1(e) and used in §247.2(1)(J), Standard 1.10, is vague and unnecessary in light of the existing term "unworthy to instruct or to supervise the youth of this state." The ATPE also commented that the proposed definition for the term "worthy to instruct or to supervise the youth of this state" and used in §247.1(e) and §247.2(1)(J), Standard 1.10, should define what "moral, mental, and psychological qualities" are required.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.1(e) with changes since published as proposed to add the definitions for words, terms, and phrases used in Chapter 247. "Good moral character" is not a new standard for educators; it has been required of applicants for certification since the SBEC first adopted 19 TAC §249.12, Administrative Denial; Appeal, in 1999 and has been incorporated as a ground for sanctions under §249.15(b)(7) since 2007. The definition of the term is the same as the definition in §249.3. In addition, "good moral character" is used as a statutory standard by approximately 17 Texas licensing authorities under the Texas Occupations Code, as well as other Texas professions and the educator licensing authorities of other states. The definition of "worthy to instruct" and the restatement of the standard of "unworthy to instruct" in the affirmative is based on the standard set by the landmark case of *Marrs v. Matthews,* 270 S.W. 586 (Texarkana--1925), which held:

"The word 'unworthy,' as used in common parlance, has a well-defined signification. As here used, it means the lack of worth; the absence of those moral and mental qualities which are required to enable one to render the service essential to the accomplishment of the object which the law has in view."

The *Marrs* court further held that a statute that attempted to enumerate those qualities "would either be incomplete or so inflexible as to defeat the ends sought" and that the very nature of the subject requires discretion in determining who is "unworthy to instruct."

§247.2. Code of Ethics and Standard Practices for Texas Educators

Comment: Brim Arnett, Texas AFT, and ATPE commented that the words "intentionally" and "knowingly" in §247.2(1)(A), Standard 1.1, are redundant and that the addition of the policies of educator preparation programs, the TEA, and the SBEC to the standard is unnecessary and unclear. Brim Arnett also commented that adding "reckless" deceptions to the standard raises First Amendment concerns.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(1)(A) as published as proposed. The words "intentionally" and "knowingly" have distinct meanings as defined in §247.1(e). The policies of educator preparation programs were added at the request of educator preparation program representatives at the stakeholder meetings, and the policies of the TEA and the SBEC were added to cover all educational matters. Several other states have policies covering deceptive practices regarding all educational matters. The word "recklessly," defined in §247.1(e) does not violate the First Amendment because it applies only to deceptive practices committed with conscious disregard for the consequences.

Comment: Brim Arnett and ATPE commented that deleting the word "applicable" from §247.2(1)(G), Standard 1.7, would expand this provision to include laws and rules unrelated to education.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(1)(G) as published as proposed. The word "applicable" is undefined and ambiguous; it could mean "applicable to the educator in

question" rather than "applicable to educational matters," as the commenters contend. The educator conduct codes of several other states provide that educators should comply with state and federal laws, and it is reasonable to state that expectation regarding Texas educators.

Comment: Brim Arnett commented that §247.2(1)(I), Standard 1.9, was unnecessary since it addresses conduct that is already a violation of criminal law. ATPE commented that the standard should clarify that it covers only actual threats of violence.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(1)(I) as published as proposed. The standard emphasizes that threats of violence by educators against other members of the education community are unethical as well as illegal. The standard clearly applies only to actual threats of violence.

Comment: Brim Arnett, Texas State Teachers Association (TSTA), and ATPE commented that use of the word "demonstrate" in §247.2(1)(J), Standard 1.10, would shift the burden in discipline cases to an educator to show that he or she possesses good moral character and is worthy to instruct.

Board Response: The SBEC agreed that the word "demonstrate" might be interpreted in the manner suggested by the commenters. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(1)(J) with changes since published as proposed to replace the phrase "demonstrate that he or she is fit" with the word "be." Also, "fit" is not a defined term.

Comment: Brim Arnett, TCTA, and ATPE commented that §247.2(1)(K), Standard 1.11, addressing misrepresentations by educators concerning prior employment, improperly intrudes into the employment relationship between educators and local school districts.

Board Response: The SBEC agreed that the proposed phrase "misrepresent the circumstances of his or her prior employment" was overly broad. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(1)(K) with changes since published as proposed to replace the phrase with the more specific phrase "misrepresent his or her employment history." However, the SBEC disagreed that it was unreasonable to state the expectation that educators should not knowingly or intentionally misrepresent their employment history, criminal history, or disciplinary record when applying for employment, and took action to adopt, subject to SBOE review, a clarifying change replacing "purposefully" with "intentionally or knowingly" since published as proposed.

Comment: Brim Arnett and ATPE commented that §247.2(1)(L), Standard 1.12, is unnecessary because the standard addresses matters already covered by criminal law. Brim Arnett made the same comment regarding §247.2(1)(M), Standard 1.13.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendments to 19 TAC §247.2(1)(L) and (M) as published as proposed. The standards are not unnecessary; they make explicit that the described conduct is a higher ethical concern for an educator than it is for the general public, because of an educator's unique right of access to students and minors and the duty to protect, instruct, supervise, and be a role model for the youth of this state.

Comment: Brim Arnett, TCTA, and Texas AFT commented that adding the word "recklessly" to proposed §247.2(2)(B), Standard 2.2, addressing false statements by an educator concerning a colleague or a school system, would make this standard overly broad and raise First Amendment concerns.

Board Response: Although the SBEC disagreed that First Amendment rights would be affected because the definition of "recklessly" in 19 TAC §247.1(e) requires conscious disregard of consequences, the SBEC took action to adopt, subject to SBOE review, the amendment to §247.2(2)(B) with a change since published as proposed to delete the word "recklessly."

Comment: Brim Arnett commented that substituting the word "gender" for the word "sex" and adding the word "sexual orientation" to §247.2(2)(E), Standard 2.5, and §247.2(3)(D), Standard 3.4, was unnecessary and already subject to sanction under other Educators' Code of Ethics provisions.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendments to 19 TAC §247.2(2)(E) and §247.2(3)(D) as published as proposed. The amendments to these standards are necessary because they make explicit that the additional types of discrimination described, as well as the types already described in the existing standards, are violations of the higher ethical standards for educators.

Comment: Brim Arnett commented that the proposed amendment to §247.2(2)(G), Standard 2.7, regarding the addition of retaliation against any individual who provides information for a disciplinary investigation, should be limited by a good faith requirement.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(2)(G) as published as proposed. Prohibiting retaliation against those who participate in a disciplinary investigation is crucial to the integrity of the process. A good faith requirement is not necessary because making false statements about a colleague is already a violation of §247.2(2)(E), Standard 2.5.

Comment: Brim Arnett, Texas AFT, TSTA, and ATPE commented that the proposed addition of "negligently" to §247.2(3)(B), Standard 3.2, would make this standard overly broad.

Board Response: The SBEC agreed that the addition of the word "negligently" might make this standard overly broad. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(B) with changes since published as proposed to delete the word "negligently."

Comment: Brim Arnett and Texas AFT commented that the proposed addition of "intentionally" to §247.2(3)(B), Standard 3.2, would be redundant since the word "knowingly" is already in the standard. Brim Arnett also commented that the proposed addition of the word "recklessly" was unnecessary and that the proposed addition of the word "minors" was not appropriate since an educator should not be subject to sanction for non-criminal conduct relating to minors who are not students.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(B) with changes since published as proposed to delete the word "negligently." The words "intentionally," "knowingly," and "recklessly" have distinct meanings as defined in §247.1(e) and are, therefore, not unnecessary or redundant. The SBEC has consistently stated its policy that mistreatment of minors, even if they are not students, is an ethical violation that should be expressly stated in the Educators' Code of Ethics.

Comment: Brim Arnett commented that the proposed addition of the word "recklessly" to §247.2(3)(C), Standard 3.3, was unnecessary and overly broad.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(C) as published as proposed. The word "recklessly," defined in §247.1(e), would not apply to misrepresentations about a student based on a mistake of fact by the educator; it applies only to misrepresentations that are made with conscious disregard for the consequences.

Comment: Brim Arnett commented that the proposed addition of the words "recklessly" and "minors" to §247.2(3)(E), Standard 3.5, is unnecessary because the conduct that would be prohibited by the proposed standard is already illegal.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(E) as published as proposed. The standard emphasizes and makes explicit the SBEC's policy that physical mistreatment, neglect, and abuse of students and minors by educators are not only illegal but also unethical.

Comment: Brim Arnett commented that the addition of the word "minors" to §247.2(3)(F), Standard 3.6, was not appropriate since an educator should not be subject to sanction for non-criminal conduct relating to minors who are not students.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(F) as published as proposed. The SBEC has consistently stated its policy that an educator's action to solicit or engage in sexual conduct or a romantic relationship with a student, whether or not the student attends the school where the educator works, or with a minor, even if not a student, is a serious ethical violation that should be expressly stated in the Educators' Code of Ethics.

Comment: Brim Arnett and ATPE commented that the proposed addition of the word "minors" to §247.2(3)(G), Standard 3.7, was overly broad. ATPE also commented that the phrase "any person under 21 years of age" did not account for Texas law that allows a parent or guardian to furnish alcohol to his or her own child.

Board Response: The SBEC agreed that the proposed amendment to 19 TAC §247.2(3)(G) did not account for the exception allowed by Texas law. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to §247.2(3)(G) with additional changes since published as proposed to replace the phrase "any student or minor" with the phrase "any person under 21 years of age unless the educator is a parent or guardian of that child."

Comment: Brim Arnett and ATPE commented that the word "appropriate" in §247.2(3)(H), Standard 3.8, was too vague and subjective. ATPE also commented that the phrase "and boundaries based on a reasonably prudent educator standard" should be deleted.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, 19 TAC §247.2(3)(H) with a change since published as proposed to clarify that educators will maintain professional educator-student relationships and boundaries based on a reasonably prudent educator standard. This standard provides guidance to educators by stating that the priority in their relationships with students is maintaining an appropriate professional relationship and, at the same time, is flexible enough to account for a broad range of educator-student interaction.

Comment: Brim Arnett, TSTA, and ATPE commented that the word "excessive" should be deleted from §247.2(3)(I), Standard 3.9.

Board Response: The SBEC agreed that the proposed amendment to 19 TAC §247.2(3)(I) should focus on inappropriateness of electronic communications and that the amount of communication is only one factor to be considered. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to §247.2(3)(I) with changes since published as proposed to delete both instances of the word "excessive."

Comment: Brim Arnett and ATPE commented that the word "appropriate" in §247.2(3)(I), Standard 3.9, was too vague and subjective and that the proposed new standard was unnecessary since the conduct would already be covered by other SBEC provisions.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the amendment to 19 TAC §247.2(3)(I) with changes since published as proposed. The standard is necessary to make explicit to educators that the educator should ensure that all communications to students, including casual electronic communications through cell phone, text messaging, instant messaging, email, blogging, and social networking be appropriate. The standard avoids setting an inflexible requirement that might restrict appropriate educator-student communications, while at the same time giving educators notice of potential dangers by listing some of the factors that might make such communications inappropriate.

The State Board of Education took no action on the review of the amendments to 19 TAC §247.1 and §247.2 at the November 19, 2010, SBOE meeting.

The amendments are adopted under the Texas Education Code (TEC), §21.041(b)(1), which requires the SBEC to propose rules that provide for the regulation of educators and the general administration of the TEC, Chapter 21, Subchapter B, in a manner consistent with the TEC, Chapter 21, Subchapter B; §21.041(b)(7), which requires the SBEC to propose rules that provide for disciplinary proceedings, including the suspension or revocation of an educator certificate, as provided by Texas Government Code, Chapter 2001; and §21.041(b)(8), which requires the SBEC to propose rules that provide for the enforcement of an educator's code of ethics.

The adopted amendments implement the TEC, §21.041(b)(1), (7), and (8).

§247.1. Purpose and Scope; Definitions.

(a) In compliance with the Texas Education Code, §21.041(b)(8), the State Board for Educator Certification (SBEC) adopts an Educators' Code of Ethics as set forth in §247.2 of this title (relating to Code of Ethics and Standard Practices for Texas Educators). The SBEC may amend the ethics code in the same manner as any other formal rule.

(b) The Texas educator shall comply with standard practices and ethical conduct toward students, professional colleagues, school officials, parents, and members of the community and shall safeguard academic freedom. The Texas educator, in maintaining the dignity of the profession, shall respect and obey the law, demonstrate personal integrity, and exemplify honesty and good moral character. The Texas educator, in exemplifying ethical relations with colleagues, shall extend just and equitable treatment to all members of the profession. The

Texas educator, in accepting a position of public trust, shall measure success by the progress of each student toward realization of his or her potential as an effective citizen. The Texas educator, in fulfilling responsibilities in the community, shall cooperate with parents and others to improve the public schools of the community. This chapter shall apply to educators and candidates for certification.

(c) The SBEC is solely responsible for enforcing the Educators' Code of Ethics for purposes related to certification disciplinary proceedings. The Educators' Code of Ethics is enforced through the disciplinary procedure set forth in Chapter 249 of this title (relating to Disciplinary Proceedings, Sanctions, and Contested Cases) pursuant to the purposes stated therein.

(d) As provided in §249.5 of this title (relating to Purpose), the primary goals the SBEC seeks to achieve in educator disciplinary matters are:

(1) to protect the safety and welfare of Texas schoolchildren and school personnel;

(2) to ensure educators and applicants are morally fit and worthy to instruct or to supervise the youth of the state; and

(3) to fairly and efficiently resolve educator disciplinary proceedings at the least expense possible to the parties and the state.

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

(1) Abuse--Includes the following acts or omissions:

(A) mental or emotional injury to a student or minor that results in an observable and material impairment in the student's or minor's development, learning, or psychological functioning;

(B) causing or permitting a student or minor to be in a situation in which the student or minor sustains a mental or emotional injury that results in an observable and material impairment in the student's or minor's development, learning, or psychological functioning;

(C) physical injury that results in substantial harm to a student or minor, or the genuine threat of substantial harm from physical injury to the student or minor, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline; or

(D) sexual conduct harmful to a student's or minor's mental, emotional, or physical welfare.

(2) Applicant--A party seeking any of the following from the Texas Education Agency staff or the State Board for Educator Certification: issuance of a certificate (including issuance of a new certificate following revocation, cancellation, or surrender of a previously issued certificate); renewal of a certificate; or reinstatement of a suspended certificate.

(3) Code of Ethics--The Code of Ethics and Standards of Practices for Texas Educators, pursuant to this chapter.

(4) Complaint--A written statement submitted to the Texas Education Agency staff that contains essential facts alleging improper conduct by an educator, applicant, or examinee, and provides grounds for sanctions.

(5) Contested case--A proceeding under Chapter 249 of this title (relating to Disciplinary Proceedings, Sanctions, and Contested Cases) in which the legal rights, duties, and privileges of a party are to be determined by the State Board for Educator Certification after an opportunity for an adjudicative hearing.

(6) Disciplinary proceedings--Contested case proceedings before the Texas Education Agency staff, the State Office of Administrative Hearings, and the State Board for Educator Certification that commence when a request for hearing is timely filed under Chapter 249 of this title (relating to Disciplinary Proceedings, Sanctions, and Contested Cases).

(7) Educator--A person who is required to hold a certificate issued under the Texas Education Code, Chapter 21, Subchapter B.

(8) Endanger--Exposure of a student or minor to unjustified risk of injury or to injury that jeopardizes the physical health or safety of the student or minor without regard to whether there has been an actual injury to the student or minor.

(9) Good moral character--The virtues of a person as evidenced, at a minimum, by his or her not having committed crimes relating directly to the duties and responsibilities of the education profession as described in §249.16(b) of this title (relating to Eligibility of Persons with Criminal Convictions for a Certificate under Texas Occupations Code, Chapter 53) or acts involving moral turpitude.

(10) Intentionally--An educator acts intentionally, or with intent, with respect to the nature of his or her conduct or to a result of his or her conduct when it is his or her conscious objective or desire to engage in the conduct or cause the result.

(11) Knowingly--An educator acts knowingly, or with knowledge, with respect to the nature of his or her conduct or to circumstances surrounding his or her conduct when he or she is aware of the nature of the conduct or that the circumstances exist. A person acts knowingly, or with knowledge, with respect to a result of his or her conduct when he or she is aware that the conduct is reasonably certain to cause the result.

(12) Minor--A person under 18 years of age.

(13) Moral turpitude--Improper conduct including, but not limited to, the following: dishonesty; fraud; deceit; theft; misrepresentation; deliberate violence; base, vile, or depraved acts that are intended to arouse or to gratify the sexual desire of the actor; drug or alcohol related offenses as described in §249.16(b) of this title (relating to Eligibility of Persons with Criminal Convictions for a Certificate under Texas Occupations Code, Chapter 53); or acts constituting abuse or neglect under the Texas Family Code, §261.001.

(14) Neglect--The placing or leaving of a student or minor in a situation where the student or minor would be exposed to a substantial risk of physical or mental harm.

(15) Recklessly--An educator acts recklessly, or is reckless, with respect to circumstances surrounding his or her conduct or the results of his or her conduct when he or she is aware of but consciously disregards a substantial and unjustifiable risk that the circumstances exist or the result will occur.

(16) Sanction--

(A) a disciplinary action by the State Board for Educator Certification, including a restriction, reprimand, suspension, surrender, or revocation of a certificate; or

(B) a reasonable and lawful punitive measure imposed by the administrative law judge or presiding officer against a party, representative, or other participant involved in a disciplinary proceeding, hearing, or other matter under Chapter 249 of this title (relating to Disciplinary Proceedings, Sanctions, and Contested Cases).

(17) State Board for Educator Certification--The State Board for Educator Certification acting through its voting members in a decision-making capacity.

(18) State Board for Educator Certification member(s)--One or more of the members of the State Board for Educator Certification, appointed and qualified under the Texas Education Code, §21.033.

(19) Student--A person enrolled in a primary or secondary school, whether public, private, or charter, regardless of the person's age, or a person 18 years of age or younger who is eligible to be enrolled in a primary or secondary school, whether public, private, or charter.

(20) Texas Education Agency staff--Staff of the Texas Education Agency assigned by the commissioner of education to perform the State Board for Educator Certification's administrative functions and services.

(21) Worthy to instruct or to supervise the youth of this state--Presence of those moral, mental, and psychological qualities that are required to enable an educator to render the service essential to the accomplishment of the goals and mission of the State Board for Educator Certification policy and this chapter. "Unworthy to instruct" serves as a basis for sanctions under §249.15(b)(2) of this title (relating to Disciplinary Action by State Board for Educator Certification) and is not limited to specific criminal convictions.

§247.2. Code of Ethics and Standard Practices for Texas Educators. Enforceable Standards.

(1) Professional Ethical Conduct, Practices and Performance.

(A) Standard 1.1. The educator shall not intentionally, knowingly, or recklessly engage in deceptive practices regarding official policies of the school district, educational institution, educator preparation program, the Texas Education Agency, or the State Board for Educator Certification (SBEC) and its certification process.

(B) Standard 1.2. The educator shall not knowingly misappropriate, divert, or use monies, personnel, property, or equipment committed to his or her charge for personal gain or advantage.

(C) Standard 1.3. The educator shall not submit fraudulent requests for reimbursement, expenses, or pay.

(D) Standard 1.4. The educator shall not use institutional or professional privileges for personal or partisan advantage.

(E) Standard 1.5. The educator shall neither accept nor offer gratuities, gifts, or favors that impair professional judgment or to obtain special advantage. This standard shall not restrict the acceptance of gifts or tokens offered and accepted openly from students, parents of students, or other persons or organizations in recognition or appreciation of service.

(F) Standard 1.6. The educator shall not falsify records, or direct or coerce others to do so.

(G) Standard 1.7. The educator shall comply with state regulations, written local school board policies, and other state and federal laws.

(H) Standard 1.8. The educator shall apply for, accept, offer, or assign a position or a responsibility on the basis of professional qualifications.

(I) Standard 1.9. The educator shall not make threats of violence against school district employees, school board members, students, or parents of students.

(J) Standard 1.10. The educator shall be of good moral character and be worthy to instruct or supervise the youth of this state.

(K) Standard 1.11. The educator shall not intentionally or knowingly misrepresent his or her employment history, criminal history, and/or disciplinary record when applying for subsequent employment.

(L) Standard 1.12. The educator shall refrain from the illegal use or distribution of controlled substances and/or abuse of prescription drugs and toxic inhalants.

(M) Standard 1.13. The educator shall not consume alcoholic beverages on school property or during school activities when students are present.

(2) Ethical Conduct Toward Professional Colleagues.

(A) Standard 2.1. The educator shall not reveal confidential health or personnel information concerning colleagues unless disclosure serves lawful professional purposes or is required by law.

(B) Standard 2.2. The educator shall not harm others by knowingly making false statements about a colleague or the school system.

(C) Standard 2.3. The educator shall adhere to written local school board policies and state and federal laws regarding the hiring, evaluation, and dismissal of personnel.

(D) Standard 2.4. The educator shall not interfere with a colleague's exercise of political, professional, or citizenship rights and responsibilities.

(E) Standard 2.5. The educator shall not discriminate against or coerce a colleague on the basis of race, color, religion, national origin, age, gender, disability, family status, or sexual orientation.

(F) Standard 2.6. The educator shall not use coercive means or promise of special treatment in order to influence professional decisions or colleagues.

(G) Standard 2.7. The educator shall not retaliate against any individual who has filed a complaint with the SBEC or who provides information for a disciplinary investigation or proceeding under this chapter.

(3) Ethical Conduct Toward Students.

(A) Standard 3.1. The educator shall not reveal confidential information concerning students unless disclosure serves lawful professional purposes or is required by law.

(B) Standard 3.2. The educator shall not intentionally, knowingly, or recklessly treat a student or minor in a manner that adversely affects or endangers the learning, physical health, mental health, or safety of the student or minor.

(C) Standard 3.3. The educator shall not intentionally, knowingly, or recklessly misrepresent facts regarding a student.

(D) Standard 3.4. The educator shall not exclude a student from participation in a program, deny benefits to a student, or grant an advantage to a student on the basis of race, color, gender, disability, national origin, religion, family status, or sexual orientation.

(E) Standard 3.5. The educator shall not intentionally, knowingly, or recklessly engage in physical mistreatment, neglect, or abuse of a student or minor.

(F) Standard 3.6. The educator shall not solicit or engage in sexual conduct or a romantic relationship with a student or minor.

(G) Standard 3.7. The educator shall not furnish alcohol or illegal/unauthorized drugs to any person under 21 years of age unless the educator is a parent or guardian of that child or knowingly allow any person under 21 years of age unless the educator is a parent or guardian of that child to consume alcohol or illegal/unauthorized drugs in the presence of the educator.

(H) Standard 3.8. The educator shall maintain appropriate professional educator-student relationships and boundaries based on a reasonably prudent educator standard.

(I) Standard 3.9. The educator shall refrain from inappropriate communication with a student or minor, including, but not limited to, electronic communication such as cell phone, text messaging, email, instant messaging, blogging, or other social network communication. Factors that may be considered in assessing whether the communication is inappropriate include, but are not limited to:

(i) the nature, purpose, timing, and amount of the communication;

(ii) the subject matter of the communication;

(iii) whether the communication was made openly or the educator attempted to conceal the communication;

(iv) whether the communication could be reasonably interpreted as soliciting sexual contact or a romantic relationship;

(v) whether the communication was sexually explicit; and

(vi) whether the communication involved discussion(s) of the physical or sexual attractiveness or the sexual history, activities, preferences, or fantasies of either the educator or the student.

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 6, 2010.

TRD-201006883

Jerel Booker

Associate Commissioner, Educator and Student Policy Initiatives, Texas Education Agency

State Board for Educator Certification

Effective date: December 26, 2010

Proposal publication date: September 3, 2010

For further information, please call: (512) 475-1497

♦ ♦ ♦

CHAPTER 249. DISCIPLINARY PROCEEDINGS, SANCTIONS, AND CONTESTED CASES

SUBCHAPTER A. GENERAL PROVISIONS

19 TAC §249.3

The State Board for Educator Certification (SBEC) adopts an amendment to §249.3, concerning disciplinary proceedings, sanctions, and contested cases. The amendment to §249.3 was adopted with changes to the proposed text as published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8041). The rule establishes definitions for words, terms, and phrases used in disciplinary proceedings, sanctions, and contested cases. The adopted amendment incorporates technical edits and adds definitions for words, terms, and phrases contained in 19 TAC Chapter 247, Educators' Code of Ethics.

The adopted amendment reflects input received at the March 25, 2010, and June 28, 2010, stakeholder meetings, including changes adopted by the SBEC at its October 2010 meeting. Following is a description of the adopted changes.

The adopted amendment to 19 TAC §249.3 adds definitions for the terms, "abuse," "endanger," "neglect," "physical mistreatment," and "student." The definition for the phrase, "unworthy to instruct or to supervise the youth of this state," was amended to clarify that a criminal conviction is not necessary to render an educator unworthy to instruct. The phrase is defined as the absence of those moral, mental, and psychological qualities that are required to enable an educator to render the service essential to the accomplishment of the goals and mission of the SBEC policy and the Educators' Code of Ethics.

Since published as proposed, changes were made to further clarify and enhance the provisions in §249.3, as well as in response to requests by the SBEC, public testimony given at the August 2010 meeting, and public comments received.

Since published as proposed, the definitions of "abuse" and "neglect" were expanded to include language as stated in the Texas Family Code. The definition of "endanger" was amended to replace the term "child" with the term "student or minor" and clarify that "the risk" is "unjustified risk," which is consistent with the adopted definition in 19 TAC §247.1, Purpose and Scope; Definitions. Also, since published as proposed, definitions for "recklessly" and "worthy to instruct or to supervise the youth of this state" were added as new paragraphs (37) and (53), respectively, to be consistent with the adopted definitions in §247.1(e)(15) and (21). In addition, the proposed definition of "negligence" was deleted and, overall, the definitions in §249.3 were renumbered accordingly to reflect the addition and deletion of definitions in this section.

Throughout 19 TAC §249.3, the acronyms were replaced with proper names since the section addresses definitions. Other technical edits were made to reflect *Texas Register* formatting requirements.

The adopted amendment has no procedural and reporting implications to school districts and educators. Also, the adopted amendment has no locally maintained paperwork requirements to school districts and educators.

There is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

Following the August 2010 SBEC meeting, the proposed amendment to 19 TAC §249.3 was filed with the *Texas Register* initiating the official public comment period. The following comments were received regarding the proposed amendment.

Comment: The Association of Texas Professional Educators (ATPE) commented that the definition of the word "abuse" in the proposed amendment to §249.3 was unnecessary and too broad because of the inclusion of the word "omission."

Board Response: The SBEC disagreed and took action to adopt, subject to State Board of Education (SBOE) review, the definition of the word "abuse" with a change since published as proposed. The definition of the word "abuse," as specified in the Texas Fam-

ily Code, §261.001(1), is given in full in 19 TAC §249.3 rather than merely being referenced. The word "abuse" is used in the definition of "moral turpitude" in §249.3 and, therefore, provides additional clarity. The Texas Family Code definition includes the word "omission."

Comment: Brim, Arnett, Robinett, Conners & McCormick, P.C. (Brim Arnett) commented that the definition of the word "endanger" in the proposed amendments to §249.3 should not be adopted. ATPE commented that the proposed definition should include a provision that the risk to which the child would be exposed must be unjustified.

Board Response: The SBEC disagreed that the definition should not be adopted, but the SBEC agreed that the definition should be amended to provide for situations where exposing a child to risk was justified under the circumstances. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to 19 TAC §249.3 with a change since published as proposed to add the word "unjustified" to the definition of the word "endanger."

Comment: Brim Arnett and the Texas State Teachers Association (TSTA) commented that the definition of the word "negligence" in the proposed amendments to §249.3 should not be adopted.

Board Response: The SBEC agreed that the definition of the word "negligence" in the proposed amendment to 19 TAC §249.3 was unnecessary since the SBEC agreed to delete all references to negligence in the proposed standards. Therefore, the SBEC took action to adopt, subject to SBOE review, the amendment to §249.3 with changes since published as proposed to delete the definition of the word "negligence."

Comment: Brim Arnett and ATPE commented that the definition of the phrase "physical mistreatment" in the proposed amendment to §249.3 was vague and improperly shifted the burden of proof to the educator.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the definition of "physical mistreatment" in 19 TAC §249.3(33) as published as proposed. In order to constitute "physical mistreatment," the definition would require proof that touching another was unreasonable or offensive to a reasonable person in similar circumstances. Conduct that was offensive and, therefore, met this definition could still be deemed not to constitute physical mistreatment under the affirmative defense if that conduct were justified.

Comment: Brim Arnett commented that the definition of the word "student" in the proposed amendment to §249.3 should be restricted to a student at the educator's school or school district.

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the definition of the word "student" in 19 TAC §249.3(46) as published as proposed. The SBEC has consistently stated its policy that unethical conduct with any student, whether or not the student attends the school or school district, is a serious ethical violation, whether or not such conduct violates criminal law.

Comment: Brim Arnett commented that the revised definition of the phrase "unworthy to instruct or to supervise the youth of this state" in the proposed amendment to §249.3 was too vague because it did not define the term "qualities."

Board Response: The SBEC disagreed and took action to adopt, subject to SBOE review, the definition of the phrase "unworthy to instruct or to supervise the youth of this state" in the amendment to 19 TAC §249.3(51) as published as proposed. As discussed earlier, the definition is based upon the holding in the case that established that Texas educators must not be "unworthy to instruct or to supervise the youth of this state." *Marrs v. Matthews.*

The SBOE took no action on the review of the amendment to 19 TAC §249.3 at the November 19, 2010, SBOE meeting.

The amendment is adopted under the Texas Education Code (TEC), §21.041(b)(1), which requires the SBEC to propose rules that provide for the regulation of educators and the general administration of the TEC, Chapter 21, Subchapter B, in a manner consistent with the TEC, Chapter 21, Subchapter B; §21.041(b)(7), which requires the SBEC to propose rules that provide for disciplinary proceedings, including the suspension or revocation of an educator certificate, as provided by Texas Government Code, Chapter 2001; and §21.041(b)(8), which requires the SBEC to propose rules that provide for the enforcement of an educator's code of ethics.

The adopted amendment implements the TEC, §21.041(b)(1), (7), and (8).

§249.3. Definitions.

The following words, terms, and phrases, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Abuse--Includes the following acts or omissions:

(A) mental or emotional injury to a student or minor that results in an observable and material impairment in the student's or minor's development, learning, or psychological functioning;

(B) causing or permitting a student or minor to be in a situation in which the student or minor sustains a mental or emotional injury that results in an observable and material impairment in the student's or minor's development, learning, or psychological functioning;

(C) physical injury that results in substantial harm to a student or minor, or the genuine threat of substantial harm from physical injury to the student or minor, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline; or

(D) sexual conduct harmful to a student's or minor's mental, emotional, or physical welfare.

(2) Administrative denial--A decision or action by the Texas Education Agency staff to deny a person any of the following based on the withholding or voiding of certification test scores; the invalidation of a certification test registration; or evidence of a lack of good moral character or improper conduct:

(A) admission to an educator preparation program;

(B) certification (including certification following revocation, cancellation, or surrender of a previously issued certificate) or renewal of certification; or

(C) reinstatement of a previously suspended certificate.

(3) Administrative law judge--A person appointed by the chief judge of the State Office of Administrative Hearings under the Texas Government Code, Chapter 2003.

(4) Answer--The initial responsive pleading filed in reply to factual and legal issues raised in a petition.

(5) Applicant--A party seeking any of the following from the Texas Education Agency staff or the State Board for Educator Cer-

tification: issuance of a certificate (including issuance of a new certificate following revocation, cancellation, or surrender of a previously issued certificate); renewal of a certificate; or reinstatement of a suspended certificate.

(6) Cancellation--The invalidation of an erroneously issued certificate.

(7) Certificate--The whole or part of any certificate, permit, approval, endorsement, or similar form of permission issued by the Texas Education Agency staff or the State Board for Educator Certification. The official certificate is the record of the certificate as maintained on the Texas Education Agency's website.

(8) Certificate holder--A person who holds a certificate issued under the Texas Education Code, Chapter 21, Subchapter B.

(9) Chair--The presiding officer of the State Board for Educator Certification, elected pursuant to the Texas Education Code, §21.036, or other person designated by the chair to act in his or her absence or inability to serve.

(10) Chief judge--The chief administrative law judge of the State Office of Administrative Hearings.

(11) Code of Ethics--The Code of Ethics and Standards of Practices for Texas Educators, pursuant to Chapter 247 of this title (relating to the Educators' Code of Ethics).

(12) Complaint--A written statement submitted to the Texas Education Agency staff that contains essential facts alleging improper conduct by an educator, applicant, or examinee, and provides grounds for sanctions.

(13) Contested case--A proceeding under this chapter in which the legal rights, duties, and privileges of a party are to be determined by the State Board for Educator Certification after an opportunity for an adjudicative hearing.

(14) Conviction--An adjudication of guilt for a criminal offense. The term does not include the imposition of deferred adjudication for which the judge has not proceeded to an adjudication of guilt.

(15) Disciplinary proceedings--Contested case proceedings before the Texas Education Agency staff, the State Office of Administrative Hearings, and the State Board for Educator Certification that commence when a request for hearing is timely filed under this chapter.

(16) Educator--A person who is required to hold a certificate issued under the Texas Education Code, Chapter 21, Subchapter B.

(17) Effective date--As applied to a non-rulemaking decision or action by the State Board for Educator Certification or the Texas Education Agency staff, the date the decision or action becomes final under the appropriate legal authority.

(18) Endanger--Exposure of a student or minor to unjustified risk of injury or to injury that jeopardizes the physical health or safety of the student or minor without regard to whether there has been an actual injury to the student or minor.

(19) Examinee--A person who registers to take or who takes a basic skills examination prescribed by the State Board for Educator Certification (SBEC) for admission to an educator preparation program or a comprehensive examination prescribed by the SBEC for a certificate.

(20) Filing--Any written petition, answer, motion, response, other written instrument, or item appropriately filed with the Texas Education Agency staff, the State Board for Educator Certification, or the State Office of Administrative Hearings under this chapter.

(21) Good moral character--The virtues of a person as evidenced, at a minimum, by his or her not having committed crimes relating directly to the duties and responsibilities of the education profession as described in §249.16(b) of this title (relating to Eligibility of Persons with Criminal Convictions for a Certificate under Texas Occupations Code, Chapter 53) or acts involving moral turpitude.

(22) Informal conference--An informal meeting between the Texas Education Agency staff and an educator, applicant, or examinee; the purpose of such a meeting being to give the person an opportunity to show compliance with all requirements of law for the granting or retention of a certificate or test score.

(23) Invalidation--Rendered void; lacking legal or administrative efficacy.

(24) Law--The United States and Texas Constitutions, state and federal statutes, regulations, rules, relevant case law, and decisions and orders of the State Board for Educator Certification and the commissioner of education.

(25) Mail--Certified United States mail, return receipt requested, unless otherwise provided by this chapter.

(26) Majority--A majority of the voting members of the State Board for Educator Certification who are present and voting on the issue at the time the vote is recorded.

(27) Moral turpitude--Improper conduct including, but not limited to, the following: dishonesty; fraud; deceit; theft; misrepresentation; deliberate violence; base, vile, or depraved acts that are intended to arouse or to gratify the sexual desire of the actor; drug or alcohol related offenses as described in §249.16(b) of this title (relating to Eligibility of Persons with Criminal Convictions for a Certificate under Texas Occupations Code, Chapter 53); or acts constituting abuse or neglect under the Texas Family Code, §261.001.

(28) Neglect--The placing or leaving of a student or minor in a situation where the student or minor would be exposed to a substantial risk of physical or mental harm.

(29) Party--Each person named or admitted to participate in a contested case under this chapter.

(30) Person--Any individual, representative, corporation, or other entity, including the following: an educator, applicant, or examinee; the Texas Education Agency staff, State Board for Educator Certification, or State Office of Administrative Hearings; any other agency or instrumentality of federal, state, or local government; or any public or non-profit corporation.

(31) Petition--The written pleading filed by the petitioner in a contested case under this chapter.

(32) Petitioner--The party having the burden of proof by a preponderance of the evidence in any contested case hearing or proceeding under this chapter. The term includes the following persons:

(A) the Texas Education Agency (TEA) staff;

(B) a person appealing the administrative cancellation of scores based on irregularities involving a TEA-administered test; and

(C) a person appealing the administrative denial of any of the following:

(i) certification (including certification following revocation, cancellation, or surrender of a previously issued certificate) or renewal of certification; or

(ii) reinstatement of a suspended certificate.

(33) Physical mistreatment--Any act of unreasonable or offensive touching that would be offensive to a reasonable person in a similar circumstance. It is an affirmative defense that any unreasonable or offensive touching was justified under the circumstances, using a reasonable person standard.

(34) Presiding officer--The chair or acting chair of the State Board for Educator Certification.

(35) Proposal for decision--A recommended decision issued by an administrative law judge in accordance with the Texas Government Code, §2001.062.

(36) Quorum--A majority of the 14 members appointed to and serving on the State Board for Educator Certification (SBEC) pursuant to the Texas Education Code, §21.033; eight SBEC members, as specified in the SBEC Operating Policies and Procedures.

(37) Recklessly--An educator acts recklessly, or is reckless, with respect to circumstances surrounding his or her conduct or the results of his or her conduct when he or she is aware of but consciously disregards a substantial and unjustifiable risk that the circumstances exist or the result will occur.

(38) Reinstatement--The reactivation to valid status of a certificate suspended by the State Board for Educator Certification; the lifting or discharging of a suspension on a certificate.

(39) Representative--A person representing an educator, applicant, or examinee in matters arising under this chapter; in a contested case proceeding before the State Office of Administrative Hearings, an attorney licensed to practice law in the State of Texas.

(40) Reprimand--The State Board for Educator Certification's formal censuring of a certificate holder.

(A) An "inscribed reprimand" is a formal, published censure appearing on the face of the educator's virtual certificate.

(B) A "non-inscribed reprimand" is a formal, unpublished censure that does not appear on the face of the educator's virtual certificate.

(41) Revocation--A sanction imposed by the State Board for Educator Certification invalidating an educator's certificate.

(42) Respondent--The party who contests factual or legal issues or both raised in a petition; the party filing an answer in response to a petition.

(43) Sanction--

(A) a disciplinary action by the State Board for Educator Certification, including a restriction, reprimand, suspension, surrender, or revocation of a certificate; or

(B) a reasonable and lawful punitive measure imposed by the administrative law judge or presiding officer against a party, representative, or other participant involved in a disciplinary proceeding, hearing, or other matter under this chapter.

(44) State Board for Educator Certification--The State Board for Educator Certification acting through its voting members in a decision-making capacity.

(45) State Board for Educator Certification member(s)--One or more of the members of the State Board for Educator Certification, appointed and qualified under the Texas Education Code, §21.033.

(46) Student--A person enrolled in a primary or secondary school, whether public, private, or charter, regardless of the person's age, or a person 18 years of age or younger who is eligible to be enrolled in a primary or secondary school, whether public, private, or charter.

(47) Surrender--An educator's voluntary relinquishment and invalidation of a particular certificate in lieu of disciplinary proceedings under this chapter and possible revocation of the certificate.

(48) Suspension--A sanction imposed by the State Board for Educator Certification (SBEC) temporarily invalidating a particular certificate until reinstated by the SBEC.

(49) Test administration rules or procedures--Rules and procedures governing professional examinations administered by the State Board for Educator Certification through the Texas Education Agency staff and a test contractor, including policies, regulations, and procedures set out in a test registration bulletin.

(50) Texas Education Agency staff--Staff of the Texas Education Agency assigned by the commissioner of education to perform the State Board for Educator Certification's administrative functions and services.

(51) Unworthy to instruct or to supervise the youth of this state--Absence of those moral, mental, and psychological qualities that are required to enable an educator to render the service essential to the accomplishment of the goals and mission of the State Board for Educator Certification policy and Chapter 247 of this title (relating to Educators' Code of Ethics). Unworthy to instruct serves as a basis for sanctions under §249.15(b)(2) of this title (relating to Disciplinary Action by State Board for Educator Certification) and is not limited to specific criminal convictions.

(52) Virtual certificate--The official record of a person's certificate status as maintained on the Texas Education Agency's website.

(53) Worthy to instruct or to supervise the youth of this state--Presence of those moral, mental, and psychological qualities that are required to enable an educator to render the service essential to the accomplishment of the goals and mission of the State Board for Educator Certification policy and Chapter 247 of this title (relating to Educators' Code of Ethics). "Unworthy to instruct" serves as a basis for sanctions under §249.15(b)(2) of this title (relating to Disciplinary Action by State Board for Educator Certification) and is not limited to specific criminal convictions.

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 6, 2010.

TRD-201006884

Jerel Booker

Associate Commissioner, Educator and Student Policy Initiatives, Texas Education Agency

State Board for Educator Certification

Effective date: December 26, 2010

Proposal publication date: September 3, 2010

For further information, please call: (512) 475-1497

♦ ♦ ♦

TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 101. DENTAL LICENSURE

22 TAC §101.1

The State Board of Dental Examiners (Board) adopts an amendment to §101.1, relating to General Qualifications for Licensure. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8236) and will not be republished.

The amendment was suggested by staff. It clarifies the rule by cross-referencing the option of a Criminal History Evaluation letter in §101.1(f) for a potential dental applicant who is uncertain whether or not he or she is qualified by rule or law for licensure.

No written comments were received regarding this amendment.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006842
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

22 TAC §101.2

The State Board of Dental Examiners (Board) adopts an amendment to §101.2, relating to Licensure by Examination. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8237) and will not be republished.

The amendment is the result of action by the Board at the April 16, 2010 meeting. It adds the Council of Interstate Testing Agencies (CITA) as a designated regional examining board for dental and dental hygiene license applicants. The amendment incorporates this change as it relates to dentists into §101.2(d)(1)(E) and permits dental applicants to submit qualifying scores from CITA with testing dates as early as January 1, 2009.

No written comments were received regarding this amendment.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006843
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

22 TAC §101.3, §101.4

The State Board of Dental Examiners (Board) adopts amendments to §101.3, relating to Licensure by Credentials, and §101.4, relating to Temporary Licensure by Credentials. The amendments are adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8237) and will not be republished.

The amendments were suggested by staff due to a name change by the American Association of Dental Examiners (AADE) to the American Association of Dental Boards (AADB). The adopted amendments are housekeeping changes to §101.3(a)(8) and §101.4(a)(8).

No written comments were received regarding these amendments.

The amendments are adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted sections affect Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006848
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

22 TAC §101.8

The State Board of Dental Examiners (Board) adopts amendments to §101.8, relating to Persons with Criminal Backgrounds. The amendments are adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8238) and will not be republished.

The amendments were suggested by staff and proposed by the Board to allow the Board to prohibit dental assistant registration

on the same grounds it prohibits dental and dental hygiene licensure. Section 101.8 governs the circumstances in which the Board can take action against an individual's license or registration. The section incorporates statutory limitations on the authority of the Board of revoke, suspend, or deny licenses and registrations found in Texas Occupations Code §§53.021 - 53.023 and Dental Practice Act §263.006. The law and rule apply equally to dentists, dental hygienists, and dental assistants. Dental Practice Act §263.001 provides additional grounds for the Board to refuse to issue licenses to dental and dental hygiene applicants. The amended section permits the Board to refuse to register a dental assistant applicant for the same reasons.

No written comments were received regarding the amendments.

Pursuant to Texas Occupations Code §262.102, the amendments were considered by the Dental Hygiene Advisory Committee. The committee had no comments on the proposal.

The amendments are adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties, and Texas Occupations Code §265.001, which provides the Board with the authority to adopt and enforce rules regarding the registration of dental assistants as necessary to protect the public health and safety.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006844
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 103. DENTAL HYGIENE LICENSURE

22 TAC §103.1

The State Board of Dental Examiners (Board) adopts an amendment to §103.1, relating to General Qualifications for Licensure. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8240) and will not be republished.

The amendment was suggested by staff. It clarifies the rule by cross-referencing the option of a Criminal History Evaluation letter in §103.1(f) for a potential dental hygiene applicant who is uncertain whether or not he or she is qualified by rule or law for licensure.

No written comments were received regarding this amendment.

Pursuant to Texas Occupations Code §262.102, the amendment was considered by the Dental Hygiene Advisory Committee. The committee had no comments on the proposal.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006845
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

22 TAC §103.2

The State Board of Dental Examiners (Board) adopts an amendment to §103.2, relating to Licensure by Examination. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8241) and will not be republished.

The amendment is the result of action by the Board at the April 16, 2010 meeting. It adds the Council of Interstate Testing Agencies (CITA) as a designated regional examining board for dental and dental hygiene license applicants. The amendment incorporates this change as it relates to dental hygienists into §103.2(b)(1)(E) and permits dental hygiene applicants to submit qualifying scores from CITA with testing dates as early as January 1, 2009.

No written comments were received regarding this amendment.

Pursuant to Texas Occupations Code §262.102, the amendment was considered by the Dental Hygiene Advisory Committee. The committee had no comments on the proposal.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006846
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 108. PROFESSIONAL CONDUCT SUBCHAPTER E. BUSINESS PROMOTION

22 TAC §108.52

The State Board of Dental Examiners (Board) adopts an amendment to §108.52, relating to False or Misleading Communications. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8241) and will not be republished.

The amendment was suggested by staff and proposed by the Board to clarify advertising restrictions. Dental Practice Act §259.005 provides a list of restrictions the Board may adopt to regulate advertising by licensees. Most permissible regulations found in this section have been explicitly integrated into the agency's rules in Chapter 108, Subchapter E, Business Promotion. The adopted amendment to §108.52 expands the list of enumerated prohibitions to include: (1) failure to disclose in advertisements reasonably predictable fees (i.e., advertising a new patient exam and cleaning without including charges for radiographs); and (2) offering a discount for dental services without disclosing the total fee to which the discount will apply. Currently these two prohibitions fall under the general proscriptions of §108.52(2) which forbid a licensee from omitting necessary facts in communications. The amendment provides greater specificity in the rule for licensees.

No comments were received regarding this amendment.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties, and Texas Occupations Code §254.002, which provides the Board with the authority to adopt and enforce reasonable restrictions to regulate advertising relating to the practice of dentistry by a person engaged in the practice of dentistry as provided by §259.005.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006847
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 114. EXTENSION OF DUTIES OF AUXILIARY PERSONNEL--DENTAL ASSISTANTS

22 TAC §114.6

The State Board of Dental Examiners (Board) adopts new §114.6, relating to General Qualifications for Registration or Certification. The new section is adopted with changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8242) and will be republished.

The new section was suggested by staff and proposed by the Board to create a process for the conditional registration of dental assistants who might otherwise not qualify for registration due to criminal conduct. The new section outlines general qualifications for individuals applying for registration or certification as a dental assistant similar to the general qualification sections for dentists, found in §101.1, and for dental hygienists, found in §103.1. In addition, the section outlines the circumstances in which the Board may refuse to issue a dental assistant registration or certification and creates a process the Board may utilize to issue a conditional dental assistant registration or certification in situations where an individual may not qualify to receive an unencumbered dental assistant registration or certification due to criminal conduct.

No comments were received regarding the new section.

The proposed rule inadvertently referred to licensure instead of registration/certification, so this non-substantive change will be made to the adopted rule. This change will affect subsection (f)(2)(B), (C) and (D). In addition, an editorial change is made to subsection (f)(4) by changing the word "of" to the word "to."

The new section is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties, and Texas Occupations Code §265.001, which provides the Board with the authority to adopt and enforce rules regarding the registration of dental assistants as necessary to protect the public health and safety.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

§114.6. General Qualifications for Registration or Certification.

(a) Any person who desires to provide dental assistant services requiring registration or certification must obtain the proper registration or certification issued by the Board before providing the services, except as provided in Texas Occupations Code §265.005(l) and §114.11 of this chapter.

(b) Any applicant for registration or certification must meet the requirements of this chapter.

(c) To be eligible for registration or certification, an applicant must provide with an application form approved by the Board satisfactory proof to the Board that the applicant:

(1) has fulfilled all requirements for registration or certification outlined in this chapter;

(2) has met the requirements of §101.8 of this title;

(3) has successfully completed a current course in basic life support;

(4) has taken and passed the jurisprudence assessment administered by the Board or an entity designated by the Board within one year immediately prior to application; and

(5) has paid all application, examination and fees required by law and Board rules and regulations.

(d) Applications for dental assistant registration and certification must be delivered to the office of the State Board of Dental Examiners.

(e) An application for dental assistant registration or certification is filed with the Board when it is actually received, date-stamped, and logged-in by the Board along with all required documentation and fees. An incomplete application will be returned to the applicant with an explanation of additional documentation or information needed.

(f) The Board may refuse to issue registration or certificate to any individual who does not meet the requirements of subsection (c)(2) of this section, who has a pending criminal case, or who has been convicted or received a deferred adjudication in accordance with §101.8 of this title. Alternatively, the Board may choose to issue a conditional registration or certificate to the individual in accordance with this subsection.

(1) At the time the registration or certificate is issued, the individual may be required to enter into an agreed settlement order with the Board.

(2) With respect to any individual who does not meet the requirements of subsection (c)(2) of this section, or who has a pending criminal case or who has been convicted or received a deferred adjudication in accordance with §101.8 of this title, the Board may consider conditional registration or certification of the individual when such registration or certification is not prohibited by law. The Board shall consider the following factors:

(A) the nature and seriousness of the crime;

(B) the relationship of the crime to the purposes for requiring a registration/certification to engage in the occupation;

(C) the extent to which a registration/certification might offer an opportunity to engage in further criminal activity of the same type as that in which the person previously had been involved;

(D) the relationship of the crime to the ability, capacity, or fitness required to perform the duties and discharge the responsibilities of the registered occupation;

(E) the extent and nature of the person's past criminal activity;

(F) the age of the person when the crime was committed;

(G) the amount of time that has elapsed since the person's last criminal activity;

(H) the conduct and work activity of the person before and after the criminal activity;

(I) evidence of the person's rehabilitation or rehabilitative effort while incarcerated or after release; and

(J) other evidence of the person's fitness, including letters of recommendation from:

(i) prosecutors and law enforcement and correctional officers who prosecuted, arrested, or had custodial responsibility for the person;

(ii) the sheriff or chief of police in the community where the person resides; and

(iii) any other person in contact with the convicted person.

(3) The applicant shall, to the extent possible, obtain and provide to the Board the recommendations of the prosecution, law enforcement, and correctional authorities. The applicant shall also furnish proof in such form as may be required by the Board that he or she has maintained a record of steady employment and has supported his or her dependents and has otherwise maintained a record of good conduct and has paid all outstanding court costs, supervision fees, fines, and restitution as may have been ordered in all criminal cases in which he or she has been convicted or received a deferred order.

(4) The order may include limitations including, but not limited to, practice limitations, stipulations, compliance with court ordered conditions, notification to employer or any other requirements the Board recommends to ensure public safety.

(5) In the event an applicant is uncertain whether he or she is qualified to obtain a dental assistant registration or certification due to criminal conduct, the applicant may request a Criminal History Evaluation Letter in accordance with §114.9 of this chapter, prior to application.

(6) Should the individual violate the terms of his or her conditional registration or certificate, the Board may take additional disciplinary action against the individual.

(g) An applicant whose application is denied by the Board may appeal the decision to the State Office of Administrative Hearings.

(h) An individual whose application for dental assistant registration/certification is denied is not eligible to file another application for registration/certification until the expiration of one year from the date of denial or the date of the Board's order denying the application for registration/certification, whichever date is later.

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 2, 2010.

TRD-201006851
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

22 TAC §114.21

The State Board of Dental Examiners (Board) adopts an amendment to §114.21, relating to Requirements for Dental Assistant Registration Courses and Examinations. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8244) and will not be republished.

The amendment was suggested by staff and proposed by the Board to update outdated references in the agency's rules.

No written comments were received regarding this amendment.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006849
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

CHAPTER 116. DENTAL LABORATORIES

22 TAC §116.10

The State Board of Dental Examiners (Board) adopts an amendment to §116.10, relating to Prosthetic Identification. The amendment is adopted without changes to the proposed text as published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8245) and will not be republished.

The amendment was suggested by the Dental Laboratory Certification Council and proposed by the Board to increase the public's accessibility to information regarding laboratory products. At the March 26, 2010 meeting of the Dental Laboratory Certification Council (DLCC), the DLCC voted to recommend the following two rule amendments to the Board in accordance with Dental Practice Act §266.101.

First, the DLCC voted to recommend an amendment to §116.10, that offers guidelines for reporting materials used by labs in the fabrication of lab products. The DLCC members agreed that full disclosure of all materials utilized in the creation of prosthetic devices could be beneficial to dentists and dental patients, but that requiring such disclosure would be cumbersome for lab owners and managers. Ultimately the DLCC voted to recommend permissive language in the amendment. Second, the DLCC voted to suggest an amendment requiring labs to specify the country of origin of all lab products. The adopted amendment to §116.10 incorporates both of the recommendations proffered by the DLCC.

No comments were received regarding this amendment.

The amendment is adopted under Texas Occupations Code §254.001, which provides the Board with the authority to adopt and enforce rules necessary for it to perform its duties, and Texas Occupations Code §266.102, which provides the Board the authority to adopt rules necessary for it to regulate dental laboratories.

The adopted section affects Texas Occupations Code, Title 3, Subtitle D and Texas Administrative Code, Title 22, Part 5.

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 2, 2010.

TRD-201006850
Sherri Sanders Meek
Executive Director
State Board of Dental Examiners
Effective date: December 22, 2010
Proposal publication date: September 10, 2010
For further information, please call: (512) 463-6400

♦ ♦ ♦

PART 6. TEXAS BOARD OF PROFESSIONAL ENGINEERS

CHAPTER 131. ORGANIZATION AND ADMINISTRATION

SUBCHAPTER A. ORGANIZATION OF THE BOARD

22 TAC §131.15

The Texas Board of Professional Engineers (Board) adopts amendments to §131.15, relating to Committees, without changes to the proposed text as published in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8467) and will not be republished.

The adopted amendment changes the frequency of the General Issues Committee meetings from twice per fiscal year to an "as required" basis. In the past, there have not been sufficient issues to consistently convene a committee meeting, and it is inefficient to have a meeting without any substantive activities simply to meet a rule requirement.

The Board received comments on the proposed rule from five individuals. Two were in support of the amendment.

One comment suggested that the rule include a maximum number of meetings of two each year. One agreed with the concept, but suggested that the committee should meet at least once per year. The third comment stated that the Board should be cautious of changing the rule to "as required" as it might result in some issues being put off and not handled in a timely manner. The Board felt that these comments are adequately addressed by the rule language and Board policies regarding holding committee meetings. No change was made in response to these comments.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and bylaws consistent with the Act as necessary for the performance of its duties, the governance of its own proceedings, and the regulation of the practice of engineering in this state.

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 November 29, 2010.

TRD-201006768

Lance Kinney, P.E.
Executive Director
Texas Board of Professional Engineers
Effective date: December 19, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 440-7723

♦ ♦ ♦

CHAPTER 133. LICENSING SUBCHAPTER C. PROFESSIONAL ENGINEER LICENSE APPLICATION REQUIREMENTS

22 TAC §133.25

The Texas Board of Professional Engineers (Board) adopts amendments to §133.25, relating to Applications from Engineering Educators, without changes to the proposed text as published in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8468) and will not be republished.

The adopted amendment clarifies the intent of this section by specifying that it apply to engineering professors who teach classes at colleges and universities in Texas as their primary employment. It would potentially reduce the number of applicants by limiting the rule applicability to a more specific group of educators. If an engineer's primary function is not education, they should use the standard licensure process to obtain a license.

The Board received comments on the proposed rule from 10 individuals. Six were in support of the amendment. Two were from educators who want a related Board rule (§133.43(a)(1)(K)) changed so that all teaching of engineering can be counted toward licensure. As explained in earlier discussions related to this rule, that limitation is based on §1001.302 of the Texas Engineering Practice Act relating to License Eligibility Requirements and cannot be changed. Responses were sent to those commenters. One comment asked why the rule is being amended to limit the applicants to those in Texas. A response was sent to this commenter stating that since applications under this rule may be associated with a request for a waiver of the PE exam, the Board historically limits approval of PE exam waivers to those practicing in Texas. Two of the comments received in support of the amendment suggested that it be broadened to include more educators and not be limited to teachers of engineering courses. Both commenters were sent responses stating that the Board's intent is to license the practice of engineering and the teaching of other subjects do not fall within that scope. One comment opposed the concept of an alternative path for engineering educators. He felt that all license applicants should meet all the standard experience and examination requirements. No change was made in response to these comments.

The amendment is adopted pursuant to the Texas Engineering Practice Act, Occupations Code §1001.202, which authorizes the board to make and enforce all rules and regulations and bylaws consistent with the Act as necessary for the performance of its duties, the governance of its own proceedings, and the regulation of the practice of engineering in this state.

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 November 29, 2010.

TRD-201006767
Lance Kinney, P.E.
Executive Director
Texas Board of Professional Engineers
Effective date: December 19, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 440-7723

♦ ♦ ♦

PART 28. EXECUTIVE COUNCIL OF PHYSICAL THERAPY AND OCCUPATIONAL THERAPY EXAMINERS

CHAPTER 651. FEES

22 TAC §651.1, §651.2

The Executive Council of Physical Therapy and Occupational Therapy Examiners adopts amendments to §651.1 and §651.2, concerning application and renewal fees, without changes to the proposed text as published in the August 20, 2010, issue of the *Texas Register* (35 TexReg 7188) and will not be republished. The rules will go into effect on January 1, 2011.

The Executive Council of Physical Therapy and Occupational Therapy Examiners (Executive Council) adopts the amendments to §651.1 and §651.2, which specify the fees charged by the Executive Council, including fees for Physical Therapy and Occupational Therapy licensees' applications and renewals, are necessary for the Executive Council to utilize revenue, as provided in Article VIII and Article IX of the General Appropriations Act (Senate Bill 1, 81st Legislature, Regular Session). This is the first increase of these fees since 2005.

No comments were received regarding the amendments.

The amendments are adopted under the Executive Council of Physical Therapy and Occupational Therapy Examiners Practice Act, Title 3, Subtitle H, Chapter 452, Texas Occupational Code, which provides the Executive Council with the authority to adopt rules consistent with the Act to carry out its duties in administering this Act.

Title 3, Subtitle H, Chapters 452 - 454, Occupational Code is affected by the adopted amendments.

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 November 29, 2010.

TRD-201006764
John P. Maline
Executive Director
Executive Council of Physical Therapy and Occupational Therapy Examiners
Effective date: January 1, 2011
Proposal publication date: August 20, 2010
For further information, please call: (512) 305-6900

♦ ♦ ♦

TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 3. LIFE, ACCIDENT AND HEALTH INSURANCE AND ANNUITIES

SUBCHAPTER M. DISCRETIONARY CLAUSES

28 TAC §§3.1201 - 3.1203

The Commissioner of Insurance (Commissioner) adopts new Subchapter M, §§3.1201 - 3.1203, relating to discretionary clauses in insurance policy forms and health maintenance organization (HMO) evidence of coverage forms. Sections 3.1201 - 3.1203 are adopted with changes to the proposed text published in the June 4, 2010, issue of the *Texas Register* (35 TexReg 4585).

REASONED JUSTIFICATION. The new subchapter prohibiting the use of discretionary clauses in certain insurance policy forms and HMO evidence of coverage forms is necessary to protect insurance and HMO consumers from the possibility of incorrect and unfair coverage determinations by insurers and HMOs (carriers) without a subsequent opportunity for a full and independent review under a non-deferential standard. Discretionary clauses are contractual provisions that purport or act to reserve for carriers the discretion to interpret the terms of an insurance contract or HMO evidence of coverage and alter the judicial standard of review upon appeal. For instance, a health insurance form reviewed by the Department contained language stating "[w]e have complete discretionary authority, subject to Texas and Federal law, to review all denied claims for benefits under this policy. In performing its review, [w]e shall have discretionary authority to determine whether and to what extent [employees] and beneficiaries are entitled to benefits; and construe any disputed or doubtful terms of this policy." A disability income insurance policy reviewed by the Department stated:

Except for those functions which this Policy specifically reserves to the Policyholder or Employer, the Company has sole authority to manage this Policy, to administer claims, to interpret Policy provisions, and to resolve questions arising under this Policy. The Company's authority includes (but is not limited to) the right to: 1. establish and enforce procedures for administering this Policy and claims under it; 2. Determine Employees' eligibility for insurance and entitlement to benefits; 3. Determine what information the Company reasonably requires to make such decisions; and 4. Resolve all matters when a claim review is requested. Any decision the Company makes in the exercise of its authority shall be conclusive and binding.

Another disability income insurance policy reviewed by the Department contained the statement that "benefits under this Plan will be paid only if the Plan Administrator or its designee (including [the insurer]), decides in its discretion that the applicant is entitled to them."

The Employee Retirement Income Security Act (ERISA) is located at 29 U.S.C. §§1001 *et seq.* The United States Supreme Court has specified that in appeals of coverage determinations governed by the Employee Retirement Income Security Act (ERISA), the appropriate standard of review is *de novo* unless the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms, in which cases a deferential standard of review is appropriate. *Firestone Tire & Rubber Co v. Bruch,* 489 U.S. 101, 115 (1989). The Department's position is that a carrier may have a conflict of interest in coverage determinations resulting in adverse financial consequences to the carrier, and therefore it is of vital importance to ensure that insureds and enrollees are provided an opportunity for a full benefit determination review by an independent decision maker. Carriers may have a conflict of interest in coverage determinations because they may result in adverse financial consequences for their company. See *Metropolitan Life Ins. v. Glenn,* 554 U.S. 105, 108 (2008):

Often the entity that administers the plan, such as an employer or an insurance company, both determines whether an employee is eligible for benefits and pays benefits out of its own pocket. We here decide that this dual role creates a conflict of interest; that a reviewing court should consider that conflict as a factor in determining whether the plan administrator has abused its discretion in denying benefits; and that the significance of the factor will depend upon the circumstances of the particular case.

Because a carrier may have a conflict of interest in coverage determinations, it is possible that such decisions may result in unfair and inequitable outcomes for insureds and enrollees. Carriers using discretionary clauses may then unfairly benefit from a deferential appellate standard of review should an insured or enrollee choose to seek judicial review of the coverage determination. In light of the United States Supreme Court opinion in *Firestone,* the use of a discretionary clause by a carrier in a coverage determination governed by ERISA has the effect of changing the appellate standard of review from de novo to "arbitrary and capricious". A *de novo* standard of review allows for a full independent examination of claim determinations without affording deference to a carrier's determination. See *Firestone,* 489 U.S. at 113 ("The trust law *de novo* standard of review is consistent with the judicial interpretation of employee benefits plans prior to the enactment of ERISA. Actions challenging an employer's denial of benefits . . . were governed by principles of contract law. If the plan did not give the employer or administrator discretionary or final authority to construe uncertain terms, the court reviewed the employee's claim as it would have any other contract claim - by looking at the terms of the plan and other manifestations of the parties' intent." (citations omitted)); and *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 385 - 386 (2002). ("Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the [ERISA] statute was silent, we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion . . . . Nothing in ERISA, however, requires that these kinds of decisions be so "discretionary" in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract." (citations omitted)); *c.f. Pierre v. Conn. Gen. Life Ins. Co.,* 932 F.2d 1552, 1553 (5th Cir. 1991), cert. denied, 502 U.S. 973 (1991) (holding that *Firestone* does not require *de novo* review for factual determinations). By contrast, an "arbitrary and capricious" appellate standard of review is a less detailed and more deferential review. See *Meditrust Financial Services Corp.*

v. Sterling Chemicals, Inc., 168 F.3d 211, 215 (5th Cir. 1999) ("When reviewing for arbitrary and capricious actions resulting in an abuse of discretion, we affirm an administrator's decision if it is supported by substantial evidence. A decision is arbitrary only if "made without a rational connection between the known facts and the decision or between the found facts and the evidence." (citations omitted)). Some courts appear to have interpreted the arbitrary and capricious standard in a manner that virtually eliminates all judicial review of a carrier's claim determination. See *Van Boxel v. Journal Co. Employees' Pension Trust,* 836 F.2d 1048, 1050 (7th Cir. 1987); and *Graham v. L&B Realty Advisors, Inc.,* 2003 WL 22388392 at 1 and 4 (N.D. Tex. Sept. 30, 2003) (holding that if an insurer's decision is based on "some concrete evidence in the administrative record" it will not constitute an abuse of discretion, and recognizing that de novo review would have led to a different result); see also *Burton v. UNUM Life Insurance Co. of America,* 2010 U.S. Dist. LEXIS 58267 at 35 (D. Tex., W.D. 2010) (noting that the overall record plainly indicated that the insured had suffered from bipolar disorder since at least 2004 but upholding UNUM's claim determination because the terms of the policy had not been adhered to by the insured, even though the non-compliance was arguably a symptom of the illness). The Department's position is that a full review by an independent decision making body is necessary because of the potential conflict of interest by the carrier making the coverage determination.

Discretionary clauses are unjust, encourage misrepresentation, and are deceptive because they mislead consumers regarding the terms of the coverage. For example, a consumer could reasonably believe that if they are disabled, they will be entitled to benefits under the policy and will be able to receive a full hearing to enforce such rights in court. Instead, a discretionary clause permits a carrier to deny disability income benefits even if the insured or enrollee is disabled, provided that the process leading to the denial was not arbitrary or capricious. See *Graham,* 2003 WL 22388392 at 4; *accord Burton,* 2010 U.S. Dist. LEXIS 58267 at 35.

The applicability of the adopted rule extends beyond ERISA cases because the Department's position is that a discretionary clause affects outcomes even in cases not governed by ERISA. As they pertain to non-ERISA cases, discretionary clauses are unjust, deceptive and encourage misrepresentation regarding the rights of the insured or enrollee. Discretionary clauses are unjust because they reverse the longstanding Texas common law doctrine that ambiguities in insurance contracts should be construed in favor of the insured. The Texas Supreme Court has repeatedly upheld this common law doctrine. *See Fiess v. State Farm Lloyds,* 202 S.W.3d 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.,* 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters,* 545 S.W.2d 755, 761 (Tex.1977); and *Continental Cas. Co. v. Warren,* 254 S.W.2d 762, 763 (Tex.1953). This common law doctrine also promotes the public policy of encouraging contract drafters to avoid ambiguities and to be as specific as necessary in avoiding legal disputes stemming from vague contractual language. Discretionary clauses encourage misrepresentation by portraying a carrier's determination of coverage as binding or mandatory. Because insureds and enrollees have the right to seek judicial review of a carrier's coverage determinations, a provision stating otherwise encourages misrepresentation because it is inaccurate and may dissuade an insured or enrollee from exercising such rights. Additionally, to the extent that a discretionary clause could be interpreted by a court as a contractual agreement to reverse the default common law doctrine that contractual ambiguities are to be construed against the drafter, the Department's position is that such a reversal of the common law doctrine is not warranted between parties with unequal bargaining power as to the terms of the contract. For these reasons, it is necessary that the adopted rule's applicability extend to life, accident, and health insurance forms and HMO evidence of coverage forms governed under the Insurance Code Chapters 1271 and 1701, including both those that are also governed by ERISA and those that are not.

On June 4, 2010, the proposed new subchapter was published in the *Texas Register* pursuant to a petition for rulemaking from the Office of Public Insurance Counsel received by the Department on October 28, 2009, requesting that the Department propose and adopt a rule prohibiting the use of discretionary clauses in life, accident, and health insurance policy forms. On December 9, 2009, the Department held a public meeting to receive comments relating to the application and use of discretionary clauses in insurance policies. On March 5, 2010, the Department made an informal posting on its website of proposed rule text and cost note estimates. Thereafter, the Department made changes to the rule text informally posted on its website on March 5, 2010, based upon both informal comments received in connection with the posting and staff recommendations. Those changes were included in the Department's proposal published in the *Texas Register* on June 4, 2010, and a public hearing on the rule was held on July 12, 2010. In response to comments received on the published proposal, both as written comments and testimony presented at the July 12, 2010 public hearing, the Department has revised some of the proposed language in the text of the rule as adopted. The Department has also made some revisions necessary to clarify the text. None of the changes made to the proposed text as a result of comment or of necessary clarification materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

With respect to §3.1201(b), the Department received several comments supporting a need to clarify the applicability of the new subchapter to forms "offered, issued, or enforced" on or after the effective date of the adopted rule. In response to these comments asking whether actions such as renewal, delivery, and amendment of forms would trigger applicability, the Department has revised the text of §3.1201(b) to clarify that the subchapter applies to forms renewed or delivered on or after June 1, 2011, except as specified in §3.1201(c) and (d). To further clarify the intended meaning of the subsection, the Department has added new subsection (d) to the section to clarify that for forms issued or delivered prior to the effective date of the subchapter that do not contain a renewal date, the subchapter applies on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. The Department further received comments that a discretionary clause prohibition may result in unintended consequences. In response to these comments, the adopted rule implements a staggered implementation date. According to comments received by the Department, the impact of discretionary clauses appears most frequently to be an issue in disability insurance policies. Therefore, the Department has revised adopted §3.1201 by: (i) adding new subsection (c) to provide that, for forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate or rider, the subchapter applies to forms offered, is-

sued, renewed, or delivered on or after February 1, 2011; and (ii) revising subsection (b) to provide that the June 1, 2011 applicability date applies to forms governed by the subchapter except as specified in subsections (c) and (d). Section 3.1201(b) is also revised to specify that forms that include premium waiver provisions based upon a disability determination are included within the scope of applicability established in the subsection, a clarification necessary to prevent any unintended ambiguity arising from the use of a staggered implementation date for disability income protection products. Using a staggered implementation provides the Department with a brief period of time to assess whether a discretionary clause prohibition will actually result in unintended consequences before its application is extended to forms other than those that include disability income protection coverage. At the same time, there will not be a delay in implementation of the prohibition with respect to forms that include disability income protection coverage, which, according to some commenters, is the insurance line for which many of the problems associated with discretionary clauses have been identified. The use in §3.1201(c) of a February 1, 2011 effective date for forms that include disability income protection coverage rather than the January 1, 2011 effective date included in the Department's published proposal is necessary to provide sufficient time for carriers to implement the changes required under §§3.1201 - 3.1203. The Department also received comments recommending that the Department specifically address severability to clarify how the subchapter will apply should any section or portion of the subchapter be held invalid for any reason. Accordingly, the Department has also revised §3.1201 by adding new subsection (e) to clarify that: (i) if any section or portion of a section of the subchapter is held to be invalid for any reason, all parts are severable from the invalid parts and remain in effect; (ii) if any section or portion of a section is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications; and (iii) to this end, all provisions of the subchapter are declared to be severable. Finally, the Department also revised the section title to reflect the clarified content of the section, such that the title is now "§3.1201. Applicability, Effective Dates, and Severability."

The Department also received several comments concerning the definition of "discretionary clauses" in §3.1202 and has made responsive changes. The Department received a comment that the proposed definition provided insufficient guidance to carriers to permit an assessment of what constituted a discretionary clause due to the open-ended nature of the definition, which specified that the term includes, but is not limited to, a provision including any of five common examples of categories of discretionary clauses. The Department also received several comments recommending greater specificity with respect to the examples of discretionary clauses, such that: (i) a provision that "acts" to bind the claimant or grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation should be included, rather than only a provision that "purports" to so bind or grant deference; (ii) references to "insurers" throughout the section should also refer to "HMOs" to preclude ambiguity in application; (iii) references to "policies or contracts" throughout the section should be revised to refer to "forms" to preclude ambiguity in application; (iv) a provision that "gives rise to" a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of the state should be included, rather than only provisions that "specify" such standards of review; (v) provisions specifying that a policyholder or other claimant may not "appeal" a denial of a claim should be included, rather than only those provisions specifying that a policyholder may not "contest" a denial; and (vi) inclusion of common law in §3.1202(4) establishing that a provision that specifies a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state, including common law, constituted an improper delegation of rulemaking authority to the judiciary in violation of the Texas Constitution. Further, the Department received several comments recommending deletion of §3.1202(5), stating that the term "discretionary clause" includes a provision specifying that the insurer has discretion to interpret the terms of the policy or contract or determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal. The commenters stated that §3.1202(5) was not necessary to permit normal administration of claims by carriers, created internal conflict between the section and §3.1203 prohibiting discretionary clauses, and could lead to a finding of preemption based upon ERISA if a court interpreted the provision to regulate the form of a discretionary clause rather than as part of a general substantive prohibition concerning such clauses. Based upon all of these comments, the Department has clarified the definition of a discretionary clause throughout §3.1202. To address the comment that the open-ended nature of the definition provides insufficient guidance to carriers to determine what constitutes a discretionary clause, the Department has deleted part of the language in §3.1202 such that the section now provides that a discretionary clause is a provision that meets one of the five criteria specified in the section, rather than retaining language stating that the term "includes, but is not limited to" one of five categories of discretionary clauses, providing greater clarity concerning the scope of the definition. The Department has revised the structure of §3.1202 to accommodate this clarification, redesignating language that defined "discretionary clauses" in the first sentence of the section to the first of the five adopted paragraphs in the section and eliminating the laundry list of administrative actions that an insurer or HMO might perform in connection with a claim ("decision, denial, or interpretation on terms, coverage, or eligibility for benefits") in favor of broader language concerning "adverse claim decisions or policy interpretations." This clarification does not permit a carrier to reserve discretion for its determinations or interpretations or indicate the Department's intent to regulate the form of a discretionary clause. The Department has further revised §3.1202(1) in response to comments to clarify its applicability to HMOs and to clarify that the paragraph includes a provision that acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or HMO, rather than only those provisions that purport to bind or grant deference in such a manner. As a necessary clarification resulting from restructuring of the section, the Department has: (i) redesignated §3.1201(1) as §3.1201(2) and renumbered the remaining paragraphs accordingly; and (ii) revised the paragraphs to correspond to the revised introductory sentence for the section by adding the word "specifies" to the beginning of paragraphs (2) - (5). The Department has also revised redesignated §3.1202(2) in response to comment by clarifying that an appeal of a denial is within the scope of the paragraph. Adopted §3.1202(2) now establishes that a provision that specifies that a policyholder or other claimant may not contest or appeal a denial of a claim is a discretionary clause. The Department has further revised redesignated §3.1202(3) and (4) in response to comment to clarify that both paragraphs apply to HMOs rather than only to in-

surers and to clarify that the paragraphs apply more broadly to "forms" rather than only to "policies or contracts." These changes clarify the consistency between the paragraphs and §3.1201(a), which specifies that the subchapter applies to any form filed under the Insurance Code Chapters 1701 or 1271. The Department has further revised redesignated §3.1202(5) in response to comment: (i) to clarify that the paragraph includes a provision that "gives rise to" a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state, rather than only provisions that actually specify such a standard of review; and (ii) to delete the reference to common law. Adopted §3.1202(5) establishes that a provision that specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state is a discretionary clause. The Department has determined that the definition of "discretionary clause" as set forth in adopted §3.1202, in conjunction with the prohibition against discretionary clauses in §3.1203, will result in elimination of the deferential standard of review currently enjoyed by those insurers and HMOs that use discretionary clauses, and common law, including the longstanding Texas common law doctrine that ambiguities in insurance contracts should be construed in favor of the insured, will be applied as appropriate by courts in reviewing cases without the necessity for referencing common law in the paragraph. *See Fiess v. State Farm Lloyds,* 202 S.W.3d 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.,* 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters,* 545 S.W.2d 755, 761 (Tex.1977); and *Continental Cas. Co. v. Warren,* 254 S.W.2d 762, 763 (Tex.1953). The revision further clarifies that it was not the intent of the Department to delegate rulemaking authority to the judiciary. Finally, the Department has revised §3.1202 by deleting paragraph (5) in response to comment. Section 3.1202(5) included as an example of a discretionary clause a provision specifying that the insurer has discretion to interpret the terms of the policy or contract to determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal. The Department agrees that: (i) the paragraph is not necessary to permit carriers to perform initial claim administration functions; (ii) the paragraph creates internal inconsistency between §3.1202(5) and the general prohibition against discretionary clauses in §3.1203; and (iii) retention of the paragraph could lead to a finding of preemption based upon ERISA if a court interpreted the provision to regulate the form of a discretionary clause rather than as part of a general substantive prohibition concerning such clauses. *Hancock v. Metropolitan Life Insurance Co.,* 590 F.3d 1141, 1149 (10th Cir. 2009). The Department has also revised §3.1203 in response to comment asking for clarification concerning the scope of the subchapter with respect to forms that are renewed, delivered, enforced, or amended. The Department determined that inclusion of this language concerning applicability was most appropriately placed in §3.1201 and that reiteration of the language in §3.1203 was both unnecessarily duplicative and increased the possibility of internal inconsistency with the subchapter. The Department has accordingly deleted such applicability language and clarified the text with respect to its purpose, the prohibition of discretionary clauses. Adopted §3.1203 provides that inclusion of a discretionary clause in any form to which the subchapter applies is prohibited.

HOW THE SECTIONS WILL FUNCTION. New §3.1201 specifies the applicability, effective dates, and severability of the adopted rules. New §3.1202 defines discretionary clauses for purposes of the subchapter. New §3.1203 specifies that inclusion of a discretionary clause in any form to which the subchapter applies is prohibited.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments.

Comment: Several commenters state strong support for the rule.

Agency Response: The Department appreciates the supportive comments.

General Comments: Authority to Adopt.

Comment: Some commenters questioned whether the Department has the legal authority to adopt the proposed rules and asked that the statutory authority relied upon for §§3.1201 - 3.1203 be identified. A commenter opines that the Insurance Code §1701.060(a)(1), which authorizes adoption of rules to establish procedures and criteria under which a particular type of form will be reviewed or exempted from review, authorizes adoption of procedural rules rather than substantive rules such as the proposed prohibition concerning discretionary clauses. The commenter asserts that the rule does not specify requirements deemed appropriate by the Legislature. The commenter argues that specific statutory requirements for various lines of insurance products, including life, annuity, health, variable life, group life, credit life and disability, employer group plans, and group health plans for persons over 65 years of age, are set forth in other chapters of the Insurance Code, and that §1701.060(a)(1) only authorizes the Department to adopt procedural rules that will be followed for exempt filings, file and use, disapprovals, withdrawal of forms and approvals, and replacement or amendment of forms. Additionally, the commenter asserts that Chapter 1701 has evolved through several legislative and codification efforts, stemming from 1875, and if Chapter 1701 was intended to authorize substantive rulemaking, that authority has not been used by the agency. The commenter also asserts that the Insurance Code §1701.055(a) does not grant rulemaking authority but is a substantive statute establishing the standard of review and approval of forms. The commenter asserts that §1701.055(a) provides that a form may be disapproved if: (i) the form violates a statute or other law of the state; or (ii) the form is misleading, unjust, would constitute misrepresentations or would be deceptive. The commenter further asserts that the Department appears to be shifting interpretations through rulemaking because discretionary clauses have been approved in Texas and used by insurers for a number of years. The commenter argues that if the Legislature had wanted to prohibit discretionary clauses it could have done so when former Insurance Code art. 3.42 was repealed and Chapter 1701 was enacted as part of the code revision efforts of the Legislature. The commenter also disputes that discretionary clauses are inherently deceptive, misleading, or unlawful because, if they were, their usage would have been prohibited under both state and federal law. The commenter asserts that the Insurance Code §1271.056 and §1271.103 apply to HMOs and do not apply to annuities or life, accident, and health insurance governed under other sections of the Insurance Code. Further, the commenter asserts that arguments concerning the Department's authority under Chapter 1701 apply equally to Chapter 1271 and argues that §1271.103 does not grant rulemaking authority to the Department. Rather, the commenter asserts that

§1271.103 authorizes the Commissioner to withdraw approval for a form that has been previously approved, after notice and hearing. The commenter questions whether the Department's reliance upon §1271.103 indicates: (i) the Department's intent to withdraw approval for previously approved forms without notice and hearing; and (ii) the Department's intent to apply the new subchapter retroactively to existing policy forms and contracts. The commenter questions whether retroactive application of the rule would violate insurer and policyholder rights against *ex post facto* laws and constitutional protections against passing laws that impair the rights of existing contracts under the United States and Texas Constitution. The commenter opines that the Insurance Code §541.401 authorizes rulemaking to regulate unfair methods of competition and unfair and deceptive acts or practices in the business of insurance but that such authority is limited by §541.401(b) to adoption of rules that bring Texas law into uniformity with other states and the procedures of the NAIC. The commenter asserts that the NAIC model statute applies to health insurance benefit and disability income protection coverage and is, as such, much more narrowly focused than the Department's proposal. Similarly, the commenter asserts that the states that have adopted a prohibition on discretionary clauses have tended to focus on disability income or health insurance rather than life insurance and annuities. The commenter states that: (i) there is no federal law prohibiting discretionary clauses; (ii) there is no uniformity among states concerning such prohibition; and (iii) the proposed rule does not relate to "procedures" of the NAIC. As such, the commenter argues that there is insufficient rulemaking authority for adoption of the rule under §541.401(b). The commenter additionally argues that the NAIC has adopted model language relating to unfair and deceptive acts and practices that is similar to the Insurance Code Chapter 541 and rules adopted thereunder. Because the commenter asserts that the model statute and regulation do not include a prohibition of discretionary clauses, the commenter asserts that it is unlikely that the Legislature intended to permit the Commissioner to adopt rules under Chapter 541 on any matter that the Commissioner wanted to define in an express provision. The commenter asserts that there are not a large number of complaints supporting the existence of a problem or indicating that consumers are being misled. As such, the commenter does not think authority under the Insurance Code §541.401 is appropriate authority on which to base this rule. The commenter asserts that although the Insurance Code §36.001 grants the Department rulemaking authority to implement the powers and duties of the Department under the Insurance Code and is routinely cited as authority by the Department on most rules, the section does not grant such broad authority that the Department can undertake rulemaking under that section alone. Instead, the commenter asserts that the section is used in the context of other statutes where clear rulemaking authority has been specifically delegated by the Legislature. The commenter opines that given the lack of references to discretionary clauses in the numerous chapters of the Insurance Code regulating the business of life, accident, and health insurance, §36.001 is insufficient authority on which to rely for adoption of this rule. The commenter argues that if §36.001 alone sufficed to authorize rulemaking concerning the use of discretionary clauses or other content of forms, then many chapters of the Insurance Code, including Chapters 1101, 1131, 1151, 1152, 1153, 1201, 1251, 1271, 1501, and 1505, would be unnecessary because the Department would have authority to determine content and prohibit provisions. The commenter opines that Chapter 1501 is of special importance because it governs insured plans subject to ERISA, including references to and definitions under ERISA. The commenter opines that the issue of discretionary clauses should more appropriately be considered by the Legislature in order to avoid unintended consequences such as: (i) uncertainty concerning court construction of the language of the rule; (ii) applicability to self-funded employer plans; (iii) applicability to life insurance, including applicability to guaranteed renewable term life policies where there has been a change in the health status of the policyholder and whether the issuer must refile all forms; (iv) applicability to guaranteed renewable individual health insurance policies, including policies where there has been a change in the health status of the policyholder; and (v) overbroad and vague definitions that may cause problems with interpretation by future staff that were not involved with this rulemaking process, especially because the word "discretion" need not be present in the clause in order to meet the definition of a discretionary clause. The commenter asserts that the Department held stakeholder meetings concerning the need to make a recommendation to the Legislature concerning the regulation of discretionary clauses in the past and did not thereafter make such a recommendation. The clauses have been used in the interim period, and the commenter questions why the Department now believes it has the authority to undertake such rulemaking without additional legislation. The commenter asserts that it is difficult to determine whether cases qualify for benefits as partial disability, residual disability, or total disability and notes that different definitions of these terms apply to different products that an employer may elect to buy. The commenter opines that it would be difficult to define such issues in a rule. Additionally, the commenter asserts that the Department lacks authority to adopt §§3.1201 - 3.1203 because the sections appear to be based upon a model act rather than a model regulation of the NAIC. Another commenter states that it offers no opinion on the Commissioner's authority to adopt §§3.1201 - 3.1203 but does opine that questions raised concerning such authority, in combination with all other negative consequences of a prohibition cited by industry stakeholders, supports restraint in rulemaking. Another commenter asserts that the Department has ample authority to implement §§3.1201 - 3.1203 because: (i) the Commissioner may disapprove a policy or evidence of coverage if he finds its language is unjust, encourages misrepresentation, or is deceptive; and (ii) the Commissioner has authority to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701. To the extent that Chapters 1271 and 1701 are intended to prevent the use of a policy or evidence of coverage with language that is unjust, encourages misrepresentation, or are deceptive, the commenter argues that §§3.1201 - 3.1203 simply announce the Commissioner's determination that discretionary clauses do have those qualities because they mislead consumers regarding the terms of the coverage and that the sections are, therefore, within the Commissioner's authority.

Agency Response: The Department disagrees with the assertion that Chapter 1701 does not authorize adoption of §§3.1201 - 3.1203 with respect to the forms governed by that chapter. The Insurance Code §1701.060(a)(1) authorizes adoption of rules to establish not only procedures but also criteria under which a particular type of form will be reviewed or exempted from review. The Department further disagrees that the existence of discretionary clauses in forms in recent years should preclude adoption of a rule prohibiting such clauses. Some of the forms containing discretionary clauses are not reviewed on submission to the Department but are instead exempt from review. Additionally, the Department disagrees that it is inappropriate

for the Department to consider new information and trends and to undertake responsive rulemaking within the scope of its authority. The Department does agree that the Insurance Code §1271.056 and §1271.103 apply to HMO forms but disagrees that rulemaking authority based upon those sections is limited to procedural rulemaking. Neither section limits the Commissioner's rulemaking authority to procedural rulemaking. Additionally, the Insurance Code §843.151 authorizes the Commissioner to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Department clarifies that §§3.1201 - 3.1203 are not ex post facto laws as contemplated under the U.S. and Texas Constitutions. An ex post facto law is a law passed after the commission of an act which retrospectively changes the consequences of the act. *Collins v. Youngblood,* 497 U.S. 37, 41-42 (1990); Bowers v. State, 914 S.W.2d 213, 216 (Tex.App.-El Paso 1996, writ ref'd.). As stated in *Bowers,* "a law violates *ex post facto* prohibitions if it (1) makes criminal an act that was innocent when done; (2) increases the punishment for an offense after its commission; (3) deprives one of a defense available at the time of the act; or (4) alters the legal rules of evidence and receives less or different evidence to convict than the law required at the time the act was committed." *Bowers,* 914 S.W.2d at 216. New §§3.1201 - 3.1203 do not establish a rule in violation of the ex *post facto* prohibition under the U.S. or Texas Constitutions because: (i) the sections do not make an act criminal; (ii) the sections do not increase the punishment for an offense after its commission, but instead establish prospective prohibitions; (iii) do not deprive one of a defense available at the time of the act committed because of the prospective nature of the sections; and (iv) do not affect rules of evidence. The Department agrees that the Texas Constitution prohibits retroactive laws. "No bill of attainder, ex post facto law, or any law impairing the obligation of contracts, shall be made." Tex. Const. art. I, §16. The Department clarifies, however, that new Subchapter M does not apply retroactively. As specified in new §3.1201(b) and (c), the subchapter applies to forms offered, issued, renewed, or delivered on or after the effective dates of the rule, respectively June 1 and February 1 of 2011. Further, as provided in §3.1201(d), the subchapter applies prospectively to forms that do not contain a renewal date on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. The Department further clarifies that the term "rate" in §3.1201(d), as opposed to the term "premium" precludes applicability of the subchapter to forms solely on the basis of premium increases made pursuant to a schedule that is included in the existing form. The Department acknowledges that both the U.S. and Texas Constitutions establish protection from the impairment of contractual obligations. U.S. Const. Art. I, §10, cl. 1; Tex. Const. Art. I, §16. Interpretation of the two prohibitions is nearly identical. *Liberty Mutual Ins. Co. v. Texas Dep't of Insurance,* 187 S.W.3d 808, 824 (Tex.App.-Austin 2006, *pet. den'd.)* (citing *Chandler v. Jorge A. Gutierrez, P.C.,* 906 S.W.2d. 195, 203 (Tex.App.-Austin 1995)). The interpretive commentary for Article I, §16 of the Texas Constitution states in part:

The guaranty of the Constitution is directed against the impairment of the obligation of contracts rather than the contract itself. A contract is an agreement in which a party undertakes to do or not to do a particular thing. Said party is required by duty and by law to perform his undertaking and this is known as the obligation of the contract. Any law which releases a part of this obligation, any act which to any extent or degree amounts to a material change or modifies it, must impair it. . . The obligation protected is not derived from the acts and stipulations of the parties alone, but includes also the relevant law in force at the time the contract is made. The contract clause forbids only laws which operate retroactively on contracts. (Vernon's Ann. Tex. Const., Art. I, §16).

The constitutional prohibitions against impairment of contracts "is directed against the impairment of the obligation of contracts rather than the contract itself, that is, what the party to a contract is required by duty and by law to perform. Any law which releases a part of this obligation, any act which to any extent or degree amounts to a material change or modifies it, must impair it." *Cardenas v. State,* 683 S.W.2d 128, 131 (Tex. App.--San Antonio 1984, no writ) (citations omitted). For the reasons outlined in this response, it is the Department's position that new Subchapter M: (i) does not relieve a carrier, insured, or enrollee of any obligation under the insurance contract or evidence of coverage between the carrier and the insured or enrollee; (ii) does not materially change or modify that contract; and (iii) does not operate retroactively on that contract. Nothing in new Subchapter M relieves a carrier, insured or enrollee of any contractual obligation. Rather, new Subchapter M prohibits the use of discretionary clauses that serve to provide a deferential standard of review to the carrier's determinations. The underlying contractual obligations of a carrier, insured, or enrollee are not relieved. The obligations of the parties under the contract are also not materially changed or modified; judicial review of whether the carrier has properly performed those obligations as they related to claim determinations will simply not be reviewed with deference as a result of new §§3.1201 - 3.1203. Analysis under federal law is comparable. See, *e.g. Energy Reserves Group, Inc. v. Kansas Power & Light Co.,* 459 U.S. 400, 411 (1983) (finding significance in the fact that the parties "are operating in a heavily regulated industry"). Even where a court does find that a law impairs a contract, the court will consider whether the industry the complaining party has entered has been regulated in the past. Id. ("The Court long ago observed: "One whose rights, such as they are, are subject to state restriction, cannot remove them from the power of the State by making a contract about them.") (citations omitted); accord *Liberty Mutual,* 187 S.W. 3d at 824. Finding a significant and legitimate public purpose, a court will determine whether "adjustment of 'the rights and responsibilities of contracting parties [is based] upon reasonable conditions and [is] of a character appropriate to the public purpose justifying' the adjustment." *Liberty Mutual,* 187 S.W. 3d at 825 (citing to *Energy Reserves Group* at 412 (quoting *United States Trust Co. v. New Jersey,* 431 U.S. 1, 22 (1977). It is the Department's position that new §§3.1201 - 3.1203 are necessary to safeguard the interests of the public by prohibiting a deceptive practice that may lead some consumers to believe that they do not have a right to appeal a carrier's determination and by affording consumers an opportunity for a full and independent judicial review of a claim determination under a standard that does not provide deference for the carrier's determination. It is further the Department's position that the prospective application of new Subchapter M and the staggered implementation established in new §3.1201 constitute reasonable conditions and are appropriate means of addressing this need for a consumer safeguard. As such, while it is the Department's position that new §§3.1201 - 3.1203 do not impair contracts, even if a court held to the contrary, it is the Department's position that new Subchapter M would not impermissibly violate these constitutional protections. The Department disagrees that §541.401(b) limits the authority of the Department under §541.401(a). The Department asserts that under a plain reading of the section each subsection

is an independent grant of authority. Further, the Department disagrees that even §541.401(b) limits the Commissioner's rulemaking authority to adoption of rules that bring Texas law into uniformity with other states and the procedures of the NAIC. Section 541.401(b) references rulemaking to achieve uniformity with the laws of other states or conformity with adopted procedures of the NAIC as authority included within the grant of authority specified in the subsection rather than as an exhaustive limitation upon that grant of authority. See Tex. Gov't Code §311.005(13) (" 'Includes' and 'including' are terms of enlargement and not of limitation or exclusive enumeration, and use of the terms does not create a presumption that components not expressed are excluded."); *Jackson Law Office, P.C. v. Chappell,* 37 S.W.3d 15, 25 (Tex.App.-Tyler 2000, *pet. den'd.).* For this same reason, the Department also disagrees that the Commissioner's rulemaking under Chapter 541 is limited to the types of acts and practices included in model acts and regulations adopted by the NAIC concerning deceptive acts and practices. The Department's position is that there is not sufficient justification for protecting only consumers of disability income and health insurance products from the detrimental effects of discretionary clauses and not affording the same level of protection to consumers of life insurance and annuity products. Carriers may have a conflict of interest in coverage determinations because they may result in adverse financial consequences for their company. *Glenn,* 554 U.S. at 108. The Department has no reason to suppose that this potential for conflict of interest is not equally applicable to life insurance and annuity products where determinations of the carrier may result in adverse financial consequences for the company. The Department also disagrees that a particular complaint level is necessary to undertake rulemaking pursuant to §541.401. The Department's position is that the lack of complaints relating to discretionary clauses does not indicate the absence of a problem. The major impact of a discretionary clause occurs by operation of law upon subsequent review by a court. Understanding and identifying a discretionary clause as the source of an unfair coverage determination and subsequent lack of full independent review requires sophisticated legal knowledge and analysis. Therefore, it is unlikely that the average consumer would be able to identify discretionary clauses as a contributing cause of a negative interaction with an insurer or HMO. Further, although the Department considers complaint information when proposing rules, it is not necessary that a prohibitory rule be prompted by a certain number of complaints regarding the practice at issue. The Department's position is that regardless of insurance and HMO consumers' ability to identify discretionary clauses as a specific problem, the potential harm resulting from discretionary clauses is sufficient reason to adopt the rule. The Department further disagrees that discretionary clauses are important only in the context of determining the standard of judicial review applicable in litigation, although that result alone is unjust to consumers that are faced with a standard of review that favors the parties that drafted the language of a form in dispute. As the Department has stated previously in this order, such a result is inconsistent with the longstanding common law doctrine in Texas that ambiguities in insurance contracts should be construed in favor of the insured. See *Fiess v. State Farm Lloyds,* 202 S.W.3d, 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.,* 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters,* 545 S.W.2d 755, 762, 763 (Tex.1977); and *Continental Cas. Co. v. Warren,* 254 S.W.2d 762, 763 (Tex.1953). That inclusion of a discretionary clause in a form results in application of a deferential standard of review for a carrier for whom there is an inherent conflict of interest compounds this injustice. See *Firestone,* 489 U.S. 101 at 115 (holding that in appeals of coverage determinations governed by ERISA, a deferential standard of review is appropriate if the benefit plan expressly gives the plan administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the plan's terms); and *Glenn,* 554 U.S. at 108 (holding that there is a conflict of interest where the plan administrator also pays benefits out of its own pocket). The use of such clauses is also misleading to the extent that it may lead consumers to believe that they do not have a right to appeal the claim determination. Such rulemaking is consistent with the consumer protection purposes of the Insurance Code Chapter 541, in addition to the substantive requirements concerning: (i) in the Insurance Code §1701.055, the use of forms that violate the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive; and (ii) in §1271.056, the use of a provision in an evidence of coverage that is unjust, unfair, inequitable, misleading, or deceptive; that encourages misrepresentation; or that is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Department disagrees that the Insurance Code §36.001 does not authorize rulemaking absent specific statutory references to discretionary clauses in other sections of the Insurance Code. The Department asserts that §36.001, in conjunction with each of the other authorizing sections of the Insurance Code cited by the Department as authority, is a proper basis of rulemaking authority for §§3.1201 - 3.1203. With respect to the comment that the Insurance Code Chapter 1501 governs insured plans that are subject to ERISA, the Department agrees and notes that ERISA specifically exempts from preemption under the statute state laws that regulate insurance. See 29 *U.S.C. §1144(b)(2)(A).* It is the Department's position that new §§3.1201 - 3.1203 do regulate insurance because the sections are specifically directed toward entities engaged in insurance and directly affect risk pooling. See *Standard Insurance Co. v. Morrison,* 584 F.3d 837, 845 (9th Cir. 2009) *cert. denied sub nom. Standard Ins. Co. v. Lindeen,* U.S. No. 09-885, 2010 LEXIS 4079 (May 17, 2010) (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); and *American Council of Life Insurers v. Ross,*558 F.3d 600, 605-07 (6th Cir. 2009). The Department agrees that it is within the legislative purview to review issues concerning the use of discretionary clauses. However, the Department disagrees that legislative review is a prerequisite to the exercise of rulemaking authority by the Commissioner. The Legislature has already considered the issue of form approval and usage generally and authorized the Commissioner to adopt rules to establish criteria under which a particular type of form will be reviewed or exempted from review with respect to form governed under the Insurance Code Chapters 1271 and 1701. See, respectively, the Insurance Code §§843.151, 1271.056, and 1271.103; and the Insurance Code §1701.055(a) and §1701.060(a)(1). The Legislature has additionally considered the issues of unfair methods of competition and unfair and deceptive acts or practices in the business of insurance and authorized the Commissioner to adopt rules necessary to accomplish the purposes of the Insurance Code Chapter 541. See the Insurance Code §541.401. Additional legislative action and review, while within the legislative purview, is not required. The Department further disagrees that legislative revision of the Insurance Code without amendments that specifically address discretionary clauses evidences specific legislative in-

tent concerning the use of discretionary clauses. The Legislature repealed art. 3.42 and added new Chapter 1701 to the Insurance Code as part of a nonsubstantive code revision, and substantive amendments are not consistent with intent to enact a nonsubstantive revision. See Acts 2003, 78th Leg., R.S., chap.1274, sec. 5, effective April 1, 2005 (caption indicating that the bill relates to a nonsubstantive revision of statutes). The Department disagrees that prior legislative review will avoid all possible uncertainty related to court construction of new Subchapter M, as courts review not only regulatory but statutory language. See *Speiser v. Randall,* 357 U.S. 513, 544, n.7 (1958). The Department also disagrees that applicability is unclear. New Subchapter M applies to all forms regulated under the Insurance Code Chapters 1271 and 1701 as provided in §3.1201. In response to comment, the Department has clarified specific applicability to renewing forms in §3.1201(b) and (c), which provide that forms renewing after the applicable effective date in those provisions are subject to the subchapter. Because legislative and regulatory actions are routinely applied to renewing forms, the Department does not anticipate that insurers or HMOs will have difficulty in determining how to apply requirements of the new subchapter in those contexts. See, e.g. Acts 2007, 80th Leg., R.S., ch. 877, §9, eff. Sept. 1, 2007 (the Insurance Code Chapter 1352, related to coverage for brain injury, applies to plans that are renewed on or after January 1, 2008); and Acts 2009, 81st Leg., ch. 1270, §4, eff. Sept. 1, 2009 (the Insurance Code Chapter 1376, related to tests for early detection of cardiovascular disease, applies to plans that are renewed on or after January 1, 2010). The Department agrees that the word "discretion" need not be present in the text of a clause in order for the clause to qualify as a discretionary clause. *See e.g. Chevron Chemical Co. v. Oil, Chemical, & Atomic Workers Local Union 4-447,* 47 F.3d 139, 142 - 143 (5th Cir. 1995). Department staff routinely review the language of forms to determine whether there are violations of law, including regulations, and the Department anticipates that the same processes currently used by the Department, insurers and HMOs to resolve questions concerning provisions for specified types of filing will be applied in the context of discretionary clauses. Additionally, the Department has considered each of definitional comments submitted in connection with §§3.1201 - 3.1203, provided specific responses to those comments in this adoption order, and made changes as appropriate and as noted in those responses. However, the Department will monitor to determine whether additional rulemaking is required. The Department disagrees that this rule is intended to define the terms such as "partial disability," "residual disability" and "total disability" as those terms are used in forms. The Department expects that issuers should clearly and unambiguously define terms important to a consumer's ability to access the benefits of a bargain in a form. The Department further disagrees that consideration of inclusion of a topic as a recommendation for consideration by the Legislature is equivalent to a lack of authority to undertake rulemaking. The Department also disagrees that the inclusion of prohibitions of discretionary clauses by the NAIC in model statutes rather than model rules reduces or negates the Commissioner's authority to adopt rules under the statutory bases established by the Legislature in the Insurance Code. Models adopted by the NAIC are, as the name implies, models subject to tailoring as appropriate to the circumstances and existing laws of a given state. In Texas, as explained in this response, statutory authority exists to adopt §§3.1201 - 3.1203 absent the requirement of a specific statute concerning discretionary clauses. The Department agrees that adoption of §§3.1201 - 3.1203 are within the Commissioner's authority and disagrees that such authority is insufficient. As stated in the Statutory Authority section of this adoption order, the rulemaking authority for §§3.1201 - 3.1203 is as follows:

The new sections are adopted under the Insurance Code §§1701.060(a)(1), 1701.055(a), 1271.056, 1271.103, 843.151, 541.401 and 36.001. The Insurance Code §1701.060(a)(1) authorizes the Commissioner to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted will be reviewed and approved by the Commissioner or exempted under the Insurance Code §1701.005(b). Section 1701.055(a) specifies that except as provided by the Insurance Code §1701.055(d), the Commissioner may disapprove, or, after notice and hearing, withdraw approval of a form if the form violates the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1271.056 specifies that an evidence of coverage may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; encourages misrepresentation; or is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Insurance Code §1271.103(a) specifies that after notice and opportunity for hearing, the Commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the Commissioner determines that the form violates the Insurance Code Chapters 1271, 843, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the Commissioner. The Insurance Code §1271.103(b) provides that if the Commissioner withdraws approval of a form under §1271.103, the form may not be issued until it is approved. The Insurance Code §843.151 specifies that the Commissioner is authorized to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Insurance Code §541.401 specifies that the Commissioner may adopt and enforce reasonable rules the Commissioner determines necessary to accomplish the purposes of the Insurance Code Chapter 541 (relating to the prohibition of trade practices that are unfair methods of competition or unfair or deceptive acts or practices). The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

General Comments: Necessity for Rule.

Comment: Some commenters questioned whether the rule proposal was prompted by complaints, and, if so, whether the number of complaints was sufficient to justify a prohibition on discretionary clauses. One commenter asserted that the evidence of a need for a prohibition of discretionary clauses was limited to a clip from a television show, testimony from attorneys that litigate cases that winning is very difficult, and assertions in a rulemaking petition that the commenter asserts to be factually incorrect. Several commenters state that discretionary clauses only become important in the context of determining the standard of review that will apply in litigation and that the significant administrative undertaking that a prohibition against the clauses will entail is not warranted. A commenter asserts that the deferential standard applied to review of insurer decisions where discretion has been granted to the insurer are comparable to the discretion that is given to decisions of the Commissioner that are judicially reviewed; per the commenter,

if there is a scintilla of evidence to support the findings of fact made by the Commissioner, the court will generally uphold the findings. However, the commenter asserts that insurers for an ERISA plan are additionally subject to fiduciary standards. The commenter disagrees that there is evidence that insurance companies will disregard fiduciary responsibilities to deny claims for their own benefit and argues that the Department's statements to the contrary in its published proposal are not substantiated. Several commenters assert that insurers are incentivized not to systematically deny meritorious claims because employers would take their business elsewhere if the plan were not administered to the actual benefit of the employees. The commenters argue that employers "have the sophistication and borrowing power necessary to take their business elsewhere if an insurer . . . consistently denies valid claims." *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan,* 144 F.3d 1014, 1021 (7th Cir. 1998); *see also* Barry D. Smith & Eric A. Wiening, How Insurance Works 3-4, 8-9 (2d ed. 1994). Thus, the commenters assert that a practice of denying claims improperly "would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers." *Id.* The commenter further submitted that most claims are granted, relying upon a study of claims submitted in 2002. Health Ins. Ass'n of America, *Results from an HIAA Survey on Claims Payment Processes* 10 (March 2003), available at www.ahipresearch.org/PDFs/21_ClaimsPaymentProcesses-SurveyChartbook.pdf *("HIAA Survey").* The commenter states that, per the study: (i) 86 percent of claims were granted; (ii) 48 percent of the denials were duplicate submissions; (iii) and 20 percent of the denials were based upon policy lapses. *Id.* The commenter further argues that only three percent of all claims were denied because the benefit was not covered, 0.4 percent were denied for eligibility reasons, and one percent of claims were denied for other reasons. *Id.* The commenter further states that there are numerous reported cases reversing decisions by fiduciaries that demonstrate that: (i) courts are not reluctant to review decisions for biases or conflicts of interest; and (ii) a *de novo* standard of review is not necessary to achieve a fair adjudication. Another commenter states that in many cases claimants that have been harmed by discretionary clauses but have settled disputes with issuers are bound by confidentiality provisions in settlement agreements and therefore prevented from testifying or giving information about the claim. The commenter notes that the confidentiality provisions sometimes affect the attorney representing the claimants, as well.

Agency Response: The Department has not been made aware of significant complaints relating to discretionary clauses apart from concerns that have arisen during this rulemaking process. However, the Department's position is that the lack of complaints relating to discretionary clauses does not indicate the absence of a problem. The major impact of a discretionary clause occurs by operation of law upon subsequent review by a court. Understanding and identifying a discretionary clause as the source of an unfair coverage determination and subsequent lack of full independent review requires sophisticated legal knowledge and analysis. Therefore, it is unlikely that the average consumer would be able to identify discretionary clauses as a contributing cause of a negative interaction with an insurer or HMO. Further, although the Department considers complaint information when proposing rules, it is not necessary that a prohibitory rule be prompted by a certain number of complaints regarding the practice at issue. The Department's position is that regardless of insurance and HMO consumers' ability to identify discretionary clauses as a specific problem, the potential harm resulting from discretionary clause is sufficient reason to adopt the rule. Additionally, the Department notes that the *HIAA Survey* submitted by commenters indicates that 20 percent of claim denials are based upon whether the benefit is covered. *HIAA Survey* at 10. The number of coverage determinations that may potentially benefit from adoption of §§3.1201 - 3.1203 is therefore significant. The Department further disagrees that discretionary clauses are important only in the context of determining the standard of judicial review applicable in litigation, although that result alone is unjust to consumers that are faced with a standard of review that favors the parties that drafted the language of a form in dispute. The use of such clauses is also misleading to the extent that it may lead consumers to believe that they do not have a right to appeal the claim determination. The Department also disagrees that there is no evidence that insurers ever make claim determinations for the benefit of the insurer because of the existence of fiduciary standards. In *Lain v. UNUM Life Ins. Co. of America,* 279 F.3d 337, 347 (5th Cir. 2002), the court held that UNUM abused its discretion where the record contained "an overwhelming amount of medical evidence supporting [the] claim of disability" and "a complete absence in the record of any "concrete evidence" supporting UNUM's determination that [the insured] was not disabled." *Lain* concerned a long-term disability insurance policy selected by a firm for its employees in Houston, Texas and governed under ERISA. *Id.* at 340 - 342. In a footnote, the *Lain* opinion also notes that the district court stated that "UNUM infused its inherent, institutional conflict of interest into its employees by providing substantial financial bonus incentives based partially on UNUM's financial achievement and its net earnings per share." *Id.* at 348, n.7. Additionally, the Department notes that a multistate market conduct examination of three disability insurers owned by UnumProvident Corp., joined by all 50 states and the District of Columbia, identified several claims handling practices that were of concern, including: (i) excessive reliance on in-house medical staff to support the denial, termination, or reduction of benefits; (ii) unfair evaluation and interpretation of attending physician or independent medical examiner reports; (iii) failure to evaluate the totality of the claimant's medical condition; and (iv) an inappropriate burden placed on claimants to justify eligibility for benefits. See Press Release on Multi-State, Federal Settlement Addresses Concerns Regarding UNUM Provident Claims Handling (November 18, 2004), available at http://www.mass.gov/?pageID=ocaterminal&L=6&L0=Home&L1=Government&L2=Our+Agencies+and+Divisions&L3=Division+of+Insurance&L4=Archive+of+DOI+News+%26+Updates&L5=2004+DOI+Press+Releases&sid=Eoca&b=terminalcontent&f=doi_Media_media_press56&csid=Eoca.*See also Glenn,* 554 U.S. at 118 (holding that a greater weight was attributable to a conflict of interest where the insurer of a long term disability plan governed under ERISA encouraged the insured to argue to the Social Security Administration that she could do no work, received the bulk of the benefits of her success in so arguing, and then ignored the agency's finding in concluding that the insured could in fact do sedentary work because the seemingly inconsistent positions were both financially advantageous to the insurer). While the Department agrees that there are cases indicating that courts are willing to consider whether the insurer making a claim determination has a conflict of interest, the Department does not agree that it is appropriate that an insured or enrollee should have to meet this additional burden of proving the extent of such conflict.

Even a judicial finding that a conflict of interest does exist will only count as a factor in the application of the arbitrary and capricious standard of review, and the significance of the factor will depend upon the circumstances of the particular case. *See id.* at 108; see *also Corry v. Liberty Life Assur. Co. of Boston,* 499 F.3d 389, 398 (5th Cir. 2007) ("only a modicum less deference" is appropriate where the only evidence of a conflict was the dual role of Liberty as administrator and insurer and that the review "need only assure that the administrator's decision fall somewhere on a continuum of reasonableness - even if on the low end.") (citations omitted). The Department acknowledges that the existence of confidentiality provisions in settlement agreements may additionally impede some parties and their representatives from filing complaints concerning the detrimental effects of discretionary clauses.

Comment: Some commenters stated that the rule is unnecessary because: (i) ERISA provides a framework sufficient to protect insureds; (ii) the presence of a discretionary clause does not void the applicability of federal law; and (iii) the use of a discretionary clause does not void the applicability of state consumer protection laws such as those that prohibit deceptive trade practices and regulate claim settlement practices. The commenters assert that plan fiduciaries under ERISA must act prudently and solely in the interest of plan participants and use discretion in interpreting provisions. When discretion is granted, the commenter asserts that a court must find that the decision to deny benefits was not supported by the evidence and was arbitrary and capricious. Another commenter asserts that the claim decision must be fair and reasonable. A commenter states that when the plan administrator is also the insurer, the court will consider whether a potential conflict of interest is a factor in determining whether there has been abuse of discretion. Further, the commenter asserts that participants and beneficiaries are granted the explicit right to sue to recover benefits or clarify their rights under a plan by ERISA and that ERISA assures an appeal process that is fair, independent, and protects consumers by requiring that: (i) the appeal be decided by a fiduciary who is neither the initial claim reviewer or a subordinate of that person; (ii) the appeal not give deference to the original claim decision; (iii) the claimant have a right to be represented; and (iv) the claimant have a right of access to information. *29 CFR Part 2560.* A commenter asserts that discretionary clauses neither affect claim administration nor limit the right of insureds to seek judicial relief. A commenter asserts that a ban on discretionary clauses will only serve to eliminate a mechanism endorsed by the United States Supreme Court. The commenter asserts that the Department regulates unfair trade practices, deceptive acts, and claim settlement practices of insurers as specified in 28 Tex. Admin. Code §21.1 et seq. and §21.201 *et seq.* Based upon existing federal and state protections that apply to claim fiduciaries, the commenter asserts that the fiduciaries do not have unfettered discretion in adjudicating claims.

Agency Response: The Department disagrees that the consumer protection framework within ERISA negates the need for §§3.1201 - 3.1203. Although ERISA prescribes certain protections for enrollees, the Department's position is that these protections are insufficient to provide the necessary consumer protections in all instances. The U.S. Supreme Court has acknowledged that the duties prescribed by ERISA may be insufficient to fully protect enrollees when an insurer faces a conflict of interest: *"Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a "facto[r] in determining whether there is an abuse of discretion." Firestone,* 489 U.S. at 115. The Department agrees with the Supreme Court that there is a possibility that an insurer may have a conflict of interest in making coverage determinations resulting in adverse financial consequences to the company. Therefore, it is of vital importance to ensure that insureds are provided an opportunity for a full benefit determination review by an independent decision maker. Because an insurer may have a conflict of interest in making coverage determinations, it is possible that such decisions may result in unfair and inequitable outcomes for insureds. Companies using discretionary clauses may then unfairly benefit from a deferential appellate standard of review should an insured choose to seek judicial review of the coverage determination. Additionally, the applicability of the rule extends beyond cases governed by ERISA. The Department also disagrees that the existence of state consumer protection laws concerning deceptive trade practices and claims settlement practices negates the need for §§3.1201 - 3.1203. It is the Department's position that adoption of §§3.1201 - 3.1203 is necessary to protect consumers from the possibility of incorrect and unfair coverage determinations without a subsequent opportunity for a full and independent review under a non-deferential standard and to notify insurers and HMOs that the Department also finds the use of discretionary clauses to be unjust, encourage misrepresentation, and be deceptive because they mislead consumers regarding the terms of the coverage. The Department does agree that it has the authority to regulate the conduct of insurers under 28 Tex. Admin. Code §21.1 *et seq.* and §21.201 *et seq.* Adoption of a prohibition concerning discretionary clauses is an effective and efficient way to exercise such authority and will provide clear guidance and notice for regulated entities to use in drafting forms.

Comment: Several commenters state that the Department should not adopt §§3.1201 - 3.1203 because consumers already have access to substantive judicial review. Per the commenters: (i) a denial of benefits is not an abuse of discretion if supported by substantial evidence and not arbitrary and capricious; *(Ellis v. Liberty Life Assurance Co. of Boston,* 394 F.3d 262, 273 (5th Cir. 2004); (ii) "[s]ubstantial evidence . . . is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion;" *(Id.);* (iii) the existence of substantial evidence must be considered "in the light of all the evidence;" *(Corry,* 499 F. 3d at 399); and (iv) a decision is arbitrary if "made without a rational connection between the known facts and the decision." *(Meditrust Fin. Servs. Corp.,* 168 F.3d at 215 (quotation marks and citation omitted)). The commenters therefore assert that the arbitrary and capricious standard of review is substantive in nature and suffices to protect consumer interests. Another commenter states that a prohibition on discretionary clauses is a necessary and proper consumer protection measure that will reduce the potential for bad faith claim denials that are nearly unchallengeable. Several commenters assert that discretionary clauses create a conflict of interest for insurers by reserving to the insurer the right to interpret the terms of a policy drafted by the insurer, placing the insurer in a position to deny benefits that a reasonable insured person would believe fall within the terms of the policy. The commenters assert that discretionary clauses make this problem worse by giving rise to the "arbitrary and capricious" standard of review, as demonstrated in *Firestone,* 489 U.S. at 115, making it more difficult for an insured to challenge a denial that may have been made in bad faith or with bias. Another commenter asserts that: (i) discretionary clauses are unjust, encourage misrepresentation, and deceptive; and (ii) a prohibition against discretionary clauses is necessary to

protect consumers from incorrect and unfair coverage determinations by allowing consumers to seek a full and independent review of the claim under a non-deferential standard. Some commenters state that the NAIC adopted model laws in 2002 and 2004 prohibiting discretionary clauses in health and disability policies, and one commenter asserts that the impetus for this adoption was the NAIC position that: (i) discretionary clauses are inequitable, deceptive, and misleading to consumers; and (ii) banning discretionary clauses prevents the conflict of interest that occurs when the insurer responsible to provide benefits has discretionary authority to determine the benefits that are due. The commenter supports that position and argues that the economic security of a family can hang in the balance as coverage determinations are made. Several commenters assert that Texans should enjoy the protections available to consumers in 22 other states that have taken action to prohibit the use of discretionary clauses. A commenter asserts that the financial and emotional toll on individuals and families attempting to challenge a benefit determination in court under a standard of review that favors insurers is significant and lasting. Another commenter supports a prohibition on discretionary clauses because: (i) the commenter opines that the clauses violate common law principles concerning contracts of adhesion; (ii) the commenter's experience indicates that insurers who have discretionary clauses are the most difficult to work with in resolving claims; and (iii) the commenter refuses to sell individual disability insurance forms with discretionary clauses because of this experience. The commenter opines that insurers will benefit from the prohibition because experienced disability insurance agents who have refused to sell products containing discretionary clauses will consider those insurer's products to be legitimate options for consideration in advising clients after such clauses are removed. Another commenter states opposition to inclusion of discretionary clauses in any type of insurance policy because: (i) the commenter believes that insurers can state in plain language the terms and conditions under which claims will be paid; (ii) the commenter opines that discretionary clauses represent subterfuge; and (iii) the commenter believes that if insurance companies cannot provide the same degree of transparency that is provided by the Social Security Administration, which makes its criteria for disability determinations readily available, the company should not be permitted to operate in Texas. Another commenter states that a recent Texas case, *Burton v. Unum Life Insurance Co.,* 2010 U.S. Dist. LEXIS 58267 (W.D. Tex. June 14, 2010), demonstrates that courts may determine that an insurer's claim determination is not fair and reasonable but still find that the adverse determination does not constitute an abuse of discretion, the standard of judicial review applicable in cases in which the underlying form includes a discretionary clause. The commenter notes that the court in *Burton* stated as follows:

However, the Court notes in conclusion that the overall record in this case plainly indicates Burton suffers from bipolar disorder, and has so suffered since at least 2004. Although the illness is episodic, and may have waned at times, it is obvious Burton has a mental illness and should have remained on medication for that illness. The SSA, considering the exact same evidence as Unum, held Burton was totally disabled as of March 2007. Unum has ignored this finding and denied Burton's claim. This Court upholds Unum's determination because of the clear terms of its Policy, with which Burton was not in compliance. Nonetheless, the Court laments the unfortunate result of this case and the fact Unum has escaped payment to a man who is clearly mentally ill by rigidly and aggressively enforcing the terms of its Policy against him, even though his non-compliance may arguably have been a symptom of his illness. However, the fix for this is not in the Court--as neither the Court nor Burton can deny he is bound by the Policy's plain terms--but in the marketplace, where Unum's aggressive claims administration seems already to have reaped it a befitting reputation. *See, e.g. McCauley v. First Unum Life Ins.* Co., 551 F.3d 126, 137 (2d Cir. 2008) (Unum "reveals a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics.")

The commenter argues that abuse of discretion reviews do not consider whether an insurer's actions were fair and reasonable but whether there is a scintilla of evidence to support the action. A commenter cites to a 7th Circuit court opinion addressing the arbitrary and capricious standard as follows: "Although it is an overstatement to say that a decision is not arbitrary or capricious whenever a court can review the reasons stated for the decision without a loud guffaw, it is not much of an overstatement. The arbitrary or capricious standard is the least demanding form of judicial review of administrative action. Any questions of judgment are left to the agency, or here to the administrator of the Plan. . . .(citations omitted)." *Pokratz v. Jones Dairy Farm,* 771 F.2d 206, 209 (7th Cir. 1985). Another commenter agrees and states that the arbitrary and capricious standard of review addresses whether the claimant's due process rights were violated rather than whether the decision made by the insurer was correct. A commenter argues that employers and claimants deserve the benefit of the bargain they have made, and they should be able to access such benefits for legitimate claims without having to overcome a deferential standard that favors insurers by requiring the claimant to demonstrate that a decision was arbitrary and capricious. A commenter states that a prohibition on discretionary clauses will return to individuals the common law and statutory rights to file a lawsuit and prove before a jury by a preponderance of the evidence whether the individual is entitled to benefits under the terms of a first-party insurance contract. The commenter opines that issuers favor discretionary clauses as a method of getting rid of juries, creating an unlevel playing field by limiting judicial review to abuse of discretion. The commenter submits that a prohibition against a provision specifying a standard of interpretation or review that is inconsistent with laws of this state should be adopted.

Agency Response: The Department agrees that the arbitrary and capricious standard of review is a substantive standard of review but disagrees that the arbitrary and capricious standard of review suffices to serve the consumer protection purposes of new §§3.1201 - 3.1203 as explained in this response and throughout this adoption order. The Department appreciates the supportive comments concerning the need for this rule and agrees that a prohibition of discretionary clauses as established in new §§3.1201 - 3.1203 is both necessary and proper in order to protect consumers from incorrect, unfair, biased and/or bad faith coverage determinations. The prohibition also serves the purpose of helping to prevent consumers from believing that they lack access to appeal based upon statements concerning the binding nature of a carrier's determination in a form. The Department further agrees that new §§3.1201 - 3.1203 will result in increased consumer access to full and independent review of claim determinations under a non-deferential standard. The Department does not agree that the deferential "arbitrary and capricious" standard of review requires only a scintilla of evidence in support of the carrier's determination. The Fifth Circuit explained the standard in *Corry,* 499 F.3d at 397 - 398:

Under the abuse of discretion standard, "[i]f the plan fiduciary's decision is supported by substantial evidence and is not arbitrary and capricious, it must prevail." *Ellis v. Liberty Life Assurance Co. of Boston,* 394 F.3d 262, 273 (5th Cir.2004). "Substantial evidence is more than a scintilla, less than a preponderance, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Id.* (quotation omitted). "An arbitrary decision is one made without a rational connection between the known facts and the decision or between the found facts and the evidence." *Bellaire Gen. Hosp. v. Blue Cross Blue Shield of Mich.,* 97 F.3d 822, 828 (5th Cir.1996).

The Department does, however, acknowledge that application of the abuse of discretion standard, which "need only assure that the administrator's decision fall somewhere on a continuum of reasonableness--even if on the low end" sometimes makes it difficult to distinguish from the *scintilla of evidence* standard of review. See *id.* at 398.

General Comments: Uniform Administration.

Comment: Several commenters state that discretionary clauses arise from a judicial requirement for specific reservation of a plan's discretion to fulfill its statutory mandate to act as a fiduciary in establishing standards and ensuring equity and non-discrimination in making uniform and consistent coverage determinations for the protection of employers and consumers. Several commenters express particular concern about the possibility of disparate results in claim determinations for persons covered under the same plan, possibly residing in different states, and the consumer confusion that the commenters assert will follow. As such, the commenters assert that the clauses are necessary for the provision of reliable and uniform benefits to employers and consumers, and should not be prohibited. A commenter additionally asserts that insurers require discretion to: (i) underwrite risks; (ii) set premiums; (iii) process changes; (iv) make claim determinations concerning total, partial, residual, permanent, or concurrent disability; (v) make claim determinations concerning decreases in earnings or income as test of disability; (vi) consult with professionals such as treating physicians, insurer physicians, physicians that have offered opinions without examining the insured, and occupational therapists; (vii) consider expert testimony, presumptions, and opinions of physicians; (viii) consider issues relating to the existence of other insurance and its impact on earnings; (ix) consider issues relating to vocational retraining and rehabilitation; and (x) consider issues related to when the particular disability occurred and whether it was in the policy period. The commenter opines that each of these factors affect the ability and willingness of insurers to underwrite and service disability insurance in Texas. The commenter asserts that prudent underwriting requires caution in both underwriting and benefit determination. Another commenter argues that uniformity and consistency in decisions concerning benefit determinations should not take precedence over whether decisions are ultimately correct. The commenter opines that the unique circumstances of each claimant merit judicial review under a non-deferential standard that does not protect issuers from poor decisions.

Agency Response: The Department disagrees that discretionary clauses are a judicial requirement needed to fulfill a statutory mandate under ERISA. As stated by the United States Supreme Court in *Rush,* 536 U.S. at 385 - 386: "Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly. When this Court dealt with the review standards on which the [ERISA] statute was silent, we held that a general or default rule of *de novo* review could be replaced by deferential review if the ERISA plan itself provided that the plan's benefit determinations were matters of high or unfettered discretion. . . . Nothing in ERISA, however, requires that these kinds of decisions be so "discretionary" in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract." (citations omitted)); c.f. Pierre, 932 F.2d at 1553 (holding that *Firestone* does not require *de novo* review for factual determinations). The Department disagrees that the prohibition of discretionary clauses will decrease the uniformity of an insurer's or administrator's claims review process. The Department's position is that because a discretionary clause prohibition allows an insured a subsequent opportunity for a full and independent review of coverage determinations, such a prohibition may encourage insurers to implement more uniform claim review procedures. Additionally, carriers have an opportunity and incentive to include consistently applied interpretations in the body of a form to ensure that insureds and enrollees, rather than only claims handlers, are equally aware of the constructions routinely applied to a plan's terms. Such action would enhance uniformity and reliability in benefit provision and reduce potential confusion for not only individuals covered under the same plan but for all individuals receiving coverage under the same form. The Department also disagrees that §§3.1201 - 3.1203 will impede a carrier's ability to perform underwriting, set premiums, process changes, or perform basic administrative functions associated with underwriting and servicing insurance and HMO coverages. Carriers can perform these functions without the necessity of a special grant of discretion. The Department notes a lack of evidence that such functions of a carrier appear to have halted in those jurisdictions that have already taken action of some kind to prohibit discretionary clauses. The Department does not agree that §§3.1201 - 3.1203 will preclude an insurer from exercising prudence in underwriting or benefit determination. The Department does, however, assert that the tension between this stated goal of prudence in benefit determination and the fact that discretionary clauses result in a deferential standard of review for the carrier making the benefit determination provides for a foundation that does not best protect the interests of a consumer. It is the Department's position that the adoption §§3.1201 - 3.1203 is necessary to ensure that consumers are afforded the opportunity for full, fair, and independent review under a standard that does not provide deference to the carrier. The Department agrees that potentially incorrect or unjust determinations of carriers should not be given deference in judicial review.

General Comments: ERISA Preemption.

Comment: A commenter asserts that prohibitions on discretionary clauses in plans governed by ERISA are preempted because ERISA authorizes plan administrators to delegate discretionary authority to interpret plan terms. The commenter argues that in *Firestone,* 489 U.S. at 110, the United States Supreme Court made it clear that ERISA allows plans to exercise discretionary authority in determining benefits and interpreting policy terms through the use of discretionary clauses. Another commenter agrees and states further that the United States Supreme Court's decision in *Aetna Health Inc. v. Davila,* 124 S. Ct. 2488 (2004) supports this position in finding that benefit determinations under ERISA are fiduciary acts and that HMOs must make discretionary decisions. *Id.* at 2501 - 2502. The commenter urges that *Davila,* in conjunction with "Congress' creation of a 'carefully integrated' civil enforcement scheme' that is "one of the essential tools for accomplishing the stated

purposes of ERISA', supports the argument that a prohibition on discretionary clauses restricts a fiduciary or administrator's ability to fulfill the role intended by ERISA and affirmed by courts. *Id.* at 2495; *Ingersoll Rand v. McClendon,* 498 U.S. 133, 137 (1990) (citations omitted). The commenter argues that the Fifth Circuit Court of Appeals has not considered the issue of whether a prohibition on discretionary clauses violates ERISA's preemption provisions by supplanting, supplementing or duplicating ERISA's remedies provisions. *Davila,* 124 S. Ct. at 2488. The commenter asserts that the issue is ripe for review by the Supreme Court. Other commenters state that legal challenges to rules broadly prohibiting discretionary clauses have been unsuccessful. Ross, 558 F.3d at 605 - 607 (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products because the rule was directed toward entities engaged in insurance, finding the rule essentially imposed a condition on the insurer's right to issue a policy and substantially affected the risk pooling arrangement between the insurer and insured because the rule altered the scope of permissible bargains between the insurer and insureds by prohibiting discretionary clauses); Morrison, 584 F.3d at 845 (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); *McClenahan v. Metropolitan Life Ins. Co.,* 621 F.Supp.2d 1135, 1138-42 (D. Colo. 2009) (holding statute not preempted but not retroactively applicable). The commenter asserts that these cases have held that state laws effectively prohibiting discretionary clauses in insurance contracts were not preempted under the Supreme Court's analysis in *Kentucky Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329 (2003) (holding that laws regulating insurance are saved under ERISA). A commenter emphasizes that the court has narrowed what will be preempted and expanded what will be saved under the insurance clause under ERISA over the last 15 years, citing to *Travelers and Miller.* The commenter opines that the United States Supreme Court's determination not to grant certiorari in *Morrison* is consistent with precedent and with the trend in the court to find fewer laws to be preempted under ERISA. A commenter also opines that, respectively, *Morrison* and Ross further rejected arguments that the Montana and Michigan laws prohibiting discretionary clauses were preempted under ERISA because they implicated ERISA's civil enforcement provisions. *Morrison,* 584 F.3d at 846 ("there is no additional remedy. Insureds may only recover the value of the denied claim from their insurers."); *accord, Ross,* 558 F.3d at 607-08. Finally, the commenter asserts that both courts rejected the argument that a state's prohibition of discretionary clauses conflicts with ERISA's purposes. Instead, the commenter asserts that the courts relied on the Supreme Court's decision in *Rush:*

In *Rush Prudential,* the insurer argued that deferential review was a substantive rule intended to be preserved by the system of uniform enforcement. 536 U.S. at 384. The Court made quick work of this argument: Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, not a uniformly lenient regime of reviewing benefit determinations. *Id.* at 385.

Morrison, 584 F.3d at 848 (internal quotations omitted); *accord, Ross,* 558 F.3d at 608. The commenter therefore argues that the states have clear authority to prohibit discretionary clauses because such actions are saved as regulating insurance and are not preempted under ERISA. A commenter asserts that the decision of the United States Supreme Court not to grant a petition for *certiorari in Morrison* is particularly important because such a grant will only be issued for compelling reasons at the discretion of the court under Supreme Court Rule 10. The commenter asserts that two of three possible bases for seeking review might have been involved in *Morrison:* (i) decisions of federal courts of appeal are in conflict with one another under Rule 10(a); and (ii) under Rule 10(c), the case presents important questions of federal law that have not been, but should be, decided by the Court or that have been decided in a manner that conflicts with relevant decisions of the Supreme Court. (Eugene Greesman et al., *Factors Motivating the Exercise of the Court's Certiorari Appellate Jurisdiction,* SUPREME COURT PRACTICE at 234276 (9th ed. 2007)). The commenter relates that Standard Insurance Company filed for certiorari of the *Morrison* decision based upon the alleged conflict that the prohibition caused with ERISA's civil enforcement provisions, recent Supreme Court decisions on the standard of review, and ERISA's purposes. The commenter further relates that the NAIC filed an *amicus* brief in support of denial of *certiorari.* The court denied certiorari in an order that states no reason for the denial, but the commenter, noting the lack of a court split on the issue, notes further that the court had previously rejected arguments similar to those raised in Standard's petition in *Rush-Prudential v. Moran.* A commenter additionally asserts that the United States Supreme Court recognized in *Rushq, 536 U.S. at 385, that ERISA permits but does not require discretionary review. The commenter therefore argues that "deferential review . . . is not a settled given." Id.*

Agency Response: The Department disagrees that prohibitions on discretionary clauses are generally preempted by ERISA. ERISA specifies an exemption to preemption, known as the savings clause. The ERISA savings clause specifies: *"Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." See 29 U.S.C. §1144(b)(2)(A).* The Supreme Court has specified that to fall within the ERISA savings clause exception, an insurance action must: (i) be specifically directed toward entities engaged in insurance; and (ii) substantially affect the risk pooling arrangement between the insurer and insured. *See Kentucky Ass'n of Health Plans v. Miller,* 538 U.S. 329, 341-42 (2003). The Department's prohibition on discretionary clauses is specifically directed towards insurers, and substantially affects the risk pooling arrangement between the insurer and the insured because it alters the permissible scope of the bargain between the two entities. See Ross, 558 F. 3d at 605-07 (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products because the rule was directed toward entities engaged in insurance, finding the rule essentially imposed a condition on the insurer's right to issue a policy and substantially affected the risk pooling arrangement between the insurer and insured because the rule altered the scope of permissible bargains between the insurer and insureds by prohibiting discretionary clauses); *Morrison,* 584 F. 3d at 842-45 (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products because the regulation is specifically directed toward entities engaged in insurance and substantially affects the risk pooling arrangement between the insurer and insured); and *McClenahan,* 621 F.Supp. 2d at 1141, 1143 (holding statute not preempted but not retroactively applicable). The Department additionally agrees that: (i) §§3.1201 - 3.1203 do not violate ERISA by conflicting with ERISA's civil enforcement provisions *(Morrison,* 584

F. 3d at 586; *accord Ross,* 558 F. 3d at 607-08); and (ii) §§3.1201 - 3.1203 do not conflict with ERISA's purpose *(Morrison,* 584 F. 3d at 848; *accord Ross,* 558 F. 3d at 608). The Department does not agree that ERISA mandates that discretionary authority be granted to insurers or that *Davila,* 542 U.S. at 220, represents this principle. Instead, the Department agrees with the United States Supreme Court that ERISA permits, but does not require, such a grant of discretion. *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 385-86 (2002). The Ninth Circuit considered and rejected the argument that the Montana policy prohibiting discretionary clauses in insurance forms conflicts with ERISA's exclusive scheme of civil enforcement, specifically considering the issue in light of *Davila:*

"[T]he detailed provisions of §[29 U.S.C. §1132](a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Aetna Health v. Davila,* 542 U.S. 200, 208-09. Accordingly, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted." *Aetna Health,* 542 U.S. at 209. In *Aetna Health,* the Court declared preempted a state law which allowed insureds to receive damages when insurers failed to "'exercise ordinary care when making health care treatment decisions.'" Id. at 205, (quoting Tex. Civ. Prac. & Rem. Code Ann. §88.002 (1997)). ERISA already provides several remedies for disgruntled litigants, including preliminary injunctions and restitution under 29 U.S.C. §1132(a)(1)(B). *Aetna Health,* 542 U.S. at 211. However, only the value of the lost claim is recoverable under the statutory remedies. Because the state statute allowed for recovery of a greater scope of damages, it upset "the careful balancing" Congress engaged in when crafting the "limited remedies under ERISA"; the state law may have "ensur[ed] fair and prompt enforcement of rights" but at the cost of discouraging employers from creating plans. *Id.* at 215. The state could not second-guess Congress's weighing of these factors by allowing for enhanced recoveries.

Morrison, 584 F. 3d at 846 (internal citations, quotes, and quotation marks omitted). The Ninth Circuit continued its analysis by determining that the policy of prohibiting discretionary clauses in insurance forms, while it would lead to *de novo* review in federal courts, could not be said to "duplicate[ ], supplement[ ], or supplant[ ] the ERISA remedy. *Id.* at 846-47. Similarly, the Department's position is that §§3.1201 - 3.1203 provide "no additional remedy" but instead "force[ ] ERISA suits to proceed with their default standard of review." *Id.* at 846; accord Ross, 558 F.3d at 607-08. It is the Department's position that the prohibition falls within the ERISA savings clause and is not preempted by ERISA.

General Comments: Litigation, Delay in Claims Process, Small Business Impact, Premium Increase.

Comment: Several commenters state that any prohibition on discretionary clauses will have unintended consequences that will be harmful to Texas consumers and employers and should not be adopted. The commenters state that a prohibition will increase and expand litigation and delay the claims process, resulting in higher health care costs and consequently higher premiums for employers and individuals. A commenter asserts that additional or more protracted litigation is not necessarily more efficient litigation. A commenter also asserts that disability insurance generates much litigation even without a prohibition on discretionary clauses because: (i) most policies and cases involve total disability; and (ii) even carefully drafted definitions may be litigated due to the cost of the insurance and consumer expectations that may vary from the actual policy. Another commenter asserts that elimination of the preferential review standard that arises from inclusion of discretionary clauses in forms will result in added expense due to the need for parties to hire experts and that this cost will be passed on to purchasers. The commenters assert that small employers are particularly vulnerable to price increases and will bear the brunt of higher costs due to a lack of resources and infrastructure to self-fund their health benefit plans. The commenters also assert that even modest premium increases in disability income insurance products lead to employer determinations to drop or forgo including the product in plans, to reduced purchasing by individuals, and to reduced options for consumers. A commenter states that the cost estimate in the Department's proposal, based on a study by Milliman, Inc., estimates that premiums will increase 3 to 4 percent "based upon anticipated increases in litigation, higher costs of litigation, and more cautious carrier behavior in managing claims." The commenter asserts that studies have found that increased premium costs result in reduced coverage. *See Jonathan Gruber, "How Elastic is the Firm's Demand for Health Insurance? Journal of Public Economics, 88 (2004)" ("Gruber study").* The commenter states that the Gruber study estimates the impact of premium increase to coverage varies between 0.2 to 0.7 percent depending upon the size of the employer. A commenter states that employers may avoid the prohibition against discretionary clauses by self-funding plans or by purchasing a product in another state in which the employer operates that does not prohibit discretionary clauses. The commenter asserts its understanding that there are 15 jurisdictions that have taken some action with respect to prohibitions against discretionary clauses. Another commenter asserts that 22 states currently prohibit the use of discretionary clauses in insurance policies in some way, with: (i) four states taking action through statute (Colorado at Colo. Rev. Stat. §10-3-1116 (2008); Maine at Me. Rev. Stat. Ann. Tit. 24-A, §4303(11) (2003); Minnesota at Minn. Stat. §62Q.107 (1998); and Wyoming at Wyo. Stat. §26-13-301 to 26-13-305); (ii) eight states taking action through regulation (Idaho at Admin. Pro. Act §18.01.29 (2009); Illinois at Admin. Code Title 50 §2001.3 (2005); Michigan at Admin. Code r.500.2201 - r.500.2202, (2007), Admin. Code r.550.111 - r.550.112 (2007), and Admin. Code r.550.301 - r.550.302 (2007); New Hampshire at Admin. Rules Ins. 401.03(1) (2006); New Jersey at Admin. Code Title 11: Insurance §§11:4-58.1 - 11:4-58.4 (2007); South Dakota at Admin. Rules Ch. 20:06:52 (2008); Utah at Admin. Code r.590-218-1 - 590-218-7 (2003); and Washington at Admin. Code 284-44-015 (2009); (iii) six states taking action through published commissioner bulletin or opinion (California, Notice to Withdraw Approval (Feb. 27, 2004); Connecticut, Bulletin HC-67 (March 19, 2008); Hawaii, Memorandum 2004-13H (Dec. 8, 2004); Indiana, Bulletin 103 (May 8, 2001); Kentucky, Advisory Opinion 2008-05 (2008); and New York, Circular Letter No. 14 (2006); and four states taking unpublished commissioner action of some type (Alaska, Group Health Policy Form Checklist; Montana, *Standard Ins. Co. v Morrison,* 584 F.3d 837 (9th Cir. 2009); Nevada, Proposed Regulation of the Commissioner of Insurance R074-2; and

Oregon, Standard Provisions for Small Employer Health Benefit Plans). The commenter further argues that the only measure of increased costs that will result from the proposed rule that have been presented by industry is a study performed in 2005 that has not been updated. The commenter further asserts that in each of the jurisdictions that have taken action regarding the use of discretionary clauses, insurance industry comments predicted higher insurance premiums, frivolous law suits, failure of small businesses, and a mass exodus of insurers. The commenter emphasizes that over a decade of experience in states that have imposed bans upon discretionary clauses has failed to support these predictions, citing to Washington State Office of the Insurance Commissioner, *Concise Explanatory Statement; Responsiveness Summary; Rule Development Process; and Implementation Plan Relating to the Adoption of WAC 284-44-010, 284-46-015, 284-50-321, 284-96-012 Discretionary Clauses Prohibited,* at 9 - 10, August 5, 2009: "Most western states have discretionary prohibition clauses in law or rule, without reported evidence of cost increases or market withdrawal based on discretionary clauses." As such, the commenter urges that these concerns should not preclude adoption of a prohibition in Texas. Another commenter, noting reliance by industry stakeholders upon a report prepared by a benefit consulting firm, Milliman, for the proposition that premiums will increase as a result of a prohibition of discretionary clauses, found such reliance problematic. The commenter notes that the Milliman report estimates that the cost to litigate group disability claims would be similar to individual claims. Robert W. Beal & Daniel D. Skwire, Milliman, Inc., *Impact of Disability Insurance Policy Mandates Proposed by California Department of Insurance* 8 - 9 (Nov. 14, 2005), available at http://ahip.org/content/default.aspx?docid=13557 ("Milliman Report"). The commenter submits that such estimate is too high because a claimant suing under an individual policy might be entitled to a jury trial and punitive damages, while a claimant suing under an ERISA plan is not so entitled. *See generally Great-West Life & Annuity Ins. Co. v. Knudson,* 534 U.S. 204 (2002); *Mertens v. Hewitt Assocs., 508 U.S. 248 (1993);* Mass. Mutual Life Insurance Co. v. Russell, 473 U.S. 134, 144 (1985). *Compare with* Tex. Ins. Code §§542.003; 542.051 and 542.055 (permitting statutory penalties, treble damages and attorney fees). The commenter further asserts that California has not experienced an exodus of insurers or an increase in premiums resulting from the prohibition of discretionary clauses since instituting its prohibitions in 2004. Similarly, the commenter argues that it is unaware of any studies evidencing an increase in litigation due to this prohibition or a significant increase in costs or litigation from any state which has approved the prohibition of discretionary clauses. A commenter further asserts that under plans governed by ERISA, claimant remedies are limited to benefits under the plan and, at the discretion of the court, attorney fees. The commenter asserts that compensatory and punitive damages are not available and that, as such, the monetary amounts at issue as a result of a prohibition concerning discretionary clauses are relatively small. The commenter further asserts that a prohibition against discretionary clauses will lead to better, correct decisions and eliminate lawsuits based upon poor decisions. As such, the commenter estimates that costs associated with lawsuits should not increase. Similarly, another commenter opines that elimination of discretionary clauses will incentivize insurers to review claims more thoroughly, resulting in a reduced number of claims that need to be appealed. The commenter also asserts that such prohibition will eliminate the need for discovery concerning the impact of the inherent conflict of interest that an insurer has in determining benefits, leading to reduced litigation costs. A commenter opines that the cost of disability coverage is only approximately 1/20 of the amount that employers and employees pay, on average, for all employer-based coverages, and as such, any increases in cost resulting from a ban on discretionary clauses are likely to be negligible. The commenter also opines that the likely increase in cost of coverage related to a prohibition of discretionary clauses does not appear to outweigh the anticipated benefits of such a prohibition. Another commenter opines that it is not ethical to sell policies that contain discretionary clauses. A commenter asserts that a prohibition on discretionary clauses has become even more necessary due to a recent U.S. Supreme Court holding that is resulting in a greater number of remands to plan administrators even where the court finds an ERISA violation. *Conkright v. Frommert,* 130 S. Ct. 1640 (April 2010). In *Conkright,* the commenter asserts that the court held that: (i) a plan administrator's interpretation of a retirement plan is entitled to deference where there is a discretionary clause in the plan, even when a court finds that the administrator has previously offered an erroneous reading; and (ii) a trial court should reject the administrator's construction of the plan terms only if the administrator "acted in bad faith or would not airly exercise his discretion to interpret the terms of the Plan." *Id.* at 1648. The commenter asserts that representatives of employers and plans are heralding *Conkright* for its expansion of the deference to which plan administrators are entitled and the resulting increase in remands to plan administrators. Heather G. *Magier, Supreme Court Rules That "Single Honest Mistake" Does Not Justify Stripping Administrator Of Judicial Deference,* PROSKAUER ROSE THE ERISA LITIGATION NEWSLETTER (May 2010) ("the Supreme Court extended the reach of the deferential standard of review it established 20 years ago for ERISA plan administrators"; "[t]he likely outcome of this broad endorsement of deference principles is that district courts will more frequently remand benefit claims to the plan administrator for additional consideration, rather than rule outright against the plan"), *available at* http://www.proskauer.com/publications/newsletters/erisa-litigation-newslettermay-2010/; see also Mayer Brown, *US Supreme Court Releases Opinion in Conkright v. Frommert;* available at http://www.mayerbrown.com/publications/article.asp?id=8898&nid=6; Jenner & Block, *Client Advisory: Supreme Court Rules in Conkright v. Frommert: "People Make Mistakes" Ruling Strengthens Firestone Administrative Deference Standard, available at http://www.jenner.com/news/pubs_item.asp?id=15379224;* Groom Law Firm, Client Memorandum, *Supreme Court Decision in Conkright v. Frommert* (April 23, 2010), available at http://www.groom.comlresources-484.html; Kutak Rock, *Supreme Court Reaffirms Deferential Standard Applied to Plan Interpretation by Plan Administrators* (May 24, 2010), *available at* www.kutakrock.com/publications/employee benefits/CA052410.pdf. The commenter asserts that a pattern of increased remands is already materializing. E.g., *Goletz v. Prudential Ins. Co. of Am.,* No. 084740, 2010 U.S. App. LEXIS 11501, at *1, 10 (3d Cir. June 7, 2010) ("Also waived is Goletz's argument that, because Prudential's handling of this case has already been faulted once by the District Court, we should now forego extending any deference to Prudential's decision and subject it to de novo review. This position was all but rejected by the Supreme Court in *Conkright,* in which the Court explained that ERISA plan administrators "make mistakes" and that a "single honest mistake in plan interpretation" does not justify "stripping the administrator of . . . deference for subsequent

related interpretations of the plan."); see also *Fortlage v. Heller Ehrman, LLP,* No. C 08-3406 VRW, 2010 U.S. Dist. LEXIS 50634, at *1,8 (N.D. Cal. Apr. 27, 2010). The commenter argues that those courts that have not remanded incorrect claims have done so where the claimant has shown a pattern of deliberate actions. *E.g., Nolan v. Heald College*, No. C 05-3399 VRW (JL), 2010 U.S. Dist. LEXIS 53997, at *1, 2 (N.D. Cal. May 6, 2010) (citing *Conkright* and refusing to remand to the administrator, "[t]his case involves not "a single honest mistake," but a number of deliberate actions by the plan administrator."). The commenter states that this trend will present insurers with even more opportunities to determine claims that have already been decided incorrectly.

Agency Response: The Department does not agree that a discretionary clause prohibition will necessarily result in an increase in litigation and consequent delay in claim resolution. The Department anticipates that a discretionary clause prohibition will likely result in: (i) an increase in the uniformity of claims review procedures; and (ii) a decrease in questionable coverage determinations made by insurers in reliance upon the subsequent lack of a subsequent full and independent review. The Department does agree that even very careful drafting will not eliminate all litigation. However, many of the concerns expressed by the commenters may be addressed through the use of clearer drafting in forms to reduce potential ambiguity and confusion, rather than reliance upon a deferential standard of review during litigation. Absent the ability to rely upon such a deferential standard of review, carriers will have incentive to include consistently applied interpretations in the body of forms, through enhanced definitions, examples, terms, or otherwise. Such inclusion would enhance uniformity and reliability in benefit provision, reduce the likelihood of litigation by providing clarity concerning benefits and provisions in the body of forms for easy access by all parties to the agreement, and provide a clear basis for the carrier's determinations in the event that there is litigation. Similarly, an increase in the uniformity of claims review processes will accelerate, rather than delay, the claims review process. The Department does agree that for those cases that are litigated under a *de novo* review rather than the deferential arbitrary and capricious standard of review, there may be greater expenses on a case-by-case basis. However, the Department does not agree that this factor outweighs the benefits of §§3.1201 - 3.1203 in providing consumers with an opportunity for full, fair, and independent review of claim determinations and reducing the potential for consumers to be misled concerning their rights of appeal. Further, the Department agrees that plans governed by ERISA have more limited relief available even in the context of litigation. See ERISA §502(a)(1)(B) (permitting a participant or beneficiary to bring a civil action to recover benefits due under the terms of the plan, to enforce rights under the plan, or to clarify rights to future benefits under the plan); see also ERISA §502(a)(3) (permitting a participant or beneficiary to sue to enjoin an act or practice that violates a provision of ERISA or to obtain other appropriate equitable relief to redress violations of ERISA or enforce provisions of ERISA or the terms of the plan); and ERISA §502(g) (permitting the recovery of attorney's fees and costs). Unless excepted, common law causes of action are expressly preempted under ERISA. *Pilot Life Ins. v. Dedeaux,* 481 U.S. 41, 48 (1987). The Department, therefore, agrees that the adoption of §§3.1201 - 3.1203 will not result in additional litigation costs arising from successful state law claims. With respect to the potential effect of a prohibition of discretionary clauses upon premium, while some commenters jointly submitted a report from Milliman, Inc. analyzing the estimated actuarial impact of disability insurance policy mandates proposed by the California Department of Insurance in October 2005, including an estimate that premiums would rise 3 - 4 percent due to a prohibition of discretionary clauses, the commenters did not provide evidence of the actual results of the prohibition and the subsequent effect upon premium. The Department agrees that it is possible that some prospective purchasers will base the decision to purchase or not purchase an insurance or HMO product on price alone. However, the Department anticipates that multiple factors may affect decisions concerning the purchase of insurance and HMO products. Along with premium price, the Department anticipates that some purchasers consider the scope of transparency concerning the terms of the bargain and the existence of an opportunity for full, fair, and independent judicial review as appropriate. For those prospective purchasers, the factors concerning transparency and the opportunity for a more favorable standard of judicial review should there be a difference of opinion concerning the terms of the bargain may actually tip the scale in favor of purchase. The Department's position is that the benefits of a prohibition concerning discretionary clauses makes adoption of new §§3.1201 - 3.1203 a necessary consumer protection. The Department further disagrees that only litigation under a deferential standard of review is efficient, because it is the Department's position that efficiency includes access to full independent review under a non-deferential standard in reviewing the terms of a bargain drafted by the party that is determining application of benefits under those terms. The Department agrees that employers considering the purchase or retention of disability income protection for employees want to protect employees that become disabled. The Department recognizes that some carriers that use discretionary clauses in forms likely do so without any intent to undertake ethically questionable behavior. However, it is the Department's position that the use of discretionary clauses creates an environment that may foster unethical behavior. It is the Department's position that §§3.1201 - 3.1203 will reduce that potential. The Department further disagrees that unintended consequences may result from the rule because the use of discretionary clauses is relatively new, since the *Firestone* decision, and the rule merely returns the market to where it was previously. Nevertheless, the rule has been revised to provide for staggered implementation. Using a staggered implementation provides the Department with a brief period of time to assess whether a discretionary clause prohibition will actually result in unintended consequences before its application is extended to forms other than those that include disability income protection coverage.

General Comments: Additional Expense to Courts.

Comment: Some commenters asserted that a discretionary clause prohibition will cause courts to expend additional resources.

Agency Response: The Department disagrees. The comment that courts will be required to expend additional resources is premised on the belief that a discretionary clause prohibition will increase litigation. However, the Department does not agree that a discretionary clause prohibition will increase litigation. The Department acknowledges that courts may expend more time and resources in a *de novo* review than they would in a deferential arbitrary and capricious review. However, as stated previously in this adoption order, absent the ability to rely upon a deferential standard of review when a claim determination is appealed, issuers will have incentive to include consistently applied interpretations in the body of forms, through enhanced definitions, examples, terms, or otherwise. Such inclusion would reduce the

likelihood of litigation by providing clarity concerning benefits and provisions in the body of forms and provide a clear basis for the issuer's determinations in the event that there is litigation. The additional resources required in *de novo* reviews will, therefore, be mitigated by the overall decrease in litigation resulting from the discretionary clause prohibition that the Department anticipates. Additionally, the Department disagrees with the premise that the expenditure of additional resources by the courts is a basis for rejecting a prohibition on discretionary clauses.

§3.1201(a): Applicability to Different Types of Coverage.

Comment: A commenter asserts that §3.1201(a) includes applicability language broad enough to encompass life, accident and health insurance forms/policies and HMO evidence of coverage forms. The commenter supports this broad applicability and recommends its retention because the commenter believes it is vital for consumers to understand the nature of the coverage offered in order to: (i) assess the value of the coverage offered; and (ii) access the benefit of the bargain. Absent such understanding, regardless of the type of coverage, the commenter asserts that a consumer's benefits are uncertain and/or illusory. The commenter asserts that broad applicability is necessary because potential conflicts of interest may arise from the presence of a discretionary clause in a form regardless of the type of coverage. Another commenter urges that the Department revise the rule to more closely track NAIC model language by restricting applicability to health and/or disability policies. The commenter asserts that the applicability is overly broad because it extends to individual and group life, credit life, disability income, accident, individual and group health, annuities, credit disability, endowment and any other form required to be filed under Chapter 1701, which may include noninsurance benefits.

Agency Response: The Department appreciates the commenter's statement of support for broad applicability of new §§3.1201 - 3.1203 and agrees that consumer understanding of coverage terms and benefits is important. The Department also agrees that the need for a prohibition of discretionary clauses stems in part from the potential for conflict of interest rather than the type of coverage in question. The Department disagrees that applicability of Subchapter M should be restricted to health and/or disability coverage products. The Department's position is that there is not sufficient justification for protecting only consumers of disability income and health insurance products from the detrimental effects of discretionary clauses and not affording the same level of protection to consumers of life insurance and annuity products. The Department does clarify that new Subchapter M does not apply to credit life or credit accident and health policies at this time. Such policies and forms are governed under the Insurance Code Chapter 1153 rather than Chapters 1271 or 1701, and as such the forms do not fall within the scope of Subchapter M.

§3.1201(b) and §3.1203: Applicability to Forms.

Comment: Several commenters state their support for applicability of new §§3.1201 - 3.1203 to forms enforced on or after January 1, 2011 and recommend that the Department explicitly address in §3.1201(b) and §3.1203 applicability to forms renewed and delivered on or after January 1, 2011 in addition to those forms offered, issued, or enforced. One commenter requests expansion of this applicability to forms advertised on or after January 1, 2011. The commenter asserts that the language is otherwise too limited and may not capture every potential use of a discretionary clause that could negatively affect consumers. Another commenter urges the Department to clarify applicability of new §§3.1201 - 3.1203 to ensure application to policies that are amended or renewed. The commenter notes that in *Golden v. Guardian Life Ins. Co.,* No. 09 C 865, 2010 U.S. Dist. LEXIS 55683 at 1 (N.D. Ill. June 1, 2010), the court held that: (i) regulations promulgated by the Illinois Department of Insurance prohibiting discretionary clauses did not apply to policies that predated the effective date of the regulation; and (ii) the addition of an addendum to the policy did not constitute a renewal of the policy and, therefore, did not suffice to bring the policy within the scope of the prohibition. The commenter states that courts have required specificity in regulatory language concerning application of prohibitions to policies that have renewed, rather than merely been issued or delivered. A commenter supports application of the subchapter to forms that do not have renewal dates. Another commenter requests that applicability to policies governed by ERISA be prospective in nature. The commenter additionally asserts that applicability to forms as the forms are renewed is not appropriate in the context of life and health insurance, especially with respect to guaranteed renewable policies, because of the potential for uncertainty. The commenter therefore requests that the rule should not apply to guaranteed renewable policies. The commenter also questions whether the broad applicability applies to form filings that are intended only to update other information in a policy such as a guaranteed interest rate provision or to add a mandate required in a health policy.

Agency Response: The Department agrees that the applicability of new §§3.1201 - 3.1203 to forms offered and issued includes application to forms renewed and delivered on or after the specific effective date applicable to the form, and the Department has revised both §3.1201 and §3.1203 to clarify this applicability and reduce duplicative language. The Department also agrees that language in §3.1201 concerning applicability to policies "issued, delivered, or enforced" is unclear as to whether the terms encompass the amendment of a form that contains a discretionary clause. The Department, therefore, has revised §3.1201 to address applicability to forms that are issued and delivered prior to the effective date of the subchapter and have no renewal date. Specifically, to clarify applicability to forms enforced after the applicable effective date, the Department has revised §3.1201 by: (i) clarifying in subsection (b) that the subchapter applies to forms offered, issued, renewed, or delivered on or after June 1, 2011, including forms that include premium waiver provisions based upon a disability determination, except as otherwise provided; (ii) added new subsection (c) to clarify that for forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate, or rider, the subchapter applies to forms issued, renewed, or delivered on or after February 1, 2011; and (iii) added new subsection (d) to clarify that for forms issued or delivered prior to the effective date of the subchapter that do not contain a renewal date, the subchapter applies on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011. Because of the clarifications made to §3.1201 to clarify applicability, the Department has determined that language concerning dates of offer, issuance, and enforcement in §3.1203 would be duplicative and unnecessary. As such the Department has revised §3.1203, and the section now provides that inclusion of a discretionary clause in any form to the subchapter applies is prohibited. As a result of this revision, additional changes to conform §3.1203 to applicability as specified in §3.1201 are not necessary. The Department does not agree that inclusion of forms advertised is a necessary addition to the terms of applicability in §3.1201 or the

prohibition in §3.1203. Instead, the Department's position is that §3.1201 and §3.1203 as adopted will best afford protection to those insureds and enrollees who would be subject to the potential harmful effects of a discretionary clause in a form. However, the Department will monitor to determine whether future rulemaking is necessary. To the extent that any commenters request that applicability of the subchapter be prospective in nature, the Department disagrees that any further limitation on applicability is appropriate or would be consistent with the consumer protection purposes of the subchapter. The Department disagrees that applicability of Subchapter M to forms renewed on or after the effective date specified in new §3.1201 is inappropriate for policies that are guaranteed renewable because such applicability creates uncertainty. The Legislature and the Commissioner routinely enact legislation and adopt rules, respectively, that apply to such policies on renewal. The Department therefore anticipates that carriers and HMOs have experience with implementation of new requirements applicable to guaranteed renewable products on renewal. The Department clarifies that for forms that are issued or delivered prior to the effective date of the subchapter as specified in §3.1201 that do not contain renewal dates, Subchapter M applies to the form on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011, as specified in §3.1201(d). The Department further clarifies that for all other forms subject to Subchapter M, the subchapter applies when such forms are offered, issued, renewed, or delivered as provided in §3.1201(b) and (c).

§3.1202: Definition of Discretionary Clause.

Comment: A commenter submits that §3.1202 gives insufficient guidance to insurers as to what constitutes a discretionary clause because: (i) it encompasses any provision that purports to grant deference to an insurer's decisions, denials, or interpretations of terms, coverage or eligibility for benefits; and (ii) the provision does not limit the definition but instead specifies that it "includes but is not limited to" several examples of such provisions. The commenter asserts that a provision in a form that implies that the insurer will make decisions in the administration of the coverage could fall within the definition of a discretionary clause. Similarly, the commenter questions: (i) whether an insurer's discretion to determine investments in a universal life policy or with respect to rate matters in a guaranteed renewable individual health policy would qualify as a discretionary clause; (ii) whether an insurer could perform determinations of medical necessity to determine benefit eligibility in a health plan without exercising discretion in violation of the prohibition; (iii) whether an insurer may determine eligibility for group plans as permitted by federal law without exercising discretion in violation of the prohibition; and (iv) whether an insurer may make complex determinations under disability income products that may involve unique medical situations, work environment, available workplace accommodations, and potential for vocational rehabilitation over an extended period of time as a claimant recovers from a disability. The commenter expresses concern that the definition of "discretionary clause" may prevent insurers from interpreting a policy even where there is no express "discretionary clause" in the policy.

Agency Response: The Department agrees that additional clarification concerning the limits of what constitutes a discretionary clause is appropriate. Specifically, the Department agrees that the additional sentence stating that the term "includes, but is not limited to" certain provisions should be modified and clarified to provide more certainty for carriers. The Department has accordingly revised the section such that it no longer contains this language of inclusion but instead emphasizes the limits of what constitutes a discretionary clause. Section 3.1202 now provides greater specificity by providing that a discretionary clause is a provision that meets one of five qualifying criteria included as paragraphs of the section. The Department does agree that carriers and the Department will need to review any provision on a case by case basis in order to determine whether the provision meets the definition established in §3.1202. This is consistent with the judicial findings in *Walley v. Interhealth, Inc.,* 1999 WL 33537135 (D. Miss. N.D. 1999), that ". . . the Supreme Court surely did not suggest [in *Firestone*] that 'discretionary authority' hinges on the incantation of the word 'discretion' or any other 'magic word.' Rather, the Supreme Court directed lower courts to focus on the breadth of the administrator's power their 'authority to determine eligibility for benefits or to construe the terms of the plan'. . . *Chevron Chemical Co. v. Oil, Chemical, & Atomic Workers Local Union 4-447,* 47 F.3d 139, 143 (5th Cir. 1995) (citations omitted)." Walley at 2. Because a case by case approach focused upon specific language is required, it is not appropriate for the Department to make statements concerning applicability with respect to broad categories of possible provisions. The Department does clarify that the definition of "discretionary clause" does not encompass general, as opposed to discretionary, provisions concerning plan administration and consequent performance of initial determinations. The Department further notes that no evidence has been submitted indicating that insurers have been precluded from such plan administration in jurisdictions that have already prohibited the use of discretionary clauses.

Comment: A commenter recommends that §3.1202 be modified to clarify that a discretionary clause is not only a provision that purports to bind a claimant to or grant deference in subsequent proceedings to the insurer's decision, denial, or interpretation on terms, coverage, or eligibility for benefits, but also to a provision that "acts" in the same manner. The commenter asserts that *Webster's Dictionary* defines the term "purport" as: "(i) to profess or claim as its meaning; and (ii) to give the appearance of, often falsely, of being, intending, etc." To clarify that intent is not required for the prohibition to be triggered and to clarify the scope of the definition, the commenter believes this modification is necessary. The commenter further asserts that this clarification will serve to ensure consumer protection in substantive effect instead of limiting the protection to restriction of misleading language.

Agency Response: The Department agrees that the suggested change is an appropriate clarification of the type of provision that constitutes a discretionary clause. It is not merely the professed or apparent purpose of a provision that characterizes a discretionary clause, but additionally the resultant effect of the language. The Department has revised §3.1202(1) accordingly to specify that a discretionary clause is a provision that purports or acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim determinations or policy interpretations of the insurer or HMO.

Comment: Some commenters recommend that the Department include references to HMOs in all provisions of §3.1202 that reference insurers for internal consistency with language concerning applicability to forms filed under Chapter 1271.

Agency Response: The Department agrees that the addition of references to HMOs in addition to insurers will clarify the scope of the rule and reduce possible confusion. The Department has accordingly revised §3.1202(1), (3), and (4) as adopted to specif-

ically reference HMOs. Because §3.1202(5) is deleted for reasons unrelated to this comment, addition of the term to that paragraph is not necessary.

Comment: A commenter recommends modification of the definition of a discretionary clause in §3.1201(1) to include provisions specifying that a policyholder or other claimant may not "appeal" a denial of a claim. The commenter states its belief that appeals of claims are encompassed by the term "contest" as used in the provision but urges that inclusion of the term "appeal" would preclude confusion as to the breadth of the provision. The commenter further requests that the Department define the term "appeal" for purposes of the subchapter similarly to the definition used in Michigan's regulatory prohibition on discretionary clauses, located at *Mich. Admin. Code R. 500.2201(a),* to mean "an appeal by a policyholder or other claimant of a claim denial by an insurer or health maintenance organization. It includes appeals to administrative agencies, arbitrators, courts and mediators."

Agency Response: The Department agrees that: (i) inclusion of the phrase "or appeal" will clarify that an appeal is within the scope of a contest as that term is used to define a discretionary clause in §3.1202(1) as proposed; and (ii) inclusion of the phrase will serve to reduce potential ambiguity. The Department has revised the paragraph, adopted as §3.1202(2), accordingly. The Department disagrees that inclusion of a definition for the term "appeal" is necessary. Section 3.1202(2) as adopted provides that a provision specifying that a policyholder or other claimant may not contest or appeal a denial of a claim is a discretionary clause. The Department believes that this language is plain, is clearly broad in scope, and does not require further clarification.

Comment: Some commenters recommend that all references to the terms "policy or contract" within §3.1202 be replaced with the term "form" to ensure correct application of discretionary clause definition and internal consistency within §§3.1201 - 3.1203. A commenter notes that §3.1201 provides that the discretionary clause prohibition applies to "any form filed under the Insurance Code Chapters 1701 or 1271" and asserts that these forms include: (i) under Chapter 1701, a policy, contract or certificate of insurance; an application attached or required to be attached to the policy contract, or certificate; and a rider or endorsement to be attached to, printed on, or used in connection with the policy, contract, or certificate; and (ii) additionally, under Chapter 1271, an HMO evidence of coverage. The commenter notes that states such as Michigan have acknowledged the importance of consistency in terminology in their own regulatory provisions at, e.g. Mich. Admin. Code R. 500.2201, 500.2202, 550.111, and 550.112.

Agency Response: The Department agrees with the suggested change. Replacing the phrase "policy or contract" with the term "form" in §3.1202 is a clarification that will: (i) promote internal consistency between the section and adopted §3.1201, which refers to "forms;" and (ii) reduce potential confusion and ambiguity concerning whether the paragraphs referencing the term are intended to vary in scope from the broader scope established in §3.1201. Accordingly, the Department has revised §3.1202(3) and (4) as adopted by substituting the term "form" for the phrase "policy or contract." Section 3.1202(5) as proposed has been deleted for reasons unrelated to this comment and therefore does not require revision.

Comment: Some commenters recommend modification of §3.1202(4) to provide that a discretionary clause includes a provision "giving rise to" a deferential standard of review in addition to a provision that "specifies" a deferential standard of review. A commenter asserts that this is a necessary change to capture the effects of a provision that fails to "specify" a deferential standard of review but nonetheless results in the court's application of a deferential standard of review. The commenter notes that Walley v. Interhealth, 1999 WL 33537135 (N.D.Miss.) demonstrates that a plan need not specify the standard of review in order to "expressly" confer discretionary authority and obtain the benefit of a deferential review. The commenter therefore recommends that the Department acknowledge this distinction in a manner similar to Michigan in Mich. Admin. Code R. 500.2201(c)(vi) and Mich. Admin. Code R. 550.111(c)(vi) by including provisions that "give rise to" a deferential standard of review in the definition.

Agency Response: The Department agrees that the suggested revision is an appropriate clarification of the type of provision that constitutes a discretionary clause because it is not only the fact of specification of a deferential standard in a form that characterizes a discretionary clause but the resultant effect of the language in question. The Department has revised the paragraph, adopted as §3.1202(5), accordingly.

Comment: A commenter asserts that defining a discretionary clause as a provision that specifies a standard of review that gives deference to any original claim decisions that are inconsistent with the laws of this state, including common law, is problematic. The commenter opines that the reference to common law is an unlawful delegation of authority to the courts because common law is that body of law that has developed through the judicial branch and subject to change by the judiciary. Common law is regularly amended by the Legislature. Courts also do not follow the requirements of the Administrative Procedure Act in the Texas Government Code Chapter 2001, such as publication in the Texas Register and opportunity for comment, in determining changes to common law. The commenter argues that delegation of authority from an administrative agency to the judiciary violates the Texas Constitution. The commenter recommends deletion of the reference to common law.

Agency Response: The Department agrees that ambiguity as to whether §3.1202(4) improperly delegates rulemaking authority to the judiciary may arise from the inclusion of the term "common law" in the definition of a discretionary clause in that paragraph, and the Department has furthermore determined that inclusion of the term in the scope of the definition is not necessary to the definition. It is not the Department's intent to delegate rulemaking authority as queried by the commenter. "Common law" is "the body of law derived from judicial decisions, rather than from statutes or constitutions." *See Black's Law Dictionary* 270 (7th ed. 1999). The Department anticipates that the definition of "discretionary clause" as set forth in §3.1202, in conjunction with the prohibition against discretionary clauses in §3.1203, will result in elimination of the deferential standard of review currently enjoyed by those carriers that use discretionary clauses, and common law, including the longstanding Texas common law doctrine that ambiguities in insurance contracts should be construed in favor of the insured, will be applied as appropriate by courts in reviewing cases without the necessity for referencing common law in the paragraph. See *Fiess v. State Farm Lloyds,* 202 S.W.3d, 744, 746 (Tex. 2006); *Nat'l Union Fire Ins. Co. v. Hudson Energy Co., Inc.,* 811 S.W.2d 552, 555 (Tex.1991); *Glover v. Nat'l Ins. Underwriters,* 545 S.W.2d 755, 762, 763 (Tex.1977); and *Continental Cas. Co. v. Warren,* 254 S.W.2d 762, 763 (Tex.1953). Accordingly, the Department has revised

§3.1202(4), redesignated as §3.1202(5), by deleting the reference to common law.

Comment: A commenter recommends the addition of a new paragraph to §3.1202 to include within the definition of a discretionary clause provisions that "give rise to a standard of review on appeal other than de novo review." The commenter asserts that inclusion of this provision within the definition will eliminate use of the arbitrary and capricious standard of review that creates such an obstacle for consumers seeking to challenge an insurer's determinations and notes that the suggested addition closely tracks usage in Michigan's regulation concerning discretionary clauses at Mich. Admin. Code R. 500.2201(c)(vii) and Mich. Admin. Code R. 550.111(c)(vii). Because the commenter asserts that §§3.1201 - 3.1203 closely track Michigan's regulation, the commenter questions the Department's rationale in failing to include this provision in §3.1202.

Agency Response: The Department disagrees that the suggested provision is necessary because §3.1202(5) as adopted already includes within the definition of a discretionary clause a provision that specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state. It is the Department's position that §3.1202(5) as adopted is sufficient to address the commenter's stated concern regarding use of the arbitrary and capricious standard of review. However, the Department will monitor to determine whether additional rulemaking is needed.

Comment: Several commenters recommend deletion of §3.1202(5) because the provision is not necessary to fulfill its stated purpose, is confusing, and seems to conflict with §3.1203. By including in the definition of a discretionary clause a provision specifying that "the insurer has discretion to interpret the terms of the policy or contract or determine the eligibility for or the amount of benefits, unless it is clearly stated that the grant of such discretion is not intended to give rise to a deferential standard of review on appeal," commenters opine that the Department risks evisceration of the protections otherwise afforded by §§3.1201 - 3.1203 as applied to plans governed by ERISA. The commenters opine that §3.1202(5), intended to create a safe harbor provision permitting insurers to continue the limited use of discretionary clauses, is not necessary to permit insurers to make initial coverage determinations. Some commenters note that paragraph (5) was included in §3.1202 specifically to address the insurance industry comment that insurers would otherwise be prevented by interpreting contracts and making such coverage determinations, as stated in the Department's proposal at *35 TexReg 4587.* The commenters assert that such a safe harbor clause is unnecessary because jurisdictions that have not included such safe harbor language in their own regulations of discretionary clauses, including Maine, Illinois, Michigan, California, New York, Oregon, South Dakota, Idaho, and Hawaii, some of which are longstanding in duration, have not experienced the chilling effect on claim processing that the safe harbor is intended to prevent. Some commenters assert that discretionary clause provisions have been universally interpreted and applied to affect the binding nature of and deference provided to an insurer's initial coverage determinations rather than the basic ability of the insurer to make initial determinations in the first place. As another basis for deletion of paragraph (5), a commenter asserts that the concern expressed by the insurance industry stakeholder concerning the chilling effect of the Department's rule upon industry claim processing was prompted by an informal posting of the rule that was arguably broader in scope than proposed §§3.1201 - 3.1203. The commenter argues that §3.1202 as proposed has sufficiently captured the timing element of the definition by clarifying that the provisions are those that affect subsequent proceedings rather than initial claim determinations, rendering the need for safe harbor language superfluous. Commenters additionally assert that under the plain meaning of §3.1202, the term does not completely restrict an insurer from making initial claim determinations but rather from making claim determinations that are not subject to full challenge. More specifically, a commenter asserts that nearly identical regulations in Michigan that do not contain safe harbor language, *Mich. Admin. Code R. 500.2201* and *500.2202* and *Mich. Admin. Code R. 550.111* and *550.112,* have been implemented without a resulting impediment to initial claim determinations. Other commenters assert that paragraph (5) should be deleted from §3.1202 based upon a holding in *Hancock v. Metropolitan Life Insurance Company,* 590 F. 3d 1141 (10th Cir. 2009) that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans; in permitting discretion-granting clauses that complied with form requirements, the 10th Circuit held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. See also Weeks v. UNUM, No. 2:07-CV-00577DAK, 2008 U.S. Dist. LEXIS 41990, 44EBC 1575 (D.Utah 2008). Under Hancock at 1149, the court clarified that the Utah rule would have escaped preemption as a prohibition substantially affecting risk pooling had the rule imposed a blanket prohibition. See also *Standard Insurance Co. v. Morrison,* 584 F.3d at 845: (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products) and *American Council of Life Insurers v. Ross,* 558 F.3d at 605-07 (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products.) Citing to these cases, a commenter asserts that a rule preventing an insurer's decision from being reviewed under a deferential standard substantially affects the risk pooling arrangement and alters the scope of permissible bargains, while a rule permitting a "limited" grant of discretionary authority might be interpreted by a court as relating to the form, rather than the substance of the underlying coverage agreement, and thus be preempted under ERISA. The commenter therefore recommends that the Department eliminate the safe harbor provision in §3.1202(5) to ensure that the regulation will fall within ERISA's saving clause requirement. Further, the commenter argues that inclusion of a safe harbor provision defeats the purpose of prohibiting discretionary clauses. The commenter cites to *Evans v. Employee Benefit Plan, Camp Dresser & Mckee, Inc.,* 311 Fed. Appx. 556 (3d Cir. 2009) for the point that a prohibition against discretionary clauses that provide "sole" discretion to a plan administrator does not apply to a provision that provided discretion, but not "sole discretion," to the administrator. *See also Baker v. Hartford Life Ins. Co.,* No. 08-cv-6382 (FLW), 2010 U.S. Dist. LEXIS 52724 (D.N.J. 2010). Based upon these cases, the commenter asserts that inclusion of the safe harbor provision language would effectively remove such forms from the scope of §§3.1201 - 3.1203 as a whole and defeat the purpose of the subchapter. Some commenters additionally assert that inclusion of §3.1202(5) creates internal inconsistency and ambiguity within the subchapter as follows. When an insurer has discretionary authority to interpret a contract or make a claim determination, a reviewing court applies a deferential standard of review to the determination. *See Firestone v. Bruch,* 489 U.S. 101, 115 (1989); and Hancock, 590 F. 3d at 1146,

quoting *Kellogg v. Metro. Life Ins. Co.,* 549 F.3d 818, 825 (10th Cir. 2008): ("[If] the administrator or fiduciary has discretionary authority, 'then, absent procedural irregularities, the denial of benefits is reviewed under an arbitrary and capricious standard.'") Stating that an insurer has discretion that does not give rise to a deferential standard of review contradicts the United States Supreme Court's interpretation of "discretionary authority" and, according to the commenter, creates uncertainty as to the meaning of "discretionary authority" and the impact of that clause on the coverage provided under the form. Another commenter asserts that it is inconsistent and illogical for a form to "grant discretion" if deferential treatment of discretionary authority is not intended.

Agency Response: The Department agrees with the suggested deletion of §3.1202(5). The Department agrees that it is possible that a reviewing court could find inclusion of the safe harbor provision to be cause for preemption under ERISA. *Hancock v. Metropolitan Life Insurance Company,* 590 F. 3d 1141, 1149 (10th Cir. 2009) (holding that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans). In permitting discretion-granting clauses that complied with form requirements, the 10th Circuit in *Hancock* held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. *Id; see also Weeks v. UNUM Group,* 585 F.Supp.2d 1305,1311 (D.Utah 2008). The Department further acknowledges that blanket prohibitions, as opposed to prohibitions providing safe harbors, have not been held to be preempted under ERISA in the cited case law. *See Morrison,* 584 F. 3d at 845 (upholding Montana's policy prohibiting the use of discretionary clauses in insurance products) and *Ross,* 558 F. 3d at 605-07, (upholding Michigan's rule prohibiting the use of discretionary clauses in insurance products.) The Department additionally agrees that inclusion of §3.1202(5) creates internal inconsistency by providing a safe harbor provision that could defeat one of the purposes of the prohibition, affording consumers the opportunity for a full and fair opportunity for review of a claim determination under a non-deferential standard, creating ambiguity and uncertainty as to how such a provision would impact the coverage. The Department has determined that inclusion of a safe harbor provision is not necessary to facilitate initial coverage determinations because §§3.1201 - 3.1203 do not impede such coverage determinations and that deletion of the safe harbor provision is the best means of fully effectuating the broad consumer protection purposes of the rule. The Department has accordingly revised §3.1202 by deleting paragraph (5).

Comment: A commenter recommends that the Department add a paragraph to §3.1202 to provide that a discretionary clause is a clause that "reserves discretion to make a determination of eligibility and amount of benefits."

Agency Response: The Department disagrees that this suggested additional language is necessary. A provision reserving discretion to make a determination of the eligibility and amount of benefits would meet the definition set forth in §3.1202(1) and (5) as adopted because such a provision would: (i) purport or act to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or health maintenance organization; and (ii) specify or give rise to a standard of review in any appeal process that gives deference to the original claim decision or provide standards of interpretation or review that are inconsistent with the laws of this state. Because the provision would meet the definition of a discretionary clause under §3.1202 as adopted, the additional suggested language is not necessary to bring such a provision within the scope of the adopted definition for the term "discretionary clause."

Severability Clause.

Comment: Some commenters state support for the addition of a severability clause. A commenter asserts that potential actions of courts are never certain and clarification concerning severability in the subchapter would, therefore, be good.

Agency Response: The Department agrees that the addition of a severability clause will clarify the relationship of provisions of the subchapter and the operation of the subchapter should any portion or section of the subchapter be held to be invalid. Accordingly, the Department has added new subsection (e) to §3.1201 to provide for the severability of the provisions of the subchapter.

Discretionary Clauses Void.

Comment: A commenter recommends that the Department adopt a new section that expressly states and clarifies the effect of including a discretionary clause in a form; i.e. that such clauses are unenforceable. The commenter asserts that Michigan uses similar language in its prohibition. *See Mich. Admin. Code R. 500.2202(c).*

Agency Response: The Department disagrees because the Department does not believe that this additional provision is necessary at this time. However, the Department will monitor to determine whether there is a need for future rulemaking with respect to this issue.

Alternative recommendations.

Comment: A commenter notes that several states that have addressed the issue of discretionary clauses have recognized that the clauses do not limit the right to judicial remedies for consumers and have, therefore, taken steps short of prohibiting the clauses to ensure consumers are aware of those remedies, such as bulletins or requirements for greater disclosure. The commenter recommends that the Department adopt a requirement for ERISA plans that provides that the Department will approve discretionary clauses related to a health policy only when such clauses are to implement a policy governed by ERISA and in which the policies contain language consistent with the following:

"This provision only applies when the [policy] is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Your [policyholder/plan sponsor] has delegated to [insurer] the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the [policy]. In exercising [such/our] discretion, [Insurer] must act prudently and in the interest of [the insured], [the insured's] beneficiaries and other plan participants. [Insurer] will pay benefits under the [policy] if [insurer] decides, after exercising [insurer] discretion, [the insured] is entitled to them. [Insured] [have/has] the right to request a review of [insurer's] decision. If after exercising the [policy's or insurer's] review procedures [the insured's] claim for benefits is denied or ignored, in whole or in part, [the insured] may file suit and a court will review [the insured's] eligibility or entitlement to benefits under the [policy]."

The commenter asserts that such language would address the concerns that individuals do not know of appeal rights if the individual does not agree with a claim decision.

Agency Response: The Department disagrees that the language suggested by the commenter is the best manner to regulate the

use of discretionary clauses. The use of such a provision could result in a finding that the provision is preempted under ERISA. *See Hancock v. Metropolitan Life Insurance Company,* 590 F. 3d at 1149 (10th Cir. 2009) (holding that Utah disclosure requirements concerning discretionary clauses were preempted as a regulation of the form, not the substance, of ERISA plans). In permitting discretion-granting clauses that complied with form requirements, the 10th Circuit in *Hancock* held that the regulation did not impact risk pooling and did not fall within the ERISA savings provision as a regulation of insurance. Id; see also *Weeks v. UNUM Group,* 585 F.Supp.2d 1305,1311 (D.Utah 2008). Additionally, the language suggested by the commenter would not address one of the primary concerns that is addressed by §§3.1201 - 3.1203 as adopted--the deferential standard of review that results from the inclusion of discretionary clauses in forms.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: National Multiple Sclerosis Society, three individuals.

For with changes: Office of Public Insurance Counsel, American Association of Retired Persons, Texas Medical Association, and Center for Public Policy Priorities.

Against: Texas Association of Life & Health Insurers, America's Health Insurance Plans, American Council of Life Insurers, and Texas Association of Health Plans.

STATUTORY AUTHORITY. The new sections are adopted under the Insurance Code §§1701.060(a)(1), 1701.055(a), 1271.056, 1271.103, 843.151, 541.401 and 36.001. The Insurance Code §1701.060(a)(1) authorizes the Commissioner to adopt reasonable rules to implement the purposes of the Insurance Code Chapter 1701, including, after notice and hearing, rules that establish procedures and criteria under which each type of form submitted will be reviewed and approved by the Commissioner or exempted under the Insurance Code §1701.005(b). Section 1701.055(a) specifies that except as provided by the Insurance Code §1701.055(d), the Commissioner may disapprove, or, after notice and hearing, withdraw approval of a form if the form violates the Insurance Code, a rule of the Commissioner, or any other law, or contains a provision, title, or heading that is unjust, encourages misrepresentation, or is deceptive. Section 1271.056 specifies that an evidence of coverage may not contain a provision or statement that is unjust, unfair, inequitable, misleading, or deceptive; encourages misrepresentation; or is untrue, misleading, or deceptive within the meaning of the Insurance Code §843.204. The Insurance Code §1271.103(a) specifies that after notice and opportunity for hearing, the Commissioner may withdraw approval of the form of an evidence of coverage or group contract or an amendment to one of those forms if the Commissioner determines that the form violates the Insurance Code Chapters 1271, 843, 1272, or 1367; Chapter 1452, Subchapter A; Chapter 1507, Subchapter B; or a rule adopted by the Commissioner. The Insurance Code §1271.103(b) provides that if the Commissioner withdraws approval of a form under §1271.103, the form may not be issued until it is approved. The Insurance Code §843.151 specifies that the Commissioner is authorized to adopt reasonable rules necessary and proper to implement, among other chapters, Chapter 1271. The Insurance Code §541.401 specifies that the Commissioner may adopt and enforce reasonable rules the Commissioner determines necessary to accomplish the purposes of the Insurance Code Chapter 541 (relating to the prohibition of trade practices that are unfair methods of competition or unfair or deceptive acts or practices). The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§3.1201. Applicability, Effective Dates, and Severability.

(a) This subchapter applies to any form filed under the Insurance Code Chapters 1701 or 1271, including forms filed by Lloyd's plans and fraternal benefit societies.

(b) Except as specified in subsections (c) and (d) of this section, this subchapter applies to forms offered, issued, renewed, or delivered on or after June 1, 2011, including forms that include premium waiver provisions based upon a disability determination.

(c) For forms that include disability income protection coverage providing for periodic payments during disability due to sickness and/or accident, whether provided through a policy, certificate, or rider, this subchapter applies to forms offered, issued, renewed, or delivered on or after February 1, 2011.

(d) For forms issued or delivered prior to the effective date of this subchapter that do not contain a renewal date, this subchapter applies on or after the effective date of any rate increase applicable to the form or any change, modification, or amendment of the form occurring on or after June 1, 2011.

(e) If any section or portion of a section of this subchapter is held to be invalid for any reason, all valid parts are severable from the invalid parts and remain in effect. If any section or portion of a section is held to be invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications. To this end, all provisions of this subchapter (relating to Discretionary Clauses) are declared to be severable.

§3.1202. Discretionary Clauses Defined.

For the purpose of this subchapter, a discretionary clause is a provision that:

(1) purports or acts to bind the claimant to, or grant deference in subsequent proceedings to, adverse claim decisions or policy interpretations by the insurer or health maintenance organization;

(2) specifies that a policyholder or other claimant may not contest or appeal a denial of a claim;

(3) specifies that the insurer's or health maintenance organization's interpretation of the terms of a form or its decision to deny coverage or the amount of benefits is binding upon a policyholder or other claimant;

(4) specifies that in any appeal the insurer's or health maintenance organization's decision-making power as to the interpretation of the terms of a form or as to coverage is binding; or

(5) specifies or gives rise to a standard of review in any appeal process that gives deference to the original claim decision or provides standards of interpretation or review that are inconsistent with the laws of this state.

§3.1203. Discretionary Clauses Prohibited.

Inclusion of a discretionary clause in any form to which this subchapter applies is prohibited.

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 3, 2010.

TRD-201006864
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 23, 2010
Proposal publication date: June 4, 2010
For further information, please call: (512) 463-6327

♦ ♦ ♦

CHAPTER 12. INDEPENDENT REVIEW ORGANIZATIONS

The Commissioner of Insurance (Commissioner) adopts amendments to §§12.1, 12.2, 12.4, 12.5, 12.101 - 12.106, 12.108, 12.201, 12.202, 12.204 - 12.208, 12.301, 12.302, 12.402 - 12.406, 12.501 and 12.502, and new §§12.6, 12.110, and 12.303, concerning independent review organizations (IROs). Sections 12.2, 12.4, 12.5, 12.101, 12.103, 12.106, 12.108, 12.110, 12.201, 12.204 - 12.208, 12.303, 12.402, 12.404, 12.406, and 12.502 are adopted with changes to the proposed text published in the June 11, 2010, issue of the *Texas Register* (35 TexReg 4859). Sections 12.1, 12.6, 12.102, 12.104, 12.105, 12.202, 12.301, 12.302, 12.403, 12.405, and 12.501 are adopted without changes.

A correction of error notice was published in the July 2, 2010, issue of the *Texas Register* (35 TexReg 5971) to correct errors in the proposal published in the June 11, 2010, issue. The following errors were corrected:

In the Cross Reference to Statute section, the Cross Reference to Statute citation for each subchapter was incomplete as published on pages 35 TexReg 4883, 4887, 4890, 4894, 4895, and 4896. For each subchapter there were two paragraphs under the Cross Reference to Statute that were corrected. The first reference as published read, "§§12.101 - 12.106, Insurance Code §§4201.002, 4202.002, 4202.004, and 12.108, and 12.110, 4202.005." It was corrected to read, "§§12.101 - 12.106, 12.108, and 12.110 Insurance Code §§4201.002, 4202.002, 4202.004, and 4202.005." The second reference as published read, "§§12.201, 12.202, Insurance Code §1305.355 and §4202.002; and 12.204 - 12.207 Labor Code §§408.0043 - 408.0045 and 413.031." It was corrected to read, "§§12.201, 12.202, and 12.204 - 12.207, Insurance Code §1305.355 and §4202.002; Labor Code §§408.0043 - 408.0045 and 413.031."

REASONED JUSTIFICATION. These amendments and new sections are necessary to: (i) implement House Bill (HB) 4519, 81st Legislature, Regular Session, effective September 1, 2009, which establishes requirements for the Commissioner of Insurance to adopt new requirements and restrictions applicable to IROs; (ii) implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which effectively revises the definition of "adverse determination" in the Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service; and (iii) make other changes deemed necessary by the Department to improve and clarify the IRO rules and effectively enforce the Insurance Code Chapter 4202.

HB 4519

The Insurance Code §4202.002, relating to Adoption of Standards for Independent Review Organizations, mandates that the Commissioner adopt standards and rules for the certification, selection, and operation of IROs to perform independent review described by the Insurance Code Chapter 4201, Subchapter I, and the suspension and revocation of the certificates of registration issued to IROs. The Insurance Code §4202.002(b) specifies what must be ensured by standards adopted under the Insurance Code §4202.002, and the standards required by the Insurance Code §4202.002(b) have previously been adopted into rule. However, HB 4519 amends the Insurance Code §4202.002 by adding new subsection (c), which specifies that in addition to the standards adopted under the Insurance Code §4202.002(b), the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. Additionally, the Insurance Code §4202.002(c) states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The amendment to §12.5 adds a new, redesignated paragraph (27) to define the term "primary office" to clarify how an IRO may comply with the requirement in the Insurance Code §4202.002(c)(2)(A) mandating location of the IRO's primary offices in this state. The amendment to §12.103 adds paragraph (10) to require an applicant for an initial or a renewal certificate of registration made on or after December 26, 2010 to submit as part of the application process evidence that the applicant's primary office is located in this state. The amendment also provides that an IRO must locate its primary office in this state and is similarly necessary to implement the requirement in the Insurance Code §4202.002(c)(2)(A) mandating location of the IRO's primary offices in this state. New §12.110 is necessary to implement the requirement in the Insurance Code §4202.002(c)(2)(C) mandating the Commissioner to adopt standards and rules that require an IRO to apply for and receive a new certification after the organization is sold to a new owner. The new section is also necessary to ensure that the Department obtains reasonable notice of pending sales and to clarify the effect of the pending sale upon: (i) the IRO's obligations concerning previous and pending independent reviews; and (ii) the random assignment of independent reviews in the 45 days prior to the date that the sale is finalized. Amendments to §12.204 are necessary to: (i) revise the section title to more accurately reflect the new content of the section; and (ii) specifically implement the prohibitions mandated in the Insurance Code §4202.002(c)(1)(A) - (D) concerning prohibited activities and relationships of IROs and individuals or entities associated with IROs by adding new subsections (c) - (h). Amendments to §12.208(b) and (f) are necessary to implement the prohibition mandated in the Insurance Code §4202.002(c)(1)(F) concerning the prohibited disclosure of confidential patient information. New §12.303 is necessary to implement the requirement in the Insurance Code §4202.002(c)(2)(B) mandating the Commissioner to adopt standards and rules that require an IRO to voluntarily surrender its certificate of registration while the IRO is under investigation or as part of an agreed order. New §12.303 is also necessary to define the term "inves-

tigation" for purposes of the section, to clarify that a certificate of registration that is surrendered under the section is temporarily suspended while the investigation is pending, to clarify the effect of the surrender upon the random assignment process, and to clarify the continuing requirements concerning maintenance and confidentiality of information generated and obtained by the IRO in the course of its operations. The amendment to §12.502(f), relating to the random assignment of independent reviews to IROs, is also necessary to revise the subsection for clarity.

Additionally, the applicability date of December 26, 2010 in §12.4(b) gives IROs time to comply with the rules adopted to implement HB 4519 and allows time to complete the last reviews assigned to IROs under the current rules for those IROs that cannot or do not wish to comply. Specific applicability dates for certain provisions implementing HB 4519 are also included. Section 12.204(h) makes §12.204(c) - (g) applicable only to IROs whose certificate of registration is issued or renewed on or after December 26, 2010 or to individuals or entities whose activity involves an IRO whose certificate of registration is issued or renewed on or after December 26, 2010. Section 12.103(10) requires evidence that the applicant's primary office is located in this state only for an application for a certificate or renewal of registration as an IRO in this state made on or after December 26, 2010.

HB 4290 The Senate Committee on State Affairs Bill Analysis for HB 4290 specifies the legislative intent of HB 4290:

"Texas consumers with managed care health plans regulated by the [Department] . . . currently are entitled to an independent review of their carriers' decisions to deny a preauthorization of treatment based on a carrier's decision that the treatment is not medically necessary, but current law does not require an independent review of a carrier's conclusion that treatment should be denied because it is experimental or investigational. In addition, current law does not provide for an independent review of a carrier's conclusion after the fact that a treatment was not medically necessary. Health plans may deny a requested service for the reason that the plan deems it to be experimental or investigational, and the provider or claimant does not have access to an administrative process to seek review both prospectively and retroactively through a process coordinated by TDI. A study by a national association of health plans found that a majority of states currently have independent review programs that cover either all adverse determinations or all adverse determinations involving medical necessity or services deemed to be experimental. Texas is the only state with limitations on retrospective reviews of denials based on medical necessity and the only state with an independent review law that does not extend to retrospective reviews of at least emergency and urgent care. TDI has received numerous complaints regarding these issues, but there is little TDI can do to address them. Carriers have varying standards for what is considered experimental and investigational and, in regard to retrospective reviews, TDI's data regarding workers' compensation claim denials show that carriers incorrectly issue retrospective denials more often than prospective denials, with retrospective medical necessity decisions, including experimental and investigational denials, overturned 68% of the time after an independent review is conducted, while prospective medical necessity decisions are overturned approximately 30% of the time. C.S.H.B. 4290 amends current law relating to retrospective utilization review and utilization review to determine the experimental or investigational nature of a health care service." TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009).

The Insurance Code §4201.002(1) provides the definition for "adverse determination" as used in the Insurance Code Chapter 4201. Although the Insurance Code §4201.002(1) defined "adverse determination" prior to the enactment of HB 4290 to mean a utilization review agent's (URA's) determination that health care services "provided" or proposed to be provided to a patient are not medically necessary or appropriate, the provision was not interpreted to include retrospective review of medical necessity. This interpretation was based upon the Insurance Code §4201.002(13) definition of "utilization review" as a system for "prospective or concurrent" review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual in this state; the definition arguably did not include retrospective review. HB 4290 addresses applicability of independent review on a retrospective basis by amending the definition of "utilization review" to specifically include retrospective review of the medical necessity and appropriateness of health care services. HB 4290 further amends the term to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The Insurance Code §4201.002 provides that the definitions in that section apply to Chapter 4201; however, pursuant to the Insurance Code §4202.002, the standards and rules adopted under that section relate to the certification, selection, and operation of IROs that perform independent review described by the Insurance Code Chapter 4201. Therefore, the definitions in the Insurance Code Chapter 4201 are relevant to the activities regulated by the Insurance Code Chapter 4202. Sections that had previously been adopted pursuant to the Insurance Code §4202.002 make reference to adverse determinations made under the Insurance Code Chapter 4201 and utilize the language used to define the term "adverse determination" in the Insurance Code Chapter 4201. Amendments to §12.5(1), (17), and (31), concerning the definitions of "adverse determination," "independent review," and "review criteria" respectively, are necessary to revise rule text which references or uses the definition of "adverse determination" to accurately reflect the use of that term as revised by HB 4290. An amendment to §12.103(1) adds subparagraph (B) to require an applicant for an initial or renewal certificate of registration to submit as part of the application process a summary of its independent review plan that includes a summary description of review criteria and review procedures to be used to determine the experimental or investigational nature of health care. This amendment further implements the statutory expansion of adverse determinations to include determinations concerning the experimental or investigational nature of health care as provided in the Insurance Code §4201.002(1).

Other necessary amendments

In addition to the need to implement HB 4519 and HB 4290, the Department has determined that other amendments are necessary to effectively enforce the Insurance Code Chapter 4202. These other necessary amendments are described in the following paragraphs.

First, the Insurance Code §4202.002(a) requires the Commissioner to adopt "standards and rules for . . . the certification, selection, and operation of independent review organizations." To implement these requirements, current rules at §§12.101 - 12.109 require a certified IRO to annually submit an application for renewal of certificate of registration. If the application

for renewal of certificate of registration is not submitted, the IRO will lose its certificate of registration. Additionally, current rules at §12.502 establish a process of random assignment of independent reviews to IROs. However, the current process establishing random assignment of independent reviews can result in an independent review being assigned to an IRO that needs to complete its annual renewal of certificate of registration, and the current rules do not address what should be done if the IRO is assigned an independent review but then fails to have its certificate of registration renewed before it completes the assigned review. To address this issue, amendments in §12.108(c) and §12.502(f)(1) provide that no assignments of an independent review will be made to an IRO within the 30 days before the IRO is required to submit its application for the annual renewal of the certificate of registration unless and until the Department receives the IRO's completed application and the application fee.

Second, a memorandum of understanding between the Department Enforcement Division (Enforcement) and the Texas Department of Insurance Division of Workers' Compensation (TDI-DWC) has been executed to formally establish the roles and responsibilities of Enforcement and TDI-DWC as they relate to particular enforcement functions subject to the authority and responsibility of the Commissioner of Workers' Compensation, and the Department and TDI-DWC specifically continue to coordinate oversight and enforcement activities in Texas. To facilitate the Enforcement Division's handling of such matters, it is necessary to revise §12.302 to address the actions the Commissioner of Insurance or designees of the Commissioner may take in regard to the Labor Code.

Third, as noted previously, the Insurance Code §4202.002(a) requires the Commissioner to adopt "standards and rules for . . . the certification, selection, and operation of independent review organizations." To implement these requirements, the Commissioner requires each IRO to develop an independent review plan that includes the criteria used by the IRO as a tool in its review process. Current rules use the term "screening criteria" to describe the criteria used in the IRO's review process. However, the term "screening criteria" is more appropriately applied to the utilization review process rather than the independent review process, while the term "review criteria" is more reflective of the independent review process. Therefore, amendments replace the term "screening criteria" with "review criteria" throughout Chapter 12. Specifically, the amendments to reflect this more accurate terminology appear in §§12.5(19) and (31), 12.103(1), 12.108, and 12.201(3). In addition, the Department adopts new and updated definitions in §12.5 and adopts amendments to §12.201 in order to provide more guidance in regard to what an IRO must take into consideration in preparing an independent review plan. Specifically, the Department adopts an amendment to update the term "medical and scientific evidence," and adopts as a new defined term "evidence-based standards." These terms are necessary to describe the basis for IRO review criteria required by §12.201. The amendment to the definition of "medical and scientific evidence" in §12.5(22) is also necessary to update reference sources and citations and to expand permitted bases of medical and scientific evidence as appropriate throughout the definition. The Department also adopts as new defined terms in §12.5 "best evidence," "case-control studies," "case series," "cohort studies," "evidence-based medicine," "evidence-based standards," "expert opinion," and "randomized clinical trial." It is necessary to define these terms because: (i) the term "evidence-based standards" is used in an amendment in §12.201 in order to clarify what an IRO must take into consideration in developing review criteria; (ii) the terms "evidence-based medicine" and "best evidence" are used in defining "evidence-based standards;" and (iii) the remaining terms are used within the definition of "best evidence." An amendment to §12.201(3)(A) requires an IRO's independent review plan to include the required use of written, medically acceptable review criteria that are, among other existing requirements, based upon medical and scientific evidence and utilize evidence-based standards. Collectively, these amendments to §12.5 and §12.201 provide for a more transparent framework for the independent review process while providing additional guidance to IROs about the necessary content of an independent review plan.

Fourth, six terms that are currently defined in §12.5 are not actually used within Chapter 12. These terms are "act," "active practice," "administrator," "dental plan," "emergency care," and "open records law." Because these terms are not used within the chapter, it is unnecessary that they be defined. For this reason, these terms are deleted.

Fifth, the Labor Code §413.031(d) provides, in part, that "[a] review of the medical necessity of a health care service requiring preauthorization under Section 413.014 or commissioner rules under that section or Section 413.011(g) shall be conducted by an [IRO] under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations." The Labor Code §413.031(d) has been implemented by the DWC in rules located in 28 Texas Administrative Code (TAC) Chapter 133, Subchapter D (relating to Dispute of Medical Bills). However, to bring Chapter 12 into accord with the Labor Code §413.031(d) and 28 TAC Chapter 133, references to address the applicability of and required compliance with applicable law concerning workers' compensation insurance carriers and certified workers' compensation health care networks are adopted to be added in: (i) §12.4(a), concerning applicability; (ii) §12.5(22), (25), and (32), respectively, defining the terms "medical and scientific evidence," "payor," and "TDI-DWC"; and (iii) 12.502(a), concerning random assignment of independent reviews. These amendments include additional terminology as required to clarify applicability in the context of independent review of health care services provided pursuant to the Labor Code Title 5. Also, new §12.6 clarifies that review of the medical necessity or appropriateness of a health care service provided under the Labor Code Chapter 408 or Chapter 413 shall be conducted under Title 28 TAC Chapter 12 in the same manner as reviews of utilization review decisions by health maintenance organizations. New §12.6 also clarifies that in the event of a conflict between Chapter 12 and the Labor Code or TDI-DWC rules, the Labor Code or TDI-DWC rules control. Additionally, an amendment to redesignated §12.201(3)(D) addresses the development of review criteria used to review health care delivered pursuant to the Labor Code Title 5. New §12.202(f) incorporates references to licensing and professional specialty requirements of personnel who perform independent review of health care services provided under the Labor Code Title 5 or the Insurance Code Chapter 1305. This new subsection requires compliance with these additional licensing and specialty requirements for performance of such independent review, provides a more comprehensive regulatory framework, and makes it easier for IROs to identify applicable requirements.

Sixth, 28 TAC §1.503 and §1.504 (relating to Application of Fingerprint Requirement and Fingerprint Requirement, respectively) require an individual who is required to provide biographical information and has similar responsibilities to principals; partners; officers; directors; or controlling shareholders,

including limited liability company members and managers, of entities that are applicants for a certificate of registration under the Insurance Code Chapter 4202, to submit a complete set of fingerprints at or near the same time that the individual submits the required biographical information. For accordance with these sections, an amendment to §12.103(9)(A) adds the requirement for submission of fingerprints in compliance with §1.503 and §1.504.

Seventh, as previously noted, the Insurance Code §4202.002(a) requires the Commissioner to adopt "standards and rules for . . . the certification, selection, and operation of independent review organizations." In establishing standards for the operation of IROs, the current §12.207 addresses accessibility of IROs by telephone. However, §12.207 only addresses URA access to IROs by telephone and does not establish accessibility provisions regarding other persons or entities. At times, this has resulted in parties other than URAs not being able to contact IROs or not having their telephone calls returned by IROs in a timely manner. To address this issue, amendments to §12.207(a) require IROs to be generally available by telephone.

Eighth, the Insurance Code §4202.006 provides: "The commissioner shall charge payors fees in accordance with this chapter as necessary to fund the operations of independent review organizations." Pursuant to this provision, the current §12.403 addresses fee amounts for independent review. However, at times independent review notification of decisions issued by IROs are incomplete, and it is necessary for the IRO to issue an amended notification of decision. Such amended notification of decision is not specifically addressed by §12.403, so it is necessary to amend the section. An amendment to §12.403 adds subsection (b) to establish that: (i) the expense of preparing an amended notification of decision is included in the IRO fee if the Department determines the initial notification of decision is incomplete; and (ii) the amended notification of decision is required to be filed with the Department no later than five working days from the IRO's receipt of notice from the Department that the initial notification of decision is incomplete.

Ninth, an amendment to §12.301 is necessary to conform the rule addressing the IRO complaint process to current Department procedures for addressing complaints and to provide sufficient flexibility for Department action as necessary to protect confidential information as required by law. Tenth, an amendment to §12.404 deletes an unnecessary requirement in existing subsection (c) for an IRO to send a copy of the bill to the Department each time it bills for a review.

Finally, amendments throughout the rule text: (i) correct typographical, grammatical, and punctuation errors in the current rule text, (ii) make changes to conform rule text to current Department drafting style, (iii) update statutory citations to conform with the non-substantive revisions to the Insurance Code, and (iv) non-substantively simplify and clarify provisions in Chapter 12.

The Department posted an informal working draft of the proposed new rules on the Department's Internet website and invited public input. The Department held a stakeholder's meeting on September 4, 2009, to discuss implementation of HB 4290 and HB 4519 and the informal working draft with interested parties. The Department received several written comments regarding the informal working draft of the proposed new rules, and these comments were taken into consideration in preparing the proposed rules. The proposed rules were formally published in the June 11, 2010, issue of the *Texas Register* (35 TexReg 4859).

The Department conducted a public hearing on the published rule proposal on July 15, 2010, under Docket Number 2714. In response to written comments on the published proposal and comments made at the hearing, the Department has made non-substantive changes to (i) proposed §12.5, adding a definition of "experimental or investigational;" (ii) proposed §12.5(21) (currently redesignated §12.5(22)), relating to the definition of "medical and scientific evidence;" (iii) proposed §12.5(23) (currently redesignated §12.5(24)), relating to the definition of "patient;" (iv) proposed §12.5(27) (currently redesignated §12.5(28)), relating to the definition of "primary office;" (v) proposed Form No. LHL006 relating to the IRO application form; (vi) proposed §12.103(10), relating to the requirement that an application for a certificate or renewal of registration as an IRO in Texas made on or after December 26, 2010 must include evidence that the applicant's primary office is located in this state; (vii) proposed §12.201(3), relating to the required use of written medically acceptable review criteria; (viii) proposed §12.207, relating to IRO telephone access; (ix) proposed §12.303, relating to the surrender of an IRO's certificate of registration while the IRO is under investigation or as part of an agreed order; (x) proposed §12.402, relating to tier two fees for the independent review of health care services rendered in certain specialties; (xi) proposed §12.404, relating to payment of fees; and (xii) proposed §12.502, relating to random assignment. In response to written comments on the published proposal and comments made at the hearing, the Department has also (i) deleted proposed §12.204(h), relating to the requirement that an IRO may not employ an attorney to represent the IRO in legal proceedings if the attorney serves or has served in the past as the registered agent for the IRO; and (ii) added new §12.204(h), relating to the applicability of §12.204(c) - (g). The Department has also made non-substantive changes to (i) proposed §12.5(32) (currently redesignated §12.5(33)), relating to the definition of "utilization review agent;" (ii) §12.2, relating to severability; (iii) §12.4, relating to applicability; (iv) §§12.101, 12.106, 12.110, 12.204, 12.206, 12.208, 12.406, and 12.502, relating to the use of the phrase "certificate of registration"; (v) §12.108, relating to renewal of certificate of registration; (vi) §12.201, relating to the independent review plan's written procedures; (vii) §12.205, relating to submission of information to the IRO; (viii) §12.206, relating to notice of determinations made by IROs; (ix) §12.502, relating to random assignment; and (x) the LHL006 Form, the IRO Application Form. None of the changes made to the proposed text or proposed form in this adoption materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

As a result of a comment, the Department has added §12.5(12), which defines "experimental or investigational" as "A service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care." A commenter recommended that the Department add to proposed §12.201(4) language establishing the standard for determinations that health care services are "investigational or experimental." Specifically, the commenter recommended the following language for inclusion in the IRO's independent review plan: §12.201(4) "independent review determinations that:. . . (E) a health care service or treatment is investigational or experimental may only be made if the procedure,

course of treatment or health care service lacks sufficient medical or scientific evidence of benefit for a particular condition. A procedure, course of treatment, or health care service is not "investigational or experimental" if it: (i) is generally accepted by the provider of record as effective and appropriate for the condition in question; or (ii) is supported by an overall balance of objective medical and scientific evidence, in which the potential risks and potential benefits are examined." The commenter asserted that adding such a definition would ensure that there is transparency and uniformity in the decision making process among IROs with regard to decisions concerning the investigational or experimental nature of a treatment and this definition would be consistent with the goals of HB 4290. The Department agrees that a definition of "experimental or investigational" would be beneficial and has added the definition in §12.5 instead of §12.402. The Department asserts that its adopted definition is consistent with the commenter's suggested definition. This change also resulted in redesignating proposed §12.5(12) - (33) to §12.5(13) - (34), respectively.

Also, as a result of a comment, the Department retained "peer-reviewed abstracts accepted for presentation at major medical association meetings" in proposed §12.5(21)(F) (currently redesignated §12.5(22)(F)) in the definition of "medical and scientific evidence." A commenter recommended that this language be retained for the following reasons: (i) the NAIC's failure to include peer-reviewed abstracts does not, per se, make the abstracts invalid as a source of medical and scientific evidence reviewable by IROs in the state of Texas; (ii) the Department previously considered the abstracts to be a valid source of medical and scientific evidence and, absent a compelling reason, should continue to do so; (iii) the fact that the abstracts are (a) peer reviewed, and (b) accepted for presentation at a major medical association meeting is sufficient indicia of reliability and acceptance in the medical community to warrant their consideration and use by IROs in their decision-making process; and (iv) to narrow the universe of acceptable material on which the aforementioned decisions are based may have the unintended result of unjustifiably restricting the consumer/patient's access to payment for health care services for which he or she contractually bargained and that he or she is, therefore, legally entitled to receive. This change also resulted in redesignating proposed §12.5(21)(F) and (G) to §12.5(21)(G) and (H), respectively.

Also, as a result of comment, the Department has revised §12.5(21)(G). First, this provision was redesignated "§12.5(22)(H)" as a result of the retention of §12.5(21)(F) and an addition of a definition in §12.5(12), as previously discussed. Secondly, the scope of subparagraph (G) was changed, although the redesignation made an actual text change unnecessary. A commenter recommended modifying proposed subparagraph (G) (currently redesignated "(H)") to reference other medical or scientific clinical evidence that is comparable to the sources listed in subparagraphs (A) - (E), rather than (A) - (F). The commenter asserted that subparagraph (F) (currently redesignated "(G)"), was limited to and specifically tailored to independent review of adverse determinations of health care provided pursuant to Labor Code Title 5 (workers' compensation decisions). Thus, it would not make sense to consider "comparable" evidence to workers' compensation treatment guidelines, treatment protocols, etc. in the context of decisions falling outside of Labor Code Title 5. The Department agrees that because proposed subparagraph (F) was limited to workers' compensation decisions, proposed subparagraph (G) should not have referenced proposed subparagraph (F). However, because the language under the previously adopted subparagraph (F) was reinstated as a result of a separate comment, proposed subparagraphs "(F)" and "(G)" were redesignated "(G)" and "(H)," respectively. Thus, the practical effect of leaving the reference to subparagraphs "(A) - (F)" within the text in newly redesignated subparagraph (H) is to exclude the reference to proposed subparagraph (F) (since it is now "(G)") as the commenter requested, without the need for an actual text change.

Additionally, as a result of a comment, the Department has revised §12.5(23) (currently redesignated §12.5(24)) to state, "Patient--The enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy, or *an injured employee* entitled to receive workers' compensation benefits pursuant to the Labor Code Title 5." Two commenters requested this revision to proposed §12.5(23). The commenters requested this revision because (i) injured employees are persons who received the health care service portion of the workers' compensation medical benefit; (ii) the use of the term "injured employee" would reduce confusion; and (iii) the revision would be consistent with draft Department rules regarding URAs currently under consideration.

Additionally, as a result of comment, the Department has amended §12.5(27) (currently redesignated §12.5(28)) to define "primary office" as "the place where, based upon the totality of the business activities related to independent review performed under this chapter, an independent review organization's books and records pertaining to independent reviews assigned by the Department are stored." The Department has also revised §12.103(10) to state, "(10) for an application for a certificate or renewal of registration as an independent review organization in this state made on or after December 26, 2010, evidence that the applicant's primary office is located in this state. As a condition of being certified to conduct the business of independent review in this state, an independent review organization must locate its primary office in this state." The Department has made a conforming change to Form No. LHL006 (relating to IRO Application Form), which previously stated, "Provide evidence that the applicant is based in the state and that its primary office is located in this state." The Department has revised this requirement in Form No. LHL006 to state, "Provide evidence that the applicant's primary office is located in this state." Three commenters stated that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas is in violation of the Commerce Clause of the U.S. Constitution. Three other commenters opposed the provision as unnecessary. A seventh commenter requested adding new language to §12.103.

The first commenter asserted that although a State's power to regulate the business of insurance is broadened by the McCarran-Ferguson Act, this extended power does not grant the Department the power to restrict all out-of-state IROs from engaging in business in Texas. The commenter further noted that there has been no evidence that out-of-state IROs pose any problems within the regulatory confines of this state. If the matter is not deemed unconstitutional, the commenter recommended removing "is based" in §12.103(10) and amending §12.103 to read as follows: "(10) Evidence of (sic) the IRO has a primary office physically located in this State, and that this is reported and declared as the Business Office of the IRO in the IRO's Application for Certification, and in annual renewal statements, and that at any time that this address is changed, that TDI be notified 10 days prior to the change of such Business Address. The pri-

mary office of an IRO shall be the physical Business Address of the IRO that is declared in the Application for Certification as an IRO, must be where the management of the processes of independent review occur, and the location where corporate records case files, and files containing information on the medical and reviewers of the IRO are maintained. With regard to credentialing and case files, IROs must maintain at the primary office documents that demonstrate that all reviewers on the IRO's medical review panel are licensed to practice in the State of Texas, and that, on a case by case basis, the IRO has assigned fully credentialed reviewers to each case, and that reviewer has signed no conflict of interest statements." Further, the commenter suggested that entities that were certified prior to the new Code shall have a grace period of 120 days to comply with the new law. During this grace period, an IRO will have the option of opening a primary office for independent review in Texas, or of selling the IRO to an owner in Texas who agrees to open a primary office, as defined above. During this grace period, which would begin on the date of the adoption of the new rules, the IRO would continue to be required to follow rules currently in effect, not the new proposed rules. The commenter asserted that the proposed language offered for implementing the requirement in the Insurance Code §4202.002(c)(2)(A) does not provide sufficient guidance to operating IROs and that the current language suggests that the actual medical reviews take place at the primary office, which is a practical impossibility.

The second commenter stated that if we eliminate the out-of-state IROs, we are going to lose their knowledge. These IROs were involved in drafting federal legislation. The small out-of-state IROs cannot afford to move to Texas. The large IROs are not going to move either, because the IRO business in Texas is not lucrative enough. This portion of the law is unnecessary. The first two levels of review are by URAs, who are located all over the country. The federal legislation is going to change the game completely. The out-of-state IROs were not involved in the stakeholder meetings. Some IROs did not know that the law had been passed.

The third commenter stated the following reasons that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas should be deleted: (i) the commenter's out-of-state IRO consistently receives 100% on its report card issued by the Department; (ii) the commenter's IRO has done nothing unscrupulous and can be trusted; (iii) the IRO has learned and abided by all of the rules and regulations of the Department that govern the IRO business and, to the commenter's knowledge, has never had a complaint filed against it; (iv) there is no public purpose for this new law; (v) the law was written by another IRO owner who was trying to increase his own business by putting out-of-state IROs out of business; and (vi) this regulation does nothing to help the patients of Texas get fairness in the health care process, which is what we should be spending time and energy discussing.

The fourth commenter stated that if the number of IRO cases is going to increase, now is not a good time to eliminate IROs. Some of the out-of-state IROs are big IROs that conduct business nationally, and the commenter asserts that they are good companies. The commenter further stated that there is no indication that out-of-state IROs posed a problem.

The fifth commenter stated the following reasons for deleting the requirement that the IRO be based in Texas and have its primary office in Texas: (i) the commenter's IRO received a 100% score in Department rankings; (ii) the IRO has never had a complaint filed against it by a patient, provider, insurance company, or URA; (iii) working with the Department is a pleasure under current rules; (iv) URAs that are similarly regulated by the Department are located all over the country; (v) one IRO owner is trying to manipulate the system for his own personal gain; (vi) there are numerous other out-of-state IROs that will be forced to relocate under this provision in order to keep their IRO business in Texas; (vii) for the commenter's family to relocate, it would cost tens of thousands of dollars and the commenter's wife would not be able to keep her job; therefore, the commenter would be forced to sell his IRO; and (viii) the effect of this regulation would be to eliminate 20% of the IROs certified in Texas, bringing less competition and less independence to the system; with the new federal legislation, Texas will need more IROs, not less, to deal with the expanding system. A sixth commenter cited the following reasons for deleting this requirement: (i) forcing a company to move its office to Texas puts an unnecessary financial strain on the company; (ii) people working for these companies will undoubtedly lose their jobs as a result of this provision, further worsening the economy; and (iii) many of the top rated IROs will no longer find it financially feasible to do Texas independent reviews and the Department will lose these quality reviewers.

A seventh commenter suggested adding the following subparagraph to §12.103: "(11) information related to out-of-state licensure of legal process. All applicants must furnish a copy of the Certificate of Registration or other licensing document from the domiciled state's licensing authority. As a condition of being certified to conduct the business of independent reviews in this State, an Independent Review Organization must locate its primary office in this State."

Although the Department disagrees that the case law on which the first commenter relies supports the proposition that an IRO's activity is not considered the "business of insurance" or that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas violates the Commerce Clause of the U.S. Constitution, the Department's revisions narrow the definition of "primary office" and impose the requirement that the primary office be located in Texas only to applicants for a new license or renewal on or after December 26, 2010. This revision to §12.103(10) also removes the requirement that Form No. LHL006 include evidence that the applicant is based in Texas, as the first commenter requested. Being based in Texas is no longer a condition of being certified to conduct the business of independent review. Additionally, the revision imposes the requirement that the primary office be located in Texas only on applicants for a new license or renewal on or after December 26, 2010. Thus, any potential applicant will be aware of the primary office requirement set forth in §12.103(10) before deciding whether to apply for licensure or renewal. Although in some instances this applicability date may result in a shorter time period than the 120 day grace period the first commenter suggested, in other cases it may create a longer time period with which to comply. This revision to the definition of "primary office" addresses the first commenter's request that books and records should be maintained at the primary office. This revision should also alleviate the first commenter's concern that the rule requires actual medical reviews take place at the primary office which is a practical impossibility, which was not the Department's intent.

The revision of §12.103(10) is also consistent with some of the fourth commenter's suggested language. However, the Department does not intend on accepting a copy of a foreign Certificate of Registration as the only other required criterion for an IRO to conduct business in Texas.

Also, as a result of comment, the Department has revised §12.201(3)(A) to state, "based on medical and scientific evidence and utilize evidence-based standards, *or if evidence is not available, generally accepted standards of medical practice recognized in the medical community."* A commenter recommended that proposed §12.201(3)(A) be modified to read as follows: "(3) required use of written medically acceptable review criteria that are: (A) established with consideration, as appropriate, given to [based on] medical and scientific evidence and [utilize] evidence-based standards;. . . ." The commenter cited the following reasons for the suggested change: (i) this language will ensure that the purpose of the HB 4290 is fulfilled; (ii) proposed §12.201(3)(A) will be consistent with 12.201(3)(B), which requires the review criteria to be "objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis;" (iii) under current §12.201, the components of the independent review plan are somewhat broadly-defined (presumably in order to provide flexibility in their application); (iv) under the current regulations, the independent review plan must be developed with input from appropriate health care providers and reviewed and approved by physician, which is similar to the statutory requirement for utilization review plans under Texas Insurance Code §4201.151; (v) the Department's proposed modifications to §12.201 provide an extra layer of detail and, unfortunately, inflexibility to the independent review plan by requiring that the plan use written medically acceptable review criteria that are "based on medical and scientific evidence and utilize evidence-based standards;" (vi) as proposed, the standards established by §12.201(3)(A) may be too rigid to account for varying circumstances and emerging science in the practice of medicine; (vii) although the commenter supports the consideration and use of appropriately tested and peer-reviewed evidence in making independent review determinations, given that the practice of medicine is an art as well as a science, it is critical that the proposed rules not be overly prescriptive in the use of so called "best evidence" to the detriment of payment for the provision of sound patient care; (viii) to require a strict adherence to the evidence-based standards would sacrifice legitimate determinations concerning medical necessity and the investigational/experimental nature of a particular treatment or drug in favor of uniform (if, sometimes, inaccurate) decisions using so-called "evidence based standards;" (ix) the Department must be mindful that what is the "best evidence" today may be outdated tomorrow and that which is the cutting edge today may be the state of the art and then the standard practice tomorrow; (x) the rules must be flexible enough to acknowledge a wide array of treatments and services that have been proven to be beneficial to patients; (xi) without providing for adequate flexibility in the rule, the review criteria required under the rule may be so stringent that many appropriate and beneficial health care services will be inaccurately classified as investigational or experimental, while HB 4290 was designed to ensure that those health care services that insurers deemed "investigational" or "experimental" were properly reviewed by an IRO; (xii) this modification would be consistent with the NAIC Model Act's focus on reviewing guidelines, as appropriate, when making the independent review determination; and (xiii) modification would be consistent with subparagraph (E) which requires the review criteria to be used only as a tool in the review process (and not determinative of the ultimate decision). The Department agrees with the commenter that proposed §12.201(3)(A) was too rigid, since evidence-based medicine may not be available in every situation and thus cannot always be relied upon. However, the Department asserts that evidence-based standards should be used when available.

Additionally, as a result of comment, the Department has deleted proposed §12.204(h) from the adopted rules. Two commenters argued that §12.204(h) appeared to be in violation of the U.S. Constitution. Both commenters noted that it was clearly unconstitutional unless the State could articulate a *compelling* reason for denying IROs the right to choose its own counsel. According to the first commenter, who has acted as a registered agent for two IROs, since there did not seem to be a valid reason for §12.204(h), it is possible that §12.204(h) was specifically included in the bill to harm him personally because of past dealings with an individual who was involved in drafting the legislation. This provision, when enacted, will require the commenter to end representation of current IRO clients and to deny his clients the right to choose him as their attorney. A registered agent simply accepts service for his or her client. Registered agents include attorneys, entity officers, professional services and others. There is a trust that has been built up and will be lost. It is also a long tradition that an individual should be able to select his own lawyer. Both commenters also noted that there is no reference to what this regulation is intended to remedy.

The Department has considered §12.204(h) further and has determined that the provision governs the practice of law by limiting the conduct of certain licensed attorneys in the state of Texas. Because the Department's regulatory authority does not extend to the practice of law, the Department has deleted this provision. Also, as a result of comment, the Department has revised §12.204 by adding a new subsection (h), which states, *"Notwithstanding §12.4(b) of this chapter (relating to Applicability), the prohibitions in subsections (c) - (g) of this section apply only to: (1) an independent review organization that: (A) is licensed on or after December 26, 2010; or (B) has its certificate of registration renewed in this state on or after December 26, 2010; and (2) an individual or entity whose activity involves an independent review organization that: (A) is licensed on or after December 26, 2010; or (B) has its certificate of registration renewed in this state on or after December 26, 2010."* This change makes §12.204(c) - (g) applicable only to IROs whose certificate of registration is issued or renewed on or after December 26, 2010 or to individuals or entities whose activity involves an IRO whose certificate of registration is issued or renewed on or after December 26, 2010. This change was in response to the general comment that legal action may be taken to challenge the constitutionality of the rules once adopted. The Department's revision clarifies that the requirements in §12.204(c) - (g) only apply to IROs that are licensed or whose certificates of registration are renewed on or after December 26, 2010 or to individuals or entities whose activity involves an IRO that is licensed or whose certificates of registration is renewed on or after December 26, 2010. This revision avoids disruption of any expectations, rights, or privileges under or related to a current certificate of registration that has already been issued and has not yet expired.

Also, as a result of comment, the Department has revised §12.207(b) to state, "An independent review organization must have a telephone system capable of accepting or recording or providing instructions to incoming calls *related to utilization review* during other than normal business hours and shall respond to such calls not later than one working day from the date the call was received." A commenter opposed the amendments to §12.207 for the following reasons: (i) the new rule requires that IROs should be "generally (sic) available by telephone" to parties other than URAs; while this appears to

make no substantive change to broaden the telephone availability requirements for IROs, in effect it would require IROs to communicate with anyone and everyone; (ii) under amended §12.207, an IRO would be compelled to discuss details of individual cases with persons other than URAs, which hinders both the patient privacy and the independence of the process; (iii) this open access creates an economic burden on IROs, which was not present in prior rules; (iv) previously, the IRO had to return calls "to URAs" in 2 working days, which allowed plenty of time to address any issue during the 20-day review process; (v) amended §12.207 significantly increases costs to the IROs, by encouraging patients to directly contact them; (vi) the proposed rule change jeopardizes the independent status of the IROs; and (vii) any change that increases the workload of the IROs should also have a corresponding fee increase. The Department's revision narrows the scope of §12.207(b) to calls *related to utilization review.*

Additionally, as a result of comment, the Department has revised §12.303 by (i) removing the terms "voluntary" and "voluntarily"; (ii) adding subsection (c) to state, "A certificate of registration that is surrendered under this section is temporarily suspended while the investigation is pending;" and (iii) adding subsection (f) to state, "Notwithstanding §12.4(b) of this chapter (relating to Applicability), this section only applies to an independent review organization that: (1) is licensed on or after December 26, 2010; or (2) has its certificate of registration renewed in this state on or after December 26, 2010." The Department has also removed the term "voluntarily" from §12.502(f)(2).

Two commenters asserted that §12.303 contains no due process of law. One commenter recommended removing the reference to a voluntary surrender of certificate and suggests referencing a surrender of certificate only after an IRO has been provided due process on the issue. This commenter further stated that the provision requiring a "voluntary suspension of a license" is neither voluntary nor legally permissible as it eliminates a vested right to continue to operate without any due process. According to the commenter, when the state vests a right to do business to a company, certain due process standards must be afforded prior to suspension of their ability to continue to do business.

The commenter further asserts that the Department is subject to Chapters 2001 and 2002 of the Texas Government Code. These chapters have been deemed by Texas courts to require agencies to assure fairness to affected persons and to assure that the public and affected persons are heard on matters that involve their interests and affairs. A *mandatory voluntary* surrender of the certificate runs afoul with the rules that govern Texas agencies because it hinders an IRO's ability to be heard and provided due process before the certificate is required to be surrendered.

The Department has removed the terms "voluntary" and "voluntarily" to clarify that the surrender is required and to avoid confusion as to whether the surrender is mandatory or voluntary. Additionally, the Department has provided that a certificate of registration that is surrendered under §12.303 is temporarily suspended while the investigation is pending, clarifying that the certificate of registration is not permanently revoked without due process of law. The addition of subsection (f) makes this provision only applicable to IROs newly licensed on or after December 26, 2010 or to existing IROs upon renewal of their certificates of registration on or after December 26, 2010. Thus, any potential applicant will be aware of the surrender process set forth in §12.303 before deciding whether to apply for licensure or renewal. Finally, the Department has also removed the term "voluntarily" from §12.502(f)(2) as a conforming change, since this section refers to §12.303.

Additionally, as a result of comment, the Department has revised §12.402(2) to state, "(2) Tier two fees will be for the independent review of *health care services* rendered in the specialties of podiatry, optometry, dental, audiology, speech-language pathology, master social work, dietetics, professional counseling, psychology, occupational therapy, physical therapy, marriage and family therapy, chiropractic, and chemical dependency counseling, and any subspecialties thereof." A commenter strongly recommended that the Department replace the reference to "medical or surgical care" with "health care services" in §12.402(2). The commenter objected to the Department's proposed reference to "medical or surgical care" rendered by the specialties listed in proposed §12.402(2); the specialties listed in proposed §12.402(2) are not M.D.s or D.O.s and, therefore, are not statutorily authorized to practice medicine or to provide general medical or surgical care; rather, they are authorized only to provide the limited health care services consistent with and within the scope of their respective enabling statutes. The commenter asserted that the suggested revision makes the proposed language of §12.402(2) consistent with Texas law. The Department has made the requested revision.

Finally, as a result of comment, the Department has revised §12.404(c) by adding a second sentence that states, "For workers' compensation network and non-network disputes, the independent review organization fees shall be paid in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations)." A commenter recommended that §12.404 regarding payment of fees be amended to address the following concerns: (i) IROs should not be allowed to submit an invoice to a URA or payor until their services have been rendered; in workers' compensation many deadlines for payment of a bill are based on receipt of the invoice, and requests for a review may be withdrawn prior to the review being performed; and (ii) the rule should be clarified to reference the Division of Workers' Compensation rules, which have different payment timelines for workers' compensation URAs.

The Department has revised §12.2 to state, "If a court of competent jurisdiction holds that any provision of this chapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this chapter that can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable." The Department has made this clarifying change to proposed §12.2 for consistency with the Government Code §312.013(a).

The Department has also changed proposed §12.4(b) to state, *"Except as otherwise provided,* this chapter is applicable to all requests for independent review filed with the department on or after *December 26, 2010.* All independent reviews filed with the department prior to *December 26, 2010* shall be subject to the rules in effect at the time the independent review was filed with the department." The addition of the language "Except as otherwise provided" was to reflect that more specific applicability dates were added to §§12.103(10), 12.204(h), and 12.303(f) as a result of other comments. The "December 26, 2010" change was necessary for compliance with the effective date requirements in the Government Code §2001.036. Section 2001.036 provides that a rule takes effect 20 days after the date on which it is filed in the Office of the Secretary of State unless certain other

statutorily specified conditions are met. The change is also necessary to avoid any retroactive effect of the rule.

The Department has revised redesignated §12.5(33) to define "utilization review agent" as "A person holding a certificate under the Insurance Code Chapter 4201," removing the reference to "of registration" for clarification because some URAs are certified and some are registered.

The Department has revised §§12.101, 12.106, 12.110, 12.204, 12.206, 12.208, 12.406, and 12.502, replacing the term "certification." The term "certification" refers to an issuance of the certificate of registration. For consistency of terminology throughout the rule text, the Department has removed references to "certification," instead referring to a "certificate of registration." As a conforming change, the Department has also changed the title of Subchapter B from "Certification of Independent Review Organizations" to "Certificate of Registration for Independent Review Organizations." The Department has revised the first sentence of §12.101 to state, "An application for a certificate of registration and for renewal of a certificate of registration as an independent review organization and *application for a certificate of registration* or renewal fee must be filed with the Texas Department of Insurance at the following address:. . .," deleting the term "certification" and replacing it with the phrase "application for a certificate of registration."

The Department has revised the first sentence of §12.106 to state, "The commissioner or the commissioner's designee may conduct an on-site qualifying examination of an applicant as a requirement of *applying for a certificate of registration or renewing a certificate of registration* as an independent review organization." This sentence previously stated, "The commissioner or the commissioner's designee may conduct an on-site qualifying examination of an applicant as a requirement of *certification or a renewal of certification* as an independent review organization." The Department has revised the phrase "certification or a renewal of certification" to "applying for a certificate of registration or renewing a certificate of registration." The Department has also revised §12.110(e), stating ". . . and applicable department and TDI-DWC rules prior to *issuance of the certificate of registration* to the independent review organization pursuant to its new ownership," replacing the phrase "certification of" with the phrase "issuance of the certificate of registration."

The Department has revised §12.204(g) to state, "An individual who has served on the board of an independent review organization that has had its *certificate of registration* revoked for cause may not serve on the board of another independent review organization earlier than the fifth anniversary of the date on which the revocation occurred." The Department has replaced the term "certification" with the phrase "certificate of registration."

The Department has revised §12.206(d)(7) to state, "the name and *certificate* number of the independent review organization," replacing the word "certification" with the word "certificate."

The Department has also revised §12.208(e) to refer to a "certificate number" instead of a "certification number."

The Department has revised the title of §12.406 from "Certification and Renewal Fees" to "Certificate of Registration and Renewal Fees."

Finally, the Department has also revised §12.502(c) to refer to the "date of issuance of the certificate of registration" instead of the "date of certification."

The Department also made a clarifying change to §12.108(b), revising the text to state, "Form No. LHL006 (IRO Application Form)," instead of "Form No. LHL006 (IRO Application *for Certification."* This change is for consistency with §12.102, which adopts by reference "Form No. LHL006 (IRO Application Form)."

Also, in addition to the revision to §12.201 made as a result of comment, the Department has also revised §12.201(2)(A) to state, "notification of the independent review organization's determinations provided to the patient or a *representative* of the patient, the patient's provider of record, and the utilization review agent, in accordance with §12.206 of this subchapter (relating to Notice of Determinations Made by Independent Review Organizations)." The Department changed the phrase "person acting on behalf" to "representative" for consistency throughout the text. As a conforming change, the Department has also revised §12.205(c), 12.206(a), and §12.502(a), again replacing "person acting on behalf" with "representative."

The Department has also revised §12.205(c) to correct a typographical error, adding a parenthesis after "(relating to Agents' Licensing and General Medical Provisions."

Additionally, the Department has made several non-substantive revisions to §12.206(d) for clarification. First, the Department has revised §12.206(d)(6) to state, "a statement of whether the context of the review is preauthorization, concurrent *utilization* review, or retrospective *utilization* review of health care services." The Department added the term "utilization" for clarification. Second, the Department has revised §12.206(d)(12) to state, "a statement that the independent review was performed by a health care provider licensed to practice in Texas if required by applicable law and of the appropriate *professional* specialty." The Department added "professional" for clarification and for consistency with §12.202(f), which refers to a "professional specialty." Third, the Department has also revised §12.206(d)(13)(B) and (C), replacing the term "physician" with the term "provider." This change was also made for consistency throughout the rule text. Fourth, the Department revised §12.206(d)(14) to state, "a summary of the patient's clinical history;" changing the word "patient'" to "patient's" for ease of readability.

Finally, in addition to the conforming change made as a result of comments to Form No. LHL006, the IRO Application Form, in which the Department revised the form to state, "Provide evidence that the applicant's primary office is located in this state," the Department determined that it was also necessary to make two clarifying changes. First, the Department revised the title of the form to "Independent Review Organization (IRO) Application Form." Proposed §12.102 adopts by reference Form No. LHL006, the "IRO Application Form." The proposed form had the title "Independent Review Organization (IRO) Application *for Certification."* The Department's revision corrects the title for consistency with §12.102. Second, the Department revised Form No. LHL006 to properly reference the biographical affidavit addendum, stating, "Biographical affidavits addendum (form #LHL652)." The proposed form stated, "Biographical affidavits addendum (form #I_____)," so it was necessary to correct the incomplete reference.

Section 12.1 addresses Statutory Basis. The amendment to §12.1 is necessary to change a statutory citation from "Texas Insurance Code, Article 21.58C" to "the Insurance Code Chapter 4202 as of September 1, 2009" to conform with non-substantive revisions to the Insurance Code.

Section 12.2 addresses Severability Clause. The amendment to §12.2 makes changes to conform rule text to current Department drafting style, consistent with the Government Code §312.013(a).

Section 12.4 addresses Applicability. One amendment to §12.4 is necessary to address applicability of Chapter 12 to workers' compensation health care networks and workers' compensation insurance carriers. This amendment better reflects the scope of applicability of Chapter 12 in conformity with the Insurance Code §1305.355 and §4201.054. Section 1305.355, concerning workers' compensation health care networks, requires a URA to permit an employee or person acting on behalf of an employee and the employee's requesting provider whose reconsideration of an adverse determination is denied to seek review of that determination by an IRO assigned in accordance with Chapter 4202 and Commissioner rules. Section 4201.054 mandates that Chapter 4201 applies to utilization review of a health care service provided to a person eligible for workers' compensation medical benefits under Title 5, Labor Code, and further provides that the Commissioner of Workers' Compensation may adopt rules as necessary to implement the section. Title 28 TAC §133.308(b), one of the TDI-DWC rules implementing this requirement, provides that each IRO performing independent review of health care provided under the section is required to be certified pursuant to the Insurance Code Chapter 4202. Additionally, amendments to §12.4 are necessary to divide the section into two subsections in order to address both general applicability and applicability to particular requests for independent review and to provide an applicability date for the rules as amended.

Section 12.5 addresses Definitions. The amendments to delete existing §12.5(1), (2), and (3) are necessary because the terms defined in the paragraphs ("act," "active practice," and "administrator") are not used within Chapter 12 and are thus unnecessary as defined terms. Additional amendments are necessary to redesignate the remaining paragraphs in the section both as a result of the deletion of §12.5(1) - (3) and due to other deletions and insertions that follow within the section. Amendments to redesignated §12.5(1) are necessary to revise the definition for the term "adverse determination" to be consistent with the definition for the term as it is defined and used in Chapter 19, Subchapters R and U of this title, the rules regulating URAs, as well as for consistency with the definition of utilization review in the Insurance Code Chapter 4201 as amended and clarified by HB 4290. Section 12.5(5) is redesignated as §12.5(2) due to the deletion of existing definitions. New §12.5(3) is necessary to define the term "best evidence" because it is used in the definition of the adopted term "evidence-based standards." New §12.5(4), (5), and (6) are necessary to define the terms "case-control studies," "case-series," and "cohort studies" because they are used in the definition of the adopted term "best evidence." Current §12.5(6) and (7) are adopted to be redesignated as §12.5(7) and (8). An amendment is necessary to delete the current §12.5(8) because "dental plan," the term defined in the paragraph, is not used within Chapter 12 and is thus unnecessary as a defined term. The amendment that adds new §12.5(10) is necessary to define the term "evidence-based medicine" because it is used to define the term "evidence-based standards." The amendment that adds new §12.5(11) is necessary to define the term "evidence-based standards." This term is necessary to define because it is used in the adopted amendment in §12.201(3)(A) in order to clarify what an IRO must take into consideration in developing review criteria. The amendment is necessary to delete current §12.5(10) because "emergency care," the term defined in the paragraph, is not used within Chapter 12 and is thus unnecessary as a defined term. New §12.5(12) is necessary to define the term "experimental or investigational," as requested by a commenter and for clarification. New §12.5(13) is necessary to define the term "expert opinion" because it is used in the definition of the adopted term "best evidence." Current §12.5(11) is redesignated as §12.5(14). An amendment to redesignated §12.5(15) is necessary to insert the words "or provider" to clarify that the term is occasionally used in lieu of the term "health care provider" within Chapter 12. Additional amendments to redesignated §12.5(15) are made to conform rule text to current Department drafting style and improve clarity. The first amendment to redesignated §12.5(16) is necessary to revise the definition for the term "health insurance policy" to be consistent with the definition for the term in the Insurance Code §4201.002(6), which defines the term in the context of utilization review as regulated under Chapter 4201. The second amendment to redesignated §12.5(16) is necessary to revise a statutory citation from "the Insurance Code Chapter 20" to "the Insurance Code Chapter 842" to conform with the non-substantive revisions to the Insurance Code. The amendment to redesignated §12.5(17) is necessary to revise the definition of the term "independent review" for consistency with the definition of utilization review in the Insurance Code §4201.002(13) as amended by HB 4290. The first amendment to redesignated §12.5(18) is necessary to insert the words "or IRO" to clarify that the term is occasionally used in lieu of the term "independent review organization" within Chapter 12. The second amendment to redesignated §12.5(18) is necessary to revise a statutory citation from "Act" to "Insurance Code Chapter 4202" to conform with the non-substantive revisions to the Insurance Code. The third amendment to redesignated §12.5(18) is necessary to change the word "title" to "chapter" in order to more accurately identify the location of the referenced section. The fourth amendment to redesignated §12.5(18) is necessary to correct the citation to the section title of §12.402. The amendment to redesignated §12.5(19) is necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. New §12.5(20) is necessary to add a definition for "legal holiday" because the term is used in an adopted amendment to redesignated §12.5(34), which defines "working day" and establishes a definition for the term that is consistent with TDI-DWC practices as provided in §102.3(b) of this title. Current §12.5(17) is redesignated as §12.5(21). The amendment to redesignated §12.5(22) is necessary to update the term "medical and scientific evidence" to update current sources of medical and scientific evidence and citations and to expand permitted bases of medical and scientific evidence as appropriate throughout the definition. As adopted, much of the term "medical and scientific evidence" is modeled on the term used by the National Association of Insurance Commissioners (NAIC) in its Uniform Health Carrier External Review Model Act. An amendment is necessary to delete the current §12.5(20) because "open records law," the term defined in the paragraph, is not used within Chapter 12 and is thus unnecessary as a defined term. The amendment to redesignated §12.5(23) is necessary to revise the definition for the term "nurse" for increased consistency with the definition for the term in Chapter 19, Subchapters R and U of this title, which provides rules regulating URAs. The amendment to redesignated §12.5(24) is necessary to revise the definition for the term "patient" to clarify applicability of the term with respect to persons entitled to receive workers' compensation benefits pursuant to the Labor Code, Title 5. The amendment to §12.5(25) is necessary to revise the definition for

the term "payor" to clarify the applicability of the term with respect to persons or entities that provide, offer to provide, or administer workers' compensation benefits as provided under the Insurance Code §4201.054. Current §12.5(23) and (24) are redesignated as §12.5(26) and (27). The amendment that adds new §12.5(28) is necessary to define the term "primary office" because the term is used in Chapter 12 in the implementation of HB 4519. The amendment in redesignated §12.5(29), which defines "provider of record," is necessary for consistency with current Department rule drafting style. New §12.5(30) is necessary to define the term "randomized clinical trial" because it is used in the definition of the term "evidence-based standards." One amendment to redesignated §12.5(31) is necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. A second amendment to redesignated §12.5(31) is necessary for consistency with the definition of "utilization review" in the Insurance Code §4201.002(13) as amended by HB 4290. New §12.5(32) adds the new defined term "TDI-DWC." This amendment is necessary to introduce an abbreviated term for the Texas Department of Insurance, Division of Workers' Compensation which can be used throughout the chapter. The amendment to redesignated §12.5(33) is necessary to update a statutory citation from "the Insurance Code, Article 21.58A" to "the Insurance Code Chapter 4201" to conform with a non-substantive revision to the Insurance Code. The amendment to redesignated §12.5(34) establishes a definition for the term "working day" that is consistent with TDI-DWC practices as provided in §102.3(b) of this title. New §12.6 addresses Independent Review of Adverse Determinations of Health Care Provided Pursuant to the Labor Code Title 5 or the Insurance Code Chapter 1305. New §12.6 is necessary to address situations where existing rules or adopted amendments to Chapter 12 conflict with the Labor Code or TDI-DWC rules when applied to independent review of adverse determinations of health care provided pursuant to the Labor Code Title 5 or the Insurance Code Chapter 1305. Pursuant to new §12.6, and in accordance with the Insurance Code §4201.054, the Labor Code or TDI-DWC rules control in such an instance.

Section 12.101 addresses Where to File Application. One amendment to §12.101 is necessary to insert a uniform term to address the certificate that an IRO can apply for pursuant to Chapter 12. A second adopted amendment to §12.101 provides the correct mailing address to file an application for a certificate of registration as an IRO with the Department. A third adopted amendment clarifies that the section also applies to filing for renewal of the certificate of registration.

Section 12.102 addresses Application and Renewal of Certificate of Registration Form; How to Obtain Forms. One amendment to §12.102 amends the section title to better reflect the content of the section. Additional amendments are necessary to establish a uniform form and attachments for purposes of applying for both initial and renewal certificates of registration. New subsection (a) is necessary to update the section to adopt by reference Form No. LHL006, the IRO Application Form for this purpose. New subsection (b) is necessary to update the section by adopting by reference Form No. FIN311, the Biographical Affidavit. IROs are required to use this form as an attachment to Form No. LHL006 (IRO Application Form). This amendment establishes the standardized form for submitting biographical information as required pursuant to the Insurance Code §4202.004(4). The amendments to redesignated §12.102(c) are necessary to provide the correct web address and mailing address from which an applicant can obtain a form for application for a certificate of registration as an IRO.

Section 12.103 addresses Information Required in Application and Renewal Form. An amendment to §12.103 amends the section title to better reflect the section content. A second amendment to §12.103 amends the section to reflect that in order that the Commissioner may properly determine whether an applicant is qualified to be certified as an IRO, the IRO must submit the information required in Form No. LHL006, including each of the data elements specified in the section. Section 12.103 also includes changes throughout for purposes of correcting grammar and conforming text to agency drafting style. An amendment to §12.103(1) is necessary to change the word "title" to "chapter" in order to more accurately identify the location of the referenced section. Another amendment to §12.103(1) is necessary to change "which" to "that" to correct a grammatical error. The amendment to §12.103(1)(A) is necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. An amendment adds new §12.103(1)(B) and redesignates the subparagraphs that follow it in order to address the revised definition of "utilization review" in the Insurance Code §4201.002(13) made by HB 4290 that incorporates determinations regarding the experimental or investigational nature of health care into the term. One amendment to redesignated §12.103(1)(C) is necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. The second amendment to redesignated §12.103(1)(C) is necessary to correct an internal reference by changing the word "title" to "chapter" and by deleting an unnecessary reference to a section heading. Adopted amendments to redesignated §12.103(D) are necessary to correct internal references by changing the word "title" to "subchapter." Amendments to redesignated §12.103(1)(D), (2), (4), and (5) are necessary to correct internal references by changing the word "title" to "chapter." An amendment to §12.103(3) is necessary to update a statutory citation from "the Act" to "Insurance Code Chapter 4202" to conform with the non-substantive revisions to the Insurance Code. Another amendment to §12.103(5) is necessary to provide the correct citation to the heading of another section. The amendment to §12.103(6)(B) is necessary to revise a reference to percentage for consistency with current Department rule drafting style. The amendment to §12.103(6)(D) is necessary to clarify that the chart the subparagraph requires to be submitted must show contractual arrangements of the applicant. The amendment to §12.103(9) is necessary to provide guidance concerning the information required for submission with Form No. FIN311 (Biographical Affidavit). One amendment to §12.103(9)(A) is necessary to correctly address the fact that the provision applies to an "applicant." The second amendment to §12.103(9)(A) is necessary to add a requirement for submission of fingerprints in compliance with §1.503 and §1.504 to more comprehensively reflect the application requirements. The third amendment to §12.103(9)(A) is necessary to revise a reference to percentage for consistency with current Department rule drafting style. A last amendment to §12.103(9)(A) changes the term "person" to "individual" to clarify whose total annual revenue, holdings, or investments are referenced in the subparagraph. An amendment to §12.103(9)(A)(vii) is necessary to delete the word "or" so an additional entity can be added to the list for which an applicant must submit information in compliance with the subparagraph. New §12.103(9)(A)(viii) is necessary to add "independent review organization" to the list of entities for which an applicant must sub-

mit information required pursuant to §12.103(9)(A), and existing §12.103(9)(A)(viii) is redesignated as a result of this change to §12.103(9)(A)(ix). One amendment to §12.103(9)(B) is necessary to clarify that it is the applicant that must identify any relationship between the applicant and any affiliate or other organization in which an officer, director, or employee of the applicant holds a five percent or more interest. The second amendment to §12.103(9)(B) is necessary to revise a reference to percentage for consistency with current Department rule drafting style. The amendment to §12.103(9)(C) is necessary to clarify that it is the applicant that must submit a list of any currently outstanding loans or contracts to provide services between the applicant and any affiliates. The amendment to §12.103(10) requires, for an application for a certificate or renewal of registration as an IRO in this state made on or after December 26, 2010, an applicant to submit evidence that the applicant's primary office is located in this state and provides that this requirement is a condition of applying for a certificate of registration. These amendments to §12.103(10) are necessary to implement this requirement pursuant to HB 4519. It is also important that the Department have the ability to conduct on-site examinations of IRO's records that relate to independent reviews conducted in Texas. If the IRO's primary office is located outside of Texas, it is more costly to conduct on-site examinations and also may cause unnecessary delay in situations where immediate on-site auditing may be necessary. An amendment to §12.103(11) is necessary to add the word "and" for consistency with current Department drafting style and to correct grammar. An amendment adds new §12.103(12). This new paragraph is necessary to require an applicant to disclose any enforcement actions related to the provision of medical care or conducting of medical reviews taken against a person subject to the fingerprint requirements under §1.503 and §1.504 of this title in order to assist the Department in assessing the qualifications of the applicant to conduct independent reviews.

Section 12.104 addresses Review of Application. The amendments to §12.104(1) and (4) are necessary to clarify the application review process that occurs after an applicant submits its application for a certificate of registration. The amendments to §12.104(3) are necessary to correct an erroneous reference to the section by revising the phrase "this subsection" to state "this section." An additional amendment to §12.104(3) is necessary to change "described" to "specified" to reflect drafting style.

Section 12.105 addresses Revisions During Review Process. The amendment to §12.105(a) is necessary to provide the correct mailing address to which revisions during the review of the application must be addressed and to delete language concerning the submission of documents that is no longer necessary due to clarifications in subsequent subsections. The amendment to §12.105(b) is necessary to clarify the scope of the requirement for an applicant to submit one original and one copy of revised pages by limiting the requirement to those revised pages required by the Department under the subchapter. The amendment to §12.105(c) is necessary to clarify that all copies of the revised page submitted by the applicant must contain the changed item or information "red-lined" or otherwise clearly designated and that the original revised page in an application shall be placed in the IRO's charter file maintained by the Department. The amendment to §12.105(d) is necessary to clarify which specific sections in Chapter 12 are referenced by the subsection. The collective amendments throughout §12.105 are necessary to make the section more reader-friendly.

Section 12.106 addresses Qualifying Examinations. One amendment to §12.106 is necessary to change the phrase "his or her" to "the commissioner's" to comply with current Department rule drafting style. The second amendment to §12.106 is necessary to clarify that an on-site qualifying examination may be conducted as a requirement of applying for or renewing a certificate of registration as an IRO. The third amendment to §12.106 is necessary to clarify that documents that support the application or renewal of the certificate of registration must be available for inspection. The fourth amendment to §12.106 is necessary to replace the term "administrative offices" with the term "primary office" for consistency within the chapter and in order to implement HB 4519.

Section 12.108 addresses Renewal of Certificate of Registration. Amendments to §12.108(b) are necessary to clarify that Form No. LHL006 (IRO Application Form), adopted by the Commissioner in §12.102 of this subchapter, is the form that the IRO must use to apply for renewal of its certificate of registration. Amendments to §12.108(b) also clarify that the form is available on the Department website and to provide more accurate references in the subsection. Amendments to §12.108(b), (c), and (d) are necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. A second amendment to §12.108(c) is necessary to add a provision that independent reviews will not be assigned to an IRO during the 30 days prior to the anniversary date of the issuance of the IRO's certificate of registration unless the completed renewal application form and application fee have been received by the Department in order to reduce the risk that independent reviews will be assigned to an IRO that does not submit its application for renewal of its certificate of registration. A second amendment to §12.108(d) is necessary to clarify that the form referenced by the subsection is a renewal application form. The amendment to §12.108(e) is necessary to update the reference to the application form referenced in the subsection. An amendment adds new §12.108(h). This subsection is necessary to provide additional clarification concerning an IRO's obligations to continue to perform its duties pursuant to the Insurance Code Chapter 4202, the Labor Code Title 5, and applicable Department and TDI-DWC rules "Until the certificate of registration renewal application process is complete or the certificate of registration expires. . .".

New §12.110 addresses Effect of Sale of an Independent Review Organization. The purpose of this new section is to implement HB 4519. New §12.110(a) is necessary to provide that an IRO's certificate is non-transferable, and an IRO must surrender its certificate upon sale of the IRO. New §12.110(b) is necessary to provide that an IRO that has been sold to a new owner must apply for and receive a new certificate pursuant to this subchapter before it can operate as an IRO. New §12.110(c) is necessary to require an IRO to notify the Department of an impending sale no later than 90 days prior to the date the sale will occur. The purpose of this subsection is to provide ample notice to the Department of the impending date of sale of an IRO so that the Department can ensure that all assigned independent reviews are completed before the date of the sale and that no new independent reviews are assigned at a point when the IRO is not certified, due to the need to recertify following the sale. New subsection (c) also: (i) clarifies that the requirement to notify the Department of an impending sale is required to include the anticipated date on which the sale will be finalized and to provide a revised notification of impending sale if such date changes; and (ii) provides an address for filing the notification. New §12.110(d) is necessary to provide notice to an IRO that notification of an impending

sale does not negate the IRO's continuing obligation to perform its duties pursuant to the Insurance Code Chapter 4202, the Labor Code, and Department and TDI-DWC rules. New §12.110(e) is necessary to establish that upon the sale of an IRO, the new owner is prohibited from performing the duties of an IRO prior to obtaining its certificate of registration pursuant to the new ownership.

Section 12.201 addresses Independent Review Plan. The amendment to §12.201 conforms rule text with current Department drafting style and for clarity. Section 12.201 provides that independent review shall be conducted in accordance with an independent review plan that is consistent with standards developed with input from appropriate health care providers and reviewed and approved by a physician. An amendment to §12.201(2)(A) changes the words "addressed in" to "in accordance with" for compliance with the Department's current rule drafting style. A second amendment to §12.201(2)(A) changes the words "person acting on behalf" to "representative," for consistency throughout the rule text. Amendments to §12.201(2)(A) and (D) changes "title" to "subchapter" in order to more accurately identify the location of the referenced section. An amendment to §12.201(2)(D) reflects the correct title of §12.205. Five amendments to §12.201(3) and the amendment to §12.201(4) are necessary to change the term "screening criteria" to "review criteria" in order to more accurately reflect the role of independent review as a review of a utilization review determination. Another amendment to §12.201(3) is necessary to change the word "utilize" to "use" in order to simplify the text of the rule. Another amendment to §12.201(3) is necessary to provide that the review criteria used by an IRO should be based on medical and scientific evidence and utilize evidence-based standards, or if evidence is not available, generally accepted standards of medical practice recognized in the medical community, in addition to the current requirement that the review criteria are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, and other health care providers, be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis. This amendment is necessary to provide a more transparent framework for the independent review process. Another amendment to §12.201(3) is necessary to provide that in the development of review criteria used to review health care delivered pursuant to the Labor Code Title 5, an IRO shall also consider the treatment guidelines, treatment protocols, and pharmacy closed formulary adopted by TDI-DWC. This change provides for greater conformity with existing TDI-DWC rules concerning review criteria. An amendment to redesignated §12.201(3)(E) deletes a reference to "screening criteria" and makes additional nonsubstantive changes for clarity. Additional amendments to §12.201(3) are necessary to change the phrase "his or her" to "the commissioner's" to comply with current Department rule drafting style. An amendment to §12.201(4) is necessary to conform the rule text to current Department rule drafting style and to make the section more reader-friendly.

Section 12.202 addresses Personnel and Credentialing. The amendment to §12.202(b) is necessary to clarify that the purpose of maintaining complete profiles of anyone conducting independent review is so that such information will be available for review by the Department and TDI-DWC upon request. The amendment to §12.202(e) is necessary to provide that in addition to physicians and dentists, other persons who perform independent review whose licenses have been revoked by any state licensing agency in the United States are not eligible to direct or conduct independent review. This amendment is necessary to ensure that quality personnel are engaged in the direction and conduct of independent review. An additional amendment to add §12.202(f) clarifies that subsection (c) of this section does not negate the requirements for an IRO performing independent review of a health care service provided under the Labor Code Title 5 or Insurance Code Chapter 1305 to comply with licensing and professional specialty requirements for personnel performing independent review as provided by the Labor Code §§408.0043 - 408.0045, 413.031, the Insurance Code §1305.355, and Chapters 133 and 180 of this title (relating to General Medical Provisions and Monitoring and Enforcement).

Section 12.204 addresses Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations. The amendment to the title of §12.204 is necessary to reflect the expanded content included in the section. The amendment to §12.204(a) makes nonsubstantive changes for clarification and also clarifies that the prohibition against an IRO imposing notice or review procedures that are contrary to the requirements of the health insurance policy or health benefit plan does not prohibit such practices as required by Texas law. Amendments add new §12.204(c) - (h), which are necessary to implement HB 4519. New §12.204(c) is necessary to establish a prohibition that an IRO may not operate out of the same office or other facility as another IRO. New §12.204(c)(1) is necessary to clarify that the prohibition added by new §12.204(c) extends to the shared use by IROs of the resources and staff that comprise an office, including: office space, telephone and fax lines, electronic equipment, supplies, and clerical staff. New §12.204(c)(2) is necessary to clarify that the prohibition added by New §12.204(c) does not extend to the use of subcontractor services or personnel employed by or under contract with the IRO to perform independent review. New §12.204(d) is necessary to establish a prohibition that an individual or an entity may not own more than one IRO. New §12.204(e) is necessary to establish a prohibition that an individual may not own stock in more than one IRO. New §12.204(f) is necessary to establish a prohibition that an individual may not serve on the board of more than one IRO. New §12.204(g) is necessary to establish a prohibition that an individual who has served on the board of an IRO that has had its certificate of registration revoked for cause may not serve on the board of another IRO earlier than the fifth anniversary of the date on which the revocation occurred. New §12.204(h) is necessary to establish specific applicability provisions for §12.204(c) - (g), stating that the prohibitions in subsections (c) - (g) apply only to (i) an IRO that is licensed or has its certificate of registration renewed in Texas on or after December 26, 2010; or (ii) an individual or entity whose activity involves an IRO that is licensed or has its certificate of registration renewed in Texas on or December 26, 2010.

Section 12.205 addresses Independent Review Organization Contact with and Receipt of Information from Health Care Providers and Patients. The amendment to §12.205(a) is necessary to correct a reference to an IRO's medical director by changing the word "advisor" to "director." One amendment to §12.205(c) is necessary to clarify that requirements concerning timely delivery and receipt of any written narrative supplied by the patient also apply to payors requesting independent review in addition to the URA or the health insurance carrier, health maintenance organization, or managed care entity. The

amendment also clarifies that this obligation is additionally required pursuant to Chapters 19 and 133 of this title (relating to Agents' Licensing and General Medical Provisions, respectively). The second amendment to §12.205(c) adds the word "of" to correct the omission of the word in the sentence. The third amendment to §12.205(c), which adds the word "the" before the words "Insurance Code" is necessary for compliance with current Department rule drafting style. The fourth amendment to §12.205(c) is necessary to update a statutory citation from "the Insurance Code, Article 21.58A" to "the Insurance Code Chapter 4201" to conform with the non-substantive revisions to the Insurance Code. The fifth amendment to §12.205(c) inserts a parenthesis after "(relating to Agents' Licensing and General Medical Provisions" to correct a typographical error. The sixth amendment to §12.205(c) is necessary to delete the words "emergency or." There is not a separate standard for emergency conditions as opposed to life-threatening conditions, making the words unnecessary. The seventh amendment to §12.205(c) replaces the words "person acting on behalf" with the word "representative" for consistency throughout the rule text. The amendment to §12.205(d) is necessary to update the section to incorporate a process concerning required notifications by the IRO to the Department that has shown to be more effective for the Department and IROs. Currently, the provision requires an IRO to notify the Department within 24 hours of the receipt of information regarding an independent review from a requesting URA, health insurance carrier, health maintenance organization, or managed care entity. However, the Department has determined that this requirement is unnecessary. As adopted, the provision only requires an IRO to notify the Department if it does not receive pertinent files containing medical and personal information from the requesting URA or the health insurance carrier, health maintenance organization, managed care entity, or other payor within three working days of receipt of the independent review assignment. One amendment to §12.205(e) is necessary to clarify that the provision references documents requested by the IRO. The second amendment to §12.205(e) is necessary to update a reference from the "Texas Workers' Compensation Commission" to the "TDI-DWC." The third amendment to §12.205(e) is necessary to clarify that other payors are included as applicable in the requirement identifying those persons required to reimburse an IRO for the expense associated with copying records as an expense of independent review. This amendment is necessary in order to more comprehensively identify payors that may be responsible for this expense when entities other than a URA forward the request for independent review. New §12.205(f) is necessary to provide additional clarification that nothing in the section prohibits a patient, representative of a patient, or a provider of record from submitting pertinent records to an IRO conducting independent review. Additional amendments redesignate the subsections that follow §12.205(f), as necessary. The first amendment to redesignated §12.205(g) is necessary to clarify the role an IRO has in regard to information by changing the word "collect" to "request and maintain." The second amendment to redesignated §12.205(g) is necessary to include "other payors" among the listed entities to more comprehensively identify those entities that may have requested independent review. The final two amendments to redesignated §12.205(g) are necessary to reflect current Department rule drafting style by changing "and/or" to "or." The amendment to redesignated §12.205(h) revises the word "should" to "is required to" to more clearly identify sharing clinical and demographic information among divisions of the IRO to avoid duplicative requests for information from patients or providers is required of an IRO under the subsection rather than suggested.

Section 12.206 addresses Notice of Determinations Made by Independent Review Organizations. The amendment to §12.206(a) is necessary to replace the phrase "person acting on behalf" with the term "representative" for consistency throughout the rule text. §12.206(b)(2) is necessary to delete a superfluous "and" and insert correct punctuation. The amendment to §12.206(c) is necessary to insert the words "the notification must be" in order to clarify what the provision addresses. The amendment to §12.206(d) provides a comprehensive list of the data elements that an IRO is required to include in its notification of determination. The list includes all items specified in the example templates that are available on the Department's website and incorporates data elements identified by the Department as necessary to ensure that the review has been performed in compliance with the requirements of this chapter. Required elements include: (i) a listing of all recipients of the notification that identifies such recipients by name and specifies the manner in which the IRO transmitted the notification to each recipient; (ii) the date of the original notification and any amendment thereto, if applicable; (iii) the independent review case number assigned by the Department; (iv) the name of the patient; (v) a statement of whether the type of coverage is health insurance, workers' compensation, or workers' compensation health care network; (vi) a statement of whether the context of the review is preauthorization, concurrent utilization review, or retrospective utilization review of health care services; (vii) the name and certificate number of the IRO; (viii) a description of the services in dispute; (ix) a complete list of the information provided to the IRO for review, including dates of service and document dates where applicable; (x) a description of the qualifications of the reviewing physician or provider; (xi) a statement that the review was performed without bias for or against any party to the dispute and that the reviewing physician or provider has certified that no known conflicts of interest exist between the reviewer and any of the persons specified in subparagraphs (A) - (F); (xii) a statement that the independent review was performed by a health care provider licensed to practice in Texas if required by applicable law and of the appropriate professional specialty; (xiii) a statement that there is no known conflict of interest between the reviewer, IRO, and/or any officer or employee of the IRO with any of the persons specified in subparagraphs (A) - (F); (xiv) a summary of the patient's clinical history; (xv) the review outcome, clearly stating whether or not medical necessity or appropriateness exists for each of the health care services in dispute and whether the health care services in dispute are experimental or investigational, if applicable; (xvi) a determination of the prevailing party, if applicable; (xvii) the analysis and explanation of the decision, including the clinical basis, findings, and conclusions used to support the decision; (xviii) a description and the source of the review criteria that were used to make the determination; (xix) a certification by the IRO of the date that the decision was sent to all recipients in the manner specified by the IRO on the notification form; (xx) for independent review of health care services provided under Labor Code Title 5 or the Insurance Code Chapter 1305, any information required by §133.308 of this title (relating to General Medical Provisions); and (xxi) notice of applicable appeal rights under the Insurance Code Chapter 1305 and the Labor Code Title 5, and instructions concerning requesting such appeal. Requirements specified in existing §12.206(d)(1) - (4) are incorporated into the more comprehensive listing of data elements in new §12.206(d)(i) - (xxi) and are amended as described for

purposes of clarity and to change a reference to "screening" criteria to "review" criteria for accuracy of terminology. New §12.206(e) is necessary to notify IROs that example templates for the notification of determination regarding health and workers' compensation cases are available on the Department's website.

Section 12.207 addresses Independent Review Organization Telephone Access. The amendment to the title of the section is necessary to make a nonsubstantive change for clarity. The amendments to §12.207(a) and (b) are necessary to broaden the telephone availability requirements for IROs. Currently, the section only requires an IRO to have personnel available to URAs by telephone; it only requires an IRO to have a telephone system capable of accepting or recording or providing instructions to incoming calls from URAs; and it only requires an IRO to respond to a call received outside of normal working hours not later than two working days from the later of the date on which the call was received or the date the details necessary to respond have been received from the caller. However, it is possible that parties other than just a URA, such as providers or patients, may need to reach an IRO. Additionally, the independent review timeframe is short in some instances, and a two day delay in response from an IRO could have an adverse impact on the party attempting to reach the IRO. Therefore, the amendments to §12.207(a) and (b) remove the limitation that an IRO have personnel reasonably available to URAs only, and the adopted amendments change the two working day response time to one working day. Additionally, an amendment to §12.207(b) states that the IRO has to respond to calls "related to utilization review," clarifying that the IRO does not have to respond to calls that are unrelated to utilization review.

Section 12.208 addresses Confidentiality. The amendments to §12.208(b) are necessary to implement the Insurance Code §4202.002(c)(1)(F), enacted in HB 4519, by providing that an IRO may provide confidential information to a provider who is under contract with the IRO for the sole purpose of performing or assisting with independent review and by noting that the information provided to a provider who is under contract to perform a review shall remain confidential. A first amendment to §12.208(f) is necessary to further implement the Insurance Code §4202.002(c)(1)(F) by requiring an IRO's procedures to specify that specific information exchanged for the purpose of conducting review will be shared by the IRO with only a provider who is under contract with the IRO to perform independent review. A second amendment to §12.208(f) is necessary to add the phrase "shall acknowledge" to provide additional clarity concerning the scope of the existing requirement that the IRO plan specify that the IRO agrees to abide by federal and state laws governing the issue of confidentiality. A third amendment to §12.208(f) is necessary to correct a grammatical error by changing the word "which" to "that." The amendments to §12.208(h) are necessary to accomplish two things. First, the provision currently requires information generated and obtained by an IRO during the course of a review only be retained "if the information relates to a case for which an adverse decision was made at any point." However, any review will have arisen from an adverse decision that was made at some point, therefore the clause addressing "an adverse decision . . . at any point" be deleted because it is redundant. Second, it is necessary that the rule make clear that the requirement for an IRO to retain the records it has generated and obtained is an ongoing obligation that does not cease because an IRO's certificate of registration has been suspended or surrendered or due to the IRO's failure to renew the certificate. Therefore, a sentence is added which reflects this continuing obligation.

Section 12.301 currently addresses Complaints, Oversight, and Information. An amendment is necessary to change the section title to "Complaints, Oversight, and Information" in order to accurately reflect the content that will be expanded as a result of amendments adopted within the section. The amendment to §12.301(a) is necessary to conform the rule addressing the IRO complaint process to current Department procedures for addressing complaints and to provide sufficient flexibility for Department action as necessary to protect confidential information as required by law. As amended, subsection (a) provides that complaints against an IRO shall be processed in accordance with the Department's established procedures for investigation and review of complaints. An amendment adds new §12.301(b), which is necessary to address the Department's oversight of IROs by providing that as part of its oversight of IROs the Department will conduct compliance audits to ensure that IROs are in compliance with the Insurance Code Chapters 1305 and 4202 and the rules and standards in Chapter 12. An amendment redesignates current §12.301(b) as §12.301(c) due to the addition of adopted new §12.301(b). The additional amendments to redesignated §12.301(c) make amendments for conformance with the current Department rule drafting style and to update a statutory citation from "the Insurance Code, Article 1.24" to "the Insurance Code §38.001" to conform with the non-substantive revisions to the Insurance Code. An amendment also adds new §12.301(d), which is necessary to clarify that the chapter does not limit the ability of the Commissioner of Workers' Compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against IROs or personnel employed by or under contract with IROs to perform independent review to determine compliance with the Labor Code Title 5 or applicable TDI-DWC rules for violations of the Labor Code Title 5 or TDI-DWC rules.

Section 12.302 addresses Administrative Violations. Amendments to §12.302(a), (d), (e), and (f) are necessary to update statutory citations referring to "the Act," or "Article 21.58C" to "the Insurance Code 4202" to conform with non-substantive revisions to the Insurance Code. Subsections (d) and (e) are also amended to update references to the "Insurance Code, Article 1.10" and "the Insurance Code, Article 1.10A" with citations to "the Insurance Code Chapter 82" and "the Insurance Code Chapter 83," respectively, also to conform with nonsubstantive changes to the Insurance Code. For the same reason, a reference in subsection (e) to "the Insurance Code, Article 1.10E" is amended to refer to "the Insurance Code Chapter 84." An amendment to §12.302(a) provides notice to IROs that if the Department believes that any person conducting independent review is in violation of Insurance Code Chapters 1305 or 4202, Chapter 12 of this title, or any provision of the Labor Code Chapters 408, 409, or 413, or Chapters 19, 133, 134, 140, or 180 of this title, the Department shall notify the IRO of the alleged violation and may compel the production of any and all documents or other information as necessary to determine whether or not such violation has taken place. The amendments to §12.302(b) are necessary to provide notice to IROs and related persons and individuals that the Department or TDI-DWC may initiate appropriate proceedings under the chapter or the Labor Code Title 5 and TDI-DWC rules. The first amendment to §12.302(d) is necessary to change the phrase "his or her" to "the commissioner's" in two places to comply with current Department rule drafting style. The second amendment

to §12.302(d) is necessary to make a grammatical correction by changing the word "the" to "an." The third amendment to §12.302(d) is necessary to add a reference in the section to persons conducting independent review. An amendment adds new §12.302(g), which is necessary to provide additional notice that if the Commissioner or the Commissioner's designee determines that an IRO or a person conducting independent review has violated or is violating any provision of the Labor Code Title 5 or rules adopted pursuant to the Labor Code Title 5, the Commissioner or the Commissioner's designee may impose sanctions or penalties under the Labor Code Title 5. An amendment adds new §12.302(h), which is necessary to provide clarification that the chapter does not limit the ability of the Commissioner of Workers' Compensation or TDI-DWC to take all actions permitted by the Labor Code against an IRO or personnel employed by or under contract with an IRO to perform independent review for violations of the Labor Code or rules adopted pursuant to the Labor Code Title 5 and applicable TDI-DWC rules.

An amendment is necessary to add new §12.303, which addresses Surrender of Certificate of Registration. New §12.303 is necessary to implement the Insurance Code §4202.002(c), enacted by HB 4519. New §12.303(a) provides that upon the request of the Department, an IRO must surrender the organization's certificate of registration while the organization is under investigation or as part of an agreed order. New §12.303(b) is necessary to clarify that for the purposes of the section, the term "investigation" is defined as the filing of a Notice of Hearing or a Notice of Violation with the State Office of Administrative Hearings by the Department or TDI-DWC against an IRO where such notice seeks revocation of the certificate of the IRO. New §12.303(c) is necessary to clarify that a certificate of registration that is surrendered under §12.303 is temporarily suspended while the investigation is pending. New §12.303(d) is necessary to provide that independent reviews shall not be assigned to an IRO during a surrender of the IRO's certificate of registration. New §12.303(e) is necessary to clarify that the surrender of an IRO's certificate of registration does not negate the requirement pursuant to §12.208(h) that an IRO retain information generated and obtained by the IRO in the course of a review for at least four years. New §12.303(f) is necessary to set forth applicability dates for §12.303. Under subsection (f), §12.303 applies to an IRO that is licensed on or after December 26, 2010; or has its certificate of registration renewed in this state on or after December 26, 2010.

Section 12.402 addresses Classification of Specialty. The first amendment to §12.402(2) is necessary to clarify that the provision regarding tier two fees is applicable to the review of "health care services" rendered in the specialties listed within the paragraph. The second amendment to §12.402(2) is necessary to include chiropractic in the types of specialties addressed by the paragraph for purposes of clarifying the applicable tier for that specialty service.

Section 12.403 addresses Fee Amounts. The amendment to §12.403 designates the current provision in the section as subsection (a) and adds new subsection (b). Section 12.403(a) is amended to more accurately identify that other payors in addition to URAs are sometimes responsible for payment of fees. New §12.403(b) is necessary to clarify that the IRO fees addressed by the section include an amended notification of decision if the Department determines the initial notification of decision is incomplete. Additionally, new §12.403(b) is necessary to provide that the amended notification of decision shall be filed with the Department no later than five working days from the IRO's receipt of notice from the Department that the initial notification of decision is incomplete.

Section 12.404 addresses Payment of Fees. An amendment to §12.402(b) is necessary to change the word "title" to "chapter" in order to more accurately identify the location of the referenced section. An amendment deletes §12.404(c) because the provision is unnecessary. The provision requires IROs, at the time of billing, to provide to the Department a copy of such bill for information. However, the Department generally does not need such information, so there is no reason to require that it be submitted to the Department. Additional amendments redesignate the subsections that follow §12.404(c) as necessary. An amendment to redesignated §12.404(c) is necessary to reference 28 TAC §133.308 (relating to MDR by Independent Review Organizations).

Section 12.405 addresses Failure to Pay Invoice. An amendment to §12.405 corrects a typographical error that cites an incorrect section number. Another amendment to §12.405 is necessary to change the word "title" to "chapter" in order to more accurately identify the location of the referenced section. An additional amendment to the section is necessary to provide greater specificity concerning the scope of the violation referenced in the section.

Section 12.406 addresses Certificate of Registration and Renewal Fees. The amendment to §12.406 is necessary to change the word "certification" to the phrase "a certificate of registration" in order to utilize the term used throughout the chapter. A conforming change is also made to the title of this section.

Section 12.501 addresses Requests for Independent Review. The amendments to §12.501 are necessary to revise a reference to the Civil Practice and Remedies Code for consistency with the current Department rule drafting style and to update a statutory citation from "the Insurance Code, Article 21.58A, §6" to "the Insurance Code Subchapter I" to conform with the non-substantive revisions to the Insurance Code. Additional amendments to the section are necessary to update the references addressing entities that submit requests for independent review to include Chapter 10 of this title (relating to Workers' Compensation Health Care Networks) and Chapter 133 of this title (relating to General Medical Provisions).

Section 12.502 addresses Random Assignment. The first amendment to §12.502(a) is necessary to add a reference to other payors to the subsection to more comprehensively state the entities that might submit a request for independent review. The second amendment to §12.502(a) replaces the words "person acting on behalf" with the word "representative" for consistency throughout the text. The amendment to §12.502(b) is necessary to update the provision to accurately reflect the role the Department plays in screening for potential conflicts. As adopted, the amendment to §12.502(b) provides that the Department shall screen payors and URAs for potential conflicts of interest with the IRO before making an assignment to the IRO. The amendment to §12.502(e) is necessary to revise the subsection for clarity. New §12.502(f) is necessary to address instances in which independent reviews will not be assigned. These instances include the 30 days prior to the anniversary date of the issuance of the IRO's certificate of registration, unless the IRO has submitted an application for renewal of its certificate of registration and application fee, and the period of time during which an IRO has surrendered its certificate of registration pursuant to §12.303. An amendment also is necessary

to redesignate the current §12.502(f) as §12.502(g). Another amendment to redesignated §12.502(g) is necessary to clarify that the list referenced in the subsection is the assignment list.

HOW THE SECTIONS WILL FUNCTION.

§12.1. Statutory basis. Section 12.1 sets forth the statutory basis for this chapter, stating that it implements the Insurance Code Chapter 4202 as of September 1, 2009.

§12.2. Severability Clause. Section 12.2 provides for severability of terms or sections of this chapter under certain circumstances. It provides that if a court of competent jurisdiction holds that any provision of 28 TAC Chapter 12 or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of 28 TAC Chapter 12 that can be given effect without the invalid provision or application, and to this end the provisions of the chapter are severable.

§12.4. Applicability. Section 12.4 sets forth the applicability of this chapter.

§12.5. Definitions. Section 12.5 contains definitions for words and terms when used in the chapter.

§12.6. Independent Review of Adverse Determinations of Health Care Provided Pursuant to the Labor Code Title 5, or the Insurance Code Chapter 1305. Section 12.6 addresses (i) how review of the medical necessity or appropriateness of a health care service provided under the Labor Code Chapter 408 or Chapter 413 should be conducted; and (ii) how independent review of adverse determinations of health care provided pursuant to the Labor Code Title 5 or the Insurance Code Chapter 1305 should be conducted, including how conflicts between 28 TAC Chapter 12 and either the Labor Code or TDI-DWC rules should be resolved.

§12.101. Where to File Application. Section 12.101 provides information on where to file an application and fees for a certificate of registration and a renewal of a certificate of registration as an IRO.

§12.102. Application and Renewal of Certificate of Registration Form; How to Obtain Forms. Section 12.102 adopts by reference Form No. LHL006 (IRO Application Form) and Form No. FIN311 (Biographical Affidavit) and provides information on how these forms may be obtained.

§12.103. Information Required in Application and Renewal Form. Section 12.103 states that Form No. LHL006 requires information necessary for the commissioner to properly determine whether an applicant is qualified to be certified as an IRO and includes a list of the information that is necessary.

§12.104. Review of Application. Section 12.104 sets forth the applicable timeframes and the duties of the applicant and the Department during the application process.

§12.105. Revisions During Review Process. Section 12.105 contains the requirements for filing revisions to the application during the review process.

§12.106. Qualifying Examinations. Section 12.106 allows the commissioner or the commissioner's designee to conduct onsite qualifying examinations as a requirement of applying for or renewing a certificate of registration.

§12.108. Renewal of Certificate of Registration. Section 12.108 provides that an IRO must apply for renewal of its certificate of registration each year and sets forth the renewal requirements and procedures. It provides that Form No. LHL006 must be used for this purpose.

§12.110. Effect of Sale of an Independent Review Organization. Section 12.110 sets forth certain requirements related to the sale of an IRO, including provisions on non-transferability of an IRO certificate of registration, the effect of the sale of an IRO, notification requirements prior to the sale, obligations to continue performing duties prior to the sale, and activities following a sale.

§12.201. Independent Review Plan. Section 12.201 describes the independent review plan, which must be filed by IROs, and lists the components that must be included in the plan.

§12.202. Personnel and Credentialing. Section 12.202 sets forth personnel and credentialing requirements for IROs.

§12.204. Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations. Section 12.204 prohibits certain activities of IROs, individuals, and entities, including provisions that (i) an IRO may not operate out of the same office or other facility as another IRO; (ii) an individual or entity may not own more than one IRO; (iii) an individual may not own stock in more than one IRO; (iv) an individual may not serve on the board of more than one IRO; and (v) an individual who has served on the board of an IRO that has had its certificate of registration revoked for cause may not serve on the board of another IRO earlier than the fifth anniversary of the date on which the revocation occurred. The prohibitions under §12.204(c) - (g) apply only to (i) an IRO that is licensed on or after December 26, 2010 or has its certificate of registration renewed in Texas on or after December 26, 2010; and (ii) an individual or entity whose activity involves an IRO that is licensed on or after December 26, 2010 or has its certificate of registration renewed in Texas on or after December 26, 2010.

§12.205. Independent Review Organization Contact with and Receipt of Information from Health Care Providers and Patients. Section 12.205 governs the IRO's contact with and receipt of information from health care providers and patients. It sets forth procedures for (i) the IRO's contact with the health care provider and/or designated persons; (ii) the timely delivery of pertinent files to the IRO; (iii) health care providers' charges for providing medical information; (iv) submission of pertinent records to the IRO by a patient, representative of a patient, or a provider of record; (v) an IRO's request for additional information; and (vi) an IRO's sharing of information among its various divisions.

§12.206. Notice of Determinations Made by Independent Review Organizations. Section 12.206 contains requirements for IRO's notification of determinations, including a list of elements that such a notification must include. This section also provides a website where example templates of a notification of determination may be obtained.

§12.207. Independent Review Organization Telephone Access. Section 12.207 contains requirements for an IRO's telephone accessibility, including requirements that an IRO (i) shall have appropriate personnel reasonably available by telephone at least 40 hours per week during normal business hours in both time zones in Texas; and (ii) must have a telephone system capable of accepting or recording or providing instructions to incoming calls related to utilization review during other than normal business hours and shall respond to such calls not later than one working day from the date the call was received.

§12.208. Confidentiality. Section 12.208 sets forth confidentiality requirements for IROs, addressing the IRO's preservation of confidential, information that is provided to a provider who is under contract to perform a review, IRO's procedures addressing confidentiality, and confidentiality requirements during the suspension or surrender of an IRO's certificate of registration or upon failure to renew the certificate of registration.

§12.301. Complaints, Oversight, and Information. Section 12.301 describes how a complaint regarding an IRO may be filed with the Department, and provides that the Department may make necessary inquiries to investigate such complaints. The section also authorizes the Department to conduct compliance audits and clarifies that 28 TAC Chapter 12 does not limit the ability of the Commissioner of Workers' Compensation or TDI-DWC to make inquiries, conduct audits, or receive and investigate complaints against IROs or personnel employed by or under contract with IROs to perform independent review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules.

§12.302. Administrative Violations. Section 12.302 sets forth regulations governing the prosecution of administrative violations. The section allows the Department or TDI-DWC to initiate proceedings under 28 TAC Chapter 12 or the Labor Code Title 5 and TDI-DWC rules. This section also sets forth the penalties that the commissioner may impose if a violation has occurred. The section also clarifies that 28 TAC Chapter 12 does not limit the ability of the Commissioner of Workers' Compensation or TDI-DWC to make inquiries, conduct audits, receive and investigate complaints, and take all actions permitted by the Labor Code against IROs or personnel employed by or under contract with IROs to perform independent review to determine compliance with the Labor Code Title 5 or applicable TDI-DWC rules.

§12.303. Surrender of Certificate of Registration. Section 12.303 sets forth the requirement for an IRO to surrender its certificate of registration while the IRO is under investigation or as part of an agreed order. The section defines "investigation," clarifies that a certificate of registration that is surrendered under §12.303 is temporarily suspended while the investigation is pending, and states that independent reviews shall not be assigned to an IRO during a surrender of the IRO's certificate of registration. The section also clarifies that confidentiality requirements still apply during the surrender of an IRO's certificate of registration. Finally, this section only applies to an IRO that is licensed on or after December 26, 2010 or has its certificate of registration renewed in Texas on or after December 26, 2010.

§12.402. Classification of Specialty. Section 12.402 divides specialty classifications of independent review into two tiers for purposes of setting fees.

§12.403. Fee Amounts. Section 12.403 sets forth fee amounts for the two specialty classification tiers prescribed by §12.402. Section 12.403(b) clarifies that the fees in this section include an amended notification of decision if the department determines the initial notification of decision is incomplete. The amended notification of decision shall be filed with the Department no later than five working days from the IRO's receipt of notice from the Department that the initial notification of decision is incomplete.

§12.404. Payment of Fees. Section 12.404 sets forth information regarding the payment of fees established in this subchapter.

§12.405. Failure to Pay Invoice. Section 12.405 addresses the failure of payors to pay invoices for the independent review within a certain timeframe and sets forth applicable enforcement actions and penalties.

§12.406. Certificate of Registration and Renewal Fees. Section 12.406 sets forth the fees for an application for a certificate of registration or renewal of a certificate of registration.

§12.501. Requests for Independent Review. Section 12.501 sets forth the manner in which requests for independent review are made to the Department.

§12.502. Random Assignment. Section 12.502 describes the procedure for random assignment of requests for independent review to IROs by the Department. Subsection (b) requires the Department to screen payors and URAs for potential conflicts of interest with the IRO before making an assignment to the IRO. Subsection (f) provides that independent reviews will not be assigned (i) to an IRO during the 30 days prior to the anniversary date of the issuance of the IRO's certificate of registration unless the completed application for renewal of its certificate of registration and the application fee have been received by the Department; or (ii) during the time that an IRO has surrendered its certificate of registration pursuant to §12.303 and the Insurance Code §4202.002(c)(2)(B).

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

General Comments.

Comment: Three commenters express their support and appreciation for the Department's rulemaking efforts. The first commenter supports the Department's efforts to amend these rules since many of the amendments are required to implement statutory amendments under HB 4519 and HB 4290.

A second commenter states that the rules as proposed adequately implement HB 4519 and HB 4290 and will strengthen the IRO statute for Health and Workers' Compensation. Revising the definition of "adverse determination" by including determinations regarding the experimental or investigational nature of a service will assist health care consumers by providing for the independent review of claims that previously were denied without such recourse. This commenter supports the adoption of the rules as proposed.

A third commenter has a keen interest in advocating for insurance reform measures directed at patient and consumer protection. The commenter strongly supports the additional patient protections provided in HB 4519 and HB 4290, which include additional conflicts of interest provisions applicable to IROs and which extend the requirements of independent review to health care services deemed "investigational or experimental" by health insurers, as well as to retrospective determinations.

Agency Response: The Department appreciates the supportive comments.

Comment: Two commenters ask that the Department request an Attorney General Opinion regarding the constitutionality of the new regulations to ensure the Department's regulations do not violate the U.S. Constitution and/or damage the current IRO system. One commenter specifically requests that the following issues be addressed by an Attorney General Opinion: (i) the provision requiring a voluntary suspension of a license while an IRO is under investigation; (ii) the prohibition on out-of-state IROs engaging in business in Texas; (iii) the requirement that a registered agent cannot be employed to represent the IRO; and (iv) the economic impact statement and regulatory flexibility analysis conducted by the Department. Both commenters further request

the Department to suspend the implementation process pending such review. The second commenter states that legal action may be taken to challenge the constitutionality of the rules once adopted.

Agency Response: The Department declines to seek an Attorney General Opinion and asserts that the rules do not violate the U.S. Constitution. The Department is implementing the requirements of HB 4519, which, et alia, requires the commissioner to adopt standards and rules that require (i) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (ii) an IRO to be based and certified in this state and to locate the organization's primary offices in this state. The right to conduct independent reviews is a statutory right. A licensee does not have a vested right in the continuation of laws. The Legislature may, in the exercise of the police power, regulate by reasonable requirements the conduct of IROs and, by proper grant, delegate the exercise of police power to the Department. The exercise of the police power hinges upon the public need for safety, health, security, and protection of the general welfare of the community. When there is a public interest involved, the rights of individual licensees may yield to the overriding public interests and are regulated under the state's police power.

Regarding the issue of voluntary surrender, the Department has revised §12.303 by (i) removing the terms "voluntary" and "voluntarily"; (ii) adding subsection (c) to state, "A certificate of registration that is surrendered under this section is temporarily suspended while the investigation is pending;" and (iii) adding subsection (f) to state, "Notwithstanding §12.4(b) of this chapter (relating to Applicability), this section only applies to an independent review organization that: (1) is licensed on or after December 26, 2010; or (2) has its certificate of registration renewed in this state on or after December 26, 2010."

The Department has removed the terms "voluntary" and "voluntarily" to clarify that the surrender is required and to avoid confusion as to whether the surrender is mandatory or voluntary. Additionally, the Department has provided that a certificate of registration that is surrendered under §12.303 is temporarily suspended while the investigation is pending, clarifying that the certificate of registration is not permanently revoked without due process of law. This temporary suspension of rights may be necessary to protect the patients whose claims are being reviewed by the IRO and to avoid harm to the patients. Finally, the addition of subsection (f) makes this provision only applicable to IROs newly licensed on or after December 26, 2010 or to existing IROs upon renewal of their certificates of registration on or after December 26, 2010. Thus, any potential applicant will be aware of the surrender process set forth in §12.303 before deciding whether to apply for licensure or renewal.

Regarding the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas, it is important for the regulation of IROs conducting independent reviews in this state that the records be available for on-site examinations. The Department could incur substantial costs in conducting on-site examinations if the necessary records were located out of state, and untimely delays in examinations could result in the destruction of records. However, to avoid an unnecessarily broad application of this provision, the Department has amended §12.5(28) to define "primary office" as "the place where, based upon the totality of the business activities related to independent review performed under this chapter, an independent review organization's books and records pertaining to independent reviews assigned by the Department are stored." Additionally, the Department has amended §12.103(10) to state, "(10) for an application for a certificate or renewal of registration as an independent review organization in this state made on or after December 26, 2010, evidence that the applicant's primary office is located in this state. As a condition of being certified to conduct the business of independent review in this state, an independent review organization must locate its primary office in this state." These revisions narrow the definition of "primary office" and apply the requirement that the primary office be located in Texas only to applicants for a new license or renewal on or after December 26, 2010. Thus, any potential applicant will be aware of the primary office requirement set forth in §12.103(10) before deciding whether to apply for licensure or renewal. This revision to §12.103(10) also removes the requirement that Form No. LHL006 include evidence that the applicant is *based* in Texas. However, the Department asserts that removal of the "is based" language still complies with the HB 4519 requirement that the commissioner adopt standards and rules that require an IRO to be based and certified in this state and to locate the organization's primary offices in this state. It is the Department's position that the "is based" language does not necessarily require the IRO's headquarters to be located in Texas, but that the IRO's records related to independent reviews conducted in Texas be located in Texas. Since the records are already accounted for in the requirement that the primary office be located in Texas, including the "is based" language would be redundant. Further, the IRO is still required to be certified in Texas, as set forth under 28 TAC Chapter 12, Subchapter B.

The Department has considered proposed §12.204(h) further and has determined that the provision governs the practice of law by limiting the conduct of certain licensed attorneys in the state of Texas. Because the Department's regulatory authority does not extend to the practice of law, the Department has deleted this provision. Therefore, there is no need to seek an Attorney General Opinion on this provision, as one of the commenters requests.

The Department has revised §12.204 by adding a new subsection (h), which states, *"Notwithstanding §12.4(b) of this chapter (relating to Applicability), the prohibitions in subsections (c) - (g) of this section apply only to: (1) an independent review organization that: (A) is licensed on or after December 26, 2010; or (B) has its certificate of registration renewed in this state on or after December 26, 2010; and (2) an individual or entity whose activity involves an independent review organization that: (A) is licensed on or after December 26, 2010; or (B) has its certificate of registration renewed in this state on or after December 26, 2010."* This change makes §12.204(c) - (g) applicable only to IROs whose certificate of registration is issued or renewed on or after December 26, 2010 or to individuals or entities whose activity involves an IRO whose certificate of registration is issued or renewed on or after December 26, 2010. This change was in response to the general comment that legal action may be taken to challenge the constitutionality of the rules once adopted. The Department's revision clarifies that the requirements in §12.204(c) - (g) only apply to IROs that are licensed or whose certificates of registration are renewed on or after December 26, 2010 or to individuals or entities whose activity involves an IRO that is licensed or whose certificate of registration is renewed on or after December 26, 2010. This revision avoids disruption of any expectations, rights, or privileges under or related to a current certificate of registration that has already been issued to an IRO and has not yet expired.

Finally, the Department has complied with the Government Code §2006.002, which requires the Department to reduce the adverse economic effects on small or micro businesses if doing so is legal and feasible considering the purpose of the statute under which the rule is to be adopted. The Department prepared an economic impact statement estimating the number of small and micro businesses subject to the proposed rule, projecting the economic impact of the rule on these entities and describing the alternative methods of achieving the purpose of the proposed rule. The Department also prepared a regulatory flexibility analysis that included the Department's consideration of alternative methods of achieving the purpose of the proposed rule. The Department estimated in the proposal that approximately 35 IROs of the 43 IROs that are currently certified are small or micro business IROs. Making the rules inapplicable to such a large number of IROs would effectively negate the provisions, and in most cases the rule would not serve its intended purposes. Requiring such a small number of IROs to comply with the rules would result in an unfair competitive market and unfair loss of income for a few IROs. Therefore, the Department declines to seek an Attorney General Opinion on the economic impact statement or regulatory flexibility analysis, which already meet the requirements of the Government Code §2006.002.

Comment: Three commenters request that the implementation of the rules be delayed for reasons other than to await an Attorney General's Opinion. Two commenters assert that the newly passed federal healthcare legislation will almost certainly require the Texas Legislature to address many of the issues raised by these rules in the upcoming legislative session. These commenters strongly believe implementation of these proposed rules should be delayed pending further legislative action. One of these two commenters further states that the current system is working very well. The commenter's IRO has a good record of compliance. Although the commenter acknowledges that the rules are proposed pursuant to the statutes, the commenter asserts that these rules are designed to reduce competition. The second commenter states that the purpose of the law was to prevent people from gaming the system. This commenter does not fault the Department for drafting the rules because they are consistent with the statutes. However, none of the 18 IROs that are members of AAIRO were aware of the legislation when it was passed. There was not enough stakeholder input. As a result, the Department has instructions from the Legislature to do things that are problematic. The law says that the Department shall make rules to make the conduct illegal. The Legislature instructed the Department to make rules as opposed to simply stating the prohibitions in the law, and with that responsibility the Department should ensure that the rules do not have unfair impact on people currently operating in the state who have such a good track record with the Department and have contributed to a system that is doing very well.

A third commenter believes that IROs are here in Texas to address situations when doctors are abusing the system by giving care that is not needed or when a patient needs care. The commenter further asserts that this law was passed by one or two IROs for personal gain to decrease competition. Texas should be the gold standard in the country for IROs. According to the commenter, adopting these rules will not accomplish that objective.

Agency Response: The Department declines to delay the implementation of the proposed rules. The Department acknowledges that federal legislation under the Patient Protection and Affordable Care Act requires a group health plan and a health insurance issuer offering group or individual health insurance coverage to comply with the applicable State external review process for such plans and issuers that, at a minimum, include the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners. The federal Department of Health and Human Services (HHS) has issued "Technical Guidance For Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review For Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act" that deems Texas' external review process compliant with federal law and regulations regarding external review processes until July 1, 2011. HHS has indicated that additional regulations to accompany this statutory provision will be promulgated. This federal legislation, along with the anticipated regulations, may require further Texas statutory amendments. Therefore, the Department awaits additional guidance and authorization from the Texas Legislature to implement changes related to the federal legislation.

Additionally, as two of the commenters note, the rules are consistent with the statutory language in HB 4519. As additional legislation is passed relating to IROs, the Department will continue to implement such legislation as authorized.

§12.5. Definitions.

Comment: Two commenters recommend revising the definition of "adverse determination." The first commenter recommends revising the definition to track the definition in Texas Insurance Code §4201.002(1) which reads: "Adverse determination" means a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational."

The second commenter recommends that §12.5(1) be revised to the following: "Adverse determination - a determination *by an insurance carrier or* by a utilization review agent made on behalf of any payor that health care services provided or proposed to be provided to a patient are not medically necessary or appropriate, or are experimental or investigational." This commenter cites the following reasons for the suggested change: (i) this revision recognizes that an adverse determination may be made by a workers' compensation insurance carrier in addition to a URA; and (ii) Title 28 TAC §133.308(i) addresses timeliness of a request for an IRO in a workers' compensation claim and it provides in relevant part: "A requestor shall file a request for independent review *with the insurance carrier (carrier) that actually issued the adverse determination* or the carrier's utilization review agent (URA) that actually issued the adverse determination no later than the 45th calendar day after receipt of the denial of reconsideration" (emphasis added); although it appears that a URA generally makes the adverse determination, even in workers' compensation cases, the plain language of §133.308(i) demonstrates that the insurance carrier may also issue the adverse determination.

Agency Response: The Department declines to revise the definition of "adverse determination." The definition's inclusion of the phrase "made on behalf of any payor" clarifies that the definition includes those payors who conduct utilization review in-house. The Department asserts that adverse determinations should include determinations made on behalf of all payors, and the first commenter's suggested language would remove this clarifying language. The Department agrees with the second commenter that an adverse determination may be made by a workers' com-

pensation insurance carrier but asserts that insurance carriers are already accounted for in the phrase "made on behalf of any payor." If the text included "by an insurance carrier or," it would also have to include other entities that could perform utilization review, such as third party administrators. To avoid having to produce an exhaustive list of entities, the language "made on behalf of any payor" encompasses all entities that can perform utilization review.

Comment: A commenter recommends that the Department delete the definition of "evidence-based medicine" in proposed §12.5(10) and its later use in the definition of "evidence-based standards" in proposed §12.5(11). In the alternative, the commenter strongly recommends that the Department modify the language to ensure that it is focused on medical and clinically-oriented research as follows: "Evidence-based medicine--The use of current best quality *clinically-based* scientific and medical evidence formulated from credible *medical and* scientific studies, including *studies published in* peer-reviewed medical literature and other current *clinically-oriented* scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." The commenter cites the following reasons for the suggested deletion or alternative text: (i) there is no current consensus as to a definition for "evidence-based medicine"; (ii) although many of the definitions added by the Department in the proposed rules were modeled after the National Association of Insurance Commissioners (NAIC) Uniform Health Carrier External Review Model Act ("Model Act"), it is important to note that the NAIC itself does not include a definition of "evidence-based medicine" in its Act; rather, it only includes a definition of "evidence-based standard," which is also proposed by the Department in §12.5(11); and (iii) it is important to note that the NAIC's definition of "evidence-based standard" (unlike the Department's definition) does not include a reference to "evidence-based medicine."

Agency Response: The Department declines to make the requested deletions or the suggested changes. Although the Model Act does not include a definition of "evidence-based medicine," the Department's definition of "evidence-based medicine" does not conflict with the Model Act. The Labor Code §401.011(18-a) defines "evidence-based medicine" as "the use of current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients." The Department's inclusion of a definition for "evidence-based medicine" in the adopted rules harmonizes the text with the existing Labor Code provision.

Comment: A commenter recommends that proposed §12.5(21) be amended to clarify that an independent review of an adverse determination of health care provided through a workers' compensation health care network must be consistent with the network's treatment guidelines.

Agency Response: The Department declines to make the suggested change. An IRO is free to adopt any evidence-based review criteria it chooses for its independent review plan and only has to consider the treatment guidelines, treatment protocols, and pharmacy closed formulary adopted by TDI-DWC when deciding on what review criteria to adopt as part of its independent review. Under 28 TAC §133.308, if the IRO's decision is contrary to (i) the policies or guidelines adopted under the Labor Code §413.011, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of non-network health care; or (ii) the network's treatment guidelines, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care. Comment: A commenter strongly recommends that the reference to "peer-reviewed abstracts accepted for presentation at major medical association meetings" in proposed §12.5(21)(F) be retained in the definition of "Medical and scientific evidence." The commenter notes that although the Department's proposed definition of "medical and scientific evidence" in proposed §12.5(21) of the rules largely tracks the language of the NAIC's Model Act, it is unclear why the Department proposes the deletion. The commenter cites the following reasons for retaining this language: (i) the NAIC's failure to include peer-reviewed abstracts does not, per se, make the abstracts invalid as a source of medical and scientific evidence reviewable by IROs in the state of Texas; (ii) the Department previously considered the abstracts to be a valid source of medical and scientific evidence and, absent a compelling reason, should continue to do so; (iii) the fact that the abstracts are (a) peer reviewed, and (b) accepted for presentation at a major medical association meeting is sufficient indicia of reliability and acceptance in the medical community to warrant their consideration and use by IROs in their decision-making process; and (iv) to narrow the universe of acceptable material on which the aforementioned decisions are based may have the unintended result of unjustifiably restricting the consumer/patient's access to payment for health care services for which he or she contractually bargained and that he or she is, therefore, legally entitled to receive. The commenter cautions the Department not to unnecessarily restrict the universe of materials that may properly be considered as medical and scientific clinical evidence used by IROs in evaluating the medical necessity and appropriateness or the investigational/experimental nature of a health care service.

Agency Response: The Department agrees to retain "peer-reviewed abstracts accepted for presentation at major medical association meetings" in proposed §12.5(21)(F) (currently redesignated §12.5(22)(F)) in the definition of "Medical and scientific evidence" and has made the suggested change.

Comment: A commenter recommends that the Department modify proposed 12.5(21)(G) as follows: "(G) any other medical or scientific *clinical* evidence that is comparable to the sources listed in subparagraphs (A) - (E) [(F)] of this paragraph." The commenter suggests two modifications to subparagraph (G). First, the commenter recommends modifying subparagraph (G) to reference other medical or scientific clinical evidence that is comparable to the sources listed in subparagraphs (A) - (E), rather than (A) - (F). The commenter opines that subparagraph (F) is limited to and specifically tailored to independent review of adverse determinations of health care provided pursuant to Labor Code Title 5 (e.g., workers' compensation decisions). Thus, it would not make sense to consider "comparable" evidence to workers' compensation treatment guidelines, treatment protocols, etc. in the context of decisions falling outside of Labor Code Title 5.

The second modification limits the "comparable" scientific evidence considered to scientific evidence that is of a *clinical* nature. The commenter cites the following reasons for the suggested change: (i) the basic definition of scientific evidence contained earlier within the same section of the rule in subparagraph (A) refers to scientific evidence contained in medical journals, which necessarily implies a limitation to scientific evidence of a clinical nature; the addition of "clinical" to subparagraph (G) would make this limitation explicit as applied to "comparable"

scientific evidence and would ensure that subparagraph (G) is interpreted consistently with subparagraph (A); and (ii) without limiting the scientific evidence to clinical information, insurers may improperly argue that scientific evidence that is of a purely cost/efficiency nature or of an actuarial nature should be considered in the IRO process; consideration of cost/efficiency evidence would be contrary to the clinically-oriented decision-making process that must be undertaken when assessing medical necessity and/or whether a particular treatment is investigational or experimental.

Agency Response: The Department agrees in part and disagrees in part. The Department agrees that because proposed subparagraph (F) was limited to workers' compensation decisions, proposed subparagraph (G) should not have referenced proposed subparagraph (F). However, because the language under the previously adopted subparagraph (F) was reinstated as a result of a separate comment, proposed subparagraphs "(F)" and "(G)" were redesignated "(G)" and "(H)," respectively. Thus, the practical effect of leaving the reference to subparagraphs "(A) - (F)" within the text in newly redesignated subparagraph (H) is to exclude the reference to proposed subparagraph (F) (since it is now "(G)") as the commenter requested, without the need for an actual text change.

However, the Department declines to make the commenter's second suggested change to limit the "comparable" scientific evidence considered to scientific evidence that is of a *clinical* nature. Although the Department agrees that the scientific evidence is limited to that of a clinical nature, the inclusion of the word "clinical" is unnecessarily redundant.

Comment: A commenter recommends that the Department adopt the following definition of "medical necessity": "Medical necessity--All health care reasonable and necessary for the diagnosis or treatment of a mental or physical illness, disease or disorder or a physical deformity or injury." The commenter cites the following reasons for the suggested definition: (i) a definition of the term "medical necessity" is conspicuously absent from the definitions contained within §12.5; (ii) given the fact that rendering a final and binding decision based upon the "medical necessity" of health care services is a key function of an IRO, defining the term "medical necessity" in the regulations would provide needed guidance to IROs in fulfilling their statutorily-mandated charge; (iii) the definition of "medical necessity" should be specific enough to provide direction to IROs, while flexible enough to encompass the goal of the legislation regarding IROs, which is to provide broad oversight and fairness in rendering ultimate decisions regarding medical necessity; (iv) in constructing a definition of medical necessity, the Department should acknowledge and stay true to the clear distinction between medical necessity and coverage decisions; and (v) the definition would ensure that those health care services that are denied by insurers on "medical necessity" grounds are properly encompassed within the definition of "adverse determinations" that must be reviewed by independent review panels (if properly requested) and that a single standard of "medical necessity" is adhered to by IROs.

Agency Response: The Department declines to define "medical necessity." What constitutes "medical necessity" should be determined by a clinician on a case-by-case basis considering all of the relevant patient's medical records and medical evidence, not by the Department. The NAIC also declined to define "medical necessity" in the Model Act.

Comment: Two commenters request that §12.5(23) be revised as follows: "Patient--The enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy, or *an injured employee* [a person] entitled to receive workers' compensation benefits pursuant to the Labor Code Title 5." The commenters cite the following reasons for the suggested change: (i) health care providers are persons who receive the payment portion of the workers' compensation medical benefit, and injured employees are persons who received the health care service portion of the workers' compensation medical benefit; (ii) the use of the term "patient" for workers' compensation claims could lead to some confusion with the use of the term "person" in the definition of "patient" since "person" is defined in definition §12.5(25) to include corporations, associations, and similar business entities; (iii) the use of the term "injured employee" instead of "person" would avoid any confusion as to whether or not the term includes persons who receive payments for workers' compensation medical benefits; and (iv) the use of the term "injured employee" would be consistent with draft Department rules regarding URAs currently under consideration.

Agency Response: The Department agrees and has made the suggested change.

§12.103. Information Required in Application and Renewal Form.

Comment: Three commenters state that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas is in violation of the Commerce Clause of the U.S. Constitution as discussed in *Lewis v. BT Inv. Managers,* 447 U.S. 27 (U.S. 1980). In that case, at issue was a regulation that bank holding companies domiciled outside of Florida could not purchase banks in Florida. The U.S. Supreme Court found this prohibition "directly burdens interstate commerce in a manner that contravenes the Commerce Clause's implicit limitation on state power." *Id.q at 44.* Three other commenters oppose the provision as unnecessary.

One commenter requests that the constitutionality of this provision be addressed by an Attorney General Opinion and further elaborates that although a State's power to regulate the business of insurance is broadened by the McCarran-Ferguson Act, this extended power does not grant the Department the power to restrict all out-of-state IROs from engaging in business in Texas. The McCarran Ferguson Act was adopted by Congress to allow the states to regulate and tax the business of insurance. There are three criteria relevant in determining whether a particular practice is part of "business of insurance" exempted from antitrust laws by section of McCarran-Ferguson Act which are (1) whether practice has effect of transferring or spreading a policyholder's risk, (2) whether practice is integral part of policy relationship between insurer and insured, and (3) whether practice is limited to entities within the insurance industry. McCarran-Ferguson Act §2(b), 15 U.S.C.A. §1012(b) (1945). According to the commenter, based on these criteria an IRO is not an insurance entity in the "business of insurance," and therefore is not exempted from federal regulation under the McCarran-Ferguson Act. Furthermore, the 5th Circuit has held that the IRO provisions reflect Texas' effort to mandate and regulate the quality of medical care for a covered condition and are not a system for implementing a mandated term of insurance regulating a minimal standard of care. *Corporate Health Ins., Inc. v. Texas Dept. of Ins.,* 220 F.3d 641, 644 (5th Cir. 2000).

Determining that the McCarran-Ferguson Act does not protect an IRO or regulation of an IRO, §12.103 of the proposed rule

imposes a substantial burden on interstate commerce and is therefore unconstitutional. The commenter has not seen any evidence that out-of-state IROs pose any problems within the regulatory confines of this state. Department staff has not offered any testimony or indications that out-of-state IROs have been a problem.

Absent a determination that §12.103 is unconstitutional, the commenter recommends removing "is based" in §12.103(10) and amending §12.103 to read as follows: "(10) Evidence the Independent Review Organization has a primary office physically located in this State, and that this is reported and declared as the Business Office of the IRO in the IRO's Application for Certification, and in annual renewal statements, and that at any time that this address is changed, that TDI be notified 10 days prior to the change of such Business Address. The primary office of an IRO shall be the physical Business Address of the IRO that is declared in the Application for Certification as an IRO, must be where the management of the processes of independent review occur, and the location where corporate records case files, and files containing information on the Medical and Reviewers of the IRO are maintained. With regard to credentialing and case files, IROs must maintain at the primary office documents that demonstrate that all Reviewers on the IRO's medical review panel are licensed to practice in the State of Texas, and that, on a case by case basis, the IRO has assigned fully credentialed Reviewers to each case, and that reviewer has signed no conflict of interest statements." Further, the commenter suggests that entities that were certified prior to the new Code shall have a grace period of 120 days to comply with the new law. During this grace period, an IRO will have the option of opening a primary office for independent review in Texas, or of selling the IRO to an owner in Texas who agrees to open a primary office, as defined above. During this grace period, which would begin on the date of the adoption of the new rules, the IRO would continue to be required to follow rules currently in effect, not the new proposed rules.

The commenter cites the following reasons for the suggested change: (i) unless this matter is deemed unconstitutional, the commenter understands that IROs will be required to comply with the Insurance Code §4202.002(c)(2)(A) provision mandating that an IRO's primary office be located in the State; however, the commenter believes that proposed language offered for implementing this Insurance Code provision does not provide sufficient guidance to operating IROs; (ii) the current language suggests that the actual medical reviews take place at the primary office which is a practical impossibility; and (iii) it should be clarified that IROs may maintain a separate mailing address in order to avoid inappropriate visits from an interested patient, which could jeopardize the independence of the process.

The second commenter states that if we eliminate the out-of-state IROs, we are going to lose their knowledge. These IROs were involved in drafting federal legislation. The small out-of-state IROs cannot afford to move to Texas. The large IROs are not going to move either, because the IRO business in Texas is not lucrative enough. This portion of the law is unnecessary. The first two levels of review are by URAs, who are located all over the country. The federal legislation is going to change the game completely. The out-of-state IROs were not involved in the stakeholder meetings. Some IROs did not know that the law had been passed.

The third commenter states the following reasons that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas should be deleted: (i) the commenter's out-of-state IRO consistently receives 100% on its report card issued by the Department; (ii) the commenter's IRO has done nothing unscrupulous and can be trusted; (iii) the IRO has learned and abided by all of the rules and regulations of the Department that govern the IRO business and, to the commenter's knowledge, has never had a complaint filed against it; (iv) the commenter sees no public purpose for this new law; (v) the law was written by another IRO owner who was trying to increase his own business by putting out-of-state IROs out of business; and (vi) this regulation does nothing to help the patients of Texas get fairness in the health care process, which is what we should be spending time and energy discussing.

The fourth commenter states that if the number of IRO cases is going to increase, now is not a good time to eliminate IROs. Some of the out-of-state IROs are big IROs that conduct business nationally, and the commenter asserts that they are good companies. The commenter further states that there is no indication that out-of-state IROs posed a problem.

The fifth commenter states the following reasons for deleting the requirement that the IRO be based in Texas: (i) the commenter's IRO received a 100% score in Department rankings; (ii) the IRO has never had a complaint filed against it by a patient, provider, insurance company, or URA; (iii) working with the Department is a pleasure under current rules; (iv) URAs that are similarly regulated by the Department are located all over the country; (v) one IRO owner is trying to manipulate the system for his own personal gain; (vi) there are numerous other out-of-state IROs that will be forced to relocate under this provision in order to keep their IRO business in Texas; (vii) for the commenter's family to relocate, it would cost tens of thousands of dollars and the commenter's wife would not be able to keep her job; therefore, the commenter would be forced to sell his IRO; and (viii) the effect of this regulation would be to eliminate 20% of the IROs certified in Texas, bringing less competition and less independence to the system; with the new federal legislation, Texas will need more IROs, not less, to deal with the expanding system.

A sixth commenter cited the following reasons for deleting this requirement: (i) forcing a company to move its office to Texas puts an unnecessary financial strain on the company; (ii) people working for these companies will undoubtedly lose their jobs as a result of this provision, further worsening the economy; and (iii) many of the top rated IROs will no longer find it financially feasible to do Texas independent reviews and the Department will lose these quality reviewers.

Agency Response: The Department agrees in part and disagrees in part. The Department disagrees that the case law on which the commenter relies supports the proposition that an IRO's activity is not considered the "business of insurance" or that the requirement in §12.103 that an IRO must be based in Texas and have its primary office in Texas violates the Commerce Clause of the U.S. Constitution. The right to conduct independent reviews is a statutory right. A licensee does not have a vested right in the continuation of laws. The Legislature, in HB 4519, required the commissioner to adopt standards and rules that require an IRO to be based and certified in this state and to locate the organization's primary offices in this state. The Legislature may, in the exercise of the police power, regulate by reasonable requirements the conduct of IROs and, by proper grant, delegate the exercise of police power to the Department. The exercise of the police power hinges upon the public need for safety, health, security, and protection of

the general welfare of the community. When there is a public interest involved, the rights of individual licensees may yield to the overriding public interests and are regulated under the state's police power. It is important for the regulation of IROs conducting independent reviews in this state that the records be available for on-site audits. The Department would incur substantial costs in conducting on-site audits if the necessary records were located out of state, and untimely delays in audits could result in the destruction of records.

However, as previously discussed in response to the requests that the Department seek an Attorney General Opinion, to avoid an unnecessarily broad application of this provision, the Department has amended §12.5(28) to define "primary office" as "the place where, based upon the totality of the business activities related to independent review performed under this chapter, an independent review organization's books and records pertaining to independent reviews assigned by the Department are stored." Additionally, the Department has amended §12.103(10) to state, "(10) for an application for a certificate or renewal of registration as an independent review organization in this state made on or after December 26, 2010, evidence that the applicant's primary office is located in this state. As a condition of being certified to conduct the business of independent review in this state, an independent review organization must locate its primary office in this state." These revisions narrow the definition of "primary office" and apply the requirement that the primary office be located in Texas only to applicants for a new license or renewal on or after December 26, 2010. This revision to §12.103(10) also removes the requirement that Form No. LHL006 include evidence that the applicant is based in Texas, as the first commenter requests.

Additionally, the revision imposes the requirement that the primary office be located in Texas only on applicants for a new license or renewal on or after December 26, 2010. Thus, any potential applicant will be aware of the primary office requirement set forth in §12.103(10) before deciding whether to apply for licensure or renewal. Although in some instances this applicability date may result in a shorter time period than the 120 day grace period the commenter suggests, in other cases it may create a longer time period with which to comply.

The Department's revision to the definition of "primary office" addresses the first commenter's request that books and records should be maintained at the primary office. This revision should also alleviate the commenter's concern that the rule requires actual medical reviews take place at the primary office, which was not the Department's intent.

Finally, the Department agrees that IROs may maintain a separate mailing address to avoid unexpected visits from patients, but asserts that a revision to the text is unnecessary. Regardless of whether a separate mailing address is maintained for patients, the IRO should provide the Department with the correct physical address for regulatory purposes.

Comment: A commenter suggests adding the following subparagraph to §12.103: "(11) information related to out-of-state licensure of legal process. All applicants must furnish a copy of the Certificate of Registration or other licensing document from the domiciled state's licensing authority. As a condition of being certified to conduct the business of independent reviews in this State, an Independent Review Organization must locate its primary office in this State."

Agency Response: While the Department declines to use the commenter's language, the Department has revised §12.103(10) in a way that is consistent with some of the commenter's suggested language. As previously discussed, the Department has amended §12.103(10) to state, "(10) for an application for a certificate or renewal of registration as an independent review organization in this state made on or after December 26, 2010, evidence that the applicant's primary office is located in this state. As a condition of being certified to conduct the business of independent review in this state, an independent review organization must locate its primary office in this state." However, the Department does not intend on accepting a copy of a foreign Certificate of Registration as the only other required criterion for an IRO to conduct business in Texas.

§12.106. Qualifying Examinations.

Comment: Two commenters request that §12.106 be amended to require the Department to provide fair and timely notice of an impending audit by the Department staff. The first commenter requests that the following text be added to §12.106: "The department shall notify an IRO of a pending routine audit no later than 60 days before the audit is performed. The department shall specify which patient and/or doctor files it wants to audit, in writing, by certified letter and/or facsimile. The department shall notify an IRO of a targeted audit no later than 30 days before the audit is to be performed. The department shall specify which patient and/or doctor files it wants to audit, in writing, by certified letter and/or facsimile. In the case of imminent danger to the public, including but not limited to, patient confidentiality breaches, late findings on life threatening issues and other issues that are deemed to be an emergency, the department may perform an on-site audit with 2 working days notice. In such a case, the department shall specify the issue(s) to the IRO and why such issues are a danger to the public. The IRO must be notified by facsimile, email and/or certified letter of the pending audit. The department shall specify which patient and/or doctor files it wants to audit in the notification to the IRO. All notifications given by the department for on-site audits shall be calculated in calendar days. All deadlines for submission for both the IRO and the department are measured in calendar days. The department shall respond to the audit and all of its components within 10 days of the audit. Should the department be unable to do that, the department shall notify the IRO of the expected date of completion."

The second commenter recommends that the following language be added to the rule: "The commissioner or the commissioner's [his or her] designee may conduct an on-site qualifying examination of an applicant as a requirement of certification or a renewal of certification as an independent review organization. Documents *that support the application for the certificate of registration or renewal of the certificate of registration* must be available for inspection at the time of such qualifying examination at the primary office [administrative offices] of the independent review organization. *The commissioner or the commissioner's designee shall provide adequate notice of the intent to conduct an on-site qualifying examination of an applicant for certification or renewal of certification that is not less than 30 days notice."*

The first commenter cites the following reasons for the suggested change: (i) the suggested language informs the IRO of what to expect; (ii) in the past, the rule has only pertained to new licensees and now the department is including those

IROs who apply for renewal; the suggested language offers a clarification in absence of published "Principles and Policies" regarding on-site audits; (iii) these audits are stressful, consume enormous amounts of time for the IROs to comply with the requested audit deadlines and the audits are arbitrary in how they are performed at this time; (iv) some IROs have been given as little as 24 hour notice and lacked life-threatening issues, while others have been given 2 months to prepare for the audit; (v) the "gotcha" aspects of the targeted audits are disturbing and interfere with the ability of the IRO to perform its normal duties while trying to find archived information, as requested by the Department, with the audits being performed by Department staff; (vi) there has been no imminent danger to the public which the department has identified in recent audits; and (vii) the suggested addition will create standards for such audits.

The first commenter further states that the intent is not to stop audits, and that the audits are a good thing that make the IROs more accountable and prevent them from being or becoming a danger to the public. The commenter further argues that the department has clear authority to make the suggested change without legislative intervention.

The second commenter cites the following reasons for the suggested change: (i) the proposed rule does not include any provision that requires Department staff to give fair and timely notice of the intention of the Department to audit an IRO who is seeking to renew their certificate as an IRO; (ii) the failure to give adequate notice to an entity regulated by the Department of an on-site audit may result in a waste of valuable resources and time of both the audited entity and the Department staff; and (iii) it is not fair nor is it prudent use of state resources to not give a regulated entity fair and timely notice of an audit whether that audit is a desk audit or on-site audit.

Agency Response: The Department declines to make the suggested change. The Department needs to maintain flexibility in its ability to monitor regulated entities, such as IROs, for compliance with statutory and regulatory requirements imposed on those entities for the protection of the patient. If a certain amount of advance notice would allow for an IRO to destroy records or otherwise alter evidence, the examination may not serve the intended purpose under certain circumstances. The Department recognizes the need for flexibility to work with the IRO on the starting date of the examination, as the circumstances allow. Additionally, there is no specific statutory requirement for advance notice.

§12.110. Effect of Sale of an Independent Review Organization.

Comment: A commenter requests that §12.110 be deleted. Two commenters, including the one requesting deletion of this section, state that the certificate is integral to the value of the IRO business. One of the key incentives for an IRO to provide exceptional service to the citizens of Texas is the potential to build the value of the business. The result of this provision is to virtually confiscate the value of the business, since the new owner would have to reapply for certification, rather than purchasing a fully functioning business entity with an established and efficient way of conducting business. This provision is not necessary to control the quality of IROs because the Department is informed when an IRO is sold or transferred and obtains information on the new owners. If an IRO was transferred to a person or entity to which the Department objects, it would be able to take appropriate action

One of these commenters further argues that this provision confiscates the value built up by IRO owners and amounts to a taking of their equity in a business. The proposed amendment to §12.110 is particularly troubling because it appears to prevent IRO owners from increasing the value of their businesses or selling them for a profit.

Agency Response: The Department declines to delete §12.110. This section is necessary to implement the requirement in the Insurance Code §4202.002(c)(2)(C) mandating the Commissioner to adopt standards and rules that require an IRO to apply for and receive a new certification after the organization is sold to a new owner. Additionally, the Department needs to ensure that the new owner is not a payor and to obtain fingerprint information on the new directors and officers before they engage in the business of independent review. While this information would be available to the Department after the IRO is sold, advance approval reduces the likelihood of consumer harm because of individuals to whom the Department would ultimately object.

§12.201. Independent Review Plan.

Comment: A commenter recommends that proposed §12.201(3)(A) be modified to read as follows: "(3) required use of written medically acceptable review criteria that are: (A) established with consideration, as appropriate, given to [based on] medical and scientific evidence and [utilize] evidence-based standards;. . . ." The commenter cites the following reasons for the suggested change: (i) this language will ensure that the purpose of the HB 4290 is fulfilled; (ii) proposed §12.201(3)(A) will be consistent with 12.201(3)(B), which requires the review criteria to be "objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis;" (iii) under current §12.201, the components of the independent review plan are somewhat broadly-defined (presumably in order to provide flexibility in their application); (iv) under the current regulations, the independent review plan must be developed with input from appropriate health care providers and reviewed and approved by physician, which is similar to the statutory requirement for utilization review plans under Texas Insurance Code §4201.151; (v) the Department's proposed modifications to §12.201 provide an extra layer of detail and, unfortunately, inflexibility to the independent review plan by requiring that the plan use written medically acceptable review criteria that are "based on medical and scientific evidence and utilize evidence-based standards;" (vi) as proposed, the standards established by 12.201(3)(A) may be too rigid to account for varying circumstances and emerging science in the practice of medicine; (vii) although the commenter supports the consideration and use of appropriately tested and peer-reviewed evidence in making independent review determinations, given that the practice of medicine is an art as well as a science, it is critical that the proposed rules not be overly prescriptive in the use of so called "best evidence" to the detriment of payment for the provision of sound patient care; (viii) to require a strict adherence to the evidence-based standards would sacrifice legitimate determinations concerning medical necessity and the investigational/experimental nature of a particular treatment or drug in favor of uniform (if, sometimes, inaccurate) decisions using so-called "evidence based standards;" (ix) the Department must be mindful that what is the "best evidence" today may be outdated tomorrow and that which is the cutting edge today may be the state of the art and then the standard practice tomorrow; (x) the rules must be flexible enough to acknowledge a wide array of treatments and services that have been proven

to be beneficial to patients; (xi) without providing for adequate flexibility in the rule, the review criteria required under the rule may be so stringent that many appropriate and beneficial health care services will be inaccurately classified as investigational or experimental, while HB 4290 was designed to ensure that those health care services that insurers deemed "investigational" or "experimental" were properly reviewed by an IRO; (xii) this modification would be consistent with the NAIC Model Act's focus on reviewing guidelines, as appropriate, when making the independent review determination; and (xiii) modification would be consistent with subparagraph (E) which requires the review criteria to be used only as a tool in the review process (and not determinative of the ultimate decision).

Agency Response: The Department agrees with the commenter that proposed §12.201(3)(A) was too rigid, as evidence-based medicine may not be available in every situation and thus cannot always be relied upon. The Department also clarifies that nothing in these proposed rules prohibits injured employees from obtaining reasonable and necessary investigational or experimental medical treatments or services when appropriate under Labor Code, Title 5. However, the Department asserts that evidence-based standards should be used when available. The Department has revised §12.201(3)(A) to state, "(A) based on medical and scientific evidence and utilize evidence-based standards, or if evidence is not available, generally accepted standards of medical practice recognized in the medical community."

Comment: Two commenters recommend that §12.201(3)(D) be amended to read as follows: "(D) [developed based on consideration of] *including* the treatment guidelines, treatment protocols, and pharmacy closed formulary as provided in orders issued or rules adopted by TDI/DWC, including Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments) and Chapter 137 of this title (relating to Disability Management) for *review of workers' compensation non-network* health care provided pursuant to the Labor Code Title 5; *and including the treatment guidelines, treatment protocols, and return-to-work guidelines adopted by certified workers' compensation health care networks for review of workers' compensation network health care."*

A third commenter recommends that: (i) the amended rules are consistent with the requirements set out in §413.011 of the Labor Code and 28 TAC §137.100; (ii) the inclusion of language in the proposed rules that allows other "written medically acceptable review criteria" to be considered by the IRO doctor undermines the required use of the adopted treatment guidelines; this language should be deleted; and (iii) the amended rules should also require IRO doctors to consider and apply the DWC's closed drug formulary rules once the rules are adopted and the adopted treatment guidelines when reviewing medical necessity issues associated with the prescribing and use of prescription drugs.

The first two commenters disagree with §12.201 as written. These commenters assert that the proposed rule amendment suggests that the IRO is free to adopt any evidence-based review criteria it chooses for its independent review plan and only has to consider the treatment guidelines, treatment protocols, and pharmacy closed formulary adopted by TDI-DWC when deciding on what review criteria to adopt as part of its Independent Review Plan. This conflicts with the statutory standards for review of workers' compensation medical care as found in the Texas Labor Code and the Texas Insurance Code in the following respects: (i) Review of WC Non-network Health Care. The proposed rule does not require the IRO to include TDI-DWC adopted treatment guidelines, treatment protocols, and pharmacy closed formulary as part of the review criteria in its independent review plan. Consequently, the IRO may review workers' compensation non-network health care without considering the TDI-DWC adopted guidelines if it chose not to include those guidelines in the review criteria specified in its Independent Review Plan. This conflicts with the legislatively mandated review of workers' compensation non-network medical claims found in Labor Code §413.011 and conflicts with DWC Rule 137.100 which requires health care providers to provide medical care in accordance with the DWC adopted treatment guidelines. Consequently, the rule should direct the IRO to include the TDI-DWC adopted treatment guidelines, treatment protocols and pharmacy closed formulary in its review criteria and to utilize that review criteria for its review of non-network workers' compensation health care; (ii) Review of WC Network Health Care. Similarly, the proposed rule conflicts with Texas Insurance Code §1305.351 and 28 TAC §10.101(a) which requires that the review criteria used for workers' compensation network health care be consistent with the network's treatment guidelines, return-to-work guidelines and individual treatment protocols. Consequently, the rule should require the IRO to include the workers' compensation health care network adopted medical treatment guideline, return-to-work guideline, and individual treatment protocols as part of its review criteria and to utilize that criteria for its review of network workers' compensation health care. Pursuant to §1305.351 (a), "In the event of a conflict between Chapter 4201 and this chapter, this chapter controls." One commenter further notes that the rule should not allow an IRO to use other treatment guidelines or other "written medically acceptable review criteria."

The third commenter cites the following reasons for the suggested changes: (i) §413.011 of the Labor Code provides, in part, that the commissioner of workers' compensation by rule shall adopt treatment guidelines and return-to-work guidelines and may adopt individual treatment protocols; treatment guidelines and protocols must be evidence-based, scientifically valid, and outcome-focused and designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care; (ii) Title 28 TAC §137.100 requires health care providers to provide medical care in accordance with the DWC adopted treatment guidelines; (iii) with the provisions of the Labor Code §413.011 and 28 TAC §137.100 in mind, it is only appropriate that the IRO rule amendments require the use of the adopted treatment guidelines and not expand the scope of the IRO doctor's review beyond what the adopted treatment guidelines provide for; and (iv) use of other "written medically acceptable review criteria" would allow the IRO doctor to inappropriately ignore and unlawfully override the closed drug formulary rules and adopted treatment guidelines.

Agency Response: The Department declines to make the suggested changes. Section 12.201(3) requires the IRO to consider the treatment guidelines, treatment protocols, and pharmacy closed formulary as provided in orders issued or rules adopted by TDI-DWC. The IRO can consider other medically acceptable review criteria. The IRO is free to adopt any evidence-based review criteria it chooses for its independent review plan and only has to consider the treatment guidelines, treatment protocols, and pharmacy closed formulary adopted by TDI-DWC when deciding on what review criteria to adopt as part of its independent review plan. Under 28 TAC §133.308, if the IRO's decision is contrary to (i) the policies or guidelines adopted under the Labor Code §413.011, the IRO must indicate in the deci-

sion the specific basis for its divergence in the review of medical necessity of non-network health care; or (ii) the network's treatment guidelines, the IRO must indicate in the decision the specific basis for its divergence in the review of medical necessity of network health care.

Comment: A commenter recommends that the Department add to proposed §12.201(4) language establishing the standard for determinations that health care services are "investigational or experimental." Specifically, the commenter recommends the following language for inclusion in the IRO's independent review plan:

§12.201(4) "independent review determinations that:. . . (E) a health care service or treatment is investigational or experimental may only be made if the procedure, course of treatment or health care service lacks sufficient medical or scientific evidence of benefit for a particular condition. A procedure, course of treatment, or health care service is not "investigational or experimental" if it: (i) is generally accepted by the provider of record as effective and appropriate for the condition in question; or (ii) is supported by an overall balance of objective medical and scientific evidence, in which the potential risks and potential benefits are examined." The commenter asserts the following reasons for the suggested change: (i) adding such a definition would ensure that there is transparency and uniformity in the decision making process among IROs with regard to decisions concerning the investigational or experimental nature of a treatment; and (ii) this definition would be consistent with the goals of HB 4290 in requiring a meaningful review of treatments that insurers have denied based upon their findings that such treatments are investigational or experimental.

Agency Response: The Department agrees to include a definition of "experimental or investigational" but declines to use the commenter's suggested language. Instead of revising §12.201(4), the Department has defined "experimental or investigational" in §12.5(12) as "A service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care." The Department asserts that this definition is consistent with the commenter's suggested definition. This change also resulted in redesignating proposed §12.5(12) - (33) to §12.5(13) - (34), respectively.

Comment: A commenter recommends amending §12.201 by adding new subsection (5) as follows: "(5) a policy indicating that a treatment or service that has been approved by the U.S. Food and Drug Administration and commercially available for not less than two years shall not be considered experimental or investigational." The commenter cites the following reasons for the suggested change: (i) the proposed rule allows for denials based on a treatment being considered experimental or investigational to be appealed to an IRO; (ii) one of the stated goals of the legislation as cited in the rule preamble is "to ensure that carriers have consistent standards for what is considered experimental and investigational;" (iii) there is little consistency or rationality in how the insurance industry defines "experimental and investigational;" and (iv) while this addition would not directly change the policy of the health insurer or workers' compensation carrier directly, it should help forward the stated legislative goal of developing consistent standards since over time carriers and insurers may modify their policies to match this standard based on decisions that are rendered by IROs.

Agency Response: The Department disagrees with the suggested change. A treatment or service that has been approved by the U.S. Food and Drug Administration and has been available for a set time period could still be considered experimental or investigational. For example, a treatment or service could be approved because it does no harm to a patient, but it may not yet have been proven to cure a specific condition. Additionally, in response to a separate comment, the Department has defined "experimental or investigational" as "A service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care." The commenter's suggested change would be inconsistent with this definition.

Comment: A commenter suggests requiring and enforcing insurance carriers to forward all documents attached to the required LHL009 form, not simply those that the insurance carrier or URA feel is relevant, which are likely to be different than the documents that an injured employee believes are relevant. The commenter cites the following reasons for the suggested change: (i) IROs may be receiving information from insurance carriers that support only their position rather than all of the relevant information that the IRO needs to make an informed decision on the medical necessity issue under review; and (ii) while the IRO has the ability to request additional information, it appears such requests are not occurring.

Agency Response: The Department disagrees with the requested change. Such a requirement could be very onerous and result in the production of documents that are not relevant to anyone. The carrier or its URA is required to forward all documents relied upon in making the adverse determination. Any party can forward documents that are relevant to the adverse determination to the IRO for consideration.

Comment: A commenter recommends that the Department add to proposed §12.201(4) a requirement that independent review determinations be based upon consideration of relevant supporting documentation, including the patient's medical records, the recommendation of the provider of record and consulting reports. Specifically, the commenter recommends the following language: "§12.201(4): independent review determinations that: (D) are made taking into consideration, as appropriate and as available: (i) the patient's medical records; (ii) the recommendation of the provider of record; (iii) consulting reports from appropriate health care providers; and (iv) other documents submitted by the patient, the patient's authorized representative, or the patient's provider of record." This language is based upon consideration of documentation that must be reviewed by the independent review panel in the NAIC Model Act. This requirement provides additional guidance to independent review panels without being overly prescriptive in terms of the information that must be considered.

Agency Response: The Department declines to make the suggested change. The documentation that was reviewed and where the support comes from is already required.

§12.204. Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations.

Comment: Three commenters request clarification of the prohibition against the use of shared staff. The first commenter objects to this prohibition for the following reasons: (i) the use of shared clerical staff, a bookkeeper and tax accountant became

necessary in order to control costs and remain in business; (ii) the nature of processing quality reviews requires the skills and professionalism of an intelligent and responsible person; (iii) the small quantity of reviews currently assigned does not financially allow for full-time employment of such an individual even though the new rules require that such a person be made available to answer to all parties involved; (iv) by eliminating a clerical worker's right to work for more than one IRO, the rule is interfering with the worker's right to gainful employment; (v) the original law and the "Author's/Sponsor's Statement of Intent" makes no mention of shared clerical staff or prohibiting employment of staff by more than one IRO; HB 4519 is aimed at business owners and not staff workers; and (vi) sharing clerical staff has made it feasible for the commenter to maintain the best standards in qualify as the number one IRO in Texas, while also remaining in business.

The second commenter objects to the requirement that IROs not share clerical staff for the following reasons: (i) as the rule is written, an individual cannot use bookkeepers, accountants, transcriptionists, or contract labor if they are used by another IRO; (ii) an IRO could unwittingly violate this amendment; (iii) it is the right of every American to seek life, liberty and the pursuit of happiness; seeking to exclude a person from earning money in a paying job is an affront to the American way of life; this rule seeks to nullify this basic principle of the Declaration of Independence; (iv) an individual should not have his or her ability to work restricted without cause; (v) the prohibition is not found in the HB 4519 bill analysis and seems to be adding to the language of the statute; and (vi) it violates the Government Code §2006.002(c-1).

The third commenter requests that the Department clarify and define the terms "clerical staff," "office," "other facility," and "subcontractor services or personnel . . . to perform independent review." The commenter questions whether the term "subcontractor services or personnel . . . to perform independent review" means only the physician reviewer or whether it also encompasses transcription services and sort and summary services. The commenter asks whether a transcriptionist is a subcontractor utilized to perform independent review. The commenter further questions whether the prohibition of shared staff extends to independent contractors such as bookkeepers, accountants and transcriptionists. The commenter asserts that when considering the anticipated income of $1,931, it is economically feasible to share a part-time experienced independent contractor such as a bookkeeper or transcriptionist but would not be economically feasible to hire independent staff to mandate that the independent contractor cannot work for any other IRO performing similar duties. If the income is $1,931 and the cost of an office clerk averages $1,755, there are essentially no funds for additional staff members.

Agency Response: The Department declines to make any additional clarifications in §12.204 on the prohibition against shared staff. The Department disagrees that the rule prohibits the shared use of independent contractors. Section 12.204(c)(2) specifically states, "This prohibition does not extend to the use of subcontractor services or personnel employed by or under contract with the independent review organization to perform independent review."

Comment: A commenter recommends that to the extent that this rule will be in place as required by the statute, the term "facility" should be defined as "a space which has a separate entrance and is separated from another facility or another office completely by four walls, but not necessarily in a different building." The commenter asserts that prohibition of an IRO from operating in the same facility with another IRO or from sharing resources and personnel that comprise an office, while is required by statute, is likely unenforceable. The commenter is unable to ascertain a rational basis for this new provision. The commenter asserts that a failure to define "facility" will create numerous problems and ambiguity. For example, the commenter opines that it is obviously not the intent of the rule that IROs be prohibited from having an office in the same multi-office building, but under the current language, such an arrangement is unclear.

Agency Response: The Department declines to make the suggested change. The sharing of an office by more than one IRO could potentially erode the independence of the review process and/or compromise patient confidentiality. However, it is not the intent of §12.204 to prohibit the use of offices in the same multi-office building.

Comment: Two commenters argue that Section 12.204(h) appears to be in violation of the U.S. Constitution. Both commenters note that it is clearly unconstitutional unless the State can articulate a *compelling* reason for denying IROs the right to choose its own counsel. *Texas Catastrophe Property Ins. Ass'n v. Morales,* 975 F.2d 1178, 1181 (5th Cir. Tex. 1992) ("If the state can show 'compelling reasons,' then a party's right to choose its own (civil) counsel may be overridden."). See also Gates v. Cook, 234 F.3d 221, 227 (5th Cir. Miss. 2000) and *Rehabilitation Facility v. Cooper,* 962 S.W.2d 151, 156 (Tex. App. Austin 1998, no pet.). Since there does not seem to be a valid reason for §12.204(h), the first commenter, who has acted as a registered agent for two IROs, asserts that it is possible that §12.204(h) was specifically included in the bill to harm him personally because of past dealings with an individual who was involved in drafting the legislation. This provision, when enacted, will require the commenter to end representation of current IRO clients and to deny his clients the right to choose him as their attorney. There does not seem to be a logical reason or any public policy justification for §12.204(h). A registered agent simply accepts service for his or her client. Registered agents include attorneys, entity officers, professional services and others. There is a trust that has been built up and will be lost. It is also a long tradition that an individual should be able to select his own lawyer.

The second commenter recommends that the Department request an Attorney General Opinion on the constitutionality of this provision. Both commenters also note that there is no reference to what this regulation is intended to remedy.

Agency Response: As previously discussed in response to the requests that the Department seek an Attorney General Opinion, the Department has considered §12.204(h) further and has determined that the provision governs the practice of law by limiting the conduct of certain licensed attorneys in the state of Texas. Because the Department's regulatory authority does not extend to the practice of law, the Department has deleted this provision.

§12.205. Independent Review Organization Contact with and Receipt of Information from Health Care Providers and Patients.

Comment: Two commenters disagree with proposed §12.205(d) and request that it be deleted. The commenters cite the following reasons for the suggested deletion: (i) the proposed rule amendment implies that there is a requirement that the URA, carrier, or other payor must get pertinent medical information to the IRO within three working days of receipt of the IRO assignment; there is no such requirement in Chapter 4202 of the Texas Insurance

Code; (ii) there does not appear to be any purpose for imposing that reporting requirement on the IRO or imposing that implied filing requirement on URAs, carriers, or other payors; and (iii) the commenters can recognize a potential public policy reason to impose such a requirement for life-threatening conditions, but this subsection does not limit its application to life-threatening conditions and is not even necessary for life-threatening conditions in light of the IRO requirements found in §12.205(c).

Agency Response: The Department declines to delete §12.205(d). This revision was made to harmonize the rule with §133.308(l), which requires the carrier or the carrier's URA to submit specific documentation to an IRO not later than the third working day after the date the carrier receives the notice of IRO assignment.

Comment: A commenter requests that §12.205(f) be modified to clarify that an Office of Injured Employee Counsel (OIEC) Ombudsman assisting an injured employee is also permitted to send pertinent records to the IRO conducting the independent review. An OIEC Ombudsman provides assistance to an injured employee and is statutorily prohibited from providing representation. Since there is no provision for payment of attorney's fees in medical dispute resolution cases in workers' compensation, OIEC Ombudsmen provide assistance in the vast majority of those cases. A significant part of providing effective assistance to the injured employee is helping to ensure that the IRO receives pertinent records and modifying the rule language to permit the Ombudsman to send those records would further that objective.

Agency Response: The Department disagrees with the suggested change. Section 12.205(f) does not prohibit the OIEC Ombudsman from assisting the injured employee in sending the pertinent records. However, expanding the role of the OIEC is beyond the Department's authority.

§12.206. Notice of Determinations Made by Independent Review Organizations.

Comment: Two commenters recommend that §12.206(d)(18) be expanded to include an explanation of how the review criteria were utilized to make the determination. One commenter recommends the following specific language: "(18) a description of the source of the review criteria that were utilized to make the determination *including an analyses of how the reviewed treatment is within the scope and extent of medical treatment recommended by the review criteria or how the clinical evidence justifies a deviation from the review criteria;. . . ."* Both commenters assert that the Department and the Division of Workers' Compensation cannot effectively review whether or not IROs are complying with the Texas Insurance Code and Texas Labor Code unless the IRO decision explains how the reviewed treatment is within the scope and extent of medical treatment recommended by the review criteria or how the clinical evidence justifies a deviation from the review criteria.

Agency Response: The Department declines to make the suggested change. The IRO is already required to explain its decision, so the commenter's suggested language will not provide any additional information.

Comment: A commenter recommends amending proposed §12.206(d)(18) as follows: "(18) a description and the source of the review criteria, *including a copy or excerpt of the specific provision of the review criteria,* that were utilized to make the determination;. . . ." While the information in the proposed rule is helpful, the commenter recommends that the IRO be required to provide the specific citation and language from their screening criteria that was used to make the determination so that the appealing parties have a full understanding of the rationale for the determination. This information may assist the parties in their decision to further appeal the determination and thereby limit appeals to those with appropriate merit.

Agency Response: The Department declines to make the suggested change. Such a requirement may require the copying and production of information in violation of copyright law.

§12.207. Independent Review Organization Telephone Access.

Comment: A commenter opposes the amendments to §12.207 for the following reasons: (i) the new rule requires that IROs should be "generally (sic) available by telephone" to parties other than URAs; while this appears to make no substantive change to broaden the telephone availability requirements for IROs, in effect it would require IROs to communicate with anyone and everyone; (ii) under amended §12.207, an IRO would be compelled to discuss details of individual cases with persons other than URAs, which hinders both the patient privacy and the independence of the process; (iii) this open access creates an economic burden on IROs, which was not present in prior rules; (iv) previously, the IRO had to return calls "to URAs" in 2 working days, which allowed plenty of time to address any issue during the 20-day review process; (v) amended §12.207 significantly increases costs to the IROs, by encouraging patients to directly contact them; (vi) the proposed rule change jeopardizes the independent status of the IROs; and (vii) any change that increases the workload of the IROs should also have a corresponding fee increase.

Agency Response: The Department agrees that proposed §12.207 was unintentionally broad and has revised §12.207(b) to state, "An independent review organization must have a telephone system capable of accepting or recording or providing instructions to incoming calls *related to utilization review* during other than normal business hours and shall respond to such calls not later than one working day from the date the call was received." The Department's revision narrows the scope of §12.207(b) to calls related to utilization review.

Comment: A commenter fully supports the change in proposed §12.207(b) that reduces the time to return a telephone call made outside of business hours to one working day from the date the call was received rather than two working days. Timely receipt of medical care is critical to an injured employee's physical recovery and ability to return to work. Any provision that hastens an IRO determination is beneficial.

Agency Response: The Department appreciates the supportive comment.

§12.208. Confidentiality.

Comment: A commenter fully supports the provisions of §12.208 that serve to protect patient confidentiality. There appears to be universal agreement that maintaining the confidentiality of medical information is paramount. Accordingly, the commenter agrees that a strong confidentiality provision, such as one in §12.208, is imperative.

Agency Response: The Department appreciates the supportive comment.

Comment: A commenter suggests that the Department clarify that the rule does not prohibit the provision of confidential information to a third party for legitimate IRO purposes when there is a HIPAA-compliant confidentiality agreement with a third party in

place. As written, the proposed rule seems to exclude the possibility of providing confidential information to a third party such as a transcriber or recordkeeping service, even when there is a HIPAA-compliant confidentiality agreement in place. Removing the ability for IROs to contract with third parties to provide routine services would jeopardize the ability of IRO to continue to function in an economical manner and continue to provide new services to the State of Texas.

Agency Response: The intent of the rule is not to prohibit the provision of confidential information to a third party when a HIPAA compliant confidentiality agreement with a third party is in place. However, the Department declines to expand the scope of §12.208 to include HIPAA privacy law. Section 12.208(b) states that an IRO may not disclose or publish individual medical records or other confidential information about a patient without the prior written consent of the patient or *as otherwise provided by law.* This reference to other law includes relevant state and federal privacy laws.

§12.303. Surrender of Certificate of Registration.

Comment: A commenter applauds §12.303, stating that this provision gives greater emphasis to the protection of the patient than to the interests of a suspect IRO. It is expected that the Department would have a solid basis for pursuing an investigation of an IRO and, as a result, it is appropriate that the Department would also have the discretion to limit the IRO's authority to operate during that period.

Agency Response: The Department appreciates the supportive comment.

Comment: Two commenters assert that §12.303 contains no due process of law. One commenter recommends that the Department request an Attorney General Opinion on the constitutionality of this requirement. The commenter further recommends removing the reference to a voluntary surrender of certificate and suggests referencing a surrender of certificate only after an IRO has been provided due process on the issue. This commenter further states that the provision requiring a "voluntary suspension of a license" is neither voluntary nor legally permissible as it eliminates a vested right to continue to operate without any due process. According to the commenter, when the state vests a right to do business to a company, certain due process standards must be afforded prior to suspension of their ability to continue to do business. *See, Guerrero-Ramirez v. Texas State Rd. of Medical Examiners,* 867 S.W.2d 911 (Tex. App.-Austin 1993); *Texas Dept. of Health v. Gulf Nuclear,* Inc., 664 S.W.2d 847,850 (Tex. App.-Austin 1984) (stating an agency is required by law to give notice and provide an opportunity for a hearing prior to suspension of a license). The proposed rules afford no due process protection to the companies affected and require a "voluntary suspension" without any proceeding to determine whether wrongdoing in fact occurred.

The commenter further asserts that the Department is subject to Chapters 2001 and 2002 of the Texas Government Code. See Tex. Ins. Code Ann. §31.101 (Vernon 1999). These chapters have been deemed by Texas courts to require agencies to assure fairness to affected persons and to assure that the public and affected persons are heard on matters that involve their interests and affairs. *Amarillo Indep. Sell. Dist. v. Meno,* 854 S.W.2d 950 (Tex. App.-Austin 1993). A *mandatory voluntary* surrender of the certificate runs afoul with the rules that govern Texas agencies because it hinders an IRO's ability to be heard and provided due process before the certificate is required to be surrendered.

Agency Response: As previously discussed in response to the requests that the Department seek an Attorney General Opinion, the Department has revised §12.303 by (i) removing the terms "voluntary" and "voluntarily"; (ii) adding subsection (c) to state, "A certificate of registration that is surrendered under this section is temporarily suspended while the investigation is pending;" and (iii) adding subsection (f) to state, "Notwithstanding §12.4(b) of this chapter (relating to Applicability), this section only applies to an independent review organization that: (1) is licensed on or after December 26, 2010; or (2) has its certificate of registration renewed in this state on or after December 26, 2010."

The Department has removed the terms "voluntary" and "voluntarily" to clarify that the surrender is required and to avoid confusion as to whether the surrender is mandatory or voluntary. Additionally, the Department has provided that a certificate of registration that is surrendered under §12.303 is temporarily suspended while the investigation is pending, clarifying that the certificate of registration is not permanently revoked without due process of law. This temporary suspension of rights may be necessary to protect the patients whose claims are being reviewed by the IRO and to avoid harm to the patients. Finally, the addition of subsection (f) makes this provision only applicable to IROs newly licensed on or after December 26, 2010 or to existing IROs upon renewal of their certificates of registration on or after December 26, 2010. Thus, any potential applicant will be aware of the surrender process set forth in §12.303 before deciding whether to apply for licensure or renewal.

The right to conduct independent reviews is a statutory right. A licensee does not have a vested right in the continuation of laws. The Legislature, in HB 4519, required the commissioner to adopt standards and rules that require an IRO to voluntarily surrender its certification while the IRO is under investigation or as part of an agreed order. The Legislature may, in the exercise of the police power, regulate by reasonable requirements the conduct of IROs and, by proper grant, delegate the exercise of police power to the Department. The exercise of the police power hinges upon the public need for safety, health, security, and protection of the general welfare of the community. When there is a public interest involved, the rights of individual licensees may yield to the overriding public interests and are regulated under the state's police power.

§12.402. Classification of Specialty.

Comment: A commenter strongly recommends that the Department replace the reference to "medical or surgical care" with "health care services" in §12.402(2) as reflected in the following: "(2) Tier two fees will be for the independent review *of health care services* [medical or surgical care] rendered in the specialties of podiatry, optometry, dental, audiology, speech-language pathology, master social work, dietetics, professional counseling, psychology, occupational therapy, physical therapy, marriage and family therapy, chiropractic, and chemical dependency counseling, and any subspecialties thereof." The commenter cites the following reasons for the suggested change: (i) the commenter strongly objects to the Department's proposed reference to "medical or surgical care" rendered by the specialties listed in proposed §12.402(2); the specialties listed in proposed §12.402(2) are not M.D.s or D.O.s and, therefore, are not statutorily authorized to practice medicine or to provide general medical or surgical care; rather, they are authorized only to provide the limited health care services consistent with

and within the scope of their respective enabling statutes; (ii) it is important to note that current §12.402(1) references tier one fees provided for "medical or surgical care" rendered by a doctor of medicine or doctor of osteopathy; this reference is accurate, because M.D.s and D.Os are statutorily authorized to provide medical and surgical care by the Texas Medical Practice Act; (iii) the suggested revision makes the proposed language of §12.402(2) consistent with Texas law.

Agency Response: The Department agrees and has made the suggested change.

§12.403. Fee Amounts.

Comment: Two commenters recommend that the fee amounts be revised. The first commenter recommends that the two-tier system should be abolished and the current Tier 1 and Tier 2 fees should be increased to a single fee of $950, with all tiers having the same billing procedure with the current 15 day rule that is in effect for Tier 1 cases. In addition, there needs to be a provision to increase the fee on a schedule into the future to avoid having to amend the law continuously to meet this anticipated change.

As previously explained to Department staff during informal stakeholder meetings, the costs of operating an IRO have increased dramatically while the fees have stayed the same. In 1998 when the IRO law was enacted there was no provision for the rising cost of doing business, and fees were set when there was only one kind of IRO review, for HC cases. The rationale for those fees was based on HC, not WC or WCN cases. With the merger of the Texas Workers' Compensation Commission into the Department, and the creation of the new network organizations, IROs now have to keep in place and maintain three separate sets of procedures for managing three different kinds of reviews, which is a heavy administrative and regulatory burden. Indeed, the regulatory burden alone suggests that the prudent IRO should set up a reserve for Regulatory Compliance on their balance sheets.

The two-tier system now in place allows payors in certain cases 30 days to pay IROs, and the 30 days begins after the case is complete. These cases are often far more complex to administer, are paid in arrears after the IRO has incurred substantial costs-and yet they pay only $460, rather than the current standard for Tier 1 of $650. The second commenter states that every fee has increased in the past 12 years. There is a possibility that there may be more IRO cases, but the commenter has been in the business for five years and there has not been an increase in IRO cases. The commenter once received a case that had 684 items in dispute. The fee in that case clearly would not exceed the disputed amounts.

Agency Response: The Department declines to increase the fees at this time. However, future implementation of federal healthcare reform may cause the Department to revisit the fee structure.

Comment: A commenter recommends that a fee of $1500 should be established for life threatening cases. The commenter cites the following reasons for the suggested fee increase: (i) life threatening cases require IROs to have a fourth set of procedures in place, which must be completed in 8 days, rather than the longer periods allowed for other cases; (ii) these cases are extremely labor intensive and require the IRO to pay larger fee to reviewers, medical professionals who must in certain cases do their work on weekends, to meet the 8 day deadline; and (iii) the patient or worker who requested these reviews are in a special status and the IRO should be funded appropriately to meet the short deadline.

Agency Response: The Department declines to make the suggested change. There is no statutory requirement that a separate fee be established for life-threatening cases.

Comment: A commenter recommends that §12.404 regarding payment of fees be amended to address the following concerns: (i) IROs should not be allowed to submit an invoice to a URA or payor until their services have been rendered; in workers' compensation many deadlines for payment of a bill are based on receipt of the invoice, and requests for a review may be withdrawn prior to the review being performed; (ii) an administrative process, with appropriate penalties, should be created to allow URAs or payors to recover overpayments to IROs; and (iii) the rule should be clarified to reference the Division of Workers' Compensation rules, which have different payment timelines for workers' compensation URAs.

Agency Response: The Department agrees in part and disagrees in part. The Department has revised §12.404(c) by adding the following second sentence: "For workers' compensation network and non-network disputes, the independent review organization fees shall be paid in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations)." However, the Department is unaware of a problem with overpayments that would require a specific rule. Further, the Department is able to assess administrative penalties and does not need a specific penalty for recovery of overpayments.

Economic Impact Statement/Regulatory Flexibility Analysis

Comment: Four commenters assert that the figures used to calculate the economic impact of this rule were incorrect. The report states that "Based on Department records, an IRO receives an average of 10 independent review assignments per month." Three commenters assert that IROs actually receive an average of seven independent review assignments per month as per 2010 figures. Based on seven assignments, two commenters calculate a gross income of $4,170 per month, while the third commenter calculates a gross income of $4131 per month.

Three commenters also state that they pay more to their reviewers than the figure provided by "one" IRO used for the example. The first commenter further asserts that this increased pay for the reviewer actually leaves $2,370 available to the commenter for *all expenses* after the reviewers are paid. This amount must then be divided to cover clerical staff, a bookkeeper, rent, utilities, copier maintenance, office supplies (paper, toner, folders, pens, labels, staples), postage fees, internet fees, telephone lines, bank service charges, storage fees and annual expenses to include tax return preparation, 1099s, W2s, and annual State License renewal. According to the Department's calculated employee costs of $1,334 to $2,176, the commenter argues that the actual figure of $2,370 does not appropriately cover the cost of this employee as well as the operating expenses actually incurred by an IRO.

The second commenter asserts that the actual pay to a reviewer is approximately $1,800 per month. This commenter agrees that the cost of an employee or employees is approximately correct, and further estimates that rent, utilities, phone, fax, internet, taxes, and other such costs are approximately $950 per month. Thus, calculating the gross income of $4,170 per month, less (i) $1,800 for reviewers; (ii) $1,334 for employees; and (iii) $950 for other office costs, this commenter projects a profit margin of $86.

The third commenter states that the compensation for reviewers is based on information from one IRO that pays $250 for Tier 1 reviews and $150 for Tier 2 reviews, but that these figures are not reflective of all IROs and a greater cross-section of payments to reviewers should be acquired prior to making a financial analysis. The commenter asserts that if in actuality an IRO pays $350 for a Tier 1 review and $200 for a Tier 2 review, and the gross income is based on 7 assignments instead of 10, the actual anticipated income would be $4,131 less $2,150 for an anticipated net income of $1,931 (sic).

The fourth commenter states that HB 4519 does nothing to improve the independent review process but puts unfair restrictions on small business. These restrictions are so unfair that they will likely cause many businesses to fail. The economic impact numbers are ridiculous. Specifically, the commenter notes that there is no place in this country that a company can move an office for $3,000 within that state, let alone a cross country move. The commenter asserts that the anticipated one-time cost of establishing a new physical location of $2,500 - $3,000 is very unrealistic.

Agency Response: The estimated average of 10 assignments per month to an IRO was based on the Department's records. At the time of the proposal, the number of IRO assignments divided by the number of IROs in Texas was 10. The Department relied on that information in estimating the average number of assignments. The Department acknowledges that the cost for a reviewer was based on information from one IRO and specifically stated in the proposal that "the overhead costs will vary for each IRO based on the IRO's business model and expenses." As previously discussed, the Department's revisions to the definition of "primary office" and §12.103(10) requires out-of-state IROs to provide evidence that its primary office is located in Texas. "Primary office" is defined as "The place where, based upon the totality of the business activities related to independent review performed under this chapter, an independent review organization's books and records pertaining to independent reviews assigned by the Department are stored." Therefore, this narrower requirement should limit the cost of compliance.

Comment: Two commenters request that the Department reconsider the economic impact of the prohibition on sharing staff. The first commenter states that the rule's prohibition on the use of shared staff places an undue financial burden on the commenter's company, which is a micro-business. The Government Code §2006.002(c) requires that if a proposed rule has an adverse economic impact on a small business, alternative methods of achieving the proposed rule must be presented. If this portion of the rule is to remain in place, the commenter requests that the Department provide an alternative method to pay operating costs and clerical staff while still maintain a profitable company.

The second commenter states that the economic impact and regulatory flexibility should be further considered in regards to part-time staff and independent contractors such as bookkeepers, accountants, and transcriptionists, for small and micro businesses. Given the fact that the actual anticipated income is $1931 per month, it is unrealistic and a financial burden to require multiple full-time staff members to carry out the duties of the IRO. Utilizing part-time experienced independent contractors to perform essential duties of the IRO is a necessary and economically viable choice for operating an IRO. Utilizing part-time experienced independent contractors is not inconsistent with the health, safety, or environmental and economic welfare of the state as referenced in the Government Code 2006.002(c-l). There will be a substantial adverse effect on the micro-businesses to comply with the prohibition of shared staff and regulatory flexibility should be considered.

Agency Response: The Department declines to make the suggested change. Utilizing part-time independent contractors is not prohibited by the rule. Section 12.204(c)(2) specifically states, "This prohibition does not extend to the use of subcontractor services or personnel employed by or under contract with the independent review organization to perform independent review."

Comment: A commenter requests that the Department revisit the idea of not applying the new rules to micro entities. These rules will put many small IROs out of business even though they have fulfilled their responsibilities and have contributed enormously to a healthy, well functioning IRO system. In these hard economic times, a more thorough study of the impact on these small businesses is vital. The commenter states that the Department, in its published proposal on the new rules, has conducted and published an initial economic impact analysis required by law on costs of regulations for micro entities, and this analysis demonstrates that the costs are substantial to small IROs. The commenter further notes that almost all IROs in Texas are micro entities, very small business organizations with fewer than 5 staff members and only some $50,000 in annual revenues. At one point in the Department's analysis, the Department states that it considered not applying the new regulations to any micro entities that were IROs, but then the idea was discarded and not mentioned again.

If the Department rejects this request, the commenter asks that the Department conduct a thorough financial study of all the costs to a single micro entity, which includes the loss of shareholder value for the IRO that will almost certainly result from the many restrictions in the new regulations on the transfer of ownership at the time of a sale of an IRO.

The commenter opines that even if the Department simply added up all the costs specified in the Department's current economic impact analysis, and placed that in the context of how marginal the profits are for these micros entities financially, the Department would conclude that an unintended consequence of the new regulations would be that large numbers of small IROs (perhaps over 70%) would be put out of existence by the financial costs of the new regulations. Moreover, the commenter points out that the five large, financially robust, IROs that are departments of large multimillion dollar entities, would also be put out of existence by the provision that the primary office be based in Texas, since most of these companies are out of state.

Perhaps as few as 10 of the current IROs would be left standing, which may have actually been the objective of the 2 IROs out of 43 that spoke in favor of the new regulations in the Legislature. Financially, if this occurred, the remaining 10 IROs would immediately expand from $50,000 a year in sales to approximately $220,000 a year in sales.

Agency Response: The Department appreciates the commenter's concerns and considered the impact when preparing the economic impact statement and regulatory flexibility analysis. The Department has complied with the Government Code §2006.002, which requires the Department to reduce the adverse economic effects on small or micro businesses if doing so is legal and feasible considering the purpose of the statute under which the rule is to be adopted. The Department prepared an economic impact statement estimating the number of small and micro businesses subject to the proposed rule,

projecting the economic impact of the rule on these entities, and describing the alternative methods of achieving the purpose of the proposed rule. The Department also prepared a regulatory flexibility analysis that included the Department's consideration of alternative methods of achieving the purpose of the proposed rule.

Therefore, the Department declines to reconsider exempting micro entities from the requirements of the rules. The Department estimated in the proposal that approximately 35 IROs of the 43 IROs that are currently certified are small or micro business IROs. Making the rules inapplicable to such a large number of IROs would effectively negate the provisions, and in most cases the rule would not serve its intended purposes. Requiring such a small number of IROs to comply with the rules would result in an unfair competitive market and unfair loss of income for a few IROs.

Additionally, revisions to the definition of "primary office" and to §12.103(10), as previously discussed, may alleviate the commenter's concern that the large out-of-state IROs will no longer conduct business in Texas.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL.

For: Office of Public Insurance Counsel.

For, with recommended changes: Insurance Council of Texas.

Neither for nor against, with recommended changes: Aurora; Med Health Review, Inc.; Medtronic; Office of Injured Employee Counsel; Property Casualty Insurers Association of America; Specialty IRO, Inc.; Texas Medical Association; Texas Mutual Insurance Company; ZRC Medical Resolutions, Inc.

Against: Advanced Reviews; American Association of Independent Review Organizations; Clear Resolutions, Inc.; I-Decisions, Inc.; Medical Review Institute of America; P&S Network, Inc.; four individuals.

SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §§12.1, 12.2, 12.4 - 12.6

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.2. Severability Clause.

If a court of competent jurisdiction holds that any provision of this chapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this chapter that can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

§12.4. Applicability.

(a) All independent review organizations performing independent reviews of adverse determinations made by utilization review agents, health insurance carriers, health maintenance organizations, and managed care entities, must comply with this chapter. Independent review organizations performing independent reviews of adverse determinations made by certified workers' compensation health care networks and workers' compensation insurance carriers must comply with this chapter, subject to §12.6 of this subchapter (relating to Independent Review of Adverse Determinations of Health Care Provided Pursuant to the Labor Code Title 5, or the Insurance Code Chapter 1305).

(b) Except as otherwise provided, this chapter is applicable to all requests for independent review filed with the department on or after December 26, 2010. All independent reviews filed with the department prior to December 26, 2010 shall be subject to the rules in effect at the time the independent review was filed with the department.

§12.5. Definitions.

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

(1) Adverse determination--A determination by a utilization review agent made on behalf of any payor that the health care services provided or proposed to be provided to a patient are not medically necessary or appropriate, or are experimental or investigational.

(2) Affiliate--A person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(3) Best evidence--Evidence based on:

(A) randomized clinical trials;

(B) if randomized clinical trials are not available, cohort studies or case-control studies;

(C) if subparagraphs (A) and (B) are not available, case-series; or

(D) if subparagraphs (A), (B) and (C) are not available, expert opinion.

(4) Case-control studies--A retrospective evaluation of two groups of patients with different outcomes to determine which specific interventions the patients received.

(5) Case-series--An evaluation of a series of patients with a particular outcome, without the use of a control group.

(6) Cohort studies--A prospective evaluation of two groups of patients with only one group of patients receiving a specific intervention(s).

(7) Commissioner--The Commissioner of Insurance.

(8) Department--Texas Department of Insurance.

(9) Dentist--A licensed doctor of dentistry holding either a D.D.S. or a D.M.D. degree.

(10) Evidence-based medicine--The use of current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients.

(11) Evidence-based standards--The conscientious, explicit, and judicious use of evidence-based medicine and the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.

(12) Experimental or investigational--A service or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device but that is not yet broadly accepted as the prevailing standard of care.

(13) Expert opinion--A belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention, or therapy.

(14) Health benefit plan--A plan of benefits that defines the coverage provisions for health care offered or provided by any organization, public or private, other than health insurance.

(15) Health care provider or provider--A person, corporation, facility, or institution that is:

(A) licensed by a state to provide or otherwise lawfully providing health care services; and

(B) eligible for independent reimbursement for those services.

(16) Health insurance policy--An insurance policy, including a policy written by a corporation subject to the Insurance Code Chapter 842, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

(17) Independent review--A system for final administrative review by a designated independent review organization of an adverse determination regarding the medical necessity and appropriateness or the experimental or investigational nature of health care services.

(18) Independent review organization or IRO--An entity that is certified by the commissioner to conduct independent review under the authority of the Insurance Code Chapter 4202. Such entity must have the capacity for independent review of all specialty classifications and subspecialties thereof contained in the two tiered structure of specialty classifications set forth in §12.402 of this chapter (relating to Classification of Specialty).

(19) Independent review plan--The review criteria and review procedures of an independent review organization.

(20) Legal holiday--A holiday:

(A) as provided in the Government Code §662.003(a), including New Year's Day; Martin Luther King, Jr. Day; Presidents' Day; Memorial Day; Independence Day; Labor Day; Veterans Day; Thanksgiving Day; and Christmas Day; and

(B) as provided in §102.3(b) of this title, (relating to Computation of Time), the Friday after Thanksgiving Day; December 24th; and December 26th.

(21) Life-threatening condition--A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(22) Medical and scientific evidence--Evidence found in the following sources:

(A) peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;

(B) peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpt--Medicus (EMBASE);

(C) medical journals recognized by the Secretary of Health and Human Services, pursuant to Section 1861(t)(2) of the federal Social Security Act;

(D) the following standard reference compendia:

(i) the American Hospital Formulary Service Drug Information;

(ii) Drug Facts and Comparisons, current edition as published by Lippincott Williams & Wilkins;

(iii) the American Dental Association Accepted Dental Therapeutics; and

(iv) the United States Pharmacopoeia--Drug Information;

(E) findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including:

(i) the Federal Agency for Healthcare Research and Quality;

(ii) the National Institutes of Health;

(iii) the National Cancer Institute;

(iv) the National Academy of Sciences;

(v) the Centers for Medicare & Medicaid Services;

(vi) the federal Food and Drug Administration; and

(vii) any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services;

(F) peer-reviewed abstracts accepted for presentation at major medical association meetings;

(G) for independent review of adverse determinations of health care provided pursuant to the Labor Code Title 5, the treatment guidelines, treatment protocols, and pharmacy closed formulary as provided in applicable orders issued or rules adopted by the TDI-DWC pursuant to the Labor Code §408.028 and §413.011, including Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments) and Chapter 137 of this title (relating to Disability Management); or

(H) any other medical or scientific evidence that is comparable to the sources listed in subparagraphs (A) - (F) of this paragraph.

(23) Nurse--A registered or professional nurse, a licensed vocational nurse, or a licensed practical nurse.

(24) Patient--The enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance policy, or an injured employee entitled to receive workers' compensation benefits pursuant to the Labor Code Title 5.

(25) Payor--

(A) an insurer that writes health insurance policies;

(B) a preferred provider organization, health maintenance organization, or self-insurance plan; or

(C) any other person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits, including workers' compensation benefits as provided under the Insurance Code §4201.054, to persons treated by a health care provider in this state under a policy, plan, or contract.

(26) Person--An individual, corporation, partnership, association, joint stock company, trust, unincorporated organization, any similar entity, or any combination of the foregoing acting in concert.

(27) Physician--A licensed doctor of medicine or a doctor of osteopathy.

(28) Primary office--The place where, based upon the totality of the business activities related to independent review performed under this chapter, an independent review organization's books and records pertaining to independent reviews assigned by the Department are stored.

(29) Provider of record--The physician or other health care provider that has primary responsibility for the care, treatment, and services rendered or requested on behalf of the patient; or the physician or health care provider that has rendered or has been requested to provide the care, treatment, or services to the patient. This definition includes any health care facility where treatment is rendered on an inpatient or outpatient basis.

(30) Randomized clinical trial--A controlled, prospective study of patients that have been randomized into an experimental group and a control group at the beginning of the study with only the experimental group of patients receiving a specific intervention, which includes study of the groups for variables and anticipated outcomes over time.

(31) Review criteria--The written policies, medical protocols, previous decisions and/or guidelines used by the independent review organization to make decisions about the medical necessity or appropriateness of a treatment, procedure, or service or the experimental or investigational nature of a treatment, procedure, or service.

(32) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(33) Utilization review agent--A person holding a certificate under the Insurance Code Chapter 4201.

(34) Working day--A weekday that is not a legal holiday.

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 6, 2010.

TRD-201006871
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

SUBCHAPTER B. CERTIFICATE OF REGISTRATION FOR INDEPENDENT REVIEW ORGANIZATIONS

28 TAC §§12.101 - 12.106, 12.108, 12.110

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including

the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.101. Where to File Application.

An application for a certificate of registration and for renewal of a certificate of registration as an independent review organization and application for a certificate of registration or renewal fee must be filed with the Texas Department of Insurance at the following address: Texas Department of Insurance, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

§12.103. Information Required in Application and Renewal Form.

Form No. LHL006 requires information necessary for the commissioner to properly determine whether an applicant is qualified to be certified as an independent review organization pursuant to the Insurance Code §4202.004, including:

(1) a summary of the independent review plan that meets the requirements of §12.201 of this chapter (relating to Independent Review Plan) and must include:

(A) a summary description of review criteria and review procedures to be used to determine medical necessity or appropriateness of health care;

(B) a summary description of review criteria and review procedures to be used to determine the experimental or investigational nature of health care;

(C) a certification signed by an authorized representative that such review criteria and review procedures to be applied in review determinations are established with input from appropriate health care providers and approved by physicians in accordance with §12.201(3) of this chapter; and

(D) procedures ensuring that the information regarding the reviewing physicians and providers is updated in accordance with §12.105(d) of this subchapter (relating to Revisions During Review Process) and §12.108(e) of this subchapter (relating to Renewal of Certificate of Registration) to ensure the independence of each health care provider or physician making review determinations.

(2) copies of policies and procedures which ensure that all applicable state and federal laws to protect the confidentiality of medical records and personal information are followed. These procedures must comply with §12.208 of this chapter (relating to Confidentiality);

(3) a certification signed by an authorized representative that the independent review organization will comply with the Insurance Code Chapter 4202.

(4) a description of personnel and credentialing, and a completed profile for each physician and provider, both as described in §12.202 of this chapter (relating to Personnel and Credentialing);

(5) a description of hours of operation and how the independent review organization may be contacted after hours, during weekends and holidays, as set forth in §12.207 of this chapter (relating to Independent Review Organization Telephone Access);

(6) the organizational information, documents and all amendments, including:

(A) the bylaws, rules and regulations, or any similar document regulating the conduct of the internal affairs of the applicant with a notarized certification bearing the original signature of an officer or authorized representative of the applicant that they are true, accurate, and complete copies of the originals;

(B) for an applicant that is publicly held, the name of each stockholder or owner of more than five percent of any stock or options;

(C) a chart showing the internal organizational structure of the applicant's management and administrative staff; and

(D) a chart showing contractual arrangements of the applicant.

(7) the name of any holder of bonds or notes of the applicant that exceed $100,000;

(8) the name and type of business of each corporation or other organization that the applicant controls or is affiliated with and the nature and extent of the affiliation or control and a chart or list clearly identifying the relationships between the applicant and any affiliates;

(9) biographical information about officers, directors, and executives, including information requested in Form No. FIN311 (Biographical Affidavit) as required in §12.102(b) of this subchapter (relating to Application and Renewal of Certificate of Registration Form; How to Obtain Forms:

(A) the applicant must submit the name, biographical information, and, in compliance with §1.503 and §1.504 of this title (relating to Application of Fingerprint Requirement and Fingerprint Requirement), a complete set of fingerprints for each director, officer, and executive of the applicant, any entity listed under paragraph (8) of this section, and a description of any relationship the named individual has which represents revenue equal to or greater than five percent of that individual's total annual revenue or which represents a holding or investment worth $100,000 or more in any of the following entities:

(i) a health benefit plan;

(ii) a health maintenance organization;

(iii) an insurer;

(iv) a utilization review agent;

(v) a nonprofit health corporation;

(vi) a payor;

(vii) a health care provider;

(viii) another independent review organization; or

(ix) a group representing any of the entities described by clauses (i) - (viii) of this subparagraph.

(B) the applicant must identify any relationship between the applicant and any affiliate or other organization in which an officer, director, or employee of the applicant holds a five percent or more interest;

(C) the applicant must submit a list of any currently outstanding loans or contracts to provide services between the applicant and any affiliates;

(10) for an application for a certificate or renewal of registration as an independent review organization in this state made on or after December 26, 2010, evidence that the applicant's primary office

is located in this state. As a condition of being certified to conduct the business of independent review in this state, an independent review organization must locate its primary office in this state;

(11) the percentage of the applicant's revenues that are anticipated to be derived from independent reviews conducted; and

(12) a disclosure of any enforcement actions related to the provision of medical care or conducting of medical reviews taken against a person subject to the fingerprint requirements under §1.503 and §1.504 of this title.

§12.106. Qualifying Examinations.

The commissioner or the commissioner's designee may conduct an on-site qualifying examination of an applicant as a requirement of applying for a certificate of registration or renewing a certificate of registration as an independent review organization. Documents that support the application for the certificate of registration or renewal of the certificate of registration must be available for inspection at the time of such qualifying examination at the primary office of the independent review organization.

§12.108. Renewal of Certificate of Registration.

(a) The commissioner shall designate annually each organization that meets the standards as an independent review organization.

(b) An independent review organization must apply for renewal of its certificate of registration every year, not later than the anniversary date of the issuance of the registration. Form No. LHL006 (IRO Application Form), adopted by reference in §12.102 of this subchapter (relating to Application and Renewal of Certificate of Registration Form; How To Obtain Forms), must be used for this purpose. Form No. LHL006 can be obtained from the website and from the address listed in §12.102 of this subchapter. The completed renewal form, a summary of the current review criteria, renewal fee, and a certification that no material changes exist that have not already been filed with the department must be submitted to the department at the address listed in §12.101 of this subchapter (relating to Where To File Application). Material changes shall include changes relating to physicians or providers performing independent review.

(c) An independent review organization may continue to operate under its certificate of registration after a completed renewal application form, application fee, and a summary of the current review criteria have been received by the department until the renewal is finally denied or issued by the department. However, independent reviews will not be assigned to an independent review organization during the 30 days prior to the anniversary date of the issuance of the independent review organization's certificate of registration unless a completed renewal application form and the application fee have been received by the department.

(d) If a completed renewal application form and a summary of the review criteria are not received prior to the anniversary date of the year in which the certificate of registration must be renewed, the certificate of registration will automatically expire and the independent review organization must complete and submit a new application for certificate of registration.

(e) The independent review organization shall report any material changes in the information required in Form No. LHL006, including changes relating to physicians and providers performing independent review, not later than the 30th day before the date on which the change takes effect.

(f) Compliance with subsection (e) of this section is exempted in the event that a contracted specialist is unavailable for review, and subsequent immediate contracting with a new specialist is necessary to complete independent review within the timeframes set forth in this chapter.

(g) The independent review organization shall notify the department within 10 days of any contracts entered into pursuant to subsection (f) of this section, and shall include in the notification a complete explanation of the circumstances necessitating such contracts.

(h) Until the certificate of registration renewal application process is complete or the certificate of registration expires, an independent review organization must:

(1) continue to perform its duties pursuant to the Insurance Code Chapter 4202, the Labor Code, and department and TDI-DWC rules, including maintenance and retention of medical records and patient-specific information pursuant to §12.208 of this chapter (relating to Confidentiality); and

(2) in regard to reviews of the medical necessity of a health care service provided under the Labor Code Title 5 or Insurance Code Chapter 1305, make responses to requests for letters of clarification pursuant to §133.308 of this title (relating to MDR by Independent Review Organizations).

§12.110. Effect of Sale of an Independent Review Organization.

(a) Non-transferability of Certificate. An independent review organization's certificate is non-transferable, and an independent review organization must surrender its certificate upon sale of the independent review organization.

(b) Effect of Sale. An independent review organization that has been sold to a new owner must apply for and receive a new certificate pursuant to this subchapter before it can operate as an independent review organization.

(c) Notification of Sale. An independent review organization must notify the department of an impending sale in writing at least 90 days prior to the date the sale will be finalized. The notification must include the date on which the sale is anticipated to be finalized, and the independent review organization must provide a revised notification of impending sale if the anticipated date for finalization of the sale changes. The notification must be filed with the Texas Department of Insurance at the following address: Texas Department of Insurance, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

(d) Obligation to Continue Performing Duties Prior to Sale. An independent review organization must continue to perform all duties prior to the date that the sale of the independent review organization is finalized. Independent reviews will not be assigned to the independent review organization during the 45 days prior to the date that the sale of the independent review organization is finalized. Notification of the impending sale of an independent review organization does not negate the independent review organization's obligation to continue to perform its duties pursuant to the Insurance Code Chapters 1305 and 4202, the Labor Code Title 5, and applicable department and TDI-DWC rules.

(e) Activities Following a Sale. Upon the sale of an independent review organization, the new owner is prohibited from performing the duties of an independent review organization specified in this chapter, the Insurance Code Chapters 1305 and 4202, the Labor Code Title 5, and applicable department and TDI-DWC rules prior to issuance of the certificate of registration to the independent review organization pursuant to its new ownership.

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 6, 2010.

TRD-201006872
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER C. GENERAL STANDARDS OF INDEPENDENT REVIEW

28 TAC §§12.201, 12.202, 12.204 - 12.208

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.201. Independent Review Plan.

Independent review shall be conducted in accordance with an independent review plan that is consistent with standards developed with input from appropriate health care providers, and reviewed and approved by a physician. The independent review plan shall include the following components:

(1) A description of the elements of review which the independent review organization provides;

(2) written procedures for:

(A) notification of the independent review organization's determinations provided to the patient or a representative of the patient, the patient's provider of record, and the utilization review agent, in accordance with §12.206 of this subchapter (relating to Notice of Determinations Made by Independent Review Organizations);

(B) review, including:

(i) any form used during the review process;

(ii) timeframes that shall be met during the review;

(C) accessing appropriate specialty review;

(D) contacting and receiving information from health care providers in accordance with §12.205 of this subchapter (relating to Independent Review Organization Contact with and Receipt of Information from Health Care Providers and Patients);

(3) required use of written medically acceptable review criteria that are:

(A) based on medical and scientific evidence and utilize evidence-based standards, or if evidence is not available, generally accepted standards of medical practice recognized in the medical community;

(B) established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, and other health care providers;

(C) objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norms when justified on a case-by-case basis;

(D) developed based on consideration of the treatment guidelines, treatment protocols, and pharmacy closed formulary as provided in orders issued or rules adopted by TDI-DWC, including Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments) and Chapter 137 of this title (relating to Disability Management) for health care provided pursuant to the Labor Code Title 5;

(E) used only as a tool in the review process; and

(F) available for review, inspection, and copying as necessary by the commissioner or the commissioner's designated representative in order for the commissioner to carry out the commissioner's lawful duties under the Insurance Code;

(4) independent review determinations that:

(A) utilize review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, and other health care providers;

(B) are made in accordance with medically accepted review criteria, taking into account the special circumstances of each case that may require a deviation from the norm; and

(C) are made by physicians, dentists, or other health care providers, as appropriate.

§12.204. Prohibitions of Certain Activities and Relationships of Independent Review Organizations and Individuals or Entities Associated with Independent Review Organizations.

(a) An independent review organization shall not set or impose any notice or other review procedures that are contrary to the requirements of the health insurance policy or health benefit plan unless those requirements are set forth in this chapter or Texas law.

(b) An independent review organization may not permit or provide compensation or anything of value to its physicians or providers that would directly or indirectly affect an independent review decision.

(c) An independent review organization may not operate out of the same office or other facility as another independent review organization.

(1) This prohibition extends to the shared use by independent review organizations of the resources and staff that comprise an office, including: office space, telephone and fax lines, electronic equipment, supplies, and clerical staff.

(2) This prohibition does not extend to the use of subcontractor services or personnel employed by or under contract with the independent review organization to perform independent review.

(d) An individual or an entity may not own more than one independent review organization.

(e) An individual may not own stock in more than one independent review organization.

(f) An individual may not serve on the board of more than one independent review organization.

(g) An individual who has served on the board of an independent review organization that has had its certificate of registration revoked for cause may not serve on the board of another independent review organization earlier than the fifth anniversary of the date on which the revocation occurred.

(h) Notwithstanding §12.4(b) of this chapter (relating to Applicability), the prohibitions in subsections (c) - (g) of this section apply only to:

(1) an independent review organization that:

(A) is licensed on or after December 26, 2010; or

(B) has its certificate of registration renewed in this state on or after December 26, 2010; and

(2) an individual or entity whose activity involves an independent review organization that:

(A) is licensed on or after December 26, 2010; or

(B) has its certificate of registration renewed in this state on or after December 26, 2010.

§12.205. Independent Review Organization Contact with and Receipt of Information from Health Care Providers and Patients.

(a) A health care provider may designate one or more individuals as the initial contact or contacts for independent review organizations seeking routine information or data. In no event shall the designation of such an individual or individuals preclude an independent review organization or medical director from contacting a health care provider or others in his or her employ where a review might otherwise be unreasonably delayed or where the designated individual is unable to provide the necessary information or data requested by the independent review organization.

(b) An independent review organization may not engage in unnecessary or unreasonably repetitive contacts with the health care provider or patient and shall base the frequency of contacts or reviews on the severity or complexity of the patient's condition or on necessary treatment and discharge planning activity.

(c) In addition to pertinent files containing medical and personal information, the utilization review agent or the health insurance carrier, health maintenance organization, managed care entity, or other payor requesting the independent review shall be responsible for timely delivering to and ensuring receipt by the independent review organization of any written narrative supplied by the patient pursuant to the Insurance Code Chapter 4201 and Chapters 19 and 133 of this title (relating to Agents' Licensing and General Medical Provisions). However, in instances of life-threatening condition, the independent review organization shall contact the patient or representative of the patient, and provider directly.

(d) An independent review organization shall notify the department if, within three working days of receipt of the independent review assignment, the independent review organization has not received the pertinent files containing medical and personal information from the requesting utilization review agent or the health insurance carrier, health maintenance organization, managed care entity, or other payor.

(e) An independent review organization shall reimburse health care providers for the reasonable costs of providing medical information in writing, including copying and transmitting any patient records or other documents requested by the independent review organization. A health care provider's charge for providing medical information to an independent review organization shall not exceed the cost of copying set by rules of TDI-DWC at §134.120 of this title (relating to Reimbursement for Medical Documentation) for records and may not include any costs that are otherwise recouped as a part of the charge for health care. Such expense shall be reimbursed by the utilization review agent, health insurance carrier, health maintenance organization, managed care entity, or other payor requesting the review as an expense of independent review.

(f) Nothing in this section prohibits a patient, the representative of a patient, or a provider of record from submitting pertinent records to an independent review organization conducting independent review.

(g) When conducting independent review, the independent review organization shall request and maintain any information necessary to review the adverse determination not already provided by the utilization review agent, health insurance carrier, health maintenance organization, managed care entity, or other payor. This information may include identifying information about the patient, the benefit plan, the treating health care provider, or facilities rendering care. It may also include clinical information regarding the diagnoses of the patient and the medical history of the patient relevant to the diagnoses; the patient's prognosis; or the treatment plan prescribed by the treating health care provider along with the provider's justification for the treatment plan.

(h) The independent review organization is required to share all clinical and demographic information on individual patients among its various divisions to avoid duplication of requests for information from patients or providers.

§12.206. Notice of Determinations Made by Independent Review Organizations.

(a) An independent review organization shall notify the patient or a representative of the patient, the patient's provider of record, the utilization review agent, the payor, and the department of a determination made in an independent review.

(b) The notification required by this section must be mailed or otherwise transmitted not later than the earlier of:

(1) The 15th day after the date the independent review organization receives the information necessary to make a determination; or

(2) the 20th day after the date the independent review organization receives the request for the independent review.

(c) In the case of a life-threatening condition, the notification must be by telephone to be followed by facsimile, electronic mail, or other method of transmission not later than the earlier of:

(1) the 5th day after the date the independent review organization receives the information necessary to make a determination; or

(2) the 8th day after the date the independent review organization receives the request for independent review.

(d) Notification of determination by the independent review organization is required to include at a minimum:

(1) a listing of all recipients of the notification of determination as described in subsection (a) of this section, identifying for each:

(A) the name; and

(B) as applicable to the manner of transmission used to issue the notification of determination to the recipient:

(i) mailing address;

(ii) facsimile number; or

(iii) electronic mail address;

(2) the date of the original notice of the decision, and if amended for any reason, the date of the amended notification of decision;

(3) the independent review case number assigned by the department;

(4) the name of the patient;

(5) a statement of whether the type of coverage is health insurance, workers' compensation, or workers' compensation health care network;

(6) a statement of whether the context of the review is preauthorization, concurrent utilization review, or retrospective utilization review of health care services;

(7) the name and certificate number of the independent review organization;

(8) a description of the services in dispute;

(9) a complete list of the information provided to the independent review organization for review, including dates of service and document dates where applicable;

(10) a description of the qualifications of the reviewing physician or provider;

(11) a statement that the review was performed without bias for or against any party to the dispute and that the reviewing physician or provider has certified that no known conflicts of interest exist between the reviewer and:

(A) the patient;

(B) the patient's employer, if applicable;

(C) the insurer;

(D) the utilization review agent;

(E) any of the treating physicians or providers; or

(F) any of the physicians or providers who reviewed the case for determination prior to referral to the independent review organization, and that the review was performed without bias for or against any party to the dispute;

(12) a statement that the independent review was performed by a health care provider licensed to practice in Texas if required by applicable law and of the appropriate professional specialty;

(13) a statement that there is no known conflict of interest between the reviewer, the IRO, and/or any officer or employee of the IRO with:

(A) the patient;

(B) the provider requesting independent review;

(C) the provider of record;

(D) the utilization review agent;

(E) the payor; and

(F) the certified workers' compensation health care network, if applicable;

(14) a summary of the patient's clinical history;

(15) the review outcome, clearly stating whether or not medical necessity or appropriateness exists for each of the health care services in dispute and whether the health care services in dispute are experimental or investigational, as applicable;

(16) a determination of the prevailing party if applicable;

(17) the analysis and explanation of the decision, including the clinical bases, findings and conclusions used to support the decision;

(18) a description and the source of the review criteria that were utilized to make the determination;

(19) a certification by the independent review organization of the date that the decision was sent to all of the recipients of the notification of determination as required in subsection (a) of this section via U.S. Postal Service or otherwise transmitted in the manner indicated on the form; and

(20) for independent reviews of health care services provided under the Labor Code Title 5 or the Insurance Code Chapter 1305, any information required by §133.308 of this title (relating to MDR by Independent Review Organizations); and

(21) notice of applicable appeal rights under the Insurance Code Chapter 1305 and the Labor Code Title 5, and instructions concerning requesting such appeal.

(e) Example templates for the notification of determination regarding health and workers' compensation cases may be found on the department's website at http://www.tdi.state.tx.us/forms.

§12.207. Independent Review Organization Telephone Access.

(a) An independent review organization shall have appropriate personnel reasonably available by telephone at least 40 hours per week during normal business hours in both time zones in Texas.

(b) An independent review organization must have a telephone system capable of accepting or recording or providing instructions to incoming calls related to utilization review during other than normal business hours and shall respond to such calls not later than one working day from the date the call was received.

§12.208. Confidentiality.

(a) An independent review organization shall preserve the confidentiality of individual medical records, personal information, and any proprietary information provided by payors. Personal information shall include, at a minimum, name, address, telephone number, social security number and financial information.

(b) An independent review organization may not disclose or publish individual medical records or other confidential information about a patient without the prior written consent of the patient or as otherwise provided by law. An independent review organization may provide confidential information to a provider who is under contract with the independent review organization for the sole purpose of performing or assisting with independent review. Information provided to a provider who is under contract to perform a review shall remain confidential.

(c) The independent review organization may not publish data which identify a particular payor, physician or provider, including any quality review studies or performance tracking data, without prior written consent of the involved payor, physician or provider. This prohibition does not apply to internal systems or reports used by the independent review organization.

(d) All payor, patient, physician, and provider data shall be maintained by the independent review organization in a confidential manner which prevents unauthorized disclosure to third parties. Nothing in this chapter shall be construed to allow an independent review organization to take actions that violate a state or federal statute or regulation concerning confidentiality of patient records.

(e) To assure confidentiality, an independent review organization must, when contacting a utilization review agent, a physician's or provider's office, or hospital, provide its certificate number and the caller's name and professional qualifications to the provider or the provider's named independent review representative.

(f) The independent review organization's procedures shall specify that specific information exchanged for the purpose of conducting review will be considered confidential, be used by the independent review organization solely for the purposes of independent review, and be shared by the independent review organization with only a provider who is under contract with the independent review organization to perform independent review. The independent review organization's plan shall specify the procedures that are in place to assure confidentiality and shall acknowledge that the independent review organization agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data that does not provide sufficient information to allow identification of individual patients, providers, payors or utilization review agents need not be considered confidential.

(g) Medical records and patient-specific information shall be maintained by the independent review organization in a secure area with access limited to essential personnel only.

(h) Information generated and obtained by the independent review organization in the course of the review shall be retained for at least four years. This requirement is not negated by the suspension or surrender of the independent review organization's certificate of registration or the failure to renew the certificate of registration.

(i) Destruction of documents in the custody of the independent review organization that contain confidential patient information or payor, physician or provider financial data shall be by a method which ensures complete destruction of the information, when the organization determines that the information is no longer needed.

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 6, 2010.

TRD-201006873
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

SUBCHAPTER D. ENFORCEMENT OF INDEPENDENT REVIEW STANDARDS

28 TAC §§12.301 - 12.303

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a

health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.303. Surrender of Certificate of Registration.

(a) Pursuant to the Insurance Code §4202.002(c)(2)(B), upon the request of the department, an independent review organization must surrender the organization's certificate of registration while the organization is under investigation or as part of an agreed order.

(b) For the purposes of this section, the term "investigation" is defined as the filing of a Notice of Hearing or a Notice of Violation with the State Office of Administrative Hearings by the department or TDI-DWC against an independent review organization where such notice seeks revocation of the certificate of registration of the independent review organization.

(c) A certificate of registration that is surrendered under this section is temporarily suspended while the investigation is pending.

(d) Independent reviews shall not be assigned to an independent review organization during a surrender of the independent review organization's certificate of registration.

(e) Surrender of an independent review organization's certificate of registration does not negate the requirement in §12.208(h) of this chapter (relating to Confidentiality) that an independent review organization retain information generated and obtained by the independent review organization in the course of a review for at least four years or the obligation to complete all independent reviews assigned to the independent review organization prior to the surrender of the certificate of registration.

(f) Notwithstanding §12.4(b) of this chapter (relating to Applicability), this section only applies to an independent review organization that:

(1) is licensed on or after December 26, 2010; or

(2) has its certificate of registration renewed in this state on or after December 26, 2010.

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 6, 2010.

TRD-201006874
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER E. FEES AND PAYMENT

28 TAC §§12.402 - 12.406

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.402. Classification of Specialty.

Fees for independent review shall be based on a two tiered structure of specialty classifications as follows:

(1) Tier one fees will be for independent review of medical or surgical care rendered by a doctor of medicine or doctor of osteopathy.

(2) Tier two fees will be for the independent review of health care services rendered in the specialties of podiatry, optometry, dental, audiology, speech-language pathology, master social work, dietetics, professional counseling, psychology, occupational therapy, physical therapy, marriage and family therapy, chiropractic, and chemical dependency counseling, and any subspecialties thereof.

§12.404. Payment of Fees.

(a) Independent review organizations shall bill utilization review agents or payors, as appropriate, directly for fees for independent review.

(b) Independent review organizations may also bill utilization review agents or payors, as appropriate, for copy expenses related to review as set forth in §12.205 of this chapter (relating to Independent Review Organization Contact with and Receipt of Information from Heath Care Providers and Patients).

(c) Utilization review agents or payors, as appropriate, shall pay independent review organizations directly within 30 days of receipt of invoice. For workers' compensation network and non-network disputes, the independent review organization fees shall be paid in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations).

(d) Utilization review agents may recover from the payors the costs associated with the independent review.

§12.406. Certificate of Registration and Renewal Fees.

Fees to be paid to the department for the original application for a certificate of registration as an independent review organization is $800. The fee for renewal of a certificate of registration is $200.

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 6, 2010.

TRD-201006875
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

♦ ♦ ♦

SUBCHAPTER F. RANDOM ASSIGNMENT OF INDEPENDENT REVIEW ORGANIZATIONS

28 TAC §12.501, §12.502

STATUTORY AUTHORITY. The amendments and new sections are adopted pursuant to the Insurance Code §4201.003 and §4202.002, the Labor Code §402.00111(b) and §413.031, and the Insurance Code §36.001. The Insurance Code §4201.003 provides that the Commissioner may adopt rules to implement the Insurance Code Chapter 4201. The Insurance Code §4202.002(a) provides that the Commissioner shall promulgate standards and rules for the certification, selection, and operation of IROs to perform independent review. The Insurance Code §4202.002(c) provides that the Commissioner shall adopt standards and rules that prohibit: (i) more than one IRO from operating out of the same office or other facility; (ii) an individual or entity from owning more than one IRO; (iii) an individual from owning stock in or serving on the board of more than one IRO; (iv) an individual who has served on the board of an IRO whose certification was revoked for cause from serving on the board of another IRO before the fifth anniversary of the date on which the revocation occurred; and (v) an IRO from disclosing confidential patient information, except to a provider who is under contract to perform the review. The Insurance Code §4202.002(c) also states that the Commissioner shall adopt standards and rules that require: (i) an IRO to be based and certified in this state and to locate the organization's primary offices in this state; (ii) an IRO to voluntarily surrender the organization's certification while the organization is under investigation or as part of an agreed order; and (iii) an IRO to apply for and receive a new certification after the organization is sold to a new owner. The Labor Code §402.00111(b) provides that the Commissioner of Insurance may delegate to the Commissioner of Workers' Compensation or to that person's designee and may redact any delegation, and the Commissioner of Workers' Compensation may delegate to the Commissioner of Insurance or to that person's designee, any power or duty regarding workers' compensation imposed on the Commissioner of Insurance or the Commissioner of Workers' Compensation under the Labor Code Title 5, including the authority to make final orders or decisions. The Labor Code §413.031 provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or commissioner rules under that section or §413.011(g) shall be conducted by an IRO under Chapter 4202, Insurance Code, in the same manner as reviews of utilization review decisions by health maintenance organizations. The Insurance Code §36.001 provides that the Commissioner of Insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

§12.502. Random Assignment.

(a) The department shall randomly assign each request for independent review to an independent review organization and shall notify the utilization review agent and the health insurance carrier, health maintenance organization, managed care entity, or other payor requesting the independent review, the independent review organization, the patient or a representative of the patient, and the provider of record of such assignment.

(b) The department shall screen payors and utilization review agents for potential conflicts of interest with the independent review organization before making an assignment to the independent review organization. The independent review organization shall screen its physicians and other providers conducting independent review for potential conflicts of interest. The department shall have the discretion to determine whether conflicts exist.

(c) Independent review organizations shall be added to the list from which random assignments for independent review are made in order of the date of issuance of the certificate of registration by the department.

(d) Random assignment shall be made chronologically from the list of independent review organizations with ultimate assignment to the first in line with no apparent conflicts of interest.

(e) Assignment of an independent review to an independent review organization moves the independent review organization receiving the assignment to the bottom of the assignment list.

(f) Independent reviews will not be assigned:

(1) to an independent review organization during the 30 days prior to the anniversary date of the issuance of the independent review organization's certificate of registration unless the completed application for renewal of its certificate of registration and the application fee have been received by the department; or

(2) during the time that an independent review organization has surrendered its certificate of registration pursuant to §12.303 of this chapter (relating to Surrender of Certificate of Registration) and the Insurance Code §4202.002(c)(2)(B).

(g) Nonselection for presence of conflicts of interest does not move the independent review organization to the bottom of the assign-

ment list. Such independent review organization retains its chronological position until selected for independent review.

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 6, 2010.

TRD-201006876
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Effective date: December 26, 2010
Proposal publication date: June 11, 2010
For further information, please call: (512) 463-6327

♦ ♦ ♦

PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 126. GENERAL PROVISIONS APPLICABLE TO ALL BENEFITS

28 TAC §126.7

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts the repeal of §126.7, concerning Designated Doctor Examinations: Requests and General Procedures. This repeal is adopted without changes to the proposal as published in the July 16, 2010, issue of the *Texas Register* (35 TexReg 6228) and will not be republished.

This repeal is necessary to ensure clarity and efficiency in designated doctor regulation and is adopted simultaneously with new Chapter 127, §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25, concerning Designated Doctor Scheduling and Examinations, which are published elsewhere in this issue of the *Texas Register* and recodify the majority of the provisions of repealed §126.7. The repeal will become effective February 1, 2011 to coincide with the effective date of newly adopted §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25.

This repeal will eliminate the obsolete provisions from repealed §126.7 and will also allow the Division to recodify the majority of the provisions of repealed §126.7 in new Chapter 127, §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25.

Comment: One commenter stated that they support the proposed repeal.

Response: The Division appreciates the support.

For without changes: Insurance Council of Texas.

Against: None

The repeal is adopted pursuant to Labor Code §402.00111 and §402.061. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the Commissioner of Workers' Compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

No other code, statute or article is affected by this rule or action.

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 6, 2010.

TRD-201006881
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: February 1, 2011
Proposal publication date: July 16, 2010
For further information, please call: (512) 804-4703

♦ ♦ ♦

CHAPTER 127. DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS SUBCHAPTER A. DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS

28 TAC §§127.1, 127.5, 127.10, 127.15, 127.20, 127.25

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

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble and rules. The preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, and the reasons why the Division agrees or disagrees with the comments and recommendations.

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

House Bill 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 (HB 7) amended §408.0041 of the Labor Code to provide that the Commissioner has the discretion to approve or deny requests for designated doctor examinations. Specifically, HB 7 changed subsection (a) of Labor Code §408.0041 to provide that the Commissioner "may" order a designated doctor examination at the request of an insurance carrier or an injured employee. Previously, Labor Code §408.0041 stated that the Commissioner "shall" order a designated doctor examination upon receiving such a request. Additionally, HB 7 also amended subsection (b) of Labor Code §408.0041 to provide that Division shall assign a designated doc-

tor 10 days after a request for an examination is "approved." Previously, Labor Code §408.0041 required the Division to assign a designated doctor within 10 days after a request was "received." Lastly, HB 7 added subsection (l) to Labor Code §408.0041, which states that if a person submits a frivolous request for a designated doctor examination, as determined by the Commissioner, that person commits an administrative violation. Taken together, these amendments to Labor Code §408.0041 demonstrate a clear mandate for the Division to take a greater role in monitoring and evaluating requests for designated doctor examinations, and these new sections are necessary to implement that mandate.

These new sections also provide that the Division may require designated doctors to remain appointed to a claim so long as that doctor is still qualified to examine the injured employee. This change will improve the quality and availability of designated doctor examinations and is anticipated to increase the efficiency of the Division's dispute resolution process. The change is also supported by the Sunset Advisory Commission. In its April 2010 Staff Report, the Sunset Advisory Commission found that appointing multiple designated doctors to a single claim can muddle the dispute resolution process for that claim, and that multiple appointments to a single claim were common (at least 906 disputes that were set for a benefit review conference at the Division in fiscal year 2009 involved claims to which multiple designated doctors had been appointed). These new adopted sections address these concerns.

Additionally, these new adopted sections also describe how parties may dispute the approval or denial of a designated doctor appointment before the disputed examination takes place and clarify several of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling and examination process. The Division has also changed some of the proposed language in the text of the rule as adopted in response to public comments received. The Division has also made some changes for clarification and editorial reasons. The changes, however, do not materially alter issues raised in the proposal, introduce new subject matter, or affect persons other than those previously on notice.

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

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

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

In response to several comments, the Division has also removed the provision of proposed §127.10(c) that permitted insurance carriers to retrospectively review designated doctor referrals for additional testing. By removing this provision, the Division returns to its previous position on this issue, expressed in the August 11, 2006, issue of the *Texas Register* (31 TexReg 6368), that stakeholder concerns regarding the necessity or reasonableness of designated doctor referrals for testing are best addressed through the Division's complaint and monitoring procedures, and the Division has now stated this position in adopted §127.10(c). This outcome ensures that designated doctors can confidently have access to all necessary testing procedures while still permitting the Division to monitor designated doctor referrals. This outcome also comports with the Labor Code §408.0041(h)(1) requirement that insurance carriers pay for designated doctor examinations, because referrals for additional testing are often absolutely necessary for and thus essentially part of the designated doctor's examination of an injured employee. Lastly, the Division has also, in light of one stakeholder comment, included a reminder to all designated doctors that their testing referrals and other referrals are subject to the financial disclosure requirements of §180.24 of this title (relating to Financial Disclosure).

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

In response to several comments, the Division has also made a clarifying change to proposed §127.10(h). Specifically, the Division has removed the phrases "otherwise due under the Texas Workers' Compensation Act and division rules" and "the applicable" from the subsection and inserted "all medical bills previously denied for reasons inconsistent with the findings of the designated doctor's report. By the end of this period, insurance carriers shall tender payment on these medical bills in accordance with the Act and Chapters 133 and 134 of this title (relating to General Medical Provisions" and Benefits--Guidelines for Medical Services, Charges, And Payments, respectively). This clarification is necessary to explain that though the findings of a designated doctor report can compel an insurance carrier to pay past or future medical benefits if the insurance carrier's reason for denial are wholly in conflict with the designated doctor's report, insurance carriers still may deny payment of those medical benefits for any other permissible reason under the Act or Division rules that does not conflict with the findings of the designated doctor's report.

The Division also made a change to proposed §127.20(d) in response to a comment. Specifically, the Division changed the

deadline for designated doctors to respond to requests for clarification, both when a reexamination is necessary and when one is not, from five days to five working days. This change ensures that designated doctors will always have one work week to respond to the request, and the change to working days also makes these deadlines consistent with other designated doctor reporting deadlines in this proposal.

In response to a separate comment, the Division made another change to proposed §127.20(d)(2). Specifically, the Division inserted "if the division orders the reexamination" at the beginning of the subsection and replaced "the request" with the "the date the order is issued." This change corresponds with the Division's original intent for this provision that after a designated doctor advises the Division of a need for a reexamination to respond to a request for clarification, the reexamination must be held within 21 days of the date the Division issues an order scheduling the examination.

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

New §127.1. New subsection (a) primarily recodifies language from repealed §126.7(a) - (c) of this title (relating to Designated Doctor Examinations: Requests and General Procedures), though it also deletes the provision that prohibited designated doctors who are working for networks under Chapter 1305 of the Insurance Code from examining injured employees who are receiving health care through the same network. This prohibition is redundant with the requirements for a designated doctor to be qualified to be appointed to a claim and is addressed by new §127.5(c) and (d). New subsection (b) describes the information requesters must include when requesting a designated doctor examination. While it primarily incorporates the provisions of current Division Form DWC032, subsection (b) also requires requesters to provide a specific reason for the examination, to state any injuries that have already been accepted by the insurance carrier as compensable or determined by the Division to be compensable, and, if the requester indicates that the injured employee's medical condition has changed since a previous designated doctor examination, to explain that change of condition. New subsection (c) requires that a requester demonstrate good cause if that requester submits a request for a designated doctor examination that would require the Division to schedule an examination within 60 days of a previous examination of an injured employee. Subsection (c) also describes the minimum demonstration of good cause. New subsection (d) provides the reasons for which the Division shall deny a request for a designated doctor examination. New subsection (e) describes the dispute resolution process system participants may use to dispute the Division's approval or denial of a designated doctor request and states that if an expedited proceeding is approved, such a dispute shall stay an approved examination request.

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

New §127.10. New subsection (a) primarily recodifies language from repealed §126.7(i) of this title. It also clarifies that analysis sent to a designated doctor by a treating doctor or insurance carrier may only be provided in accordance with Labor Code §408.0041(c) and that the cost of copying medical records provided to designated doctors shall be reimbursed in accordance with §134.120 of this title (relating to Reimbursement of Medical Documentation). Additionally, new subsection (a) also requires that insurance carriers and treating doctors must ensure that designated doctors receive an injured employee's medical records three working days, rather than the previous requirement of one working day, before a designated doctor's examination of an injured employee. New subsection (b) recodifies the language of repealed §126.7(j) of this title. New subsection (c) primarily recodifies the language of repealed §126.7(k) of this title. New subsection (c) also clarifies when a designated doctor may make a referral to another health care provider and that additional testing or referral to another health care provider extends designated doctors' time to complete the testing and file their reports by 15 additional working days from the date of their physical examination of the injured employee. New subsection (d) recodifies the language of repealed §126.7(n) of this title. New subsection (e) primarily recodifies the language of repealed subsection §126.7(o) of this title. It also clarifies the specific provisions of §129.5 of this title (relating to Work Status Reports) applicable to Work Status Reports filed by designated doctors. Additionally, new subsection (e) extends the time to file a Work Status Report under this subsection to seven working days, as opposed to calendar days, and requires Work Status Reports to be filed with the Division as well. New subsection (f) primarily recodifies language from repealed §126.7(p) of this title. It also extends the time designated doctors have to file their narrative reports under that subsection to seven working days, as opposed to the previous requirement of calendar days, requires the narrative reports to be filed with the Division, and lists the required elements of the narrative reports. New subsection (g) primarily recodifies the language of repealed §126.7(d) of this title but also clarifies that presumptive weight only applies to issues the designated doctor was properly appointed to address. New subsection (h) primarily recodifies the language of repealed §126.7(r) of this title but also clarifies that, as required by Labor Code §408.0041, insurance carriers must pay all accrued benefits, including medical benefits, pursuant to a designated doctor's report. New subsection (i) primarily recodifies the language of repealed §126.7(q) of this title. It also clarifies that designated doctors shall maintain injured employee records, analyses, and narratives provided by insurance carriers and treating doctors for five years from the anniversary date of the date of the designated doctor's last examination of the injured employee. This requirement is intended to harmonize the Division's record retention requirements with the minimum requirements for record retention among licens-

ing boards applicable to designated doctors. Importantly, this subsection also clarifies that this record retention requirement does not reduce or replace any other record retention requirement imposed on designated doctors by their respective licensing boards. Additionally, new subsection (i) requires designated doctors to maintain reports they generate as well as documentation that they fulfilled certain administrative requirements when applicable. New subsection (j) clarifies that parties may dispute any entitlement to benefits affected by a designated doctor report through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title.

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

New §127.20. New subsection (a) primarily recodifies language from repealed §126.7(u) of this title. It also clarifies that parties may only request clarification on issues already addressed by the designated doctor's report or on issues that the designated doctor was ordered to address but did not address. New subsection (b) lists required elements for all requests for clarification. New subsection (c) recodifies language from repealed §126.7(u) of this title. New subsection (d) primarily recodifies language from repealed §126.7(u) of this title and also clarifies various administrative requirements for designated doctors responding to requests for clarification and for the scheduling of reexamination pursuant to a request for clarification. New subsection (e) clarifies that any failure to respond to a request for clarification is an administrative violation.

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

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

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

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

Response: The Division disagrees in part. Labor Code §§408.0041(b), 408.0043, 408.0044, and 408.0045 all require the Division to take a designated doctor's credentials into consideration when appointing a designated doctor to a claim. The remainder of this comment regarding the Division's current designated doctor selection matrix is outside the scope of these rules, which do not address how the Division determines a designated doctor's credentials.

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

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

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

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

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

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

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

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

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

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

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

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

Comment: One commenter states that the Division should allow some reimbursement when an injured employee fails to show

because a doctor will have done significant preparation. This will encourage more high quality doctors to enter the system.

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

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

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

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

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

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

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

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

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

§127.1(a)

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

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

§127.1(b)

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

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

§127.1(b)(6)(B)

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

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

§127.1(b)(6)(D)

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

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

§127.1(b)(6)(F)

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

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

§127.1(b)(7)

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

Response: The Division disagrees. The commenter's suggested change significantly weakens the standard to which requesters must attest, and the Division, in light of the impor-

tance of accuracy in designated doctor requests, declines to lower this standard.

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

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

§127.1(c)

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

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

§127.1(c)(1) and (2)

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

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

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

Response: The Division agrees and has made these changes.

§127.1(d)

Comment: Commenter states that it appears §127.1(d) permits the Division to deny a request for a designated doctor examination simply because the Division cannot schedule the examination within the Labor Code §408.0041 timeline. If this is the case, the Division should provide an alternative mechanism through which the party can obtain resolution of the question.

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

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

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

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

Response: The Division disagrees that a change is necessary. The Division agrees that not every part of §127.1(b) and (c) applies to every request. The Division disagrees, however, that any change is necessary because §127.1(b) and (c) indicates which provision are required for a particular request and which provisions are not.

§127.1(d)(2)

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

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

§127.1(d)(3)

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

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

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

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

§127.1(e)

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

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

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

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

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

Response: The Division disagrees. While the Division intends to respond to all requests for expedited contested case hearings as quickly as possible, the Division sees no reason to impose an arbitrary deadline on its administrative discretion that is not required by statute.

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

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

Comment: One commenter states that it should be clarified that failure to request expedited proceedings or any other hearing under §127.1(e) in order to dispute an ordered designated doctor examination does not waive a party's right to dispute the appointment of a designated doctor at a later time.

Response: The Division agrees and disagrees. The Division agrees that parties do not waive their right to contest the appointment of a designated doctor or approval of an examination if they fail to do so under §127.1(e). The Division disagrees that any clarification is necessary, however, as nothing in the rule would imply this outcome. Moreover, the rule states no deadline for non-expedited disputes, thus it is not clear how a party could lose the ability to seek dispute resolution under this rule provided the subject of dispute had not already been adjudicated through the Division's dispute resolution process.

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

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

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

Response: The Division disagrees. While the Division does recognize that in some cases the deadline may be difficult or impossible to meet, extending the deadline any further would lead to delayed examinations in too many cases. Furthermore, the Division notes that even if a party fails to request expedited proceedings, that party may still dispute the approval of the designated doctor request through the Division's general dispute resolution procedures.

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

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

§127.5(a)

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

Response: The Division disagrees. While the Division does generally agree that examinations can, in some cases, be scheduled too soon after a request for examination is approved, the Division declines to prohibit the possibility of an examination scheduled

within 14 days of the Division's order preemptively. Moreover, the Division notes that designated doctors always are aware of the possible dates of the examination before they accept the examination.

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

Response: The Division disagrees. Though the Division will strive in all cases to process these requests as timely as possible, imposing an arbitrary and extra-statutory deadline upon approving these requests would unnecessarily restrict the Division's administrative flexibility.

§127.5(b)

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

Response: The Division disagrees. Permitting location changes without the knowledge of the Division would permit examinations to be held at potentially non-approved examination locations, thus preventing the Division from monitoring the suitability of the new location. Moreover, the Division selects designated doctors, in part, based on their stated available practice locations. Allowing these locations to change without Division approval thwarts this process.

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

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

§127.5(c)(4)

Comment: One commenter states that §127.5(c)(4) improperly operates as a special exception to the disqualifying associations described in 28 TAC §180.21. The commenter explains that this exception is improper because a designated doctor who had a doctor/patient relationship with an injured employee regarding another medical condition thirteen months before the designated doctor examination certainly creates a sufficient appearance of influence to preclude the designated doctor from being the designated doctor on the claim under 28 TAC §180.21.

Response: The Division disagrees. Section 127.5(c)(4) does not qualify any designated doctor to perform an examination, exempt any designated doctor from the disqualifying association provisions of 28 TAC §180.21, or otherwise operate as a special exception; instead, §127.5(c)(4) simply disqualifies two particular classes of designated doctors: those who have treated the injured employee on an unrelated medical condition within the past 12 months and those who have treated the injured employee on the medical condition at issue at any time. Thus, §127.5(c)(4) does not disqualify or qualify the designated doctor described in the commenter's example, because that designated doctor does not fit in either class addressed by §127.5(c)(4). Pursuant to §127.5(c)(1), however, the disqualifying association provisions of 28 TAC §180.21 would apply to the designated doctor described in the commenter's example just as it would apply to any other designated doctor. If the commenter, therefore, believes the application of 28 TAC §180.21 to such a designated doctor should disqualify that doctor from the claim at issue, the commenter may pursue that argument through the Division's dispute resolution process.

§127.5(d)

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

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

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

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

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

Response: The Division disagrees. Permitting location changes without the knowledge of the Division would permit examinations to be held at potentially non-approved examination locations, thus preventing the Division from monitoring the suitability of the new location. Additionally, in the case of subsequent examinations, the designated doctor has already performed an examination on the injured employee at the scheduled location because the designated doctor stated they were available to perform examinations at that location; therefore, the designated doctor should explain why this location is no longer feasible before the Division permits a change.

§127.5(e)

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

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

Comment: Two commenters suggest that the Division should require good cause before parties can reschedule the time or date of a designated doctor examination, because Labor Code §408.0041(i) requires injured employees to have good cause for failure or refusal to appear at an examination. Furthermore, this rescheduling provides parties an opportunity to game the system by creating false scheduling conflicts.

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

§127.10(a)

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

Response: The Division disagrees. While this requirement may save designated doctors time in sorting through records, it will only increase the time it takes for insurance carriers and treating doctors to prepare the records. Moreover, the Division does not believe that it could possibly enforce such a rule, because the Division could never determine the exact order the records were in when they were received by the designated doctor. The Division notes, however, that these adopted rules require medical records to be received by designated doctors at least three working days before the examination whereas the repealed §126.7(i)(4) only required the records to arrive one working day before the examination. The Division believes this change may help address the commenter's concerns.

§127.10(a)(2)

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

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

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

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

§127.10(a)(3)

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

Response: The Division disagrees. While the Division acknowledges that insurance carriers and treating doctors may not be able to achieve absolute certainty in the timely delivery of medical records to designated doctors, the Division clarifies that, for the purposes of compliance, the deemed receipt provisions of 28 TAC 102.4 (relating to General Rules for Non-Commission Communication) apply to this rule and should resolve the commenter's concerns. Additionally, the Division changed the deadline for designated doctors to receive medical records from one working day before the examination to three working days before the examination in order to provide designated doctors with more time to prepare for examinations and in response to several stakeholder comments on its informal draft of these rules requesting such a change.

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

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

§127.10(c)

Comment: One commenter states that the Division should omit the requirement that testing be completed within 10 days of the

original examination of the injured employee, and only require that it be done 17 working days from the examination, since this is when the report is due.

Response: The Division agrees in part and disagrees in part. While the Division generally agrees that the time for designated doctor testing is insufficient and needs extending, it disagrees with the commenter's suggested deadline. Instead, for administrative consistency, these adopted rules will require all testing and reports to be completed within 15 working days of the designated doctor's original physical examination of the injured employee.

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

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

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

Response: The Division appreciates the support but disagrees with premise of this comment. Neither designated doctor examinations nor designated doctor referrals for testing constitute treatment of an injured employee; therefore, the ODG, which the Division has adopted as treatment guidelines, is not the applicable standard of review for these forms of health care.

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

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

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

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

Comment: Two commenters disagree with the Division's proposed change that would make designated doctor referrals for additional testing subject to retrospective review by insurance carriers. The commenters disagree because they believe that retrospective review will disrupt, invalidate, and interfere with designated doctors' ability to answer the questions posed to them by the Division.

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

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

Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that any attestations made by designated doctors in the insurance system regarding the necessity of their testing referrals are alone sufficient to ensure that designated doctors always make testing referrals that are necessary to determine the issues in question in their examinations. The Division does agree, however, that its financial disclosure requirements under 28 TAC §180.24 should discourage unnecessary referrals for testing in some instances and does remind designated doctors to be aware of these provisions when making such referrals for testing. Therefore, for this and other reasons explained in other responses, the Division has removed

the proposed language that permitted insurance carriers to retrospectively review designated doctor testing from its adopted rules and, instead, clarified that designated doctor testing referrals are not subject to retrospective review by insurance carriers.

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

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

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

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

§127.10(e)

Comment: One commenter states that the Division should add "disability" to §127.10(e) because disability opinions also require Work Status Reports. Response: The Division disagrees. Disability is a legal determination that cannot be made by designated doctors.

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

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

§127.10(f)

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

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

§127.10(f)(5)

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

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

§127.10(f)(7)

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

Response: The Division appreciates the support.

§127.10(h)

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

Response: The Division agrees in part and has made a change. The Division's proposed language sought to address this issue, but the Division agrees that the language was not clear enough. The Division also notes, however, that this provision does not entitle insurance carriers to any new defenses or expand previous defenses, and insurance carriers that have lost a defense for other reasons under the Act or Division rules, such as failure to timely raise them under Labor Code §408.027, may not rely upon this provision to cure those defects.

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

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

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

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

§127.20(a)

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

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

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

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

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

Response: The Division disagrees. Labor Code §408.0041 and §408.125 both state that after an examination contact with the designated doctor may only be made through the Division, and there would be no reason for this requirement if the Division was only expected to forward all requests for clarification to designated doctors without monitoring the character of those requests.

§127.20(b)

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

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

§127.20(b)(2)

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

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

§127.20(b)(3)

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

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

§127.20(d)

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

Response: The Division disagrees. The statute plainly only gives presumptive weight to the report of a designated doctor,

and any doctor who is not on the designated doctor list is, by definition, not a designated doctor. Permitting these doctors to respond to letters of clarification could, therefore, not cure the commenters' complaints. Moreover, the Division declines to entitle parties to new designated doctor examinations if a doctor is no longer available to respond to a request for clarification. The Division's dispute resolution process and, in the case of insurance carriers, potential for subsequent injury fund reimbursement are sufficient remedies for any harm caused by complying with an incorrect designated doctor report.

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

Response: The Division agrees and has made the change.

§127.20(d)(1)

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

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

§127.25

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

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

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

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

The new sections are adopted under the Labor Code §§408.0041, 408.0043, 408.0044, 408.0045 and under the general authority of §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. In relevant part, §408.0043 requires designated doctors, other than dentists and chiropractors, who review a specific workers' compensation case to meet certain professional specialty requirements. In relevant part, §408.0044 provides that a designated doctor who is a dentist and reviews a dental service in conjunction with a specific workers' compensation case must be licensed to practice dentistry. Section 408.0045 provides, in relevant part, that a designated doctor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be license to engage in the practice of chiropractic.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

§127.1. Requesting Designated Doctor Examinations.

(a) At the request of the insurance carrier, an injured employee, the injured employee's representative, or on its own motion, the division may order a medical examination by a designated doctor to resolve questions about the following:

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

(2) the attainment of maximum medical improvement (MMI);

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

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

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

(6) issues similar to those described by paragraphs (1) - (5) of this subsection.

(b) To request a designated doctor examination a requestor must:

(1) provide a specific reason for the examination;

(2) explain any change of condition if the requestor indicates that the injured employee's medical condition has changed since a previous designated doctor examination on the same claim;

(3) report the injured employee's current medical condition and the type of health care the injured employee is currently receiving;

(4) provide a list of all injuries determined to be compensable by the division or accepted as compensable by the insurance carrier;

(5) provide general information regarding the identity of the requestor, injured employee, employer, treating doctor, insurance carrier, as well as the statutory date of maximum medical improvement, if any;

(6) submit the request on the form prescribed by the division under this section. A copy of the prescribed form can be obtained from:

(A) the division's website at www.tdi.state.tx.us/wc/indexwc.html; or

(B) the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744 or any local division field office location;

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

(A) if the requestor seeks an examination on the attainment of MMI, include the date of MMI if any; the date of certification of MMI if any; and the name of the certifying doctor, if any, and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor;

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

the date of certification of MMI and prior assigned impairment rating, if any, and the name of the certifying doctor, if any, and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor;

(C) if the requestor seeks an examination on the extent of the compensable injury or an examination regarding the causation of the claimed injury, include a description of the accident or incident that caused the claimed injury; and a list of all injuries in question;

(D) if the requestor seeks an examination on whether the injured employee's disability is a direct result of the work-related injury, include the beginning and ending dates for the claimed periods of disability; state if the injured employee is either not working or is earning less than pre-injury wages as defined by Labor Code §401.011(16); and list all injuries determined to be compensable by the division or accepted as compensable by the insurance carrier;

(E) if the requestor seeks an examination regarding the injured employee's ability to return to work in any capacity and what activities the injured employee can perform, include the beginning and ending dates for the periods to be addressed and a job description for job offers the employer intends to offer the injured employee;

(F) if the requestor seeks an examination to determine whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, include the beginning and ending dates for the periods to be addressed and whether or not this period involves the ninth quarter or a subsequent quarter of supplemental income benefits;

(G) if the requestor seeks an examination on topics under subsection (a)(6) of this section, specify the issue in sufficient detail for the doctor to answer the question(s); and

(8) provide a signature to attest that every reasonable effort has been made to ensure the accuracy and completeness of the information provided in the request.

(c) If a party submits a request for a designated doctor examination under subsection (b) of this section that would require the division to schedule an examination within 60 days of a previous examination of the injured employee that party must provide good cause for scheduling that designated doctor examination in order for the division to approve the party's request. For the purposes of this subsection, the commissioner or the commissioner's designee shall determine good cause on a case by case basis and will require at a minimum:

(1) if that requestor also requested the previous examination, a showing by the requestor that the submitted questions could not have reasonably been included in the prior examination and a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits; or

(2) if that requestor did not request the previous examination, a showing by the requestor a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits.

(d) The division shall deny a request for a designated doctor examination:

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

(2) if the request would require the division to schedule an examination in violation of Labor Code §§408.0041, 408.123, or 408.151; or

(3) if the commissioner or the commissioner's designee determines the request to be frivolous because it lacks either any legal or any factual basis that would merit approval.

(e) A party may dispute the division's approval or denial of a designated doctor request through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures). Additionally, a party is entitled to seek an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings) to dispute an approved request for a designated doctor examination. The division, upon receipt and approval of the request for expedited proceedings, shall stay the disputed examination pending the decision and order of the expedited contested case hearing. Parties seeking expedited proceedings and the stay of an ordered examination must file their request for expedited proceedings with the division within three days of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

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

§127.5. Scheduling Designated Doctor Appointments.

(a) The division, within 10 days after approval of a valid request, shall issue an order that assigns a designated doctor and shall notify the designated doctor, the treating doctor, the injured employee, the injured employee's representative, if any, and the insurance carrier that the designated doctor will be directed to examine the injured employee. The order shall:

(1) indicate the designated doctor's name, license number, examination address and telephone number, and the date and time of the examination or the date range for the examination to be conducted;

(2) explain the purpose of the designated doctor examination;

(3) require the injured employee to submit to an examination by the designated doctor;

(4) require the designated doctor to perform the examination at the indicated examination address; and

(5) require the treating doctor, if any, and insurance carrier to forward all medical records in compliance with §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations).

(b) The examination address indicated on the order in subsection (a)(4) of this section may not be changed by any party or by an agreement of any parties without good cause and the approval of the division.

(c) Except as provided in subsection(d) of this section, the division shall select the next available doctor on the designated doctor list for a medical examination requested under §127.1 of this title (relating to Requesting Designated Doctor Examinations). A designated doctor is available to perform an examination at any address the doctor has filed with the division if the doctor:

(1) does not have any disqualifying associations as described in §180.21 of this title (relating to Division Designated Doctor List);

(2) has credentials appropriate to the issue in question, the injured employee's medical condition, and as required by Labor Code §§408.0043, 408.0044, 408.0045, and applicable rules;

(3) is on the designated doctor list on the day the examination is offered; and

(4) has not treated or examined the injured employee in a non-designated doctor capacity within the past 12 months and has not examined or treated the injured employee in a non-designated doctor capacity with regard to a medical condition being evaluated in the designated doctor examination.

(d) If the division has previously assigned a designated doctor to the claim at the time a request is made, the division may use that doctor again if the doctor meets the requirements of subsection (c)(1) - (4) of this section. Examinations under this subsection must be conducted at the same examination address as the designated doctor's previous examination of the claimant or at another examination address approved by the division.

(e) The designated doctor's office and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24-hour requirement will be waived in an emergency situation. The rescheduled examination shall be set to occur within 21 days of the originally scheduled examination. Within 24 hours of rescheduling, the designated doctor shall contact the division's field office, the injured employee or the injured employee's representative, if any, and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled within 21 days of the originally scheduled examination, the designated doctor shall notify the division immediately, and the division may select a new designated doctor.

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

§127.10. General Procedures for Designated Doctor Examinations.

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

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

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

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are received by the designated doctor no later than three working days prior to the date of the designated doctor examination. If the designated doctor has not received the medical records or any part thereof at least three working days prior to the examination, the designated doctor shall report this violation to the division and reschedule the examination. The doctor shall conduct the rescheduled examination regardless of whether or not the injured employee's complete medical records have been timely received.

(b) The designated doctor shall review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance carrier and treating doctor in accordance with subsection (a) of this section, as well as the injured employee's medical condition and history as provided by the injured employee, and shall perform a complete physical examination. The designated doctor shall give the medical records reviewed the weight the doctor determines to be appropriate.

(c) The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor may also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements or retrospective review requirements in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agent's Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee.

(d) A designated doctor who determines the injured employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, or who determines the injured employee has not reached MMI, shall complete and file the report as required by §130.1 and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment and Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor, respectively).

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

(f) A designated doctor who resolves questions on issues other than those listed in subsections (d) and (e) of this section, shall file a report within seven working days of the date of the examination of the injured employee. This report shall be filed with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall provide the report to the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipi-

ent, otherwise, the designated doctor shall send the report by other verifiable means. Reports under this subsection must be filed in the form and manner prescribed by the division and must contain at a minimum:

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

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

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

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

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

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

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

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

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

(h) The insurance carrier shall pay all benefits, including medical benefits, in accordance with the designated doctor's report for the issue(s) in dispute. For medical benefits, the insurance carrier shall have 21 days from receipt of the designated doctor's report to reprocess all medical bills previously denied for reasons inconsistent with the findings of the designated doctor's report. By the end of this period, insurance carriers shall tender payment on these medical bills in accordance with the Act and Chapters 133 and 134 of this title. For all other benefits, the insurance carrier shall tender payment no later than five days after receipt of the report.

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

(1) the date and time of any designated doctor appointments scheduled with an injured employee;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled and, if applicable, documentation of the notice that the doctor provided to the division and the insurance carrier within 24 hours of rescheduling an appointment;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person;

(5) the date reports described in subsections (d), (e) and (f) of this section were submitted to all required parties and documentation that these reports were submitted to the division, treating doctor, and insurance carrier by facsimile or electronic transmission and to other required parties by verifiable means;

(6) the name(s) of any referral health care providers used by the designated doctor, if any; the date of appointments by referral health care providers; and the reason for referral by the designated doctor; and

(7) the date, if any, the doctor contacted the division for assistance in obtaining medical records from the insurance carrier or treating doctor.

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

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

§127.15. Undue Influence on a Designated Doctor.

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

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

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

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

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

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

§127.20. Requesting a Letter of Clarification Regarding Designated Doctor Reports.

(a) Parties may file a request with the division for clarification of the designated doctor's report. A copy of the request must be provided to the opposing party. The division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. Parties may only request clarification on issues already addressed by the designated doctor's report

or on issues that the designated doctor was ordered to address but did not address.

(b) Requests for clarification must:

(1) include the name of the designated doctor, the reason for the designated doctor's examination, the date of the examination, and the name and signature of the requestor;

(2) explain why clarification of the designated doctor's report is necessary and appropriate to resolve a future or pending dispute;

(3) include questions for the designated doctor to answer that are neither inflammatory nor leading; and

(4) provide any medical records that were not previously provided to the designated doctor and explain why these records are necessary for the designated doctor to respond to the request for clarification.

(c) The division, at its discretion, may also request clarification from the designated doctor on issues the division deems appropriate.

(d) To respond to the request for clarification, the designated doctor must be on the division's designated doctor list at the time the request is received by the division. The designated doctor shall respond, in writing, to the request for clarification within five working days of receipt and send copies of the response to the parties listed in §127.10(f) of this title (relating to General Procedures for Designated Doctor Examinations). If, in order to respond to the request for clarification, the designated doctor has to reexamine the injured employee, the doctor shall:

(1) respond, in writing, to the request for clarification advising of the need for an additional examination within five working days of receipt of the request and provide copies of the response to the parties specified in §127.10(f) of this title;

(2) if the division orders the reexamination, conduct the reexamination within 21 days from the date the order is issued by the division at the same examination address as the original examination; and

(3) respond, in writing, to the request for clarification based on the additional examination within seven working days of the examination and provide copies of the response to the parties specified in §127.10(f) of this title.

(e) Any refusal or failure by a designated doctor to conduct a reexamination that is necessary to respond to a request for clarification is an administrative violation.

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

§127.25. Failure to Attend a Designated Doctor Examination.

(a) An insurance carrier may suspend temporary income benefits (TIBs) if an injured employee, without good cause, fails to attend a designated doctor examination.

(b) In the absence of a finding by the division to the contrary, an insurance carrier may presume that the injured employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the injured employee has both:

(1) failed to submit to the examination; and

(2) failed to contact the designated doctor's office to reschedule the examination.

(c) If, after the insurance carrier suspends TIBs pursuant to this subsection, the injured employee contacts the designated doctor to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor. The insurance carrier shall reinstate TIBs effective as of the date the injured employee submitted to the examination unless the report of the designated doctor indicates that the injured employee has reached MMI or is otherwise not eligible for income benefits. The re-initiation of TIBs shall occur no later than the seventh day following:

(1) the date the insurance carrier was notified that the injured employee submitted to the examination; or

(2) the date that the insurance carrier was notified that the division found that the injured employee had good cause for not attending the examination.

(d) An injured employee is not entitled to TIBs for a period during which the insurance carrier suspended benefits pursuant to this subsection unless the injured employee later submits to the examination and the division finds or the insurance carrier determines that the injured employee had good cause for failure to attend the examination.

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

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 6, 2010.

TRD-201006880
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: February 1, 2011
Proposal publication date: July 16, 2010
For further information, please call: (512) 804-4703

CHAPTER 133. GENERAL MEDICAL PROVISIONS
SUBCHAPTER D. DISPUTE OF MEDICAL BILLS

28 TAC §133.306

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division) adopts amendments to §133.306, concerning Interlocutory Orders for Medical Benefits. These amendments are adopted with changes to the proposed text published in the July 16, 2010, issue of the *Texas Register* (35 TexReg 6236).

In accordance with Government Code §2001.033, the Division's reasoned justification for these amendments is set out in this order, which includes the preamble, which in turn includes the rule. The preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of the entities that commented and whether they were in support of or in opposition to the adoption of the rule, and the reasons why the Division agrees or disagrees with the comments and recommendation.

The public comment period ended on August 16, 2010. The Commissioner conducted a public hearing on August 16, 2010.

These amendments are necessary to coordinate with, and supplement, rules pertaining to the implementation of statutory provisions of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 which require the adoption of a pharmacy closed formulary.

HB 7 added requirements to the Labor Code concerning pharmaceutical services which provided under amended Labor Code §408.028(b) that:

The commissioner by rule shall adopt a closed formulary under Labor Code §413.011. Rules adopted by the commissioner shall allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury.

To fulfill the legislative requirements of Labor Code §408.028 to adopt a pharmacy closed formulary, the Division also adopts amendments to §134.500 and §134.506 and adopts new §§134.510, 134.520, 134.530, 134.540, and 134.550 of this title (relating to Pharmaceutical Benefits), which are adopted elsewhere in this edition of the *Texas Register.*

Additionally, HB 2515, enacted by the 76th Legislature, Regular Session, effective September 1, 1999 adopted Labor Code §413.055, which allows the Commissioner of Workers' Compensation to enter an interlocutory order for the payment of all or part of medical benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits. An insurance carrier is entitled to request reimbursement from the Subsequent Injury Fund for any overpayments of benefits made under an order entered if the order is reversed or modified by final arbitration, order, or decision of the Commissioner, or a court.

Labor Code §402.042 requires the Commissioner to develop and implement policies that clearly define the respective responsibilities of the Commissioner and the staff of the Division. Section 133.306 of this title was originally adopted to achieve this goal. Subsection (a) provided for the delegation of the Commissioner's authority to enter interlocutory orders to Division staff and subsections (b) and (c) set forth standards for Division staff to enter such orders.

In order to supplement the legislative requirement to adopt a pharmacy closed formulary, the Division, in consultation with the Division's Medical Advisor, adopts amendments to this section for consistency of issuing interlocutory orders for medical benefits.

There are two non-substantive changes from proposal. In subsection (b), paragraph (3) replaces the term "a utilization review agent" with "an insurance carrier" when describing the circumstances in which the Division may enter an interlocutory order, including when an insurance carrier makes an adverse determination for drugs excluded from the Division's closed formulary. This change from proposal allows for consistently applied terms in both this section and the adopted sections relating to a pharmacy closed formulary published elsewhere in this issue. Subsection (b) paragraph (3) also includes a second non-substantive change for clarification to indicate that the Division may enter an interlocutory order for drugs "prescribed on or after September 1, 2011" after an insurance carrier makes an adverse determination when a drug is excluded from the Division's closed formulary. This change harmonizes this subsection with applicable provisions of the Division's closed formulary. These changes do not materially alter issues raised in the proposal, introduce new subject matter or affect persons other than those previously on notice.

The adopted rule amendments provides the process in which the Division may enter interlocutory orders in certain situations relating to the delivery of pharmaceutical benefits, and apply to both certified network claims and those claims not subject to certified networks. The adopted rule amendments further update the existing interlocutory order process after an adverse determination by an insurance carrier for drugs prescribed on or after September 1, 2011 and excluded from the Division's pharmacy closed formulary. The amendments to §133.306 accommodate the Medical Interlocutory Order (MIO) as set forth in the new adopted §134.550 with the purpose of providing a system by which a prescribing doctor or pharmacy is able to obtain an MIO in cases where an injured employee faces an unreasonable risk of a medical emergency because they have been denied drugs excluded from the closed formulary and that were previously prescribed and dispensed to them. The distinction between the interlocutory orders is that injured employees continue to have access to interlocutory orders for medical care through §133.306 without the need to meet the medical emergency component or other specific requirements outlined in §134.550. Under §134.550 a prescribing doctor or pharmacist may request an MIO for drugs excluded from the closed formulary when the drug was previously prescribed and dispensed and failure to fill the prescription may result in an unreasonable risk of a medical emergency for an injured employee. However, an injured employee or any other party may also pursue an interlocutory order for medical benefits as set forth in §133.306, including pharmaceutical services excluded from the closed formulary, when the injured employee would not be able to receive medical benefits that are medically necessary and constitute health care reasonably required. Additionally, §133.306 does not limit interlocutory orders to prescription services as does §134.550.

Under adopted subsection (a), the Commissioner may delegate the authority to issue interlocutory orders for approved and/or future medical benefits to Division staff.

Adopted subsection (b) provides that the Division may enter an interlocutory order for accrued or future medical benefits. Adopted paragraph (1) states the first circumstance, which is when the Division determines that an insurance carrier has disputed medical benefits as the result of the liability dispute that an insurance carrier has raised in accordance with §124.2 concerning Carrier Reporting and Notification Requirements. Adopted paragraph (2) sets forth the second set of circumstances, which occur at the conclusion of the medical dispute process, namely (A) the Division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2, and the Division deems that the disputed medical benefits are or were medically necessary and constitute health care reasonably required; or (B) the Division determines that future medical benefits for which preauthorization is required are medically necessary and constitute health care reasonably required. Adopted paragraph (3) indicates the third circumstance, which is when an insurance carrier makes an adverse determination for drugs prescribed on or after September 1, 2011 and excluded from the Division's closed formulary as set forth in §§134.510, 134.530, 134.540, and 134.550 of this title concerning Requirements for the Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011; Requirements for the Use of the Closed Formulary for Claims Not Subject to Certified Networks; Requirements for the Use of the Closed Formulary for Claims Subject to Certified Networks; and Medical

Interlocutory Order, respectively, and the Division determines that those medical benefits are or were medically necessary and constitute health care reasonably required.

Under adopted subsection (c), absent the interlocutory order in subsections (a) and (b), the Division shall enter an interlocutory order only when the injured employee would not receive medical benefits that are medically necessary and constitute health care reasonably required.

Under adopted subsection (d), a party shall comply with an interlocutory order on the earlier of the seventh day after receipt of the order or the date the Division establishes in the body of the order.

Under adopted subsection (e), the insurance carrier may dispute an interlocutory order by filing a written request for a hearing in accordance with Labor Code §413.055 and §148.3 concerning Requesting a Hearing.

Adopted subsection (f) provides that an insurance carrier that makes an overpayment pursuant to an interlocutory order may be eligible for reimbursement from the Subsequent Injury Fund (SIF). An insurance carrier must make a request for SIF reimbursement in accordance with applicable Division rules.

§133.306: A commenter recommends the Division provide a process where injured employees may obtain medications through interlocutory orders. The commenter is concerned that the process in proposed §134.550 concerning Medical Interlocutory Order may be too complex, and recommends streamlining such that once a prima facie showing has been made that the potential for a medical emergency exists if the medication is suddenly withdrawn, the MIO should be entered.

Agency Response: The Division agrees in part that injured employees do need a process, and that process is identified in the interlocutory order of §133.306 of this title. The distinction between the types of interlocutory orders is that §134.550 is established to allow health care providers to provide necessary information to validate the need for the continued use of a previously prescribed and dispensed drug that is now being denied through the statutorily required appeals process. The prescribing doctor and pharmacists are best qualified to provide the information required by §134.550 including the unreasonable risk of a medical emergency. Section 133.306 was originally adopted to provide an injured employee access to an interlocutory order for certain medical benefits and is amended to include any potential need for an interlocutory order that may arise due to adoption and implementation of the Division's closed formulary. Without these amendments, this section would only have allowed an interlocutory order to be entered into in situations where there is a compensability, liability, or extent of injury dispute and the Division determines that the prescribed drug was medically necessary or after the conclusion of the medical dispute process. The amendments to §133.306 allow the injured employee to seek an interlocutory order from the Division for needs that may arise due to the adoption and implementation of the Division's pharmacy closed formulary.

§133.306: Commenters provided statements concerning both this proposed amended section as well as proposed new §134.550, that may indicate confusion on the part of system participants as to why there are two sections dealing with apparently the same issue of interlocutory orders.

Agency Response: The Division clarifies the amendments to §133.306 are necessary to coordinate with, and supplement, rules pertaining to the implementation of statutory provisions of House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 which require the adoption of a pharmacy closed formulary. The adopted amendments to §133.306 clarify and update the circumstances for existing interlocutory orders after an adverse determination by an insurance carrier for drugs prescribed on or after September 1, 2011 and excluded from the Division's pharmacy closed formulary as set forth in §§134.510, 134.530, 134.540, and 134.550 of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011; Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks; Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks; and Medical Interlocutory Order, respectively). Without this amendment, this section only allows an interlocutory order to be entered into in situations where there is compensability, liability or extent of injury dispute and the Division determines that the prescribed drug was medically necessary or after the conclusion of the medical dispute process.

Since new §134.550 addresses instances where preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency to an injured employee, the purpose of new §134.550 then, is to provide a system by which a prescribing doctor or pharmacy is able to obtain an MIO in cases where an injured employee faces an unreasonable risk of a medical emergency because they have been denied "N" drugs that have previously been prescribed and dispensed to them.

Consequently, §133.306 is amended to accommodate the MIO process as set forth in new §134.550.

§133.306(f): Commenter recommends substitute language, consistent with Labor Code §413.055 and HB 2512: "An insurance carrier that makes an overpayment pursuant to an interlocutory order shall be eligible for reimbursement from the Subsequent Injury Fund. An insurance carrier must make a request for reimbursement in accordance with §116.11 of this title (relating to Request for Reimbursement from the Subsequent Injury Fund)."

Agency Response: The Division disagrees and declines to make the change. Labor Code §413.055 allows for reimbursement from the SIF for reversed or modified interlocutory orders. However, the reimbursement is contingent on meeting the requirements specified under §116.11 concerning when and how a reimbursement request is to be submitted. Further, reimbursement made pursuant to Labor Code §413.055 requires that the insurance carrier timely provide all documentation reasonably required to the SIF Administrator and to provide notice of any relevant pending dispute, litigation or other information that may affect the reimbursement request. Additionally, reimbursement is subject to §116.12 of this title (relating to Subsequent Injury Fund Payment/Reimbursement Schedule), which sets forth the reimbursement priority schedule, payment allocation and processing of reimbursement of claims. According to the priority schedule, claims by insurance carriers for reimbursement pursuant to Labor Code §413.055 are (a)(3) on the priority list. Since there are two categories of claims that have higher priority, namely (a)(1) and (a)(2), reimbursement is not guaranteed. The insurance carrier is eligible for reimbursement, but payment is not always assured.

For: None.

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

Against: None.

Neither for or Against: None.

These amendments are adopted under Labor Code §§413.055, 410.032, 410.168, 408.027, 408.0271, 409.009, 409.0091 410.209, 408.028, 401.011(22-a), 408.021, 413.002, 413.011, 413.013, 413.031, 413.051, 402.042, 402.00128, 402.00111, 402.061, and 402.00116, and Insurance Code Chapters 1305, 4201, and 4202.

Labor Code §413.055 allows the Commissioner to enter interlocutory orders regarding medical benefits and these orders may be disputed at a hearing but the order is binding during the appeal. Labor Code §413.055 also allows for reimbursement from the Subsequent Injury Fund for reversed or modified orders. Labor Code §410.032 requires a benefit review officer who presides at the benefit review conference to consider a request for an interlocutory order and to give the opposing party the opportunity to respond before issuing an interlocutory order. Labor Code §410.168 allows a hearing officer to enter an interlocutory order for the payment of all or part of medical benefits or income benefits. The order may address accrued benefits, future benefits, or both accrued benefits and future benefits. The order is binding during the pendency of an appeal to the appeals panel. Labor Code §408.027 requires a health care provider to submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee and the insurance carrier must pay, reduce, deny, or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the carrier of the provider's claim. Labor Code §408.0271 allows an insurance carrier to demand a refund from the health care provider for the portion of payment on the claim that was received by the health care provider but which the insurance carrier determines to be inappropriate. The health care provider may appeal the insurance carrier's determination. Labor Code §409.009 allows a person to file a written claim with the Division as a subclaimant if the person has provided compensation, directly or indirectly, to or for an employee, has sought, and has been refused compensation by the insurance carrier. Labor Code §409.0091 provides for reimbursement procedures for certain entities such as an insurance carrier and an authorized representative of an insurance carrier and includes reimbursement procedures for subclaims of health care insurers. Labor Code §410.209 provides that the Subsequent Injury Fund shall reimburse an insurance carrier for any overpayment of benefits made under an interlocutory order or decision that is reversed or modified. Labor Code §408.028 requires the adoption of a pharmacy closed formulary in the workers' compensation system. Labor Code §408.028 also requires an appeals process for the pharmacy closed formulary. Labor Code §401.011(22-a) defines the term "health care reasonably required" when used in the Texas workers' compensation system. Labor Code §408.021 states that an injured employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Labor Code §413.002 sets forth specified Division duties and responsibilities regarding medical review. Labor Code §413.011 requires the Commissioner to adopt health care reimbursement policies and guidelines to ensure the quality of medical care and to achieve effective medical cost control, in addition the Commissioner is required to adopt treatment guidelines, return-to-work guidelines, disability management rules, and establish medical policies and guidelines. Labor Code §413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring and review. Labor Code §413.031 provides procedures for medical dispute resolution. Labor Code §413.0511 states that the Medical Advisor shall make recommendations regarding the adoption of rules and policies. Labor Code §402.042 requires the Commissioner to develop and implement policies that clearly define the respective responsibilities of the Commissioner and the staff of the Division. Labor Code §402.00128 vests general operational powers to the Commissioner to conduct daily operations of the Division and implement Division policy including the duty to delegate, assess and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rule making authority, under Labor Code Title 5. Labor Code §402.061 provides the Commissioner of Workers' Compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act. Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner and the authority to enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the Division or Commissioner. Insurance Code Chapter 1305 contains all the provisions of the Workers' Compensation Health Care Network Act and applies to certified networks. Insurance Code §1305.101 provides that prescription medications and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the Commissioner of Workers' Compensation. Insurance Code Chapter 4201 concerns utilization review agents and applies to utilization review of health care services provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5 or Insurance Code Chapter 1305. Insurance Code §4201.054 provides that Labor Code Title 5 prevails in the event of a conflict between Insurance Code Chapter 4201 and Labor Code Title 5. Insurance Code Chapter 4202 concerns independent review organizations, entities utilized in a dispute over the issue of medical necessity and reasonableness.

§133.306. Interlocutory Orders for Medical Benefits.

(a) The Commissioner of Workers' Compensation may delegate the authority to issue interlocutory orders for accrued and/or future medical benefits to division staff.

(b) The division may enter an interlocutory order for accrued or future medical benefits when:

(1) the division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), and the division determines that those medical benefits are or were medically necessary and constitute health care reasonably required and are not subject to the medical dispute resolution process set forth in Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills);

(2) at the conclusion of the medical dispute resolution process:

(A) the division determines that an insurance carrier has disputed medical benefits as the result of a liability, compensability, or extent of injury dispute that an insurance carrier has raised in accordance with §124.2 of this title, and the division deems that the disputed medical benefits are or were medically necessary and constitute health care reasonably required; or

(B) the division determines that future medical benefits for which preauthorization is required are medically necessary and constitute health care reasonably required; or

(3) an insurance carrier makes an adverse determination for drugs prescribed on or after September 1, 2011 and excluded from the division's closed formulary as set forth in §§134.510, 134.530, 134.540, and 134.550 of this title (relating to Requirements for the Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011, Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks, Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks, and Medical Interlocutory Order respectively) and the division determines that those medical benefits are or were medically necessary and constitute health care reasonably required.

(c) Absent the interlocutory order as set forth in subsections (a) and (b) of this section, the division shall enter an interlocutory order only when the injured employee would not receive medical benefits that are medically necessary and constitute health care reasonably required.

(d) A party shall comply with an interlocutory order entered in accordance with this section on the earlier of the seventh day after receipt of the order or the date the division establishes in the body of the order.

(e) The insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing in accordance with Labor Code §413.055 and §148.3 of this title (relating to Requesting a Hearing).

(f) An insurance carrier that makes an overpayment pursuant to an interlocutory order may be eligible for reimbursement from the Subsequent Injury Fund. An insurance carrier must make a request for reimbursement in accordance with §116.11 of this title (relating to Request for Reimbursement from the Subsequent Injury 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.

Filed with the Office of the Secretary of State on December 6, 2010.

TRD-201006878
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: September 1, 2011
Proposal publication date: July 16, 2010
For further information, please call: (512) 804-4703

♦ ♦ ♦

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

SUBCHAPTER F. PHARMACEUTICAL BENEFITS

28 TAC §§134.500, 134.506, 134.510, 134.520, 134.530, 134.540, 134.550

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division) adopts amendments to §134.500, concerning Definitions, and §134.506, concerning Outpatient Open Formulary for Claims with Dates of Injury Prior to September 1, 2011. The Division also adopts the addition of five new sections to this subchapter: §§134.510, 134.520, 134.530, 134.540, and 134.550 of this title concerning Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011; Outpatient Closed Formulary for Dates of Injury On or After September 1, 2011; Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks; Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks; and Medical Interlocutory Order, respectively. These amendments and new sections are adopted with changes to the proposed text published in the July 16, 2010, issue of the *Texas Register* (35 TexReg 6239). In accordance with Government Code §2001.033, the Division's reasoned justification for these amended and new sections is set out in this order, which includes the preamble, which in turn includes the rules. The preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of the entities that commented and whether they were in support of, or in opposition to, the adoption of the rules, and the reasons why the Division agrees or disagrees with the comments and recommendations.

The public comment period ended on August 16, 2010. The Commissioner conducted a public hearing on August 16, 2010.

These amendments and new sections are necessary to implement provisions of House Bill 7 (HB 7), enacted by the 79th Legislature, Regular Session, and effective September 1, 2005. HB 7 added requirements to the Labor Code concerning pharmaceutical services, which provided under amended §408.028(b) that: The commissioner by rule shall adopt a closed formulary under Section 413.011. Rules adopted by the commissioner shall allow an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury.

To fulfill the legislative requirements of Labor Code §408.028 to adopt a pharmacy closed formulary, and to be consistent with the provisions contained in §134.550 of this title regarding Medical Interlocutory Order, the Division also adopts amendments to §133.306 of this title (relating to Interlocutory Order for Medical Benefits) which are adopted elsewhere in this issue of the *Texas Register.*

Additional HB 7 legislative objectives stated in Labor Code §413.0111 provide the rules adopted for reimbursement of prescription medication must authorize pharmacies to use agents or assignees to process claims and act on behalf of pharmacists.

HB 7 defined two new terms in the Labor Code that are pertinent to these adopted sections concerning a pharmacy closed formulary. Labor Code §401.011(18-a) defines evidence-based medicine to mean the use of current best quality scientific and medical evidence formulated from credible scientific studies, including peer-reviewed medical literature and other current scientifically based texts, and treatment and practice guidelines in making decisions about the care of individual patients. Building on the definition of evidence-based medicine, HB 7 also clarified in Labor Code §401.011(22-a) that health care reasonably required means health care that is clinically appropriate and considered effective for the injured employee's injury and provided in accordance with best practices that are consistent with evidence-based medicine or if that evidence is not available, gen-

erally accepted standards of medical practice recognized in the medical community.

Applicability to Certified Networks

The Division's pharmacy closed formulary is also applicable to claims receiving care through certified workers' compensation health care networks (certified networks) pursuant to Insurance Code §1305.101(c). Both Insurance Code Chapter 1305 and the Labor Code §408.028(b) provision, requiring the Commissioner of Workers' Compensation (Commissioner) to adopt a pharmacy closed formulary, were enacted by HB 7 during the 79th legislative session.

Changes from Proposal

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

Adopted §134.500(3)(C) of this title concerning Definitions, contains non-substantive clarification from proposal that deletes the terms "in accordance with," and replaces the terminology with "as defined by." Reference to Labor Code §413.014 was changed to §413.014(a) in the adopted language to clarify and specify the subsection. This change is made to acknowledge the Labor Code citation as the source for the definition of investigational or experimental when applied in the context of the closed formulary.

Adopted §134.500(13) contains two changes from proposal made as a result of public comments. The first change is a deletion of the phrase "and supporting evidence-based documentation" from the requirements of a statement of medical necessity. The Division notes the potentially burdensome nature of providing this information, especially by an injured employee, and also notes that §134.500(13)(F) satisfies the Division's expectation that the statement of medical necessity should thoroughly provide the documentation that supports the medical necessity for the drug. The second adopted change to the rule from proposal is to change the term, "includes" to "shall include" to clarify the mandatory nature of all elements of a statement of medical necessity. The adopted change strengthens and clarifies the requirements for a complete statement of medical necessity.

Adopted §134.506 contains changes from proposal to the title of the rule from "Outpatient Open Drug Formulary for Claims with Dates of Injury Prior to January 1, 2011" to "Outpatient Open Formulary for Claims with Dates of Injury Prior to September 1, 2011." The word "Drug" is deleted from the title as proposed for consistency of terminology used in the remainder of these adopted rules and Labor Code §408.028(b) which uses the term "formulary" and not the term "drug formulary." The dates in the title and subsection (a) are changed to September 1, 2011 in response to public comment concerning a request for delayed implementation so that system participants may change policies; develop, test, and implement programming requirements; appropriately train and educate prescribing doctors, pharmacists, insurance carriers, and other affected entities; and to allow insurance carriers to implement and refine their utilization review processes. As a result of public comment, subsection (a) is also re-worded to clarify the intent of the amendments to continue the use of the open formulary, which implements changes to Labor Code §408.028 made by HB 2600 in 2001, until such time that all claims become subject to the pharmacy closed formulary. The amended language is as follows: "For claims with dates of injury prior to September 1, 2011 (for purposes of this section, referred to as 'legacy claims'), the open formulary as described in §134.500(9) of this title (relating to Definitions) remains in effect until those claims become subject to the closed formulary in accordance with §134.510 of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011)." Subsection (f) is changed from proposal, which a commenter stated provided broad language that could potentially circumvent certified network and non-network preauthorization requirements for investigational or experimental drugs. Adopted subsection (f) now clarifies that drugs included in the open formulary that do not require preauthorization and are prescribed and dispensed for legacy claims are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier. Without the clarification to subsections (a) and (f), there would be no guidance or direction, including utilization review requirements, provided to system participants for those claims with the latter phase-in date (legacy claims). Absent a clear continuation of the open formulary, there would be confusion as to medically appropriate prescription medications, treatment guidelines, preauthorization requirements, and retrospective review considerations.

Adopted §134.510 contains conforming, non-substantive changes from proposal to the title of the rule concerning the applicability date from January 1, 2011 to September 1, 2011. Similarly, and based on public comment, subsection (a) also contains conforming applicability date changes. Adopted subsection (a) applies to claims with dates of injury prior to September 1, 2011 (for purposes of this section, referred to as "legacy claims"). These claims are subject to §§134.530, 134.540, and 134.550 on and after September 1, 2013. Subsection (b)(1) of this adopted rule also contains a conforming date change that allows at any time after September 1, 2011 and prior to September 1, 2013, the initiation of the steps towards transition of legacy claims. Based on public comment, changes from proposal to the adopted rule at subsection (b)(1)(C) and (b)(2)(B)(i) and (ii) are modified to allow and require equal exchange of information between the prescribing doctor and the insurance carrier. New subsection (b)(1)(C) states, "When a prescribing doctor or insurance carrier is contacted by the other party regarding ongoing pharmacological management, the parties must provide each other a name, phone number, and date and time to discuss ongoing pharmacological management of the injured employee's claim." Additionally, new subsection (b)(2) states, "Beginning no later than March 1, 2013, the insurance carrier shall: (A) identify all legacy claims that have been prescribed a drug excluded from the closed formulary after September 1, 2012; and (B) provide written notification to the injured employee, prescribing doctor, and pharmacy if known, that contains the following: (i) the notice of the impending date and applicability of the closed formulary for legacy claims; and (ii) the information required in subsection (b)(1)(C) of this section." As a result of public comments, the language in subsections (c) and (d) is changed from proposal to clarify that an agreement can be made between an insurance carrier and a prescribing doctor to ensure continuity of care during this transition of legacy claims. The specific reference to §134.600 of this title is not necessary, and is therefore removed because the statutory authority of Labor Code §413.014 allows for voluntary preauthorization. The adopted language now reads, "(c) Agreement. To ensure continuity of care, notwithstanding subsection (a) of this section, an insurance carrier and a prescribing doctor may enter

into an agreement regarding the application of the pharmacy closed formulary for individual legacy claims on a claim-by-claim basis." Adopted subsection (d)(3) now reads, "(3) Denial of a request for an agreement is not subject to dispute resolution." Lastly, subsection (d)(4) contains a conforming applicability date change to September 1, 2013.

Labor Code §408.028(b) requires the Commissioner to adopt a closed formulary and appeals process for drugs not included in the closed formulary. The rules adopted under Labor Code §408.028, including adopted §134.510, apply to certified networks pursuant to Insurance Code §1305.101(c). The transition provisions contained in adopted subsections (c) and (d) are intended to provide a tool of pharmacological management for use within certified networks or within the non-network system. These provisions allow and encourage a prescribing doctor and the insurance carrier to discuss the ongoing pharmacological management of legacy claims and develop appropriate transition agreements for injured employees. Under Labor Code §§402.0111, 402.00116, 402.00128 and 402.061, the Commissioner has the statutory authority to exercise executive, administrative and operational powers and duties including rulemaking and enforcement functions.

Adopted §134.520 contains conforming, non-substantive changes from proposal to the title of the rule from "Outpatient Closed Drug Formulary for Dates of Injury On or After January 1, 2011" to "Outpatient Closed Formulary for Dates of Injury On or After to September 1, 2011." The word "Drug" is deleted from the title as proposed for consistency of terminology used in the remainder of these adopted rules and Labor Code §408.028(b) which uses the term "formulary" and not the term "drug formulary." The dates in the title and rule have changed to September 1, 2011 in response to public comments concerning delayed applicability.

Adopted §134.530 contains conforming applicability language change in subsection (a) to September 1, 2011. Adopted subsection (b) is changed from proposal to state that preauthorization for non-network claims subject to the Division's closed formulary is only required for those three instances as stated in the definition of a closed formulary as cited in §134.500(3). The proposed language only provided a reference to the definition and not the specific detail included in the adopted rule. This non-substantive clarification is included in the adopted rule because some public commenters seemed uncertain in understanding when preauthorization of a drug is necessary. A non-substantive clarification to proposed §134.530(b)(4) is made with a new subsection (c) that addresses and clarifies preauthorization of an intrathecal drug delivery system and its refills. An intrathecal drug delivery system and its refills require preauthorization in accordance with §134.600, and therefore the language, "prior to its initial use" is unnecessary and has been deleted from the adopted rule. The new subsection (c) addressing an intrathecal drug delivery system has necessitated the re-lettering of the remaining subsections of this section. Additionally, adopted subsection (f)(2) changes a proposal reference from subsection (b)(2) to reference adopted (b)(1)(C) as a result of changes made in subsection (b).

Adopted §134.540 contains conforming applicability language change in subsection (a) to September 1, 2011. Adopted subsection (b) is changed from proposal to state that preauthorization for certified network claims subject to the Division's closed formulary is only required for those three instances as stated in the definition of a closed formulary as defined in §134.500(3). This clarification is included in the adopted rule because some public commenters seemed uncertain in understanding when preauthorization of a drug is necessary. Because of public comment that recommended that intrathecal drug delivery system language for certified networks mirror provisions of non-network, the adopted language in proposed §134.540(b)(3) is changed to a new subsection (c) that addresses and clarifies preauthorization of an intrathecal drug delivery system. The new subsection (c)(2) reads, "(c)(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever: (A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or (B) there is a change in prescribing doctor." The change makes the certified network intrathecal drug delivery system refill appeal "process" for drugs excluded from the closed formulary consistent with the appeal "process" applicable to non-network claims for similar intrathecal drug delivery system refills. The closed formulary applies to certified networks and non-networks and includes an appeal process. The adopted language addresses and explains the appeal process for refills when the drug is excluded from the closed formulary. The new subsection (c) addressing intrathecal drug delivery system refills has necessitated the re-lettering of the remaining subsections of this section.

Also as a result of public comment, a new subsection (f) is added to address initial pharmaceutical coverage for claims subject to certified networks. The adopted language now reads, "(f) Initial pharmaceutical coverage. (1) Drugs included in the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are not subject to retrospective review of medical necessity. (2) Drugs excluded from the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141 may be dispensed without preauthorization and are subject to retrospective review of medical necessity."

The initial pharmaceutical coverage provisions of Labor Code §413.0141 apply to both non-network and certified network claims since there is no conflict between Labor Code §413.0141 and Insurance Code Chapter 1305 and because reimbursement of pharmaceutical medication and services are governed by the Act and Division rules. Insurance Code §1305.101(c) states that: "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

As a result of new subsection (f), new subsection (g) is also changed and now reads, "(g) Retrospective Review. Except as provided under subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill), §133.240 of this title (relating to Medical Payments and Denials), the Insurance Code, Chapter 1305, applicable provisions of Chapters 10 and 19 of this title."

Adopted §134.550 contains a non-substantive clarification from proposal in subsection (a) to include a reference to Insurance Code §1305.004(a)(13) in addition to §134.500(7) in the definition of "medical emergency". This reference clarifies that the medical emergency definition used in §134.550 is the same standard for both certified network and non-network claims.

Adopted amendment of §134.500. The adopted amendments provide definitions of new terms to the subchapter: *brand name drug, certified workers' compensation health care network (certified network), closed formulary, generically equivalent, pharmaceutically equivalent, therapeutically equivalent, medical emergency, and substitution.*

The adopted amendments also clarify the definitions of *compounding, open formulary, statement of medical necessity, prescribing doctor, and prescription.*

Under adopted new §134.500(3), a *closed formulary* is defined as, "all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes: (A) drugs identified with a status of "N" in the current edition of the *Official Disability Guidelines Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates, and (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by Labor Code §413.014(a)."

In summary, the pharmacy closed formulary includes all FDA-approved drugs except drugs with status "N" in the ODG Appendix A, compounds that include drugs with status "N" and investigational or experimental drugs as defined by Labor Code §413.014(a).

The "N" drug designation means that a drug is not included in the drug formulary and will require preauthorization. Investigational or experimental drugs are not yet broadly accepted as the prevailing standard of care, and would require preauthorization as well.

The added definitions and clarification of the existing definitions increase the ability of system participants to understand their responsibilities.

Adopted amendment of §134.506. The adopted amendments to subsection (a) clarify that for claims with dates of injury prior to September 1, 2011 (for the purposes of §134.506 referred to as "legacy claims"), the open formulary as defined in §134.500(9) remains in effect until those claims become subject to the closed formulary in accordance with §134.510. The Division currently has an open formulary that has been in effect since 2002. The continuation of the open formulary for legacy claims until September 1, 2013 is necessary in order to provide a successful transition to the pharmacy closed formulary. The transition provides an implementation "bridge" between the two systems because of the anticipated volume of preauthorization and the time needed for system participants to prepare for the inclusion of legacy claims.

Adopted new subsection (b) provides that the prescribing of drugs for claims not subject to a certified network shall be in accordance with the Division's adopted treatment guidelines. The treatment guidelines provide evidence-based direction for the appropriate use of treatments and services, including drugs, for claims not subject to a certified network. The treatment guidelines are the standards by which medical necessity is evaluated, including retrospective review.

Under adopted new subsection (c), the prescribing of drugs for claims subject to a certified network under the open formulary shall be in accordance with the certified network's treatment guidelines pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title (relating to Workers' Compensation Health Care Networks).

Adopted new subsection (d) sets forth that drugs included in the open formulary prescribed and dispensed for claims not subject to a certified network with dates of injury prior to September 1, 2011 do not require preauthorization, except as required by Labor Code §413.014. With this new subsection, system participants are not required to pursue preauthorization in accordance with §134.600(p)(12), and as a result, subsection (f) will require the retrospective review of these services.

Under adopted new subsection (e), drugs included in the open formulary prescribed and dispensed for legacy claims subject to a certified network shall be preauthorized pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title.

Under adopted new subsection (f), drugs included in the open formulary that do not require preauthorization under adopted new subsections (d) and (e) and are prescribed and dispensed for legacy claims are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier.

Adopted new §134.510. Adopted new §134.510 concerns the transition from an open formulary to the pharmacy closed formulary for claims with dates of injury prior to September 1, 2011, which for purposes of this section, are referred to as "legacy claims."

Adopted new subsection (a) addresses the applicability of the section and states that the section applies to claims with dates of injury prior to September 1, 2011, which are subject to §134.530 concerning Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks, §134.540 concerning Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks, and §134.550 concerning Medical Interlocutory Order on and after September 1, 2013.

Adopted new subsection (b) provides for transition of legacy claims. Paragraph (1) sets forth the transition activities that should occur for any time after September 1, 2011 and prior to September 1, 2013. Under subparagraph (A), a prescribing doctor should include a statement of medical necessity as defined in §134.500(13) with the prescription for drugs excluded from the closed formulary. Under subparagraph (B), the prescribing doctor or the insurance carrier may contact each other for a discussion of ongoing pharmacological management of the injured employee's claim. Under subparagraph (C), when a prescribing doctor or insurance carrier is contacted by the other party regarding ongoing pharmacological management, the parties must provide each other a name, phone number, and date and time to discuss ongoing pharmacological management of the injured employee's claim. Paragraph (2) sets forth what the insurance carrier shall do beginning no later than March 1, 2013, which are: to identify all legacy claims that have been prescribed a drug excluded from the closed formulary

after September 1, 2012; and provide written notification to the injured employee, prescribing doctor, and pharmacy if known, the notice of the impending date of the applicability of the closed formulary and the information required when a prescribing doctor or insurance carrier is contacted by the other party regarding ongoing pharmacological management.

Under adopted subsection (c), prior to the applicability date of the closed formulary, an insurance carrier and prescribing doctor may enter into an agreement regarding the application of the pharmacy closed formulary for individual legacy claims on a claim-by-claim basis.

Adopted subsection (d) addresses the agreement requirements. Under paragraph (1), the insurance carrier shall document any agreement and the terms, and share a copy of the agreement with the prescribing doctor and injured employee. Under paragraph (2), the health care provided as a result of the agreement is not subject to retrospective review of medical necessity. Under paragraph (3), the denial of a request for an agreement is not subject to dispute resolution. Under paragraph (4), if no agreement is reached and documented by September 1, 2013 for a legacy claim, the requirements of §§134.530, 134.540, and 134.550 are to apply.

Adopted new §134.520. The Commissioner adopts a pharmacy closed formulary under adopted new §134.520, as defined in §134.500(3) concerning Definitions, with dates of injury on and after September 1, 2011.

Adopted new §134.530. Adopted new §134.530 concerns the requirements for the use of the pharmacy closed formulary for claims not subject to certified networks.

Adopted new subsection (a) of the section addresses applicability and provides that the closed formulary will be applicable to all drugs that are prescribed and dispensed for outpatient use on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011.

Adopted new subsection (b) addresses preauthorization requirements for non-network claims subject to the Division's closed formulary. Adopted paragraph (1) sets forth that preauthorization is only required for: (A) drugs identified with a state of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; (B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by Labor Code §413.014(a). Adopted paragraph (2) provides that when §134.600(p)(12) concerning Preauthorization, Concurrent Review, and Voluntary Certification of Health Care conflicts with this section, this section prevails.

Adopted new subsection (c) addresses preauthorization of intrathecal drug delivery systems. Under new paragraph (1), an intrathecal drug delivery system requires preauthorization in accordance with §134.600 and the preauthorization request must include the prescribing doctor's drug regime plan of care, and the anticipated dosage or range of dosages for the administration of pain medication. Additionally, the subsection addresses preauthorization requirements for the refilling of previously preauthorized intrathecal drug delivery system with drugs excluded from the closed formulary. Under adopted paragraph (2), refills of an intrathecal drug delivery system excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever: (A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or (B) there is a change in prescribing doctor.

Adopted new subsection (d) addresses treatment guidelines, and provides that except as provided in this subsection, the prescribing of drugs shall be in accordance with the Division's treatment guidelines. Under adopted Paragraph (1), the drugs included in the Division's closed formulary and recommended by the Division's adopted treatment guidelines may be prescribed and dispensed without preauthorization. Under adopted paragraph (2), the prescription and nonprescription drugs included in the closed formulary that exceed or are not addressed by the Division's adopted treatment guidelines may be prescribed and dispensed without preauthorization. Under adopted paragraph (3), the drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (g). The treatment guidelines provide evidence-based direction for the appropriate use of treatments and services, including drugs, for claims not subject to a certified network. The treatment guidelines are the standards by which medical necessity is evaluated. Treatment provided within the treatment guidelines is presumed to be health care reasonably required. Additionally, treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines. Where the treatment guidelines and closed formulary differ is that drugs excluded from the closed formulary require preauthorization regardless of the recommendations included in the Division's treatment guidelines.

Adopted new subsection (e) explains the appeals process for drugs excluded from the closed formulary. Adopted paragraph (1) provides that when the prescribing doctor determines and documents that a drug excluded from the pharmacy closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor or other requestor (which may be the pharmacist or injured employee), may request the drug in a specific case by requesting preauthorization, including reconsideration under §134.600 and under the applicable provisions of Chapter 19. Adopted paragraph (2) states that if preauthorization is being requested by an injured employee or a requestor other than the prescribing doctor, the prescribing doctor shall provide a statement of medical necessity as set forth in current §134.502 concerning Pharmaceutical Services. Under adopted paragraph (3), if preauthorization is denied for drugs excluded from the pharmacy closed formulary, the requestor may submit a request for medical dispute resolution in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations). Adopted paragraph (4), provides that in the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 concerning Interlocutory Orders for Medical Benefits or §134.550 concerning Medical Interlocutory Order. The distinction in the interlocutory orders is that un-

der §134.550 a prescribing doctor or pharmacist may request a medical interlocutory order (MIO) for drugs excluded from the closed formulary when the drug was previously prescribed and dispensed and failure to fill the prescription may result in an unreasonable risk of a medical emergency for an injured employee. However, an injured employee or any other party may pursue an interlocutory order for medical benefits, as set forth in §133.306, for continued access to health care, including pharmaceutical services excluded from the closed formulary, when the injured employee would not be able to receive medical benefits that are medically necessary and constitute health care reasonably required.

Adopted new subsection (f) addresses initial pharmaceutical coverage. Under adopted paragraph (1), drugs included in the closed formulary which are prescribed for initial pharmaceutical coverage in accordance with Labor Code §413.0141, may be dispensed without preauthorization, except as required by Labor Code §413.014, and are not subject to retrospective review of medical necessity. Under adopted paragraph (2), drugs excluded from the closed formulary, which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization, except as required by Labor Code §413.014, and are subject to retrospective review of medical necessity.

Adopted new subsection (g) addresses retrospective review, and states that except as provided in subsection (f)(1), drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 and §133.240 of this title (relating to Insurance Carrier Audit of a Medical Bill, and Medical Payments and Denials respectively), and applicable provisions of Chapter 19. Under adopted paragraph (1), health care provided in accordance with the Division's treatment guidelines is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a). Under adopted paragraph (2), in order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the Division's treatment guidelines, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017. Adopted paragraph (3) provides that a prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by the Division's treatment guidelines is required to provide documentation upon request in accordance with §134.500(13) and §134.502(e) and (f).

Adopted new §134.540. Adopted new §134.540 concerns the requirements for the use of the pharmacy closed formulary for claims subject to certified networks.

Adopted new subsection (a) of the section addresses applicability and provides that the closed formulary will be applicable to all drugs that are prescribed and dispensed for outpatient use on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011.

Adopted new subsection (b) addresses preauthorization requirements for certified network claims subject to the Division's closed formulary. Adopted subsection (b) sets forth that preauthorization is only required for: (1) drugs identified with a state of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; (2) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and (3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by Labor Code §413.014(a). Adopted new subsection (c) addresses preauthorization of intrathecal drug delivery systems. Under new paragraph (1), an intrathecal drug delivery system requires preauthorization in accordance with the certified network's treatment guidelines and preauthorization requirements pursuant to Insurance Code Chapter 1305 and Chapter 10. Under adopted paragraph (2), refills of an intrathecal drug delivery system excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever: (A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or (B) there is a change in prescribing doctor.

Adopted new subsection (d) addresses treatment guidelines, and provides that the prescribing of drugs shall be in accordance with the certified network's treatment guidelines and preauthorization requirements pursuant to Insurance Code Chapter 1305 and Chapter 10. Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (f).

Adopted new subsection (e) explains that the preauthorization process is the appeals process for drugs excluded from the closed formulary. Under adopted paragraph (1), for situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee may request approval of the drug in a specific instance by requesting preauthorization in accordance with the certified network's preauthorization process established pursuant to Chapter 10, Subchapter F and applicable provisions of Chapter 19. Adopted paragraph (2) states that if preauthorization is pursued by an injured employee or requestor other than the prescribing doctor, and the injured employee or other requestor requests a statement of medical necessity, the prescribing doctor shall provide a statement of medical necessity to facilitate the preauthorization submission as set forth in §134.502. Under adopted paragraph (3), if preauthorization for a drug excluded from the closed formulary is denied, the requestor may submit a request for medical dispute resolution in accordance with §133.308. Under adopted paragraph (4), in the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 or §134.550. The distinction in the interlocutory orders is that under §134.550 a prescribing doctor or pharmacist may request an MIO for drugs excluded from the closed formulary when the drug was previously prescribed and dispensed and failure to fill the prescription may result in an unreasonable risk of a medical emergency for an injured employee. However, an injured employee or any other party may pursue a traditional interlocutory order under §133.306 for continued access to

health care, including pharmaceutical services excluded from the closed formulary, when the injured employee would not be able to receive medical benefits that are medically necessary and constitute health care reasonably required.

Adopted new subsection (f) addresses initial pharmaceutical coverage. Under adopted paragraph (1), drugs included in the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are not subject to retrospective review of medical necessity. Under adopted paragraph (2), drugs excluded from the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are subject to retrospective review of medical necessity.

Adopted new subsection (g) describes retrospective review and indicates, except as provided in subsection (f)(1), drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 and §133.240, and the Insurance Code, Chapter 1305, applicable provisions of Chapter 10 and Chapter 19. Under adopted paragraph (1), in order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that fall within the treatment parameters of the certified network's treatment guidelines, the denial must be supported by documentation of evidence-based medicine that outweighs the evidence-basis of the certified network's treatment guidelines. Under adopted paragraph (2), upon request, a prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by the treatment parameters of certified network's treatment guidelines, is required to provide documentation in accordance with §134.500(13) and §134.502(e) and (f).

Adopted new §134.550. Adopted new §134.550 concerns a medical interlocutory order (MIO).

Adopted new subsection (a) addresses the purpose of the new section, which is to provide a system by which a prescribing doctor or pharmacy is able to obtain an MIO in cases where preauthorization denials of a previously prescribed and dispensed drug(s) excluded from the pharmacy closed formulary poses an unreasonable risk of a medical emergency to an injured employee. The adopted subsection references the definition of a medical emergency in §134.500(7) and Insurance Code §1305.004(a)(13). The definition is used in combination with "unreasonable risk" to establish the need for an MIO.

Adopted new subsection (b) states that a request for an interlocutory order that does not meet the criteria described by this section may still be requested pursuant to §133.306 of this title (relating to Interlocutory Order for Medical Benefits). To fulfill the legislative requirements of Labor Code §408.028 to adopt a pharmacy closed formulary, the Division also adopts amendments to §133.306, which are addressed elsewhere in this adoption issue of the *Texas Register.*

Adopted new subsection (c) states that an MIO will be issued if the request for an MIO contains 12 specific pieces of information. The adopted new paragraphs (1) through (12) of subsection (c) list those specific information components as: the injured employee name; the date of birth of injured employee; the prescribing doctor's name; the name of drug and dosage; the MIO requestor's name (pharmacy or prescribing doctor); the MIO requestor's contact information; a statement that a preauthorization request for a previously prescribed and dispensed drug(s), which is excluded from the closed formulary, has been denied by the insurance carrier; a statement that an independent review request has been submitted to the insurance carrier or the insurance carrier's utilization review agent in accordance with §133.308; a statement that the preauthorization denial poses an unreasonable risk of a medical emergency; a statement that the potential medical emergency has been documented in the preauthorization process; a statement that the insurance carrier has been notified that a request for an MIO is being submitted to the Division; and a signature with a certification by the MIO requestor stating, "I hereby certify under penalty of law that the previously listed conditions have been met."

Adopted new subsection (d) notes that a complete request for an MIO under this section shall be processed and approved by the Division in accordance with this section. At the discretion of the Division, an incomplete request for an MIO under this section may be considered in accordance with this section.

Adopted new subsection (e) provides that the request for an MIO may be submitted on the designated Division form available on the Division's website, *http://www.tdi.state.tx.us/wc/indexwc.html.* In the event the Division form is not available, the written request must contain the provisions of subsection (c).

Adopted new subsection (f) states the MIO requestor shall provide a copy of the MIO request to the insurance carrier, prescribing doctor, injured employee, and dispensing pharmacy, if known, on the date the request for MIO is submitted to the Division.

Adopted new subsection (g) indicates that an approved MIO shall be effective retroactively to the date the complete request for an MIO is received by the Division.

Adopted new subsection (h) provides further specifications for an MIO that is notwithstanding §133.308. Under adopted paragraph (1), a request for reconsideration of a preauthorization denial is not required prior to a request for independent review when pursuing an MIO under this section. If a request for reconsideration or an MIO request is not initiated within 15 days from the initial preauthorization denial, then the opportunity for an MIO under this section does not apply. Under adopted paragraph (2), if pursuing an MIO after denial of a reconsideration request, a complete MIO request shall be submitted within five working days of the reconsideration denial.

Adopted new subsection (i) states an appeal of an independent review organization (IRO) decision relating to the medical necessity and reasonableness of the drugs contained in the MIO shall be submitted in accordance with §133.308(t).

Adopted new subsection (j) provides that the MIO is to continue in effect until the later of (1) a final adjudication of a medical dispute regarding the medical necessity and reasonableness of the drug contained in the MIO, (2) the expiration of the period for a timely appeal, or (3) an agreement of the parties.

Adopted new subsection (k) states that withdrawal by the requestor of a request for medical necessity dispute resolution constitutes acceptance of the preauthorization denial.

Under adopted new subsection (l), a party shall comply with an MIO entered in accordance with this section and the insurance carrier shall reimburse the pharmacy for prescriptions dispensed in accordance with an MIO.

Under adopted new subsection (m), the insurance carrier shall notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required in accordance with subsection (j).

Under adopted new subsection (n), payments made by insurance carriers pursuant to this section may be eligible for reimbursement from the Subsequent Injury Fund in accordance with Labor Code §410.209 and §413.055, and applicable rules.

Adopted new subsection (o) states that a decision issued by an IRO is not an agency or Commissioner decision.

Under adopted new subsection (p), a party may seek to reverse or modify an MIO issued under this section if (1) a final determination of medical necessity has been rendered; and (2) the party requests a benefit contested case hearing (CCH) from the Division's chief clerk no later than 20 days after the date the IRO decision is sent to the party. A benefit review conference is not a prerequisite to a Division CCH under this subsection. Except as provided by this subsection, a Division CCH shall be conducted in accordance with Chapters 140 and 142 concerning Dispute Resolution--General Provisions, and Dispute Resolution--Benefit Contested Case Hearing.

Under adopted new subsection (q), the insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing in accordance with Labor Code §413.055 and §148.3 concerning Requesting a Hearing.

The Division notes that in responding to public comments, the numbering of certain subsections may have changed from proposal. In order to avoid confusion concerning the written comments as received, the Division has maintained the commenter's numerical references to the proposed sections.

General: Commenters acknowledge and express appreciation for the Division's deliberative approach and close involvement with system participants while developing the closed formulary rules. Several of the commenters additionally recognize that the intensive stakeholder meetings and informal working draft rules processes have resulted in a vastly improved proposal product.

Agency Response: The Division appreciates the supportive comments.

General: A commenter requests that all stakeholders have continuous password access to the ODG link to the drugs identified in Appendix A.

Agency Response: The Division clarifies that information concerning how to obtain full access to *ODG Treatment in Workers' Comp* is currently available on the Division's website. Additionally, the Division anticipates separately listing drugs with an "N" status on Appendix A on the Division's website as a convenience for system participants.

General: A commenter opines that the proposed rules provide no evidence that addresses a process or system of reviewing the ODG and evaluating on an ongoing basis to allow for refinements of inclusion/exclusion (formulary maintenance) that reflects the ever-changing new drug information, nor the intent to employ a drug review process to target and refine drug therapy that has become problematic regarding effectiveness, safety and/or cost.

Agency Response: The Division disagrees. As required by Labor Code §413.011(e), the Commissioner has adopted *ODG Treatment in Workers' Comp* as the Division's treatment guidelines. The Division's treatment guidelines are evidence-based and reviewed and updated by the Work Loss Data Institute (WLDI). The details of the review process for new evidence, which employs the Appraisal of Guidelines Research and Evaluation (AGREE) Instrument and the open invitation to submit new evidence regarding treatments and services, is available on the WLDI website. Labor Code §413.011(e) further states treatment may not be denied solely on the basis that treatment for the compensable injury in question is not specifically addressed by the treatment guidelines. Consequently, evidence that is not included in the treatment guidelines may be presented in a statement of medical necessity to substantiate the need for the use of a pharmaceutical that is not recommended or addressed by the guidelines. The guidelines in ODG Appendix D also provide suggestions for documenting instances regarding the medical necessity of treatments and services that are not recommended, not included in, or exceed the recommendations of the treatment guidelines.

General: A commenter states that the proposed rules provide no evidence of the system's intent to employ any utilization management process, other than preauthorization, to address inappropriate prescribing and suggests much can be accomplished through simpler and easier processes, such as quantity of prescription limits and step therapy edits as an integral part of the formulary utilization management process.

Agency Response: The Division disagrees. Injured employees in the Texas workers' compensation system are entitled to all health care reasonably required that relieves or cures the compensable injury or facilitates an injured employee's return-to-work. Although preauthorization is a component of reviewing the medical necessity of specific services, other services not requiring preauthorization are subject to either concurrent or retrospective review. These medical necessity reviews are primarily based upon the recommendations included in either the Division's or a certified network's adopted treatment guidelines. Step therapy and quantity limits may be adequately addressed through the medical necessity reviews of the preauthorization and retrospective review processes.

General: A commenter states there is no evidence of what, if any, clinical, drug-specific, preauthorization criteria would be employed for each drug requiring preauthorization, and without specific criteria for approving or disapproving a preauthorization request for a specific drug, subjectivity and approval rates will be higher than necessary or appropriate.

Agency Response: The Division disagrees. The preauthorization process for drugs not included in the closed formulary is subject to the utilization review requirements as outlined in Chapters 10, 19, 134, and 137 of this title (relating to Workers' Compensation Health Care Networks, Utilization Review, Benefits--Guidelines for Medical Services, Charges and Payments, and Disability Management, respectively). Utilization review requires determinations to be made on a case-by-case basis; however, preauthorization determinations of all treatments and services, including pharmaceutical services, are required to consider recommendations included in either the Division's or a certified network's adopted treatment guidelines. Consequently, approvals will be appropriate and only for medically necessary services.

General: A commenter seeks further information regarding the proposal preamble's estimates of the increased costs to be incurred by insurers. The commenter states, "According to the Division, the costs of each prospective review will range from $60 to $120." If the costs of each prospective review will range from $60 to $120, then the question is whether $60 to $120 is a reasonable estimate of a cost of a prospective review. When

there is a denial of a claim, usually a physician is involved in the process. If a licensed medical provider is typically involved in the process of a denial, the projected cost would likely be somewhat significantly greater than $60 to $120.

Agency Response: The Division clarifies that the estimate provided in the proposal preamble is a range based on ongoing conversations and stakeholder meetings with insurance carrier representatives in Texas. This range is not intended to illustrate the actual cost of any particular utilization review activity. It is, however, an attempt to quantify a range of average costs as communicated to the Division throughout this and other rule development processes. Since each insurance carrier develops and implements its own review process within the structure required by Chapter 19 of this title, the actual costs for each insurance carrier varies and are best estimated by each insurance carrier. System participants have not provided more specific information to the Division regarding their cost structures for the Division to provide a more definitive estimate of the net impact of preauthorization costs.

General: A commenter states that overall the new closed formulary will complicate care for injured employees and many physicians who currently provide care for injured employees will decide to stop treating injured employees when they find that their prescriptions are not filled. This simply adds another "hassle" and the detrimental side effects of the requirements will outweigh any beneficial effects to the system.

Agency Response: The Division agrees in part. The Division agrees that there may be additional work for some health care providers in some circumstances. However, the additional review will help to ensure the medical necessity of drugs prescribed to injured employees. The Division disagrees in part. The Commissioner's adoption of the closed formulary is required under Labor Code §408.028(b). Its adoption and use is consistent with the existing recommendations included in the Division's treatment guidelines. The Division's treatment guidelines have been in effect since May 1, 2007 and prescribing doctors may already be prescribing in a manner consistent with the adopted closed formulary. Further, the Division reconfirmed the applicability of the ODG Treatment Guideline pharmaceutical recommendations as found in the treatment summaries when the Division issued an August 29, 2008 memo titled "Use of Pharmaceuticals in the Texas Workers' Compensation System." Preauthorization of drugs excluded from the closed formulary assures that these drugs are medically necessary and increases surety of payment for the providers of pharmaceutical services. Additionally, these concepts extend to pharmaceutical services provided for claims subject to a certified network when the certified network's treatment guidelines are applicable.

General: A commenter seeks clarification on several jurisdictional issues, such as whether the closed formulary rules apply to an injured employee: (1) who is receiving pharmaceutical benefits from a retail pharmacy located out of state; (2) with a jurisdiction from another state, but receiving pharmaceutical benefits from a retail pharmacy located in the state of Texas; (3) with Texas jurisdiction, living in the state of Texas but receiving medications from a mail order pharmacy located out of state; and (4) with Texas jurisdiction, living out of state, but receiving medications from a mail order pharmacy located in Texas.

Agency Response: The Division clarifies that these adopted rules apply to all drugs that are prescribed and dispensed for outpatient use for Texas workers' compensation injury claims and that without knowledge of all pertinent facts concerning conflict-of-law issues related to any particular medical bill processing, the Division cannot provide an advisory opinion to a disagreement on reimbursement that may be later presented in the dispute processes of the Division or other out of state dispute resolution forums. While the Division may not be able to resolve such out of state disputes due to the Division's potential lack of jurisdiction over out of state health care providers, the Division does clarify, however, that Texas workers' compensation injury claims generally are subject to Texas laws and rules. Additionally, the Department has the responsibility to regulate Texas insurance carriers and expects insurance carriers to work with out of state health care providers to ensure that Texas injured employees receive medically necessary health care services. Further, the Division clarifies that the insurance carrier should communicate with the jurisdiction responsible for the injured employee to provide direction regarding the processing of the claim.

For resource purposes only, the Division notes three Texas Supreme Court opinions that may be helpful to system participants in examining conflict-of law issues. In summary, those cases held that the basic rule is that a court need not enforce a [worker's compensation] foreign law if enforcement would be contrary to Texas public policy; that the "most significant relationship" test applied by the court requires the court to consider which state's laws has the most significant relationship to the particular issue to be resolved and that the contacts with a state must be evaluated in light of the state's policies underlying the particular substantive issue. See *Larchmont Farms, Inc. v. Parra,* 941 S.W. 2d 93, 95 (Tex.1997), *Hughes Wood Products, Inc. v. Wagner,* 18 S.W.3d 202, 205 (Tex. 2000) and *The Torrington Co. v. Stutzman,* 46 S.W.3d 829, 848 (Tex. 2000) An additional resource is Lawson's Workers' Compensation Law, Volume 9, Conflict of Laws, a Matthew Bender & Company, Inc. publication. The Division further clarifies that the preceding information provided does not constitute legal advice or legal opinion and any system participant with a conflict-of law legal issue is encouraged to seek legal counsel of their choice.

General: A commenter recommends inserting the term, "or their agent or assignee" throughout the closed formulary rules whenever referencing pharmacy or pharmacists, and to include a definition of "pharmacy processing agent."

Agency Response: The Division declines to make the change. Rules adopted by the Commissioner concerning prescription medications and services, authorize pharmacies to use agents or assignees to process claims and act on the behalf of the pharmacies under terms and conditions agreed on by the pharmacies. These rules are §§133.2, 133.10, and 133.240 concerning Definitions, Required Billing Forms/Formats, and Medical Payments and Denials, respectively. Pharmacies and their agents are best suited to coordinate their communication activities and there is no need for the Division to insert a requirement directing that communication in these rules.

General: A commenter requests clarification if the Department or Division will be going into and inspecting pharmacies to see if drugs are properly mixed, and if so what expertise exists in the Department or Division to undertake such oversight. The commenter requests further clarification if there will be a partnership between the state and federal agencies that already provide such oversight, and if so, where the rules are that govern this type of activity by the agency, including type of penalties the Department or Division will administer, and where the penalties are listed.

Agency Response: The Division notes that pharmacies and pharmacists are regulated through the Occupations Code and rules established by the Texas State Board of Pharmacy. The Division does not have jurisdiction over the formulation of drugs or compounds and does not intend to interfere with the regulatory authority of the Texas State Board of Pharmacy, but may refer complaints to them if necessary.

General: A commenter inquires why insurance carriers have been allowing the prescription medications to be prescribed for such extended periods of time and why the prescribing doctors that have been prescribing the medications for so long have been given a free pass on responsibility.

Agency Response: The Division clarifies that HB 7 required the adoption of treatment guidelines, the adoption of a closed formulary, and allowed certified networks as components of the Texas workers' compensation system. Certified networks were implemented in early 2006, Division treatment guidelines became effective in May 2007, and these rules adopt a closed formulary. The use of these tools is intended to provide injured employees with appropriate medical services when needed to assure appropriate utilization of those services. Additionally, prescribing doctors are subject to review by the Division, the Texas Medical Board or other appropriate licensing boards if they are prescribing in a manner inconsistent with their licensure.

General: A commenter requests clarification why there is a comparison between the prescription rates for "legacy" claims between California and Texas as noted in the proposal preamble. The commenter states it makes no sense, causing the remainder of the research to be questionable, and requests an explanation.

Agency Response: The Division notes that the research comparisons between California and Texas are not specifically related to legacy claims, but are based only on prescription years 2005 and 2006 since at the time the research was conducted; this was the most current data available. Additionally, comparisons between California and Texas are relevant because both are large states with comparable pharmaceutical utilization and industry mixes.

General: A commenter inquires within the context of the proposed rules, whether a payor can choose to be more or less restrictive than the proposed formulary, and if there would be any considerations regarding the application of different utilization review standards, based on a more restrictive formulary.

Agency Response: Regarding the commenter's inquiry as to whether a payor can choose to be more or less restrictive than the proposed formulary, the Division notes the closed formulary applies to both certified network and non-network claims, and may not be amended by system participants. Drugs excluded from the closed formulary require preauthorization in both the network and non-network settings. For non-network claims prescribing doctors are subject to the recommendations included in the Division's adopted treatment guidelines, while for certified network claims, prescribing doctors are subject to the recommendations included in treatment guidelines and treatment protocols as approved during the network certification process. Regarding the commenter's inquiry as to any considerations regarding the application of different utilization review standards, the Division further notes, in both claims subject to certified network and non-networks, the preauthorization process must conform to the utilization review requirements of Chapters 10, 19, 134, and 137 of this title (relating to Workers' Compensation Health Care Networks, Utilization Review, Benefits--Guidelines for Medical Services, Charges and Payments, and Disability Management, respectively). Since certified networks may adopt their own treatment guidelines and protocols, in certain instances a drug included in the closed formulary may not be recommended by the certified network's treatment guidelines. In this instance, the prescribing doctor should conform to the network's instructions for processing prescriptions for that drug, including preauthorization, if required, and may be subject to retrospective review based on the certified network's treatment guidelines.

General: A commenter requests clarification if the application of the closed formulary will be different for subscribers vs. non-subscribers.

Agency Response: The Division clarifies that these adopted rules do not apply to employers who do not subscribe to the workers' compensation system.

General: A commenter notes that the rules do not address off-label use. The commenter states removing the protection for off-label prescribing could hinder patient/injured employee access to many commonly used medicines. Agency Response: The Division clarifies that there have been no changes concerning the off-label use of prescriptions by adoption of these rules.

General: A commenter recommends consideration beyond ODG status "N" to restrain medical and pharmaceutical practices in areas that are subject to abuse. If practicable, a list of non-status "N" and non-experimental drugs that are subject to abuse should be researched, compiled and excluded from the formulary or require additional scrutiny.

Agency Response: The Division declines to make the change. Drugs not included in the closed formulary are excluded based on the medical evidence contained in the Division's adopted treatment guidelines. Experimental and investigational drugs are not included in the closed formulary in order to comport with the requirements of Labor Code §413.014 concerning Preauthorization Requirements; Concurrent Review and Certification of Health Care. It is not practicable for the Division to create a sub-formulary or a system where system participants must use a section of the ODG methodology and not use other sections of the ODG. This approach would complicate the use of the closed formulary and would be confusing for system participants. Any evidence supporting a change in the treatment guidelines should be submitted to the WLDI for evaluation and potential inclusion in the treatment guidelines based on the AGREE Instrument.

General: A commenter states the closed formulary rules should mandate that all physicians and other health care practitioners who are prescribing drugs in the Texas workers' compensation system must complete training in the safe use of narcotics in order to prevent over-use of narcotics.

Agency Response: The Division disagrees. Prescribing doctors are subject to review by the Division, the Texas Medical Board and other appropriate licensing boards if they are prescribing in a manner inconsistent with their licensure. Further, prescribing doctors suspected of unsafe, improper prescription of narcotics for specific claims may be referred to either the Texas Medical Board or the Division's Office of the Medical Advisor. System participants may file complaints to the Medical Advisor through the Division's complaint resolution process.

General: Commenters recommend the Division's Medical Advisor and the Medical Quality Review Panel should identify and review physicians who have a high number of injured employ-

ees who may be addicted to prescription drugs or may have an inappropriate habituation wherein they use unnecessary and/or an excessive amount of prescription drugs.

Agency Response: The Division recognizes the commenters' recommendations regarding review of prescribing physicians, but notes that recommendations regarding the duties of the Office of the Medical Advisor and the Medical Quality Review Panel are outside the scope of these proposed rules. The Division will forward the comments to the Office of the Medical Advisor for consideration in the development of the Medical Quality Review Panel audit plan. System participants may file complaints to the Medical Advisor for over-utilization through the Division's complaint resolution process. The Division recognizes that insurance carriers, through the utilization review process, are able to identify physicians who have a high number of injured employees who may be addicted to prescription drugs or may have an inappropriate habituation. When identified and appropriate, insurance carriers should file complaints with the Division. If there is a danger to the public, the insurance carrier should make an appropriate referral to the Texas Medical Board. Additionally, prescribing doctors are subject to review by the Division, the Texas Medical Board and other appropriate licensing boards if they are prescribing in a manner inconsistent with their licensure.

General: A commenter observes that it is critical that formulary changes and development are made not only with scientific evidence and medical review in mind, but also with input from those directly providing care, and those directly receiving care. This requires knowledge of the available and clear process by which to provide comment and information and to whom those comments must be directed. As the ODG is developed by a private organization, there appears to be no clear, transparent process for providing information on products or to have products added to or removed from the closed formulary. The general public, patients, providers, and interested product manufacturers are not only unable to access the closed formulary without providing payment, but also are unable to determine how to provide evidence-based relevant research information to WLDI for review for potential formulary inclusion. The process by which input can be provided is not readily available or accessible to the public, nor is it established in the TDI rules process, and therefore is subject to change at the discretion of WLDI or an entity responsible for implementing future formularies for workers' compensation. The commenter further states it is unclear from both the rule proposals and the vendor's website if and how factors are taken into consideration in the process of making formulary recommendations.

Agency Response: The Division clarifies that the Division's adopted treatment guidelines, required by statute, are evidence-based, scientifically valid, and outcome-focused. The evidence included in the Division's adopted treatment guidelines is based on the AGREE Instrument and is described in detail in the hard copy and electronic version of *ODG Treatment in Workers' Comp* and on the WLDI website. Instructions are also provided in WLDI/ODG for the submission of new evidence relating to treatments and services. Further, instructions are available in Appendix D of ODG for providers attempting to overcome the evidence basis of treatments and services included in the guidelines. Access to the electronic version of *ODG Treatment in Workers' Comp* is available at a nominal cost. A list of drugs excluded from the closed formulary will be added to the Division's website and will be available to system participants at no cost. The adoption of treatment guidelines and a closed formulary is a statutory requirement of HB 7, 79th Legislature, Regular Session.

General: A commenter objects to the fact that no measurements have been implemented to determine the success of these outside guidelines in improving outcomes. A benchmark review or finite timeline for reviewing the effectiveness and health outcomes of the guidelines implementing a closed formulary to determine if such action is in the best interests from a health and successful work integration perspective to the patients covered under workers' compensation insurance should be conducted. Another commenter recommends the Division provide a study and/or review within 18-24 months from initial implementation of the closed formulary to determine if the program has been effective in controlling utilization of dangerous, and often addictive, medications and thwarting drug spend cost increases and pharmacy access.

Agency Response: The Division declines to make any specific additions to the rule. The Division is interested in return-to-work outcomes and the effectiveness of return to work guidelines, treatment guidelines, and the closed formulary in both the certified network and non-network settings, and may pursue research concerning these topics without additional rule language. Further, the Department's Workers' Compensation Research and Evaluation Group (REG) completes a network report card on an annual basis and conducts research on the non-network system as well, including the production of a biennial report required by Labor Code §405.0025, which analyzes the impact of HB 7 reforms. Additionally, the REG produces an annual research agenda and solicits input from system stakeholders regarding the projects included in the final research agenda. For example, in 2007, the REG conducted and published research and analysis concerning the use of pharmaceutical services in the Texas workers' compensation system.

General: Regarding injured employees treated in emergency rooms, a commenter recommends if a prescription is written, such an acute circumstance should merit the dispensing and payment of the medication as emergency room doctors have too much to worry about besides complying with the Division's closed formulary. The commenter requests clarification how an emergency room doctor is expected to stay informed as to which medications are approved under the Texas workers' compensation system.

Agency Response: The Division declines to make the recommended change. All prescribing doctors are required to prescribe only medically necessary treatments and services. The Division's adopted treatment guidelines and certified network treatment guidelines provide recommendations that are consistent with the evidence-based medicine requirements of the Labor Code and the Insurance Code as they relate to the Texas workers' compensation system. The drugs excluded from the closed formulary are noted in Appendix A of the *ODG Treatment in Workers' Comp,* and a list of those drugs is anticipated to be posted on the Division's website. Additional evidence-based treatment recommendations for the use of pharmaceuticals are included in *ODG Treatment in Workers' Comp* and in each certified network's treatment guidelines. Drugs excluded from the closed formulary, but dispensed for use during the first seven days post-injury, including prescriptions written as a result of an emergency room visit, do not require preauthorization, but are subject to retrospective review of medical necessity. While drugs excluded from the closed formulary require preauthorization, a prescribing doctor may

prescribe any other FDA-approved drug without preauthorization. Additionally, drugs included in the closed formulary, but dispensed for use during the first seven days post-injury, do not require preauthorization and are not subject to retrospective review of medical necessity.

General: A commenter recommends that only brand name drugs be excluded from the closed formulary, and that the Division should establish a pharmaceutical and therapeutics committee, comprised of pharmacists and doctors, to review the use of brand name drugs on a claim-by-claim basis when a prescribing doctor wishes to prescribe a brand name drug for an injured employee.

Agency Response: The Division declines to make the changes. Drugs excluded from the closed formulary are excluded based on the chemical composition of the pharmaceutical and not upon a drug's generic or brand name status. For example, the risks and benefits of the brand name drug Soma and the generic drugs Carisoprodol are, with few exceptions, essentially the same. Further, there is no need to establish a separate pharmaceutical and therapeutics committee since the Division has developed an appeals process as required by the Labor Code to review on a claim-by-claim basis the use of drugs excluded from the closed formulary. The appeals process will assess the medical necessity of the prescription for a drug excluded from the closed formulary, including the necessity of a brand name drug versus a generic drug, if requested by the prescribing doctor.

General: Commenters provide various recommendations and reasons for delaying the implementation dates of the proposed rules, offering the following suggestions: One commenter recommends delaying implementation to July 1, 2011 without impacting the proposed January 1, 2013 date for legacy claims. Another commenter recommends delaying implementation of all of the proposed rules to sometime between September 1, 2011 and January 1, 2012, and two corresponding years for legacy claims. Other comment recommendations include moving the implementation date to September 1, 2012 with legacy claim implementation date delayed to January 1, 2014. Another commenter recommends the implementation of new rule change from 2013 to 2015 to allow adequate time to adjust patient care where needed. A different commenter further supports delaying application of the closed formulary to legacy claims, further segmenting application of the closed formulary to legacy claims based on date of injury, or not specifying an effective date at this time. The reasons provided for delayed implementation include: the need to change policies; develop, test, and implement programming requirements; the need to appropriately train and educate prescribing doctors, pharmacists, insurance carriers, and other affected entities; and for insurance carriers to implement and refine their utilization and review processes.

Agency Response: The Division carefully reviewed and considered these recommendations and has amended the rules to provide additional time for system participants to prepare for the implementation of the rules. All dates that were proposed to be January 1, 2011, are changed to September 1, 2011. All legacy claim date references are similarly changed by the corresponding eight months. The insurance carrier's identification activity for legacy claims is changed from proposal in subsection (b)(2) to reflect a date of "Beginning no later than March 1, 2013," rather than the proposal date of July 1, 2012. Also, the effective date for claims with dates of injury proposed to be on or after January 1, 2013 is changed to September 1, 2013.

General: Commenters express support for the phased-in applicability and implementation date approach as proposed for the closed formulary over time to allow for continuity of care. Providing for no transition period would disrupt the continuity of care of injured employees in many cases by requiring sudden changes in drug regimens in use for many years.

Agency Response: The Division agrees with and appreciates the supportive comments and notes that the specific applicability dates for the rules have been adjusted as noted in the previous comment and response.

General: A commenter advises that there are a number of other systemic problems without the closed formulary that adversely affect pharmacy stakeholders, including chronic short pays due to vague and ambiguous reimbursement guidelines and standards, as well as inadequacy of the dispute resolution process to curb bad faith patterns of deliberate reimbursement gamesmanship.

Agency Response: The Division recognizes the commenter's concerns, but notes that these comments are outside the scope of the proposed rules.

General: Commenters recommend that the Department adopt rules allowing bundling of egregious claims and issue swift and serious enforcement action on any carriers that abuse the system.

Agency Response: The Division recognizes the commenters' concerns regarding claim disputes and potential complaints, but notes that these comments are outside the scope of the proposed rules.

General: Commenters recommend that the Division amend each proposed rule to clarify the applicability of the rules in order to specifically exclude claims subject to Labor Code §504.053.

Agency Response: The Division disagrees. Labor Code §504.053 is explicit in its details concerning political subdivisions that self-insure individually and collectively, their ability to contract directly with health care providers and the consequences of the election and applicable statutory provisions related to the election. Inserting amendments to the adopted rules would be duplicative of the statutory provisions of Labor Code §504.053 and is unnecessary.

§134.500(3): Commenters are concerned with adopting the ODG formulary and whether there will be sufficient "Y" drugs in all categories. A commenter states it is critical that sufficient options are available for each category to provide medication alternatives when some medications prove ineffective or when the injured employee has an adverse reaction to a drug prescribed. The commenter is further concerned that the Division has not adequately addressed this issue in the proposal and believes the closed formulary must serve the goal of limiting access to inappropriate medications while still ensuring that a broad range of medication remains available to treat the injured employees of Texas. Another commenter offers numerous shortcomings of the rule proposals and ODG Appendix A, such as: some of the drugs listed should not be covered by workers' compensation as they have no injury-related use; all appropriate generic versions of drugs in some therapeutic categories are not included; some high cost, brand name drugs that have generic alternatives are inappropriately included in the closed formulary; and some therapeutic categories of drugs commonly employed in workers' compensation are omitted completely. One commenter states there are certain drugs in the drug classes considered that do

not appear to have been considered at all. If a closed formulary is implemented, the commenter recommends that all drugs in that particular class should be considered.

Agency Response: The Division clarifies that the closed formulary is not just the "Y" drugs listed in ODG Appendix A that are available to treat an injured employee. The closed formulary is defined as, "all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes: (A) drugs identified with a status of 'N' in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; (B) any compound that contains a drug identified with a status of 'N' in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates, and (C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined by Labor Code §413.014(a)."

The Division further clarifies that the closed formulary identifies drugs that require preauthorization and injured employees have access to all other FDA-approved drugs that are reasonable and necessary to their health care. Pharmaceutical services included in the closed formulary and prescribed for injured employees have to conform to the treatment guidelines and are subject to retrospective review. For purposes of understanding the closed formulary and those medications that require preauthorization approval (the appeals process), the ODG "N" drug designation and investigational and experimental drugs are the key and critical elements to the closed formulary. Drugs identified in ODG Appendix A with a status of "Y" are only a small subset of all FDA-approved drugs, which are included in the closed formulary. The "N" designation means that a drug is not recommended for use and will require preauthorization. Investigational or experimental drugs are not yet broadly accepted as the prevailing standard of care in the health care community and will require preauthorization as well.

The ODG meets the provisions outlined in Labor Code §413.011(e). Appendix A is a reflection of the recommendations detailed in the Division's adopted treatment guidelines.

§134.500(3): A commenter suggests the Division has not adopted a traditional, more commonly acceptable closed formulary, noting that generally, a closed formulary includes drugs that are covered, while an open formulary specifies drugs that are not covered. While it does not appear that the instant proposed formulary possesses the hallmarks of a formal closed formulary system, it does take steps in that direction.

Agency Response: The Division understands the commenter's concerns; however, the Division adopts a closed formulary that fulfills the statutory definition of closed formulary under Labor Code §408.028(b) and the related legislative objectives of HB 7.

§134.500(3): A commenter opines that if a physician is forced to use the closed formulary, he or she will be using drugs which are actually more expensive than those now being used.

Agency Response: The Division clarifies that the guiding principle for adopting a closed formulary is primarily to focus on the appropriateness and medical necessity of the particular medication. It is not clear from the commenter's noted concern whether the cost referenced is the actual unit cost, or the interest in curbing unnecessary utilization and controlling costs. In any event, the Division believes the added scrutiny through the preauthorization process will control the overall system cost use of medications for work-related injuries. Under the closed formulary, a prescribing doctor still has access to all FDA-approved drugs and the "N" drugs, which are excluded from the closed formulary and are still available through the preauthorization process.

§134.500(3): A commenter states there appears to be a level of ambiguity between the ODG guidelines and the closed formulary. For instance, the commenter appears to note from review of the ODG treatment guidelines that opioids can only be given for two-week time periods. The decision to prescribe opioids for less than 30 days is best left to the judgment of the physician based on the specific circumstances for a given patient.

Agency Response: The Division clarifies that the Division selected the most current edition of the ODG because it meets the provisions outlined in Labor Code §413.011(e). Additionally, the guidelines are updated by integrating the findings of new studies as they are conducted and released. Further, the ODG guidelines are designed to reduce excessive or inappropriate medical care while safeguarding necessary medical care by providing clear data on optimum frequency and duration of treatments. However, the health care provider must consider care above or below the guidelines consistent with the unique factors associated with the injury. The Division notes that treatment may not be denied solely on the basis that the treatment for the compensable injury in question is not specifically addressed by the treatment guidelines. The Division anticipates that prescribing doctors will support their decisions to treat outside the guidelines through the statement of medical necessity or when required, a request for preauthorization. The guidelines in ODG Appendix D provide suggestions for documenting instances regarding the medical necessity of treatments and services that are not recommended, not included in, or exceed the recommendations of the treatment guidelines.

§134.500(3): A commenter states that opioids are not warranted once maximum medical improvement (MMI) has been attained. The commenter seeks clarification as to how that translates to the need for pain medication disappearing. If opioids are stopped, the commenter states, appropriate weaning guidelines should be followed.

Agency Response: The Division clarifies that the proposed rules did not address the continued use of opioids after MMI. The closed formulary rules, as adopted, provide communication tools regarding appropriate weaning efforts. Likewise, the pain chapter of ODG addresses weaning.

§134.500(3): Regarding the first sentence in Appendix A, "...formulary only applies to the classes listed...," a commenter seeks clarification if this means the entire class of drugs is now an "N," or just the specific ones listed, for example, Chlonidine and Fentanyl. In addition, the commenter seeks clarification about the various forms drugs come in, for example, tablets or transdermal patches. The commenter seeks clarification as to what the proper approach is when an ODG "N" drug is not recommended as a first line drug, but is recommended as a third line treatment, and whether preauthorization is required if the physician is prescribing the drug as a third line drug.

Agency Response: The Division clarifies that for purposes of the closed formulary, a drug requires preauthorization approval if it has a drug status "N" and is on the "N" list regardless of whether the drug was prescribed as first, second, or third line, and regardless of the form in which it comes.

§134.500(3): A commenter believes that the Legislature intended that there be a use of all generic drugs, and for those drugs that are not generic, to have a closed formulary for the trade name type drugs that should be used. Further, all generic drugs that are FDA-approved should be used, and then the closed formulary should address those drugs that are not generic.

Agency Response: The Division clarifies that there is already a statutory provision in and rule that require the use of generic drugs in the Texas workers' compensation system. Labor Code §408.028(b) and §134.502 of this title (relating to Pharmaceutical Services) require prescribing doctors to prescribe generics and over-the-counter alternatives to treat injured employees when appropriate. Additionally, all FDA-approved drugs are included in the closed formulary, except drugs with ODG status "N," compounds that include drugs with ODG status "N," and investigational or experimental drugs as defined by Labor Code §413.014(a). Therefore, the closed formulary includes all generic drugs or compounded generic drugs that are not excluded as a result of their "N" status.

The Division disagrees that the closed formulary should consist only of trade name type drugs. Such a model is not required under the Texas Workers' Compensation Act (Act).

§134.500(3)(A): Commenters seek clarification as to how the system is to handle a drug which initially was not indicated as an "N" and which was prescribed for prolonged therapy (180-day prescription calls for multiple refills) and prior to a subsequent refill, ODG switched the drug indication from "Y" to "N." The commenters seek additional clarification regarding whether the injured employee will be required to switch to a different medication therapy mid-prescription; whether the pharmacy and pharmacy processor would be denied payment if the refill is dispensed/processed; whether this prevents a refill from being dispensed until the proper preauthorization is secured; when should preauthorization requirements for indicated "N" drugs apply: date of prescription, dispense, or date the bill is presented to the end payer; and whether drugs not on the list as "Y" or "N" will inherently be treated exactly like a "Y" drug by PBM/payers. One commenter recommends the Division determine if the application of "N" status would apply to claims by date of prescription, date of dispensing, or date of billing.

Agency Response: The Division clarifies that it is the date the prescription is written that controls its status, which is then considered good and binding for the duration of the prescription. Consequently, if a drug's status changes at some point after the prescription date, the change will not have an effect on that particular prescription, and preauthorization will not be required since the applicable drug's status is based on the date of the prescription. There are additional pharmacy rules and laws, including but not limited to, the Texas Pharmacy Act and the Texas State Board of Pharmacy rules that will also control where applicable. Regarding the commenter's concern whether drugs not on the list as "Y" or "N" will inherently be treated exactly like a "Y" drug, the Division clarifies that not all FDA-approved drugs are listed in Appendix A of ODG. Only drugs specifically identified with a status of "N," compounds which include a drug with a status of "N" and experimental or investigational drugs are excluded from the closed formulary and require preauthorization. Drugs included in the closed formulary may be prescribed without preauthorization, but are subject to retrospective review of medical necessity.

§134.500(3)(A) and (B): Some commenters seek clarification concerning the use of the term "current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary."* Commenters are concerned that the Division failed to indicate an official "implementation" time frame or lead time according to which the pharmacy marketplace should integrate any changes to the ODG drug appendix, since Appendix A is not static and is subject to change with addition and removal of drugs as well as changes in drug indication of "Y" or "N." Commenters seek clarification whether updated ODG drug appendix data should be applied on a monthly, quarterly, or annual basis when released/published by ODG. Other commenters recommend that whenever an ODG formulary modification is made, that there be a minimum of a 30-day notice before having system-wide effect as this will provide payers and pharmacies, and/or their agents, time to adequately invest the necessary resources to program updates in the system. Some commenters believe without clarification regarding the timing of ODG updates, confusion as to the proper edition on which to base preauthorization approval requests may occur.

Agency Response: The Division disagrees and declines to make the suggested change. Information regarding Appendix A in ODG, and any updates or changes, will be kept on the Division's website, just as changes with other treatments and services within the ODG treatment guidelines are currently maintained.

§134.500(3)(B) and §134.500(4): Some commenters suggest all compound drugs should be excluded from the closed formulary, or require preauthorization. A commenter encourages the Division to adopt a rule to restrict compounding to instances where it is medically necessary, and require the prescribing physician to provide a scientifically valid reason as to why non-compounded existing medications are not sufficient to treat the injured employee.

Agency Response: The Division disagrees. The purpose of these rules is to adopt a closed formulary which excludes drugs with status "N," compounds that include drugs with status "N," and investigational or experimental drugs as defined by Labor Code §413.014(a). The Division initially considered requiring preauthorization for all compound drugs. However, with stakeholder feedback and, in the interest of curbing the expense of numerous preauthorization requests, the Division reconsidered and adopts a more measured approach as specified in the proposal, which is requiring preauthorization only for those compounds that contain an "N" drug. The Division notes that an insurance carrier has the ability to conduct retrospective utilization review for all compounds not containing an "N" drug so that insurance carriers have the ability to only pay for medically necessary care.

§134.500(3)(B) and §134.500(4): A commenter states the inclusion of all compounds violates statutory standards that the Division must use in adopting a closed formulary since the commenter asserts the closed formulary is a treatment guideline. The commenter further opines that allowing compounds is contrary to evidence-based, scientifically valid, and the outcome-focused regulation of the Labor Code, including the requirement to reduce excessive or inappropriate medical care. Nevertheless, the commenter concedes that compound drugs may be medically necessary at times.

Agency Response: The Division disagrees in part. The Division disagrees that including compounds in the closed formulary

violates statutory standards. The Division is required to adopt a closed formulary wherein an injured employee who sustains a compensable injury is afforded all health care reasonably required by the nature of the injury as and when needed in accordance with Labor Code §408.021. Compounds containing an "N" drug will require preauthorization. The commenter's premise that the closed formulary is a treatment guideline is incorrect since Appendix A is a reflection of the evidence-based recommendations detailed in the Division's adopted treatment guidelines, and Appendix A does not provide specific recommendations regarding an appropriate course of care for specific types of injuries, whereas the ODG treatment summaries do provide specific direction concerning appropriate care. The Division agrees with the commenter's concession that compound drugs may at times be medically necessary.

§134.500(3)(B) and §134.500(4): Commenters recommend rule wording regarding compounding that reiterates the requirements of Labor Code §408.021 by stating: "The compounding of a drug must be reasonably required by the nature of the injury and must cure or relieve the effects naturally resulting from the compensable injury, promote recovery, or enhance the ability of the employee to return to or retain employment."

Agency Response: The Division disagrees. The recommended wording is applicable by statute and it is not necessary to re-state statutory language in adopted rules.

§134.500(3)(B) and §134.500(4): Commenters recommend the rules state compounding shall not be used to provide nutritional supplements, medical foods or other non-pharmaceutical substances unless a clear and compelling medical need exists based on the patient's original industrial injury and current clinical status.

Agency Response: The Division disagrees. The Division has defined "Nonprescription drug or over-the-counter medication" and "Prescription drug" under §134.500(8) and §134.500(12) of this title. Additionally, injured employees are entitled to medically necessary treatments and services including non-prescription drugs and over-the-counter medications. Therefore, no additional clarification regarding compounding is necessary.

§134.500(3)(B) and §134.500(4): A commenter clarifies that the need for compounding is based on a physician's decision for a specific patient's need, and not a pharmacist's profit goals.

Agency Response: The Division agrees and further clarifies that the health care must be reasonably required pursuant to Labor Code §408.021 and in accordance with Labor Code §401.011(18-a) and §401.011(22-a).

§134.500(3)(B) and §134.500(4): A commenter states the pharmacy fee guideline rule should stress the statutory requirements set forth in Labor Code §408.021. The fee guideline should place a cap on the amount pharmacies are paid if a drug is compounded. Such a provision should preclude the likelihood that future abusive behavior involving compounding will occur and will not financially incentivize compounding.

Agency Response: The Division recognizes the commenter's concerns regarding the pharmacy reimbursement structure, but notes that these comments are outside the scope of the proposed rules.

§134.500(6): Commenters state the definition for generically equivalent is incorrect, and the commenters therefore have concerns about "switching" or assuming that another drug in the same therapeutic category would have the same effect as the original one the physician prescribed.

Agency Response: The Division disagrees. Occupations Code Title 3 Subtitle J (Texas Pharmacy Act) governs health professions in Texas and is applicable to pharmacy and pharmacists. The Legislature enacted the definitions of "Generically equivalent," "Pharmaceutically equivalent" and "Therapeutically equivalent" under Occupations Code §562.001(1), (2) and (3), respectively, which the Division has incorporated in its adopted rule.

§134.500(6)(B): A commenter indicates the word "intensity" in the proposed definition of "generically equivalent" is not a pharmaceutical or medical term, and implied in the rule proposal, probably refers to either efficacy, potency or another medical term. The commenter requests clarification and proper medical wording to define what the rule is attempting to state.

Agency Response: The Division clarifies that the word "intensity" is a component of the Occupations Code §562.001(3) definition of "therapeutically equivalent," which "means pharmaceutically equivalent drug products that, if administered in the same amounts, will provide the same therapeutic effect, identical in duration and intensity." Since the word "intensity" is part of the statutory definition, the Division does not have the authority to replace what has been enacted, or substitute the word with a medical term that the legislature might not have intended. What is meant by "intensity" may be interpreted by applicable medical experts on a case-by-case basis if the issue of "generically equivalent" arises during a medical dispute.

§134.500(6) and (14): A commenter states the proposed rules contain multiple terms relating to equivalency of medications which are at once duplicative, but also seem to open an avenue for utilization of therapeutic substitution, which is neither acceptable nor has been decisively approved by the Texas Legislature as public health policy. The proposed definition of generically equivalent is common and accepted public health policy in formularies; however, it also contains a definition for "substitution" in §134.500(14), which is too vague and appears to provide an avenue for substituting an entirely different drug than prescribed.

Agency Response: The Division disagrees. The adopted definition of "substitution" in §134.500(14) is taken directly from the Texas Pharmacy Act, which states that substitution "means the dispensing of a drug or a brand of drug other than the drug or brand of drug ordered or prescribed." (Occupations Code §551.003(41)). The Texas Pharmacy Act also defines "generically equivalent" and "therapeutically equivalent" under Occupations Code §562.001(1) and §562.001(3). Occupations Code §551.002 declares the legislative public health, safety, and welfare purpose of the Texas Pharmacy Act.

§134.500(7): A commenter opines the proposed definition of "medical emergency" is too restrictive and that not every medical emergency will include severe pain. If it can reasonably be expected that a patient's health or bodily function is placed in serious jeopardy or that serious dysfunction of a body organ or part will result, but there is no severe pain, it would seem that immediate medical attention would still be required. Another commenter states that a medical emergency means a patient's health would be in "serious jeopardy" or an organ would be in "serious dysfunction," and this requirement puts the patient at unnecessary risk and is not in line with either the standard of care, or rules in other government sponsored health programs.

Agency Response: The Division clarifies that the definition of "medical emergency" does not limit the circumstances to severe pain; rather severe pain is included as one of the many components. Furthermore, the definition of "medical emergency" is a long-standing definition in the Texas workers' compensation system as adopted in §133.2 of this title (relating to Definitions). Also, the definition is consistent with Insurance Code §1305.004(a)(13) and §4201.002(2). The Division notes that the term "unreasonable risk" is used throughout the rules as a modifier to clarify an action may be taken prior to a medical emergency or to prevent a medical emergency.

§134.500(10): A commenter recommends new language for the term "prescribing doctor," which is "a physician or dentist who prescribes prescription drugs or over the counter medications in accordance with the physician's or dentist's license and state and federal laws and rules." The commenter states the inclusion of an advanced practice nurse or physician assistant as included in the proposed definition conflicts with how the term "doctor" is defined by the Labor Code §401.011(10), and requests that all references to these terms be deleted, and placed in a new definition for "Other prescribing health care practitioners." The suggested definition for the new term is, "an advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders, under Occupations Code Chapter 157, and who prescribes prescription drugs or over the counter medication under the physician's supervision and in accordance with the health care practitioner's license and state and federal laws and rules."

Agency Response: The Division disagrees and declines to make the recommended change, and believes the definition provides clear delineation that an advanced practice nurse or physician's assistant are delegated this authority by doctors, specifically physicians, and is not an assumed authority. Occupations Code Chapter 157 governs the authority of physicians to delegate certain medical acts including the delegation to advanced practice nurses and physician assistants. Occupations Code §157.001 grants general authority to a physician to delegate to a qualified and properly trained person acting under the physician's supervision any medical act that a reasonable and prudent physician would find within the scope of sound medical judgment, which includes the "carrying out or signing a prescription drug order" as defined by Occupations Code §155.051(2). The advanced practice nurse and physician assistant are appropriate delegatees under Occupations Code Chapter 157 and they are defined in Occupations Code §157.051(1) and §157.051(3).

§134.500(13): Commenters recommend that the language be modified to provide, "A statement of medical necessity shall include..." to clarify the mandatory nature of all elements. Failure to submit a complete statement should constitute both an act of non-compliance with the rule by the prescribing doctor or health care practitioner, and failure to submit a complete statement.

Agency Response: The Division agrees that the recommended language does provide clarity to the mandatory nature of each of the elements, and adopted §134.500(13) has been changed to state, "A statement of medical necessity shall include: ..."

§134.500(13): A commenter states the phrase, "and supporting evidence-based documentation" is unnecessary and unduly burdensome. The commenter contends that the information required in (13)(F) is more than sufficient to show medical necessity and that requiring "supporting evidence-based documentation" would make it significantly more difficult for an injured employee to obtain necessary medication. The commenter would further emphasize that any medications dealt with in (13) would have received FDA approval based upon valid scientific study of their safety and efficacy. While the prescribing doctor might not have these studies in his or her possession, they certainly exist for the drug to have been approved by the FDA. The evidence-based medicine of the safety and efficacy of medications approved by the FDA are the studies that led to the drug receiving FDA approval. A prescription should be filled, if the injured employee or prescribing doctor establishes that the medication satisfies the requirements of §134.500(13)(F). Another commenter opines that supporting evidence-based documentation should not include documentation from the manufacturer of the drug.

Agency Response: The Division notes the commenter's concern regarding the burdensome nature of providing this information, especially by an injured employee, and agrees with the first commenter's recommendation. Moreover, the Division also agrees that §134.500(13)(F) satisfies the Division's expectation that the statement of medical necessity should thoroughly provide the documentation that supports the drug exclusion. Consequently, the Division has deleted from the adopted rule the requirement to provide supporting evidence-based documentation in the definition of statement of medical necessity. Because of this deletion in the adopted rules, the issue raised by the second commenter is moot.

§134.500(13): A commenter believes that required preauthorization of drugs excluded from the closed formulary is going to result in basically a 100 percent denial rate because a statement of medical necessity submitted as part of the preauthorization process will require proof of a medical emergency, and proof that the requested drug has previously been prescribed and dispensed. For example, the commenter states that because it is not a medical emergency, an injured employee will not have access to compounds that include drugs on the "N" list, such as Ketamine or Ketoprofen. This is too time-consuming and the result is not beneficial to the injured employee.

Agency Response: The Division disagrees. Preauthorization is the appeals process in the closed formulary that is required by Labor Code §408.028. Preauthorization enables the injured employee to have access to "N" drugs, compounds that include "N" drugs and investigational or experimental drugs as defined by Labor Code §413.014(a), if these drugs are determined to be medically necessary. A medical emergency need not exist for the preauthorization of a drug excluded from the closed formulary. An unreasonable risk of medical emergency is required when a prescribing doctor or pharmacist is pursuing an MIO in accordance with §134.550. The unreasonable risk of medical emergency is evaluated by the prescribing doctor and is not limited to certain circumstances, severe pain or set components for which the prescribing doctor has the final decision based on the health care reasonably required by the injured employee. 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.

§134.506: Some commenters state it is unclear whether the Commissioner has the statutory authority to adopt an open formulary and request clarification of the purpose of amending the section. One commenter suggests deleting references to "open formulary" from both the title and from subsections (a), (d), and (f) of this section. Additionally, a commenter seeks clarification of what, if any, utilization review requirement would apply to legacy claims if the open formulary is not adopted. The com-

menter states it is also unclear when the open formulary applies to legacy claims as the proposal does not provide a specific effective date as in other proposed rules.

Agency Response: The Division clarifies the intent of the proposed §134.506 is to implement amendments to Labor Code §408.028 and update and continue the existing rule until such time that all claims become subject to the pharmacy closed formulary. The Division notes there would be no guidance or direction, including utilization review requirements, provided to system participants for those claims with the latter phase-in date (legacy claims) without such an extension of the open formulary, thus creating confusion as to medically appropriate prescription medications, treatment guidelines, preauthorization requirements, and retrospective review considerations. Additionally, to address commenters' concerns and to provide further clarification, the Division has re-worded the adopted subsection as follows: "For claims with dates of injury prior to September 1, 2011 (for purposes of this section, referred to as 'legacy claims'), the open formulary as described in §134.500(9) of this title (relating to Definitions) remains in effect until those claims become subject to the closed formulary in accordance with §134.510 of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011)."

§134.506: A commenter recommends that rule 134.506 should provide that in the interim period of January 1, 2011 and December 31, 2012, physicians and other prescribing health care practitioners can prescribe all FDA-approved prescription and over-the-counter drugs. Additionally, the commenter recommends the rule provide that physicians and other prescribing health care practitioners are required to prescribe generic pharmaceutical medications and clinically appropriate over-the-counter alternatives to prescription medications unless otherwise specified by the prescribing doctor, in accordance with applicable state law.

Agency Response: The Division declines to make the change because the definition of an open formulary in adopted §134.500(9) covers much of this recommended language. Further, the adopted changes to §134.506 clarifies that the open formulary as described in §134.500(9) remains in effect until those claims become subject to the closed formulary in accordance with §134.510 of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011). There also remain in effect other rules in Chapter 134, Subchapter F relating to Pharmaceutical Benefits. These rules are §134.502 of this title (relating to Pharmaceutical Services) and §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

§134.506(b): A commenter supports the provisions of this subsection, as it should reduce the prescribing of medically unnecessary and inappropriate drugs to injured employees.

Agency Response: The Division agrees and appreciates the supportive comment.

§134.506(c): A commenter supports this provision of the rule proposal.

Agency Response: The Division appreciates the supportive comment.

§134.506(d): A commenter recommends the deletion of subsection (d) of this section based on the commenter's previous assertion that the Commissioner does not have the statutory authority to amend §134.506 or adopt a new rule. The commenter offers the following recommended language should the Division not delete subsection (d) as suggested: "Drugs prescribed and dispensed for claims not subject to a certified network with dates of injury before January 1, 2011 do not require preauthorization, except as required by Labor Code §413.014."

Agency Response: The Division disagrees and declines to make the change. The section as proposed, and with further adopted modifications as indicated, provides a sufficient definition and applicability of legacy claims.

§134.506(e): A commenter offers the following recommended language should the Division not delete subsection (e) as suggested: "Drugs prescribed and dispensed for claims subject to a certified network with dates of injury before January 1, 2011 shall be preauthorized in accordance with Insurance Code Chapter 1305 and Chapter 10 of this title (relating to Workers' Compensation Health Care Networks)."

Agency Response: The Division disagrees and declines to make the change. The section as proposed and with further adopted modifications as indicated provides a sufficient definition and applicability of legacy claims.

§134.506(f): A commenter is concerned that the broad language could circumvent network and non-network preauthorization requirements for investigational or experimental drugs. If preauthorization is required and is not requested, the insurance carrier should be able to deny payment for failure to obtain preauthorization. The language in proposed subsection (f) suggests that if it is prescribed and dispensed without preauthorization (even if required), it would be subject to retrospective review for medical necessity.

Agency Response: The Division agrees the language is confusing and has changed the wording in adopted subsection (f) to clarify that drugs included in the open formulary that do not require preauthorization and are prescribed and dispensed for legacy claims are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier.

§134.510(a) and (b): Commenters support bifurcated implementation of the closed formulary for drugs that are prescribed and dispensed for outpatient use as the phase-in approach for non-catastrophic legacy claims with over-use of prescription medications would devastate the system if all preauthorization were to be required at once.

Agency Response: The Division agrees and appreciates the supportive comments.

§134.510(a) and (b): A commenter opposes the staggered implementation of the closed formulary for legacy claims and recommends deletion of this section as it is inappropriate and unworkable, and is merely a method to eliminate all the benefits of the closed formulary for such claims. While understanding that in some rare, particular situations, treatment with a drug excluded from the closed formulary may be appropriate, the commenter opines it is the medical provider that should be able to file a statement of medical necessity. After review, if medical necessity to depart from the closed formulary is demonstrated, the claimant could be treated with drugs excluded from the closed formulary.

Agency Response: The Division disagrees and declines to make the suggested deletion. Cognizant of the complex clinical questions related to the ongoing use of drugs excluded from the pharmacy closed formulary and the significant change to require prospective review for drugs excluded from the pharmacy closed formulary, the Division is utilizing a measured approach

to implement the pharmacy closed formulary. This phased-in application will facilitate an orderly transition from the existing open formulary to the pharmacy closed formulary. This is important due to the number of injured employees that are currently utilizing drugs that will be excluded from the pharmacy closed formulary and the potential number of preauthorization requests if the dates are not staggered. Through the transition process, which includes ongoing system-wide education and training of the pharmacy closed formulary, a reduction of requests to use drugs not included in the pharmacy closed formulary would reduce the potential impact on the system. This reduction of requests should occur with the appropriate and measured utilization of the pharmacological management of legacy claims.

§134.510(a) and (b): Commenters understand the reason for separate implementation dates for new and legacy injured employees. However, these two timelines working in tandem may create an opportunity for some insurance carriers to abuse the system and deny legitimate payment to pharmacies.

Agency Response: The Division disagrees. All system participants are required to comply with all Division rules concerning the closed formulary, including billing and reimbursement requirements, and as such are subject to the monitoring and compliance activities of the Division.

§134.510(a) and (b): Commenters recommend the Division, insurance carriers, and treating physicians begin transitioning legacy patients over the next couple of years from "N" drugs to approved formulary drugs.

Agency Response: The Division agrees, and further clarifies this as one of the goals through adoption of this section.

§134.510(a) and (b): Commenters suggest the Division should work with the Texas Medical Board and the Texas Medical Association to educate physicians through continuing education units and seminars on the transition provisions. The benefits would be a smoother transition to the new closed formulary guidelines, fewer burdens on pharmacy stakeholders, and more reliable care for injured employees.

Agency Response: The Division agrees that education is an important component and is developing initiatives to educate system participants on the appropriate application of the pharmacy closed formulary rules and other pertinent Department and Division rules. The Division is currently coordinating educational content and opportunities with system participants, including professional organizations.

§134.510(a) and (b): Regarding the three-year period for legacy claims, a commenter seeks clarification regarding who, in the process, is to ensure that a statement of medical necessity accompanies the prescription for "N" drugs; and, what an insurance carrier's recourse would be if that is not provided. The commenter requests clarification regarding whether the insurance carrier can stop payment for a drug based in that situation.

Agency Response: The Division clarifies that the adopted rules concerning the pharmacy closed formulary designate a two-year period for preparing to transition legacy claims to the requirements of the closed formulary. This two-year period is changed from proposal and is September 1, 2011 to September 1, 2013. Until that time, there should not be a denial of payment on a legacy claim by an insurance carrier based on the applicability of the closed formulary, since the effective date of the closed formulary for legacy claims will not occur until September 1, 2013. However, during this transition period the Division's and certified networks' adopted treatment guidelines continue to apply and should be utilized as the standard for retrospective review of pharmaceutical services. Additionally during that two-year transition time, all system participants are encouraged to help educate one another to ensure that the need for the medications excluded from the closed formulary are conveyed with a statement of medical necessity by the prescribing doctor, which will facilitate discussions of alternatives and injured employee needs with the insurance carrier. This discussion of ongoing pharmacological management will help alleviate a forced preauthorization request when the closed formulary becomes applicable.

The Division clarifies the intent is to facilitate a transition of legacy claims through a mutual agreement between the parties. However, it is not the Division's intent to create another administrative requirement and potential administrative violation by mandating the statement of medical necessity. An insurance carrier may request a statement of medical necessity, but this request alone does not authorize the insurance carrier to approve or deny the request. Further, the Division notes the requirements for responding to a request for a statement of medical necessity are included in §134.502 of this title.

§134.510(b): A commenter recommends that a process needs to be set in an additional rule that provides for pharmacological case management (e.g., where the insurer believes the injured employee may be addicted to the prescription drugs) for both legacy and new claims in which prescription drugs that have been excluded from, exceed, or are not addressed by the ODG treatment guidelines can be discussed by the prescribing doctor, treating doctor (if appropriate), and insurance carrier's medical advisor to determine an appropriate course of action with future prescriptions and refills for the drug(s) in question. The commenter states it is probable that the majority of physicians will not be willing to timely respond to requests by insurers to discuss pharmacological management of legacy claims since there is no requirement to do so, and as borne by the attempt in a previous pilot study on treatment planning. The commenter will be working with other associations and interested stakeholders to develop a rule concept for pharmacological case management to be shared with the Division at a future date.

Agency Response: The Division disagrees that a new rule for pharmacological case management is necessary at this time to prepare for the transition of legacy claims to the pharmacy closed formulary. However, the Division acknowledges the concerns of the commenter, and clarifies that the adopted rule at subsection (b)(1)(C) and (b)(2)(B)(i) and (ii) are modified from proposal to allow and require equal exchange of information between the prescribing doctor and the insurance carrier. New subsection (b)(1)(C) clarifies, "When a prescribing doctor or insurance carrier is contacted by the other party regarding ongoing pharmacological management, the parties must provide each other a name and phone number and date and time to discuss ongoing pharmacological management." Additionally, new subsection (b)(2) states, "Beginning no later than March 1, 2013, the insurance carrier shall: (A) identify all legacy claims that have been prescribed a drug excluded from the closed formulary after September 1, 2012; and (B) provide written notification to the injured employee, prescribing doctor, and pharmacy if known, that contains the following: (i) the notice of the impending date and applicability of the closed formulary for legacy claims; and (ii) the information required in paragraph (1)(C) of this subsection." The Division plans to closely monitor the implementation of the initial closed formulary for new claims in anticipation of the transition

for legacy claims, including the review and consideration of any future rule concepts submitted by interested system participants.

§134.510(b): A commenter opines that injured employees who are in great pain, not likely to ever return-to-work, and when taking appropriate medications over a period of time, have no need to have their prescribing doctors justify to insurance carriers why the best care they can get is being delivered. The commenter asserts that group health plans once in a while request a doctor to justify major changes; but once is all it takes and there is no continued back and forth communications as is common in the workers' compensation system.

Agency Response: Labor Code §408.028(b) requires the Commissioner by rule to adopt a closed formulary, which includes the identification of an appeals process for claims in which a treating doctor determines and documents that a drug not included in the formulary is necessary to treat an injured employee's compensable injury. Prior to implementation of rules addressing this closed formulary objective, prescription medications for injured employees have not consistently been subject to prospective scrutiny for medical necessity, and subsequently have become a significant driver of long-term medical costs to the Texas workers' compensation system. Implementation of Labor Code §408.028(b), through this rule adoption, attempts to address potential overutilization of prescription medications, as these noted drug exclusions from the closed formulary are treatment and services that are now folded into other treatments and services that also require preauthorization. The Division further clarifies that the prescribing doctor has the opportunity, through preauthorization, to explain any circumstances that might be unique to the injured employee's situation, as noted by the commenter.

§134.510(b)(1): A commenter recommends the Division Medical Advisor and Medical Quality Review Panel actively identify prescribing doctors who prescribe "N" drugs to injured employees or who prescribe an inordinate amount of drugs within the closed formulary and initiate appropriate remedial action or impose sanctions as a proactive measure if the administrative burden is too high to apply the closed formulary to all open claims effective January 1, 2011.

Agency Response: The Division notes that recommendations regarding the duties of the Office of the Medical Advisor and the Medical Quality Review Panel are outside the scope of these proposed rules. However, regardless of the applicability of the closed formulary, prescriptions are subject to retrospective review and the applicability of the Division's or certified network's treatment guidelines. In prescribing pharmaceutical services, prescribing doctors must comply with Division rules as well as the rules of the Texas Medical Board. Further, the Division clarifies that system participants may file complaints to the Medical Advisor through the Division's complaint resolution process when appropriate to facilitate necessary care of the injured employee.

§134.510(b)(1)(A): Commenters recommend changing the word "should" to "shall" to ensure that whenever a physician prescribes an "N" drug, that they be required to include a statement of medical necessity to facilitate an efficient utilization review process for 72-hour preauthorization determinations. One commenter additionally recommends the words "or that exceed or are not recommended by" be added so that subsection (b)(1)(A) would read, "The prescribing doctor shall include a statement of medical necessity as defined in §134.500(13) of this title (relating to Definitions) with the prescription for drugs excluded from, or that exceed or are not recommended by the closed formulary."

Agency Response: The Division declines to make the changes. The Division clarifies the intent is to facilitate a transition of legacy claims through a mutual agreement between the parties. However, it is not the Division's intent to create another administrative requirement and potential administrative violation by mandating the statement of medical necessity. Since the services are subject to retrospective review, the additional recommended language for subsection (b)(1)(A) is unnecessary.

§134.510(b)(1), (c), and (d): A commenter recommends a revision of subsection (b)(1) with additional subparagraphs be added as follows: "(D) When contacted by the insurance carrier, the prescribing doctor must participate in discussions of ongoing pharmacological management. The failure to participate constitutes a violation of a commission rule. (E) If no agreement is made about future pharmacological benefits, the prescribing doctor shall submit a treatment plan for preauthorization. The insurance carrier shall process the request for preauthorization of the pharmacological treatment plan in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care). (F) If an agreement about future pharmacological benefits is reached, the insurance carrier and a prescribing doctor will be deemed to have entered into a voluntary certification agreement in accordance with §134.600 of this title regarding the application of the pharmacy closed formulary for individual legacy claims on claim-by-claim basis. (G) A voluntary certification agreement shall document the agreement and the terms of the agreement. A copy of the agreement shall be sent by U.S. mail or via transmission of a facsimile to the prescribing doctor, treating doctor and injured employee. (H) Health care provided as a result of the agreement is not subject to retrospective review of medical necessity. (I) If no agreement is reached and documented by January 1, 2013 for a legacy claim, the requirements of §§134.530, 134.540, and 134.550 of this title shall apply." The commenter recommends deletion of proposed subsections (c) and (d) based on these recommended rule revisions by the commenter, which incorporate the concepts of proposed (c) and (d).

Agency Response: The Division declines to make the changes and declines to delete subsections (c) and (d) as proposed; but clarifies that some modifications have been made to this section to allow and require equal exchange of information between the parties, which are the prescribing doctor and the insurance carrier. These rules, with additional modifications, and other Division rules address the commenter's concerns regarding agreements, but without imposing further administrative requirements.

§134.510(b)(2): A commenter suggests duties imposed on the insurance carriers for legacy claims be restricted to only those claims where active treatment (received prescriptions in the preceding 180 days) is being rendered. Identifying all legacy claims is too administratively burdensome to the insurance carriers. Another commenter requests clarification as to whether these notices are to be sent to all legacy claimants, or only those legacy claimants with ongoing active prescriptions.

Agency Response: The Division agrees that the proposed language is potentially confusing and adopted §134.510(b) is modified to clarify the expectations concerning notifications for legacy claims and that notifications should be provided for all legacy claims that have been prescribed a drug excluded from the closed formulary after September 1, 2012.

§134.510(b)(2): A commenter recommends prescribing doctors who continue to prescribe "N" medication on legacy claims after January 1, 2011 should be required to timely respond to the notices required by subsection (b)(2) with a plan for ongoing pharmacological management consistent with Division adopted treatment guidelines and closed formulary as a proactive measure if the administrative burden is too high to apply the closed formulary to all open claims effective January 1, 2011.

Agency Response: The Division agrees and changes have been made in the adopted subsection (b)(1) and (2) that address the parties providing each other a name, phone number, and date and time to discuss ongoing pharmacological management when one of the parties initiates the discussion. Although a plan is not required by the rule, the discussion between the parties is intended to result in an agreement for ongoing pharmacological management consistent with Division adopted treatment guidelines and closed formulary.

§134.510(b)(2): A commenter affirms that it should be peer-to-peer review and discussions of such activity, and not an adjuster, and additionally opines that the rule fails to acknowledge the treating doctor as gatekeeper for the provision of all health care. The commenter recommends the rule be amended to incorporate the treating doctor's role as the gatekeeper for the delivery of all health care benefits to include pharmaceutical benefits.

Agency Response: The Division agrees with the commenter's statement that peers are to review and discuss such ongoing pharmacological management. The Division notes that discussions regarding ongoing pharmacological management are considered a component of utilization review and therefore adjusters are prohibited from participating in those discussions. However, the Division disagrees that the roles of a treating doctor as outlined in the Texas Workers' Compensation Act and Division rules need further clarification or restatement because the purpose of this subsection is to facilitate transition of legacy claims through active communication between the treating doctor and the insurance carrier to assure the continuity of care for injured employees during the transition to the closed formulary. Although the treating doctor and prescribing doctor should be in communication concerning the injured employee's care, the prescribing doctor is likely the most appropriate individual to substantiate the need for the prescribed medication and any attendant requirements of the closed formulary.

§134.510(c): A commenter recommends the rules be changed to have the voluntary certification go through the preauthorization process since it is unlikely insurance carriers will seriously consider voluntary certification requests and without preauthorization, there would be no process for appealing a denial to an insurance carrier.

Agency Response: The Division declines to make the specific change recommended by the commenter; however, the Division notes changes to this subsection have been made based on public comment to clarify that agreements may be made for both certified network and non-network claims. The preauthorization process will become effective upon implementation of the legacy claims to the closed formulary, or September 1, 2013. The agreements referenced in §134.510 are a voluntary process, and are documented by a signed and binding agreement reached by two or more parties, which eliminates the need for any denial appeals. Since these agreements are voluntary, there is no need to impose the time constraints required in the preauthorization process.

§134.510(c): A commenter requests clarification regarding 28 TAC §134.600 and its adoption under Labor Code §413.014, and how networks are meant to follow the requirements of §134.600 as it relates to voluntary certification of pharmaceuticals. The commenter suggests the requirements regarding voluntary certification needs to be specified for networks. The commenter provides pertinent language references from proposed §134.510(c), Insurance Code §1305.351(c), and Labor Code §413.014(f).

Agency Response: The Division disagrees that specific direction is necessary to apply §134.510(c) to claims subject to a certified network. The Division, however, notes that the language in subsections (c) and (d) is amended from proposal to clarify that an agreement can be made between an insurance carrier and a prescribing doctor to ensure continuity of care during this transition of legacy claims. The specific reference to §134.600 of this title is not necessary, and is therefore removed. The adopted language now reads, "(c) Agreement. To ensure continuity of care, notwithstanding subsection (a), an insurance carrier may enter into an agreement regarding the application of the pharmacy closed formulary for individual legacy claims on a claim-by-claim basis." Adopted subsection (d)(3) now reads, "(3) Denial of a request for an agreement is not subject to dispute resolution."

§134.530(a) and §134.540(a): Commenters offer differing recommendations about the use of the terms "prescribed and dispensed." One commenter recommends rule language be based on the date of prescription, and not the date dispensed. Another commenter recommends the deletion of the words "prescribed and," stating it would be better to base the rules only on the date of the dispensing of the drug since the industry tracks pharmaceuticals based on dispensing date. Records are not kept regarding the date of prescription and using the date of prescription creates the potential for possible abuse if application of the rules depends on the date of writing the prescription.

Agency Response: The Division disagrees. The purpose for using the terms is to clarify that the closed formulary applies to the prescribing doctor at the beginning of the prescription process, as well as to the pharmacy at the actual dispensing of the medication. It is the prescription date that controls the determination of whether the drug requires preauthorization. This concept is important during the initial implementation of the closed formulary, when both conditions might not be met. Consequently, inclusion of both prescribing and dispensing emphasizes these requirements.

§134.530(b): Commenters seek clarification and guidance on how the application of the closed formulary impacts or influences prescription refills. Commenters request clarification whether each and every refill of a standing prescription require preauthorization and whether preauthorization requirements apply to each new prescription (standing long-term therapies), or only changes in treatment therapies.

Agency Response: The Division clarifies that refills of previously preauthorized prescriptions should not require additional preauthorization, as it is covered in the initial approval. New prescriptions for previously prescribed and dispensed drugs require preauthorization.

§134.530(b): Clarification is requested by commenters whether insurance carriers/employers may contract with their PBM to provide blanket preauthorization for specific drugs, drug classes, treatment therapies or prescribing doctors in lieu of sending each indicated "N" drug through the required preauthorization process. Commenters reference costs of preauthorization com-

pared to the price of some "N" drugs, where the preauthorization cost would far exceed actual reimbursement.

Agency Response: The Division clarifies that insurance carriers/employers cannot contract with their PBM to provide blanket preauthorization for specific drugs, drug classes, treatment therapies or prescribing doctors in lieu of sending each indicated "N" drug through the required preauthorization process. This type of contracting would essentially permit insurance carriers/employers and their PBMs to nullify the closed formulary through contract, because drugs are excluded from the formulary to ensure their proper use on a case by case basis. Moreover, a "blanket" determination of medical necessity would not meet the statutory goals of providing cost-effective and necessary medical care to injured employees, because a "blanket" determination would, by definition, not actually determine whether the health care at issue was medically necessary for any particular claim. The Division also clarifies that unless PBMs are certified utilization agents, PBMs, in accordance with Department rules, are not permitted to conduct any utilization review activities.

§134.530(b): Commenters state the rules create a gap between prescribing of a drug by the treating doctor, dispensing by retail pharmacy, processing by PBM/third party biller, billing/reimbursement for the medication and pharmacy related pharmacy services, and further summarizing that the Division Form-066 lacks proper designated space on the physical bill form for capture and transmittal of either a preauthorization number and/or a statement of medical necessity, while the NCPDP 5.1 file format lacks the elements necessary to capture and transmit information related to attachment data such as statement of medical necessities. Commenters note this will raise costs for all pharmacy providers, insurance carriers and slow delivery of care to injured employees waiting for their "N" drugs at the retail pharmacy, and recommend as a long-term solution that the Division examine possible alterations to the Form-66 billing form or delay implementation until adoption of the NCPDP D.0 file format in 2012. Another commenter recommends the Division revise the DWC-066 form to include diagnosis codes on the billing form. The prescribing doctor would be responsible for providing the diagnosis codes to the dispensing pharmacy to support usage of a specific medication, whether it is for standard treatment or off-label use. This information addition to the billing form will put it in line with other billing forms used in the workers' compensation industry. The form could be structured similarly to the CMS-1500 in which each line item is cross referenced to the corresponding diagnosis code. It could be potentially used in combination with a letter of medical necessity if further medical evidence is needed, or alone if the diagnosis is descriptive enough to explain why the medication was prescribed.

Agency Response: The Division notes that modification to the billing forms is outside the scope of the proposed rules. The commenters' suggestions have been forwarded to Division staff responsible for billing and reporting requirements.

§134.530(b)(1) and §134.540(b)(1): A commenter states the preauthorization process for network and non-network claims must follow an identical action plan. As currently stated, the preauthorization process should be revised such that any request be reviewed based upon medical necessity and relatedness to the compensable injury at all levels of preauthorization.

Agency Response: The Division clarifies that the preauthorization processes of medical necessity in both network and non-network settings qualify as utilization review, pursuant to Chapters 10, 19, 134, and 137 of this title (relating to Workers' Compensation Health Care Networks, Utilization Review, Benefits--Guidelines for Medical Services, Charges and Payments, and Disability Management, respectively). Certified utilization review agents and insurance carriers are given certain administrative flexibility to effectively apply the requirements set forth in Chapters 10, 19, 134, and 137.

§134.530(b)(1) and §134.540(b)(1): A commenter notes, by not providing direction on the diagnoses of: infection, prophylaxis for infection - including prophylaxis for HIV infection, eye injury, and allergic reaction, the commenter will be required to obtain preauthorization before the medications can be dispensed to the patient by the pharmacy. The preauthorization requirement will cause delays in patients receiving proper care and will create significant bottlenecks in pharmacies ability to provide timely service.

Agency Response: The Division clarifies use of a particular drug is dependent on medical necessity, generally established by evidence-based medicine of the treatment guidelines. However, a diagnosis is not specifically required to be listed or noted in the treatment guidelines for the closed formulary to apply. For example and regardless of diagnosis, drugs excluded from the closed formulary (e.g., "N" drugs) require preauthorization, and all other drugs (e.g., drugs included in the closed formulary) do not require preauthorization and are subject to retrospective review.

§134.530(b)(1) and §134.540(b)(1): A commenter is concerned that the cost and complexity of the preauthorization and appeals process will interfere with a physician's prescribing authority and prevent patients from receiving the treatment best suited to treat their conditions.

Agency Response: The Division disagrees that the prescribing physician's ability to provide appropriate and medically necessary care to injured employees is compromised by the applicability of the closed formulary. Prescribing doctors have access to essentially the entire pharmacopeia of FDA-approved drugs with a relatively small number requiring preauthorization. The Labor Code requires that the Division's treatment guidelines and protocols be evidence-based, scientifically valid, and outcome focused, and designed to reduce excessive or inappropriate medical care while safeguarding appropriate medical care. The preauthorization process for those drugs excluded from the closed formulary will validate the medical necessity of those drugs using the concepts of evidence-based medicine outlined in the treatment guidelines.

§134.530(b)(1), (d)(1), and §134.540(b)(1), (d)(1): Commenters state when a treating physician writes a prescription which includes an "N" drug, the physician should be required to provide a statement of medical necessity which should accompany the prescription. The treating doctor is the only one who can provide this documentation.

Agency Response: The Division disagrees that additional language is necessary. The Division recognizes, however, that certain pharmacies might wish to coordinate this activity with the prescribing doctor when the prescribing doctor has not requested preauthorization for a drug excluded from the closed formulary. Additionally, a pharmacy, as a business practice, might also wish to communicate with the prescribing doctor if additional documentation is likely to be needed for the use of the drug included in the closed formulary. A pharmacy may request a statement of medical necessity when necessary to substantiate the medical necessity of a prescription, and the prescribing doctor

shall provide the statement of medical necessity within 14 days in accordance with §134.502 of this title.

§134.530(b)(4) and (5) and §134.540(b)(2) and (3): A commenter requests clarification whether a trial for an intrathecal drug delivery system (not typically a surgical procedure) requires preauthorization. The commenter also requests clarification on the following scenario: if two doctors treating a patient, a surgeon who implants, and a pain management doctor who handles the drug prescription and refills, whether one or both preauthorizations should be submitted. The commenter requests clarification whether both preauthorizations are required, and whether they are required at the same time. For example, some surgeons will fill the pump with saline at implantation and have the pain management doctor fill the initial pain pump drug.

Agency Response: The Division clarifies that a trial may not require preauthorization if certain criteria for the trial is recommended by the Division's adopted treatment guidelines or the applicable network's treatment guideline. For injured employees not subject to a certified network in this example, surgeries in a facility setting require preauthorization in accordance with §134.600 of this title. If a separate provider is prescribing medications that are excluded from the closed formulary beyond the trial, this provider, too, must seek preauthorization. The Division notes, however, that the provisions regarding preauthorization for intrathecal drug delivery system refills is provided under adopted new subsection (c) of §134.530 and §134.540.

§134.530(b)(4) and (5) and §134.540(b)(2) and (3): A commenter agrees with the proposed annual preauthorization requirements, stating it is very good and appreciated. However, regarding annual preauthorization for drug refills, commenter hopes the Division will be available for assistance and facilitation when working out these arrangements between insurance carriers and health care providers to ensure continual patient coverage and access to care.

Agency Response: The Division appreciates the supportive comment, and believes that the rules provide clear direction concerning refills of previously preauthorized intrathecal drug delivery systems. Additionally, the MIO process provides a mechanism to continue the use of a previously preauthorized drug in the event of an unreasonable risk of a medical emergency. Further, the Division clarifies the Office of the Medical Advisor is available when appropriate to facilitate necessary care of the injured employee.

§134.530(b)(4) and (5) and §134.540(b)(2) and (3): A commenter objects to the rule provisions and states there should be no assumptions made that refills warrant a one year preauthorization approval. As a minimum, refills should require re-evaluation by the prescribing physician and be subject to preauthorization at least every six months if the drugs are either excluded from, exceed the treatment parameters, or is not recommended by the closed formulary. This proposal is contrary to the Division's statutory duty to promote the delivery of high quality, medically necessary health care treatment.

Agency Response: The Division disagrees. Cognizant of utilization review costs in Texas, which the Workers' Compensation Research Institute reports is high compared to other states, an annual review of a previously preauthorized medication is a measured, cost effective approach. This is particularly important since prior to the adoption of these rules, the review of intrathecal drug delivery system refills was not previously required at any time after implantation of the pump.

§134.530(b)(5) and §134.540(b)(3): A commenter recommends added language to include "exceed the treatment parameters, or is not recommended by..." so that the recommended additions to §134.530(b)(5) and §134.540(b)(3) read, "Refills of an intrathecal drug delivery system with drugs excluded from, exceed the treatment parameters, or is not recommended by the closed formulary, ..."

Agency Response: The Division declines to make the change. The implementation of the closed formulary is the primary focus of these rules. However, throughout the rule development process, system participants consistently noted there was confusion as to the application of the treatment guidelines concerning "drugs excluded from, exceeding the treatment parameters, or not recommended by the treatment guidelines" when often these concepts were conditional and difficult for pharmacists to evaluate. A stakeholder consensus was formed early in the rule development process that a clear demarcation of drugs requiring preauthorization be implemented. Drugs excluded from the closed formulary require preauthorization. All other drugs are subject to retrospective review. In either case, the prescribing and dispensing of drugs must be consistent with the Division's or network's treatment guidelines.

§134.530(b)(6) and §134.540(b)(4): A commenter recommends a new paragraph to both rule subsections as follows: "A statement of medical necessity shall be submitted with the request for preauthorization that discusses and justifies the continuing need for drug delivery by an intrathecal drug delivery system and must be accompanied by evidence-based medical evidence."

Agency Response: The Division declines to make the change. The preauthorization process includes all the required information of a statement of medical necessity. Hence, requiring an additional statement of medical necessity is a redundant and unnecessary administrative function. If a utilization review agent believes that the submitted information will lead to a denial, the utilization review agent may pursue any necessary information through a peer-to-peer discussion with the requestor as required by Insurance Code Chapter 4201 and Chapter 19 rules.

§134.530(c): A commenter states clarification is needed on "Y" drugs that are used outside of the ODG guideline as this situation places the pharmacy in a position of risk, and regulations should be provided to help minimize or eliminate much risk as possible to the pharmacy. The commenter recommends a maximum time period of 20 days for retrospective review should be established.

Agency Response: The Division clarifies that drugs included in the closed formulary are subject to retrospective review. Most services provided in the Texas workers' compensation system are provided on this basis, regardless of the provider type. Additionally, only about ten percent of the total number of prescriptions written in calendar year 2008 was denied retrospectively. Although this is not an insignificant number, the alternative is to require preauthorization of all prescriptions, regardless of the closed formulary. This approach was universally rejected by system participants during the rule development process. Regarding the commenter's recommendation of a maximum time period for retrospective reviews, the Division clarifies that these time frames for processing claims are addressed in Labor Code §408.027.

§134.530(c) and §134.540(c): A commenter states the proposed rules are at odds with how workers' compensation drugs are commonly dispensed under current practice. The commenter further states that ignoring the current practices creates a dan-

ger of unintended consequences and runs the risk of increasing retrospective reviews, and thus, inadvertently increasing the administrative costs of handling pharmacy reimbursements. The proposal poses the risk that pharmacies may be reluctant to provide prescription fills in the absence of an immediate electronic guarantee of payment.

Agency Response: The Division disagrees. Labor Code §408.028 requires the adoption of a closed formulary. Current Division rules require pharmaceutical services to be provided in accordance with the Division's treatment guidelines, which became effective May 1, 2007. All current prescribing practices, therefore, should be conforming to these treatment guidelines. There may be some additional costs for preauthorization when compared to retrospective review; however, these costs may be offset by a potential decreased utilization of drugs excluded from the closed formulary. This is especially relevant in light of the Workers' Compensation Research Institute's March 2010 report titled, *Prescription Benchmarks for Texas,* which indicated that Texas was higher on the utilization of prescription drugs compared to most other states studied. The average number of pills per claim with prescriptions in Texas was 41 percent higher than the 16-state median and the average number of prescriptions per claim was 34 percent higher. The Division clarifies that insurance carriers may guarantee payment to health care providers through an agreement for any drugs that do not require preauthorization. The same rationale applies to claims that are subject to a network as indicated in §134.540 of this title.

§134.530(c)(2): A commenter supports this provision and hopes there will be few instances where the retrospective review provision will result in non-payment to a pharmacy, ensuring timely access to medication is a laudable goal advanced by not requiring preauthorization for drugs included in the closed formulary.

Agency Response: The Division appreciates the supportive comment.

§134.530(c)(2): A commenter recommends deletion of this paragraph because if adopted, it would undermine the effectiveness of the treatment guidelines, at least as applied to pharmaceuticals. The Legislature's recent comprehensive reform legislation will not achieve its goals of providing quality medical care while at the same time providing such medical care in the most cost-efficient manner if adopted treatment guidelines are not rigorously enforced. Allowing prescriptions that exceed or not addressed in the medical treatment guidelines to be dispensed without any preauthorization defeats the purpose of treatment guidelines, and signals a worrisome trend that the guidelines will not be enforced in the future.

Agency Response: The Division disagrees. The applicability of treatment guidelines (as proposed in subsection (c)(2) of this section, but adopted as (d)(2)) remains in place and acts as the standard for determining medical necessity in the Texas workers' compensation system. The Division's discussions with system participants, through numerous informal drafts and stakeholder meetings, indicate that current practice does not support the concept that pharmaceuticals are currently being preauthorized in the workers' compensation system even when they are outside or in excess of the treatment guidelines. Consequently, most prescriptions are reviewed retrospectively with an approximate ten percent denial rate in calendar year 2008. This rule conforms with the actual utilization review practice in the majority of the system today, and removes confusion concerning which drugs require preauthorization, and when they require preauthorization.

§134.530(d)(1): A commenter states since antibiotics are not considered in the closed formulary, one should assume that special authorization will be required to get such prescriptions filled.

Agency Response: The Division disagrees. FDA-approved antibiotics are included in the closed formulary. The Division notes, however, that the provisions regarding the appeals process is provided under adopted new subsection (e) of §134.530.

§134.530(d)(1): A commenter recommends that the section be modified to give the insurance carrier the power to issue certification periods of up to 90 days for excluded drugs that require preauthorization.

Agency Response: The Division disagrees that any modifications are required. Labor Code §413.014(f) supports insurance carriers and health care providers voluntarily discussing health care treatment and treatment plans, and pharmaceutical services. Therefore, if an insurance carrier, through its utilization review agent, believes that a prescription should be written or approved for a time period other than what is submitted by the requestor, the insurance carrier may discuss that alternative with the requestor.

§134.530(d)(1): Commenters seek clarification on how non-formulary drugs will be preauthorized. A commenter opines that the introduction of a loosely standardized preauthorization process and unclear guidance on medical necessity could result in unintended costs, unfairly shift the burden further onto pharmacists, and potentially damage reliable and timely access to care by injured employees for certain drugs. Of particular concern is the process of preauthorizing drugs that are not included in the closed formulary. The commenter is concerned that 28 TAC §134.502(f) gives the prescribing doctor up to 14 working days to issue a statement of medical necessity when asked by a nonphysician, creating a potentially serious delay in the timely delivery of care. The treating physician is best suited and appropriately licensed to determine what pharmacy care will best meet the needs and desired outcomes for an injured employee.

Agency Response: The Division clarifies that the preauthorization process for non-network claims is set out in §134.600 of this title, and the utilization review standards of preauthorization are detailed in Chapter 19 of this title (relating to Agents' Licensing). Further, the Division's adopted treatment guidelines provide direction for the delivery of services in the Texas workers' compensation system. For network services, individual network treatment guidelines apply as well as specific preauthorization processes that are outlined and available for participating network providers. Although the prescribing doctor is allowed 14 days to respond to a request for a statement of medical necessity, the prescribing doctor may respond as soon as the request is made. Since the treating physician is best suited and appropriately licensed to determine what pharmacy care will best meet the needs and desired outcomes for an injured employee, the prescribing doctor should build those concepts into the timeframes for the response to the request for a statement of medical necessity.

§134.530(d)(1): A commenter requests clarification regarding ongoing coverage for "N" drugs, and if an insurance carrier is allowed to identify certain drugs for which there are no benefits, and perform utilization review for those drugs and/or allow or approve those drugs.

Agency Response: The Division clarifies that injured employees are entitled to all medical benefits in accordance with Labor Code §408.021. The adoption of the closed formulary does not contradict this portion of the Labor Code, but identifies drugs that are not included in the closed formulary and which require preauthorization to establish medical necessity.

§134.530(d)(1): A commenter states the appeal process should require approval within 24 hours and allow for dispensing of a 72-hour emergency supply of the prescribed medication. Neither the Department nor the Division has set guidelines as to how to proceed with prior approval process; instead, the responsibility is on the physician to contact the insurance carrier for preauthorization and procedures may vary depending on the insurance carrier.

Agency Response: The Division clarifies that the preauthorization period for approval is governed by the Insurance Code Chapter 4202 and Chapter 19 of this title (relating to Agents' Licensing, and the dispensing of emergency supplies is governed by the Occupations Code and/or Texas State Board of Pharmacy rules.

§134.530(d)(1): A commenter recommends that the Division host on its website and include in the rule-making process, a requirement of insurance carriers to post and keep current their preauthorization approval processes in a public, clear, and transparent manner, accessible to both patient and provider.

Agency Response: The Division clarifies that preauthorization in the Texas workers' compensation system is utilization review and must be conducted by certified utilization review agents, or insurance carriers registered to perform utilization review. The Life, Health and Licensing Division of the Department is responsible for reviewing and approving applications for utilization review certification. Utilization review must be conducted in accordance with the Insurance Code requirements and Department rules, and consequently the utilization review processes do not vary by insurance carrier.

§134.530(d)(1), (f)(2) and §134.540(d)(1): A commenter observes the use of outside guidelines for formulary and treatment decisions takes the power of medical decision-making out the hands of the physician, and guidelines are not easily obtained and publicly available. To assure the transparency and validity of the process by which patients will be switched from a stabilized medicine to a price-based alternative, the guidelines establishing such a switch should be made available to the public at no cost. Evidence-based medicine is vaguely described and can result in the implementation of a system that is cost-based instead of outcomes focused. Another commenter opines the use of evidence-based medicine as vaguely described in the proposed rules could lead to a system where it is only used as an arbitrary cost-cutting tool, placing cost-savings over patient well-being.

Agency Response: The Division disagrees. The Labor Code §413.011(e) requires the Commissioner of Workers' Compensation to adopt treatment guidelines that are evidence-based for use in the non-network system. Similarly, Insurance Code Chapter 1305 and Chapter 10 of this title also require a certified network to have treatment guidelines that are evidence-based and that care provided within these guidelines is considered reasonably required. These guidelines are the standard to apply for the care of injured employees in whose claim is not subject to a certified network, or is subject to a certified network respectively. The health care provider must consider care above or below the guidelines consistent with the unique factors associated with an injury. These rules and the disability management concept anticipate certain care outside or inconsistent with the treatment guidelines be managed by the treating doctor as coordinated by the utilization review processes. Care provided within the guidelines is presumed reasonable as specified in Labor Code §413.017 and also assumed to be health care reasonably required as specified in Labor Code §401.011(22-a). Labor Code §413.011(e) also states treatment may not be denied solely on the basis that the treatment for the injury in question is not specifically addressed by the treatment guidelines. Further, Labor Code §401.011(18-a) defines evidence-based medicine. The Division also clarifies that the decisions concerning the drugs excluded from the closed formulary are not priced-based, but are consistent with the recommendations outlined in the Division's treatment guidelines. Injured employees continue to have access to drugs excluded from the closed formulary through the preauthorization process based on medical necessity. The Division notes, however, that the provisions regarding the appeals process is provided under adopted new subsection (e) of §134.530 and §134.540.

§134.530(d)(2): A commenter suggests this portion of the rule proposal should be modified to state that the Division will request the statement of medical necessity from the prescribing doctor. The commenter agrees that a statement of medical necessity will facilitate the preauthorization process, but is concerned that these provisions will be of limited effectiveness if the Division is not the requestor. If the Division were the requestor, there would be a greater chance that the statement of medical necessity would be provided and, accordingly, that information essential to making the correct preauthorization decision would be obtained and considered. The only apparent consequence of a prescribing doctor not providing the statement of medical necessity would be a referral for an administrative violation. However, that enforcement mechanism cannot feasibly be pursued by injured employees against their treating doctors due to the negative consequences such a referral would pose to the doctor-patient relationship. If the Division is going to be the requestor, the rule should be revised to clearly state that and to explain how an injured employee or a non-prescribing doctor requestor would ask the Division to request the statement of medical necessity. Alternatively, if the Division is not to be the requestor, the rule should delineate sufficient consequences of the prescribing doctor's failure to comply to ensure that the statement can be obtained.

Agency Response: The Division disagrees. Utilization review, including preauthorization, is a process of review of the medical necessity and appropriateness of health care services, generally on a peer-to-peer basis that is traditionally between the requesting health care provider and the insurance carrier. The commenter's suggestion that the Division begin processing statements of medical necessity for specific bills is contrary to the recommendations in the Sunset Advisory Committee Report issued July 20, 2010, which suggested that the Division has a limited role in making decisions on individual claims. Further, the Sunset Advisory Committee Report indicated that insurance carriers are well positioned to manage individual claims. System participants are capable of communicating with each other and sharing required information without inserting the Division into a completely clerical process. However, the Division is available to resolve disputes if the system participants fail to complete the documentation requirements.

§134.530(d)(3): A commenter recommends that this be modified to permit a reconsideration process of preauthorization denials

prior to requests for a full independent review organization (IRO) review because it would be more efficient if there was an opportunity for the insurance carrier to process a reconsideration of a denied medication prior to requesting an IRO review.

Agency Response: The Division declines to make the change, but notes that proposed subsection (d)(3) has been relettered to (e)(3) as a result of renumbering changes made throughout the section. Further, the Division clarifies that the reconsideration process is not required in the event of an MIO request in order to expedite the process and avoid a medical emergency for the injured employee. The insurance carrier may continue to attempt to resolve any potential dispute with the prescribing doctor as Labor Code §413.014(f) supports insurance carriers and health care providers voluntarily discussing health care treatment and treatment plans, and pharmaceutical services.

§134.530(e)(1): A commenter recommends deletion. The commenter states retrospective review of medical treatment and pharmaceuticals is essential to effective workers' compensation medical cost containment. Rules that would eliminate both preauthorization and retrospective review for initial pharmaceutical coverage for drugs within the closed formulary increases the risk that unnecessary pharmaceutical costs will continue to impair the Texas workers' compensation system. At the very least, drugs within the closed formulary should be within the treatment guidelines and should be subject to retrospective review. Drugs that are excluded from the closed formulary should be subject to preauthorization and the treatment guidelines as well as retrospective review. The commenter recommends adoption of the language proposed in the initial December 2008 informal working draft rules that struck the correct balance by retaining retrospective review of initial pharmaceutical coverage but prohibiting preauthorization: "Subject to retrospective review, drugs prescribed in accordance with §134.501 of this title (relating to Initial Pharmaceutical Coverage) may be dispensed without preauthorization in accordance with §134.600 of this title. However, such prescription and dispensing is subject to the process for review and audit of workers' compensation medical bills in accordance with §133.230 and §133.240 of this title." The commenter states there is no justification or policy rationale for prohibiting preauthorization and retrospective review for initial pharmaceutical coverage where such prescriptions are either not within the medical treatment guidelines or are not within the adopted closed formulary.

Agency Response: The Division declines to make the change, and notes, however, that the provisions regarding initial pharmaceutical coverage is provided under adopted new subsection (f) of §134.530. The provisions of Labor Code §413.0141 allow the Commissioner to require payment for specified pharmaceutical services for the first seven days following the date of injury when certain criteria are met. Additionally, the initial pharmaceutical requirements (initial fill) were considered in several stakeholder meetings. Although medical necessity is a key component of the delivery of any services in the Texas workers' compensation system, the unique delivery system for pharmaceutical services complicates the medical necessity decisions for initial fill pharmaceutical services in the first seven days after an injury. Allowing initial fills of prescriptions assures timely access to needed drugs for injured employees and begins their immediate journey to return-to-work. Further, this approach assures that pharmacists are not denied payment due to a retrospective review of medical necessity for the initial seven day period post-injury. Retrospective review and denial of payment for these initial pharmacy services in the first seven days post-injury threatens the ability of injured employees to receive these initial fill prescriptions when the claim itself may not yet be reported to the insurance carrier.

§134.530(e)(1): A commenter expresses support of proposed language and agrees that retrospective review of medication decisions made during that period would have the potential to significantly undermine the statute.

Agency Response: The Division appreciates and agrees with the supportive comments.

§134.530(e)(1): Commenters state that the injury speaks for itself, pain level is self-evident, allergies to medications and the timing of the event (weekends). Although the proposal calls for a seven-day period, the cost of providing a 30-day versus a seven-day prescription is not substantially different. Certainly there is a decrease in product cost, however splitting a prescription and then establishing a mechanism to track/monitor the remaining balance is costly and the recommendation is to change this to 30 days first fill in all circumstances.

Agency Response: The Division declines to make the change and clarifies the requirement of Labor Code §413.0141 only provides the Commissioner the authority to extend first fill payments to pharmaceutical services sufficient for the first seven days following the date of injury.

§134.530(e)(1): A commenter seeks clarification regarding proposed language and whether "no preauthorization" means PBMs/payers must allow that "Y" or "N" drug, or can allow it. As an example, the commenter seeks clarification if a PBM has to allow Embeda ("Y") and Enbrel ("N") for first fill.

Agency Response: The Division clarifies that adopted §134.530(e) allows drugs included in the closed formulary to be dispensed without preauthorization and are not subject to retrospective review of medical necessity during the initial seven days after the date of injury. Drugs excluded from the closed formulary ("N" drugs), may also be dispensed without preauthorization during the initial seven days after the date of injury, but are subject to retrospective review, except investigational and experimental drugs which always require preauthorization. Regarding the commenter's notation of PBMs, the Division clarifies that unless PBMs are certified utilization review agents, PBMs, in accordance with Department rules, are not permitted to conduct any utilization review activities.

§134.530(e)(1) and (2): Commenters recommend deletion of language subjecting initial fill of "N" drugs to subsequent retrospective review to ensure that injured employees can receive immediate pharmacy treatment with medications that are indicated as "N" on the closed formulary, and note that proposal language may be somewhat confusing and possibly force a chilling effect, specifically on initial dispensing of "N" drugs meant to protect the injured employee where instant preauthorization is unattainable, and defeat the purposes of the Labor Code in addressing initial fills. One commenter asserts that because the initial fill is subject to retrospective review, many pharmacies may choose not to provide the initial fill on "N" drugs since there is significant risk of non-payment. Another commenter disagrees with proposal and states the existence of Labor Code §413.0141 demonstrates the legislative intent to provide broad access to medication during the first seven days following an injury. Retrospective review runs counter to that objective and intent and the commenter recommends appropriate modification of this provision so that there is no retrospective review in the first seven days, not even those drugs not included in the closed formulary.

Agency Response: The Division declines to make the changes. In developing the rules, the Division was required to harmonize the requirement to adopt a closed formulary and the authority of the Commissioner to adopt rules regarding initial pharmaceutical services. Although some system participants requested retrospective review of all initial pharmaceutical services, others requested the opposite approach of no review of any initial fill regardless of status relative to the closed formulary. As a result, the Division has established an approach that maintains the intent of the adoption of a closed formulary and provides access to initial pharmaceutical services without requiring a potentially burdensome and costly preauthorization process. Further, the Division clarifies that the initial fill drugs dispensed in the first seven days after the injury are currently subject to retrospective review for medical necessity.

§134.530(f) and §134.540(e): A commenter opposes the ability and authority of insurance carriers to retrospectively review the dispensing of prescriptions that do not require preauthorization, which the commenter states punishes the pharmacist, not the prescribing doctor.

Agency Response: In accordance with Labor Code §§408.021, 408.027, 413.014 and 413.031, and other relevant provisions under the Texas Workers' Compensation Act, Insurance Code, department and division rules, the Division clarifies that insurance carriers are required to pay only for medically necessary treatments or services. The medical necessity of a treatment or service is established through the utilization review process, which includes prospective, concurrent, and retrospective review. If pharmacies believe that prescribing doctors are consistently prescribing drugs that are not medically necessary, the pharmacy may file a complaint with the Department. The Division clarifies that the initial fill drugs dispensed in the first seven days after the injury are currently subject to retrospective review for medical necessity. The Division notes, however, that the provisions regarding retrospective review is provided under adopted new subsection (g) of §134.530 and §134.540.

§134.530(f) and §134.540(e): In regards to ongoing coverage, the commenter seeks clarification about "Y" drugs that require no preauthorization, but are subject to retrospective review, and whether this means PBMs/payer must allow, or can allow.

Agency Response: The Division clarifies that preauthorization requirements for pharmaceutical services only apply to those drugs excluded from the closed formulary. Further, the Division clarifies that unless PBMs are certified utilization review agents, PBMs, in accordance with Department rules, are not permitted to conduct any utilization review activities.

§134.530(f)(3): A commenter recommends the language be modified to read: "A prescribing doctor who prescribes pharmaceuticals that exceed, are not recommended, or are not addressed by §137.100 of this title, is required to provide documentation of evidence-based medicine demonstrating that treatment within the guidelines of §137.100 of this title would not be effective and documentation upon request in accordance with §134.500(13) of this title and §134.502(e) and (f) of this title." To be effective, treatment guidelines must be consistently followed. While for particular individuals, variances from the guidelines may be necessary, it is critical that such variances be kept at a bare minimum. Otherwise, the guidelines will become "paper tigers" and easily breached. In addition to the statement of medical necessity, a prescribing doctor who is prescribing drugs that are either inconsistent with the guidelines or at levels in excess of the guidelines, should need to provide objective medical documentation demonstrating that treatment within the guidelines would be ineffective for the particular claimant.

Agency Response: The Division declines to make the change. The treatment guidelines continue to be in effect, and services not preauthorized continue to be subject to retrospective review. Currently, approximately ten percent of claims are denied retrospectively. If health care providers consistently practice outside the Division's treatment guidelines, the Division's Office of the Medical Advisor may pursue a review of those specific practices.

§134.540: A commenter questions the Commissioner's statutory authority to apply the open and closed formularies to workers' compensation networks because Insurance Code Chapter 1305 prohibits the delivery of prescription medication services through a network. Networks have contracts and relationships with their prescribing doctors and should have the ability to develop treatment guidelines and preauthorization requirements and processes that are tailored to the network's needs and relationships, which could be more restrictive or more liberal than preauthorization requirements and treatment guidelines adopted by the Commissioner for non-network claims.

Agency Response: The Division clarifies that Insurance Code §1305.101(c) states that: "Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not be delivered through a workers' compensation health care network." Insurance Code §1305.101(c) is also explicit that "Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

An open formulary is applicable to both non-networks and certified networks because it is a continuation of pharmaceutical services initiated by the 77th Legislature, Regular Session through enactment of HB 2600 for the benefit of all injured employees in the workers' compensation system and implemented by the Division. The open formulary continues in effect for all prescription medication and services until such time as the closed formulary that is required by Labor Code §408.028(b) is fully implemented. The continuation through a transition period is necessary in order for the claims with dates of injury prior to September 1, 2011 (legacy claims) to have a successful transition to the closed formulary. The transition provides an implementation "bridge" between the two systems because of the anticipated volume of legacy claims requiring preauthorization.

The Division's pharmacy closed formulary is also applicable to certified networks. Both Insurance Code Chapter 1305 which created certified networks and the Labor Code §408.028(b) provision requiring the Commissioner to adopt a closed formulary were enacted under HB 7 by the 79th Legislature, Regular Session. As clearly set forth by the Legislature, certified networks are only authorized to adopt treatment guidelines, return to work guidelines, and individual treatment protocols in accordance with Insurance Code §1305.304. Consequently, certified networks have the ability to develop treatment guidelines and preauthorization requirements and processes that are tailored to the network's needs and relationships, which could be more restrictive or more liberal than preauthorization requirements and treatment guidelines adopted by the Commissioner for non-network claims.

§134.540: A commenter recommends closed formulary rules be contained within one rule, not in separate rules, for network and non-network claims since the preauthorization process

and treatment guidelines would never apply. Insurance Code §1305.351(c) provides that the Division's preauthorization requirements do not apply to health care provided through a workers' compensation health care network, and the commenter asserts that under the Texas Workers' Compensation Act, prescription medication is never considered to be health care provided through a workers' compensation health care network, and therefore, Division preauthorization requirements should apply. The commenter further opines that Insurance Code §1305.101(c) also provides that prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the Commissioner of Workers' Compensation; network treatment guidelines are adopted pursuant to Insurance Code §1305.304 and TDI rules; therefore, the Division's treatment guidelines apply to reimbursement for all prescription medication and not network treatment guidelines.

Agency Response: The Division disagrees and declines to make the change. The separation of sections 134.530 and 134.540 as adopted are necessary to clearly delineate the statements made by the commenter regarding differing treatment guidelines and preauthorization processes between claims subject to a certified network and claims not subject to a certified network. Regarding the commenter's statement concerning reimbursements for prescriptions, the Division notes it is outside the scope of the proposed rules.

§134.540: A commenter seeks clarification whether 28 TAC §134.501 of this title (relating to Initial Pharmaceutical Coverage) applies to certified networks as stated in Labor Code §413.0141 and by proposed §134.530(e)(1).

Agency Response: The Division clarifies that initial pharmaceutical requirements of Labor Code §413.0141 apply to both certified network and non-network claims since there is no conflict between Labor Code §413.0141 and Insurance Code Chapter 1305 and because reimbursement of pharmaceutical medication and services are governed by the Act and Division rules. Insurance Code §1305.101(c) states that: "(c) Notwithstanding any other provision of this chapter, prescription medication or services, as defined by Section 401.011(19)(E), Labor Code, may not be delivered through a workers' compensation health care network. Prescription medication and services shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation." Consequently, the language in adopted §134.540 (f) is amended to indicate applicability to certified networks.

§134.540(b)(2) and (3): Commenters recommend that language for certified networks mirror provisions of non-network in §134.530(b)(4) and (5) as it pertains to preauthorizing and pain pumps. It would benefit patient care to have consistent processes in place for network and non-network settings since the closed formulary must be utilized in both scenarios, and would better facilitate the entire treatment process. A commenter further states that any deviation from one guideline to another is difficult for health care providers to keep up with.

Agency Response: The Division agrees and the adopted rule language is changed to be consistent with the language included in §134.530. The change makes the certified network intrathecal drug delivery system refill appeal "process" consistent with the appeal "process" used by non-networks for intrathecal drug delivery system refills. The closed formulary applies to certified networks and non-networks and includes an appeal process. The adopted language addresses and explains the appeal process for refills when the drug is excluded from the closed formulary. The new subsection (c) addressing an intrathecal drug delivery system has necessitated the re-lettering of the remaining subsections of this section. This change simplifies the process for delivery of health care in both the certified network and non-network settings.

§134.550: A commenter recommends an injured employee be allowed to request an MIO, because they are the people most affected if medication is withheld.

Agency Response: The Division disagrees. Adopted elsewhere in this issue of the *Texas Register* are amendments to §133.306 of this title which allow injured employees to request an interlocutory order for drugs excluded from the closed formulary. The process of requesting an MIO under adopted §134.550 requires the involvement of the prescribing doctor to protect against potential abuse and also should help avoid an unreasonable risk of a medical emergency. The distinction in the interlocutory orders is that under §134.550 a prescribing doctor or pharmacist may request an MIO for drugs excluded from the closed formulary when the drug was previously prescribed and dispensed and failure to fill the prescription may result in an unreasonable risk of a medical emergency for an injured employee. However, an injured employee may pursue an interlocutory order for continued access to health care, including pharmaceutical services excluded from the closed formulary, under §133.306 when the injured employee would not be able to receive medical benefits that are medically necessary and constitute health care reasonably required.

§134.550: A commenter indicates there is not opposition to the MIO concept, but believes as drafted, the MIO process could circumvent the preauthorization process. The commenter states there should be strict requirements for getting an MIO and some initial scrutiny as this should be a rare exception and not the rule. While the MIO will address the short-term problems with discontinuing an excluded drug, there is no requirement that the prescribing doctor submit a separate plan to transition the injured employees to a drug(s) that is included in the closed formulary.

Agency Response: The Division clarifies that the adopted requirements to request an MIO under adopted §134.550 requires the requestor to include documentation that a preauthorization request has been submitted and denied and that a request for an independent review has already been submitted. If an MIO is ordered, the disputed medical necessity of the prescription at issue will continue through the utilization review and medical dispute resolution process until the issue is resolved and becomes final. At that time a party may seek to overturn the MIO and may also seek reimbursement from the Subsequent Injury Fund (SIF). This process does not compromise the initial preauthorization process. The MIO process will prevent medical emergencies that could be created by preauthorization denials and the prescribing doctor who has his or her MIO overturned would have to seek other treatment alternatives. The MIO will have initial scrutiny since there are many requirements that must be met before an MIO can be submitted as complete. Additionally, the Division will continue to monitor the MIO process during the time that the closed formulary takes effect for new injuries until the closed formulary applies to legacy claims in September of 2013, and will make changes if necessary.

§134.550: A commenter recommends deletion of this section as it creates a process by which a medical provider can bypass the closed formulary. The MIO process creates an easy method to short circuit the entire closed formulary and establishes a system

ripe for abuse since it authorizes the medical provider to file for an MIO where there was a preauthorization denial. Drugs are excluded from the closed formulary for a reason, and it makes no sense to allow a doctor to bypass the safeguards of the closed formulary via an unsubstantiated claim of medical emergency. A commenter questions the creation of a closed formulary and a preauthorization process to combat inappropriate and costly use of pharmaceuticals if the system is then going to authorize the same medical providers to bypass the system by filing an MIO.

Agency Response: The Division disagrees. The MIO process will prevent medical emergencies that could be created by preauthorization denials and a prescribing doctor whose MIO is overturned would have to seek other treatment alternatives. Section 134.550 contains documentation requirements providing initial scrutiny that must be met and completed and therefore would prevent abuse. Further, the medical threshold to meet is the unreasonable risk of a medical emergency. If an MIO is ordered the disputed medical necessity of the prescription at issue will continue through the utilization review process until the issue is resolved and becomes final. At that time a party may seek to overturn the MIO and may also seek reimbursement from the SIF. This process does not circumvent the preauthorization process.

§134.550: A commenter recommends the Division provide a process where injured employees may obtain medications through interlocutory orders. The commenter is concerned that the process may be too complex, and recommends streamlining such that once a prima facie showing has been made that the potential for a medical emergency exists if the medication is suddenly withdrawn, the MIO should be entered.

Agency Response: The Division agrees that injured employees need a way to have access to drugs if an unreasonable risk of a medical emergency arises. Section 134.550 is established to allow health care providers to provide necessary information to validate the need for the continued use of a previously prescribed and dispensed drug that is now being denied through the statutorily required appeals process. The prescribing doctor and pharmacists are best qualified to provide the information required by §134.550 including the unreasonable risk of a medical emergency. These adopted provisions in §134.550 are a safety net for injured employees subject to a potential medical emergency when denied preauthorization of a previously prescribed drug which is not included in the Division's pharmacy closed formulary. Without the section amendments, §133.306 would only have allowed an interlocutory order to be entered into in situations where there is a compensability, liability, or extent of injury dispute and the Division determines that the prescribed drug was medically necessary or after the conclusion of the medical dispute process. The amendments to §133.306 accommodate the MIO as set forth in the new adopted §134.550 with the purpose of providing a system by which a prescribing doctor or pharmacy is able to obtain an MIO in cases where an injured employee faces an unreasonable risk of a medical emergency because they have been denied "N" drugs that have previously been prescribed and dispensed to them. Although the process outlined for an MIO in §134.550 is limited to pharmacists and prescribing doctors, injured employees may continue to use the processes outlined in amended §133.306 to pursue interlocutory orders concerning medical benefits.

§134.550(a): A commenter states it is clear from review of the legislative intent of HB 2512 that the Commissioner of Insurance or his designee must review a request for an interlocutory order and conclude that a disputed prescription constitutes essential medical benefits prior to the issuance of an MIO. The commenter recommends that the Medical Advisor, or Assistant Medical Advisors, as his designees, review the request and issue the MIOs. The commenter asserts the MIOs should not be reviewed and processed by non-medical staff and without determination by clinically qualified individuals that the disputed prescription is essential medical benefits.

Agency Response: The Division clarifies that under Labor Code §§402.0111, 402.00116, 402.00128 and 402.042, the Commissioner has the authority to designate who will review the request for an interlocutory order or MIO, and issue such orders.

§134.550(c)(9): A commenter states it is not clear how the required statement differs from a statement of medical necessity.

Agency Response: The Division clarifies that the information included in the statement of medical necessity document is required as part of the preauthorization process to establish medical necessity. The information required by §134.550(c)(7) to (c)(11) are affirmative statements that the requirements for an MIO have been met.

§134.550(d): A commenter expresses concern about the proposal to process incomplete requests and opines that an incomplete request for an MIO should not be accepted by the Division. Inappropriate and unnecessary pharmaceutical benefits could be provided to an injured employee if the Division acts upon an incomplete request for an MIO. The commenter states the Division should identify the required elements of the request that are missing and contact the submitting physician, providing the physician with an opportunity to submit the missing elements of the request within a specific period of time set out in the rule. The MIO process should include a review of the proposed prescription refill to determine appropriateness, medical necessity, quality health care, and potential for medical emergency has been met if prescription drugs not provided to the injured employee.

Agency Response: The Division disagrees that additional restrictions are required for the Division to evaluate a request for an MIO. The purpose of the MIO is to prevent the potential medical emergency noted in the request. Since time is of the essence, the Division needs the flexibility to approve requests in the event that an administrative error or omission by the requestor would potentially jeopardize the health of an injured employee. Additionally, the Division will continue to monitor the MIO process during the time that the closed formulary takes effect for new injuries until the closed formulary applies to legacy claims in September of 2013, and will make changes if necessary.

§134.550(d) and (h): A commenter indicates there is an incentive to forego the requirement for reconsideration of denied drugs. The commenter asserts the Division reserves the discretion to find an MIO as complete retroactively, notwithstanding a lack of rule requirements, compliance, increasing the danger of circumvention, and increased system cost seeking resolution of a vagueness.

Agency Response: The Division clarifies that the requirement for reconsideration prior to pursuing dispute resolution is waived when pursuing an MIO thereby facilitating the filling of a prescription in order to avert a potential medical emergency.

§134.550(k): A commenter requests clarification of the consequences of treating withdrawal as acceptance of the preauthorization denial of this subsection. Specifically, the commenter requests clarification of how the effects of acceptance of the de-

nial differ from an adverse decision in a preauthorization medical necessity dispute resolution proceeding.

Agency Response: The Division is unable to comment on the effects of a withdrawal of an MIO request without a more detailed illustration of the question. The specific effects of a withdrawal are likely to be conditioned on the specifics of the case and the application of those factors to the case by the requestor.

§134.550(n): A commenter states the word "may" is cause for concern, and should be substituted with the word "shall." The commenter further recommends that rule language should clarify that payments made by insurance carriers pursuant to this section shall be eligible for reimbursement from the SIF in the event the MIO order is found to have been issued in error or a final decision of an IRO or contested case hearing determines that the underlying prescription drugs were not medically necessary and/or appropriate and the MIO should not have been issued. Such recommended changes are consistent with the intent of HB 2512 and Labor Code §413.055.

Agency Response: The Division disagrees and declines to make the change. Labor Code §413.055 allows for reimbursement from the SIF for reversed or modified interlocutory orders. However, the reimbursement is contingent on meeting the requirements specified under §116.11 of this title (regarding Request for Reimbursement from the Subsequent Injury Fund) concerning when and how a reimbursement request is to be submitted. Further, reimbursement made pursuant to Labor Code §413.055 requires that the insurance carrier timely provide all documentation reasonably required to the SIF Administrator and to provide notice of any relevant pending dispute, litigation or other information that may affect the reimbursement request. Additionally, reimbursement is subject to §116.12 of this title (relating to Subsequent Injury Fund Payment/Reimbursement Schedule), which sets forth the reimbursement priority schedule, payment allocation and processing of reimbursement of claims. According to the priority schedule, claims by insurance carriers for reimbursement pursuant to Labor Code §413.055 are (a)(3) on the priority list. Since there are two categories of claims ahead, reimbursement is not guaranteed. The insurance carrier is eligible for reimbursement but payment is not always assured.

§134.550(p)(2): A commenter requests clarification on the need to provide for a second hearing process when an MIO has been entered. It is axiomatic that in any case where an MIO is being sought, the medical dispute process has already been invoked and the case is headed toward a hearing. Yet §134.550(p)(2) provides that if an MIO is entered, the insurance carrier may request a hearing. The commenter believes this would seem to be redundant unless it is envisioned that a separate hearing process where the MIO is granted has been held. If this is the case, the commenter questions what will happen if the results of the two separate hearings are inconsistent. In addition, it is unclear why the insurance carrier would need a hearing because this rule already provides for reimbursement from the SIF if the MIO is reversed.

Agency Response: The Division clarifies that Labor Code §413.055 establishes that a party that disputes an order under §413.055(a) is entitled to a hearing and that the order is binding during pendency of that appeal. Since the insurance carrier did not have a hearing when the MIO was requested, the hearing allowed by §413.055 is not redundant.

For: None.

For, with changes: Corporate Pharmacy Services, Inc.; CorVel Corporation; Covington Healthcare Associates, LLC; Insurance Council of Texas; Injured Workers' Pharmacy; Law Office of Pamela R. Beachley; myMatrixx; Office of Injured Employee Counsel; Pfizer, Inc.; PMSI; Property Casualty Insurers Association of America; St. Mary's Managed Prescription Program; Texas Association of School Boards; Texas Lobby Solutions; Texas Mutual Insurance Company; Texas Pain Society; Texas Pharmacy Association; Texas Pharmacy Business Council; and Workers' Compensation Pharmacy Alliance.

Against: Memorial Compounding Pharmacy and PhRMA.

Neither for or Against: American Insurance Association; CompPharma; Coventry Workers' Comp Services; First Script Network Services; OccuMed; ReCept Pharmacy; State Office of Risk Management; and Stone River.

The amendments and new sections are adopted under the Labor Code §§408.028, 401.011, 413.0111, 413.055, 410.209, 413.0141, 402.042, 408.021, 408.027, 408.0271, 413.011, 413.013, 413.014, 413.015, 413.017, 413.020, 413.031, 409.009, 409.0091, 413.0511, 413.053, 402.00111, 402.00116, 402.00128, and 402.061; Insurance Code Chapters 1305, 4201, and 4202, Occupations Code §§551.003, 562.001 and 562.154 and Occupations Code Chapter 157 and Chapter 563. Labor Code §408.028 requires the adoption of a closed formulary in the workers' compensation system. Section 408.028 also requires an appeals process for the closed formulary as well as the use of generics and clinically-appropriate over-the counter alternatives to prescription medication. Section 401.011 contains definitions used in the Texas workers' compensation system (in particular, §401.011(18-a), the definition of "evidence-based medicine," §401.011(19)(E), the definition of "health care," which includes a prescription drug, medicine or other remedy, and §401.011(42), the definition of "health care reasonably required."). Section 413.0111 requires that a rule on reimbursement of prescription medication or services must authorize pharmacies to use agents or assignees to process claims and act on behalf of pharmacies. Section 413.055 provides that the Commissioner may enter interlocutory orders regarding medical benefits, allows reimbursement under the Subsequent Injury Fund for reversed or modified orders and entitlement to a hearing to dispute the order which is binding during the pendency of the appeal. Section 410.209 requires the Subsequent Injury Fund to reimburse an insurance carrier any benefits overpayment made under an interlocutory order or decision that is reversed or modified. Section 413.0141 sets forth that the Commissioner may by rule provide that an insurance carrier shall provide for payment of specified pharmaceutical services for the first seven days following the date of injury if certain conditions are met. Section 402.042 requires the Commissioner to develop and implement policies clearly defining respective responsibilities of the Commissioner and Division staff. Section 408.021 states that an injured employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed. Section 408.027 requires a health care provider to submit a claim for payment to the insurance carrier for health care services provided to the injured employee not later than the 95th date on which the health care services are provided and the insurance carrier must pay, reduce, deny or determine to audit the health care provider's claim not later than the 45th day after the date of receipt by the insurance carrier of the health care provider's claim. Section 408.0271 allows for reimbursement by the health care provider if the insurance carrier determines

that the health care services provided to the injured employee are inappropriate. Section 413.011 requires the Commissioner by rule to establish medical policies and guidelines relating to necessary treatment for injuries and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.013 requires the Commissioner by rule to establish programs related to health care treatments and services for dispute resolution, monitoring and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. This section also provides that a preauthorized treatment or service is not subject to retrospective review of its medical necessity. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Commissioner by rule to ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with Division medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent or retrospective review as required by Division policies and authorized by the insurance carrier. Section 413.020 requires the Commissioner by rule to establish Division charges for evaluation of an insurance carrier or health care provider's services and fees. Section 413.031 provides for procedures for medical dispute resolution. Labor Code §409.009 allows a person to file a written claim with the Division as a subclaimant if the person has provided compensation, directly or indirectly, to or for an employee, has sought, and has been refused compensation by the insurance carrier. Labor Code §409.0091 provides for reimbursement procedures for certain entities such as an insurance carrier and an authorized representative of an insurance carrier and includes reimbursement procedures for subclaims of health care insurers. Section 413.0511 requires that the Medical Advisor must make recommendations regarding the adoption of rules and policies concerning health care. Section 413.053 requires the Commissioner by rule to establish standards of reporting and billing governing both form and content. Section 402.00111 provides that the Commissioner shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner and the authority to enforce Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the Division or Commissioner. Section 402.00128 vests general operational powers to the Commissioner to conduct daily operations of the Division and implement Division policy including the duty to delegate, assess and enforce penalties and enter appropriate orders as authorized by Labor Code Title 5. Section 402.061 provides the Commissioner the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act. Insurance Code Chapter 1305 is the Workers' Compensation Health Care Network Act and contains treatment guidelines and authorization requirements applicable to certified networks. Chapter 4201 concerns utilization review agents and applies to utilization review of health care service provided to a person eligible for workers' compensation medical benefits under Labor Code Title 5. Labor Code Title 5 prevails in the event of a conflict between Chapter 4201 and Labor Code Title 5. Chapter 4202 concerns independent review organizations, entities utilized in a dispute over the issue of medical necessity and reasonableness. Occupations Code §551.003 provides the definitions of "compounding" and "substitution". Section 562.001 provides the definition of "generically equivalent". Section 562.154 provides for distribution of compounded and prepackaged products to certain pharmacies. Occupations Code Chapter 157 allows a physician to delegate the authority to carry out or sign prescription drug orders to an advanced practice nurse or physician assistant. Chapter 563 concerns prescription requirements; delegation of administration and provision of dangerous drugs. The chapter also allows the dispensing of dangerous drugs in certain rural areas.

§134.500. Definitions.

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

(1) Brand name drug--A drug marketed under a proprietary, trademark-protected name.

(2) Certified workers' compensation health care network (certified network)--An organization that is certified in accordance with Insurance Code Chapter 1305 and department rules.

(3) Closed formulary--All available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but excludes:

(A) drugs identified with a status of "N" in the current edition of the *Official Disability Guidlines Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;

(B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and

(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

(4) Compounding--As defined under Occupations Code §551.003(9), the preparation, mixing, assembling, packaging, or labeling of a drug or device:

(A) as the result of a practitioner's prescription drug order based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(B) for administration to a patient by a practitioner as the result of a practitioner's initiative based on the practitioner-patient-pharmacist relationship in the course of professional practice;

(C) in anticipation of a prescription drug order based on a routine, regularly observed prescribing pattern; or

(D) for or as an incident to research, teaching, or chemical analysis and not for selling or dispensing, except as allowed under Occupations Code §562.154 or Occupations Code Chapter 563.

(5) Generic--See generically equivalent in definition of paragraph (6) of this section.

(6) Generically equivalent--As defined under Occupations Code §562.001, a drug that, when compared to the prescribed drug, is:

(A) pharmaceutically equivalent--Drug products that have identical amounts of the same active chemical ingredients in the same dosage form and that meet the identical compendia or other applicable standards of strength, quality, and purity according to the United States Pharmacopoeia or another nationally recognized compendium; and

(B) 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) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain that in the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(8) 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.

(9) Open formulary--Includes all available Food and Drug Administration (FDA) approved prescription and nonprescription drugs prescribed and dispensed for outpatient use, but does not include drugs that lack FDA approval, or non-drug items.

(10) Prescribing doctor--A physician or dentist who prescribes prescription drugs or over the counter medications in accordance with the physician's or dentist's license and state and federal laws and rules. For purposes of this chapter, prescribing doctor includes an advanced practice nurse or physician assistant to whom a physician has delegated the authority to carry out or sign prescription drug orders, under Occupations Code Chapter 157, who prescribes prescription drugs or over the counter medication under the physician's supervision and in accordance with the health care practitioner's license and state and federal laws and rules.

(11) Prescription--An order for a prescription or nonprescription drug to be dispensed.

(12) 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;" "Rx only;" or another legend that complies with federal law; 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.

(13) Statement of medical necessity--A written statement 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 shall include:

(A) the injured employee's full name;

(B) date of injury;

(C) social security number;

(D) diagnosis code(s);

(E) whether the drug has previously been prescribed and dispensed, if known, and whether the inability to obtain the drug poses an unreasonable risk of a medical emergency; and

(F) how the prescription treats the diagnosis, promotes recovery, or enhances the ability of the injured employee to return to or retain employment.

(14) Substitution--As defined under Occupations Code §551.003(41), the dispensing of a drug or a brand of drug other than the drug or brand of drug ordered or prescribed.

§134.506. Outpatient Open Formulary for Claims with Dates of Injury Prior to September 1, 2011.

(a) For claims with dates of injury prior to September 1, 2011 (for the purposes of this section, referred to as "legacy claims"), the open formulary as described in §134.500(9) of this title (relating to Definitions) remains in effect until those claims become subject to the closed formulary in accordance with §134.510 of this title (relating to Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011).

(b) Health care, including a prescription drug, for legacy claims not subject to a certified network shall be in accordance with the division's adopted treatment guidelines under §137.100 of this title (relating to Treatment Guidelines) except as provided by subsections (d) and (f) of this section.

(c) Health care, including a prescription drug, for legacy claims subject to a certified network shall be in accordance with the certified network's treatment guidelines pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title (relating to Workers' Compensation Health Care Networks).

(d) Drugs included in the open formulary prescribed and dispensed for legacy claims not subject to a certified network do not require preauthorization, except as required by Labor Code §413.014.

(e) Drugs included in the open formulary prescribed and dispensed for legacy claims subject to a certified network shall be preauthorized in accordance with Insurance Code Chapter 1305 and Chapter 10 of this title.

(f) Drugs included in the open formulary that do not require preauthorization under subsections (d) and (e) of this section and are prescribed and dispensed for legacy claims are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier.

§134.510. Transition to the Use of the Closed Formulary for Claims with Dates of Injury Prior to September 1, 2011.

(a) Applicability. This section applies to claims with dates of injury prior to September 1, 2011 (for the purposes of this section, referred to as "legacy claims"), which are subject to §134.530 of this title (relating to Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks), §134.540 of this title (relating to Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks), and §134.550 of this title (relating to Medical Interlocutory Order) on and after September 1, 2013.

(b) Transition of legacy claims.

(1) At any time after September 1, 2011 and prior to September 1, 2013:

(A) The prescribing doctor should include a statement of medical necessity as defined in §134.500(13) of this title (relating to Definitions) with the prescription for drugs excluded from the closed formulary.

(B) The prescribing doctor or the insurance carrier may contact each other for a discussion of ongoing pharmacological management of the injured employee's claim.

(C) When a prescribing doctor or insurance carrier is contacted by the other party regarding ongoing pharmacological management, the parties must provide each other a name, phone number,

and date and time to discuss ongoing pharmacological management of the injured employee's claim.

(2) Beginning no later than March 1, 2013, the insurance carrier shall:

(A) identify all legacy claims that have been prescribed a drug excluded from the closed formulary after September 1, 2012; and

(B) provide written notification to the injured employee, prescribing doctor, and pharmacy if known, that contains the following:

(i) the notice of the impending date and applicability of the closed formulary for legacy claims; and

(ii) the information required in paragraph (1)(C) of this subsection.

(c) Agreement. To ensure continuity of care, notwithstanding subsection (a) of this section, an insurance carrier and a prescribing doctor may enter into an agreement regarding the application of the pharmacy closed formulary for individual legacy claims on claim-by-claim basis.

(d) Agreement requirements.

(1) The insurance carrier shall document any agreement and the terms, and share a copy of the agreement with the prescribing doctor and injured employee.

(2) Health care provided as a result of the agreement is not subject to retrospective review of medical necessity.

(3) Denial of a request for an agreement is not subject to dispute resolution.

(4) If no agreement is reached and documented by September 1, 2013 for a legacy claim, the requirements of §§134.530, 134.540, and 134.550 of this title shall apply.

§134.520. Outpatient Closed Formulary for Dates of Injury On or After September 1, 2011.

The Commissioner of Workers' Compensation hereby adopts a closed formulary as defined in §134.500(3) of this title (relating to Definitions) for claims with dates of injury on or after September 1, 2011.

§134.530. Requirements for Use of the Closed Formulary for Claims Not Subject to Certified Networks.

(a) Applicability. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011.

(b) Preauthorization for claims subject to the Division's closed formulary.

(1) Preauthorization is only required for:

(A) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;

(B) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and

(C) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

(2) When §134.600(p)(12) of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) conflicts with this section, this section prevails.

(c) Preauthorization of intrathecal drug delivery systems.

(1) An intrathecal drug delivery system requires preauthorization in accordance with §134.600 of this title and the preauthorization request must include the prescribing doctor's drug regime plan of care, and the anticipated dosage or range of dosages for the administration of pain medication.

(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:

(A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications, dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or

(B) there is a change in prescribing doctor.

(d) Treatment guidelines. Except as provided by this subsection, the prescribing of drugs shall be in accordance with §137.100 of this title (relating to Treatment Guidelines), the division's adopted treatment guidelines.

(1) Prescription and nonprescription drugs included in the division's closed formulary and recommended by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.

(2) Prescription and nonprescription drugs included in the division's closed formulary that exceed or are not addressed by the division's adopted treatment guidelines may be prescribed and dispensed without preauthorization.

(3) Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (g) of this section.

(e) Appeals process for drugs excluded from the closed formulary.

(1) For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug by requesting preauthorization, including reconsideration, in accordance with §134.600 of this title and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing).

(2) If preauthorization is being requested by an injured employee or a requestor other than the prescribing doctor, and the injured employee or other requestor requests a statement of medical necessity, the prescribing doctor shall provide a statement of medical necessity to facilitate the preauthorization submission as set forth in §134.502 of this title (relating to Pharmaceutical Services).

(3) If preauthorization for a drug excluded from the closed formulary is denied, the requestor may submit a request for medical

dispute resolution in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations).

(4) In the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 of this title (relating to Interlocutory Orders for Medical Benefits) or §134.550 of this title (relating to Medical Interlocutory Order).

(f) Initial pharmaceutical coverage.

(1) Drugs included in the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are not subject to retrospective review of medical necessity.

(2) Drugs excluded from the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization, except as referenced in subsection (b)(1)(C) of this section, and are subject to retrospective review of medical necessity.

(g) Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) and §133.240 of this title (relating to Medical Payments and Denials), and applicable provisions of Chapter 19 of this title.

(1) Health care, including a prescription for a drug, provided in accordance with §137.100 of this title is presumed reasonable as specified in Labor Code §413.017, and is also presumed to be health care reasonably required as defined by Labor Code §401.011(22-a).

(2) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that are recommended by the division's adopted treatment guidelines, §137.100 of this title, the denial must be supported by documentation of evidence-based medicine that outweighs the presumption of reasonableness established under Labor Code §413.017.

(3) A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by §137.100 of this title, is required to provide documentation upon request in accordance with §134.500(13) of this title (relating to Definitions) and §134.502(e) and (f) of this title.

§134.540. Requirements for Use of the Closed Formulary for Claims Subject to Certified Networks.

(a) Applicability. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims subject to a certified network on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011.

(b) Preauthorization for claims subject to the Division's closed formulary. Preauthorization is only required for:

(1) drugs identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates;

(2) any compound that contains a drug identified with a status of "N" in the current edition of the *ODG Treatment in Workers' Comp* (ODG) / Appendix A, *ODG Workers' Compensation Drug Formulary,* and any updates; and

(3) any investigational or experimental drug for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, but which is not yet broadly accepted as the prevailing standard of care as defined in Labor Code §413.014(a).

(c) Preauthorization of intrathecal drug delivery systems.

(1) An intrathecal drug delivery system requires preauthorization in accordance with the certified network's treatment guidelines and preauthorization requirements pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title (relating to Workers' Compensation Health Care Networks).

(2) Refills of an intrathecal drug delivery system with drugs excluded from the closed formulary, which are billed using Healthcare Common Procedure Coding System (HCPCS) Level II J codes, and submitted on a CMS-1500 or UB-04 billing form, require preauthorization on an annual basis. Preauthorization for these refills is also required whenever:

(A) the medications, dosage or range of dosages, or the drug regime proposed by the prescribing doctor differs from the medications dosage or range of dosages, or drug regime previously preauthorized by that prescribing doctor; or

(B) there is a change prescribing doctor.

(d) Treatment guidelines. The prescribing of drugs shall be in accordance with the certified network's treatment guidelines and preauthorization requirements pursuant to Insurance Code Chapter 1305 and Chapter 10 of this title. Drugs included in the closed formulary that are prescribed and dispensed without preauthorization are subject to retrospective review of medical necessity and reasonableness of health care by the insurance carrier in accordance with subsection (f) of this section.

(e) Appeals process for drugs excluded from the closed formulary.

(1) For situations in which the prescribing doctor determines and documents that a drug excluded from the closed formulary is necessary to treat an injured employee's compensable injury and has prescribed the drug, the prescribing doctor, other requestor, or injured employee must request approval of the drug in a specific instance by requesting preauthorization in accordance with the certified network's preauthorization process established pursuant to Chapter 10, Subchapter F of this title (relating to Utilization Review and Retrospective Review) and applicable provisions of Chapter 19 of this title (relating to Agents' Licensing).

(2) If preauthorization is pursued by an injured employee or requestor other than the prescribing doctor, and the injured employee or other requestor requests a statement of medical necessity, the prescribing doctor shall provide a statement of medical necessity to facilitate the preauthorization submission as set forth in §134.502 of this title (relating to Pharmaceutical Services).

(3) If preauthorization for a drug excluded from the closed formulary is denied, the requestor may submit a request for medical dispute resolution in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations).

(4) In the event of an unreasonable risk of a medical emergency, an interlocutory order may be obtained in accordance with §133.306 of this title (relating to Interlocutory Orders for Medical Benefits) or §134.550 of this title (relating to Medical Interlocutory Order).

(f) Initial pharmaceutical coverage.

(1) Drugs included in the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are not subject to retrospective review of medical necessity.

(2) Drugs excluded from the closed formulary which are prescribed for initial pharmaceutical coverage, in accordance with Labor Code §413.0141, may be dispensed without preauthorization and are subject to retrospective review of medical necessity.

(g) Retrospective review. Except as provided in subsection (f)(1) of this section, drugs that do not require preauthorization are subject to retrospective review for medical necessity in accordance with §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill), §133.240 of this title (relating to Medical Payments and Denials), the Insurance Code, Chapter 1305, applicable provisions of Chapters 10 and 19 of this title.

(1) In order for an insurance carrier to deny payment subject to a retrospective review for pharmaceutical services that fall within the treatment parameters of the certified network's treatment guidelines, the denial must be supported by documentation of evidence-based medicine that outweighs the evidence-basis of the certified network's treatment guidelines.

(2) A prescribing doctor who prescribes pharmaceutical services that exceed, are not recommended, or are not addressed by the certified network's treatment guidelines, is required to provide documentation upon request in accordance with §134.500(13) of this title (relating to Definitions) and §134.502(e) and (f) of this title.

§134.550. Medical Interlocutory Order.

(a) The purpose of this section is to provide a prescribing doctor or pharmacy an ability to obtain an medical interlocutory order (MIO) in instances where preauthorization denials of a previously prescribed and dispensed drug(s) excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in §134.500(7) of this title (relating to Definitions) and Insurance Code §1305.004(a)(13).

(b) A request for an interlocutory order that does not meet the criteria described by this section may still be requested pursuant to §133.306 of this title (relating to Interlocutory Order for Medical Benefits).

(c) An MIO will be issued if the request for an MIO contains the following information:

(1) injured employee name;

(2) date of birth of injured employee;

(3) prescribing doctor's name;

(4) name of drug and dosage;

(5) MIO requestor's name (pharmacy or prescribing doctor);

(6) MIO requestor's contact information;

(7) a statement that a preauthorization request for a previously prescribed and dispensed drug(s), which is excluded from the closed formulary, has been denied by the insurance carrier;

(8) a statement that an independent review request has already been submitted to the insurance carrier or the insurance carrier's utilization review agent in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations);

(9) a statement that the preauthorization denial poses an unreasonable risk of a medical emergency as defined in §134.500(7) of this title;

(10) a statement that the potential medical emergency has been documented in the preauthorization process;

(11) a statement that the insurance carrier has been notified that a request for an MIO is being submitted to the division; and

(12) a signature and the following certification by the MIO requestor for paragraphs (7) - (12) of this subsection, "I hereby certify under penalty of law that the previously listed conditions have been met."

(d) A complete request for an MIO under this section shall be processed and approved by the division in accordance with this section. At the discretion of the division, an incomplete request for an MIO under this section may be considered in accordance with this section.

(e) The request for an MIO may be submitted on the designated division form available on the Texas Department of Insurance's website, http://www.tdi.state.tx.us/wc/indexwc.html. In the event the division form is not available, the written request must contain the provisions of subsection (c) of this section.

(f) The MIO requestor shall provide a copy of the MIO request to the insurance carrier, prescribing doctor, injured employee, and dispensing pharmacy, if known, on the date the request for MIO is submitted to the division.

(g) An approved MIO shall be effective retroactively to the date the complete request for an MIO is received by the division.

(h) Notwithstanding §133.308 of this title:

(1) A request for reconsideration of a preauthorization denial is not required prior to a request for independent review when pursuing an MIO under this section. If a request for reconsideration or an MIO request is not initiated within 15 days from the initial preauthorization denial, then the opportunity to request an MIO under this section does not apply.

(2) If pursuing an MIO after denial of a reconsideration request, a complete MIO request shall be submitted within five working days of the reconsideration denial.

(i) An appeal of the independent review organization (IRO) decision relating to the medical necessity and reasonableness of the drugs contained in the MIO shall be submitted in accordance with §133.308(t) of this title.

(j) The MIO shall continue in effect until the later of:

(1) final adjudication of a medical dispute regarding the medical necessity and reasonableness of the drug contained in the MIO;

(2) expiration of the period for a timely appeal; or

(3) agreement of the parties.

(k) Withdrawal by the requestor of a request for medical necessity dispute resolution constitutes acceptance of the preauthorization denial.

(l) A party shall comply with an MIO entered in accordance with this section and the insurance carrier shall reimburse the pharmacy for prescriptions dispensed in accordance with an MIO.

(m) The insurance carrier shall notify the prescribing doctor, injured employee, and the dispensing pharmacy once reimbursement is no longer required in accordance with subsection (j) of this section.

(n) Payments made by insurance carriers pursuant to this section may be eligible for reimbursement from the Subsequent Injury Fund in accordance with Labor Code §410.209 and §413.055, and applicable rules.

(o) A decision issued by an IRO is not an agency or commissioner decision.

(p) A party may seek to reverse or modify an MIO issued under this section if:

(1) a final determination of medical necessity has been rendered; and

(2) the party requests a benefit contested case hearing (CCH) from the division's chief clerk no later than 20 days after the date the IRO decision is sent to the party. A benefit review conference is not a prerequisite to a division CCH under this subsection. Except as provided by this subsection, a division CCH shall be conducted in accordance with Chapters 140 and 142 of this title (relating to Dispute Resolution--General Provisions and Dispute Resolution--Benefit Contested Case Hearing).

(q) The insurance carrier may dispute an interlocutory order entered under this title by filing a written request for a hearing in accordance with Labor Code §413.055 and §148.3 of this title (relating to Requesting a Hearing).

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 6, 2010.

TRD-201006879
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: September 1, 2011
Proposal publication date: July 16, 2010
For further information, please call: (512) 804-4703

♦ ♦ ♦

CHAPTER 137. DISABILITY MANAGEMENT
SUBCHAPTER A. GENERAL PROVISIONS

28 TAC §137.5

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts new §137.5, concerning Case Manager Certification. The new section is adopted with changes to the proposed text as published in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8477).

In accordance with Government Code §2001.033, the Division's reasoned justification for these amendments is set out in this order, which includes the preamble, which in turn includes the rule. The preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of the entities that commented and whether they were in support of or in opposition to the adoption of the rule, and the reasons why the Division agrees or disagrees with the comments and recommendations.

This new section implements statutory amendments to Labor Code §401.011(5-a) and §413.021 under House Bill (HB) 7, enacted by the 79th Legislature, Regular Session, effective September 1, 2005 and Senate Bill (SB) 1814, enacted by the 81st Legislature, Regular Session, effective June 19, 2009. One of the objectives of HB 7 was to amend Labor Code §413.021 to require insurance carriers to evaluate compensable injuries that could potentially result in lost time from employment as early as practicable to determine if case management is necessary for the injured employee's case. HB 7 amended Labor Code §413.011 to allow the Commissioner to adopt rules relating to return-to-work guidelines and disability management that are designed to improve return-to-work outcomes through appropriate management of work-related injuries or conditions. In addition, HB 7 defined case management in Labor Code §401.011(5-a) as "a collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and application of available resources to promote quality, cost-effective outcomes." HB 7 also provided that case managers must be appropriately licensed in this state to perform services and that insurance adjusters cannot serve as case managers. SB 1814 modified Labor Code §413.021 from requiring that case managers be appropriately licensed in Texas to requiring that case managers be appropriately certified.

The Legislature has determined that a basic goal of the workers' compensation system is that "each injured employee shall receive services to facilitate the employee's return to employment as soon as it is considered safe and appropriate by the employee's health care provider," Labor Code §401.021(a)(4), and that "[i]t is the intent of the legislature that, in implementing the goals described by Subsection (a), the workers' compensation system of this state must . . . (2) encourage the safe and timely return of injured employees to productive roles in the workplace" Labor Code §401.021(b). The Commissioner has also determined that the Division wants the best return-to-work outcomes for the injured employee. The Legislature has further given the Commissioner rulemaking authority to promulgate rules to regulate the workers' compensation system and enforce the Workers' Compensation Act (Act). Labor Code §§402.00111, 402.00128(b)(12) and 402.061. When the Legislature provides general rulemaking authority to an agency as necessary to carry out the purposes of a statute, it forecloses the position that the Legislature intended to spell out the exact details of all operations under the statute. *Gerst v. Oak Cliff Savings and Loan Ass'n,* 432 S.W.2d 702 (Tex. 1968). Due to the breadth of the coverage in the Act and the myriad of complex regulatory issues facing the Division, such rulemaking authority must be inherently broad. The delegation of authority to the Commissioner allows for the regulatory flexibility necessary for the Commissioner to fulfill his statutorily imposed duties in adopting rules as necessary to fully implement the Act while meeting the changing demands facing the workers' compensation system in Texas.

Additionally, if the plain language of a statute is ambiguous, as it seems to be based on the different interpretations proposed by the various commenters, then the Commissioner may exercise his rulemaking authority to promulgate rules as long as "the rule harmonizes with the general objectives of the statute," which, in this circumstance, would be returning more injured employees back to work and having better return-to-work outcomes for injured employees through the use of case management. *State Bd. Of Ins. v. Deffebach,* 631 S.W.2d 794, 798 (Tex. Civ. App. 1982) (promulgation of presumptive rates for credit life and health and accident insurance); see also, *State Bd of Examiners In Optometry v. Carp,* 412 S.W.2d 307 (Tex. 1967). In addition, the Division has determined that Labor Code §413.021(a), at most, provides a minimum standard and not a maximum ceiling for the certification requirements for case managers in the workers' compensation system. Because it acts as a minimum requirement, the Division may still rely on general rulemaking authority to ensure that the general objectives of the Act are met.

In the case of workers' compensation health care networks, the Legislature has specified that appropriately certified case managers are to be used to provide medical case management services. Insurance Code §1305.303(j). In non-network settings, the Legislature has required insurance carriers to use case managers who are appropriately certified to conduct evaluations when case management services may be required. Labor Code §413.021(a). That section also requires insurance carriers, with the agreement of participating employers, to "provide the employer with return-to-work coordination services on an ongoing basis as necessary to facilitate an employee's return to employment." §413.021(a). Part of the return-to-work coordination services, as defined in §413.021(b), consists of "vocational case management to coordinate the efforts of the employer, the treating doctor, and the injured employee to achieve timely return to work." §413.021(b)(3). The Legislature has also required the Division to "use certified rehabilitation counselors or other appropriately trained or credentialed specialists to provide training to division staff regarding the coordination of return-to-work services." Labor Code §413.021(d). In the case of vocational rehabilitation services, the statute gives the Commissioner the authority to require certain credentials and qualifications in order to provide services in connection with a workers' compensation insurance claim. Labor Code §409.012(e). Those credentials and qualifications would include certifications to perform case management functions. All of the above statutory citations show a legislative intent to focus on requiring certifications on the part of both the Division and insurance carriers.

As part of its determination that the Division seek the best return-to-work outcomes for the injured employees and in response to comments received for the proposed rule, the Division has determined that requiring appropriately certified case managers when providing all case management activities is consistent with the legislative intent to provide quality case management for all injured employees. The Division has also determined that the requirement to utilize only appropriately certified case managers is consistent with cost-effective treatment and return-to-work principles established by using appropriately certified case managers, will alleviate ambiguity in the system, will improve return-to-work outcomes for injured employees, and will provide a higher quality of care for all injured employees. The requirement for using appropriately certified case managers in all settings will better harmonize health care management and return-to-work services for injured employees within both the network and non-network systems. This clarification to Division rules will simplify and streamline regulatory oversight of the case management process while further implementing the primary objective of the Workers' Compensation Act which is returning injured employees to work. The Division has determined that this requirement will be most efficiently and fully achieved through a phase-in process, using skilled, non-certified case managers under the supervision of appropriately certified case managers as an interim step which will allow those skilled, non-certified case managers the opportunity to accumulate sufficient work experience to sit for an appropriate certification examination.

Initially the Division formally proposed new §137.5 (regarding Certified Case Managers) in the November 27, 2009, issue of the *Texas Register* (34 TexReg 8460). Notice of a public hearing regarding this proposal was published in the January 1, 2010, issue of the *Texas Register* (35 TexReg 137) and the hearing was held on January 11, 2010 at the Division's central office in Austin, Texas. After the public hearing and receipt of 119 public comments, the Division withdrew the proposed rule from the April 23, 2010, issue of the *Texas Register* (35 TexReg 3246).

The Division informally posted a revised draft new rule to the Division's website on May 18, 2010. The Division then formally proposed new §137.5 (regarding Case Manager Certification) in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8477). The Division received 16 comments during the comment period.

In response to comments from interested parties, the Commissioner has adopted these sections with some changes to the proposal as published.

In response to written comments on the published proposal and to clarify the rule, the Division has made non-substantive changes to: (1) proposed §137.5(f)(1), by adding the word "work" before "experience;" and (2) proposed §137.5(g) by changing "shall" to "may" and by adding the phrases "that occurs after the effective date outlined in subsection (a) of this section," and "accrual of the."

Also as a result of comments, the Division has amended §137.5(g) which, as proposed, provided an 18-month period for skilled, non-certified case managers to provide case management services before certification was required to provide for a 24-month aggregate total of providing supervised case management services in order to accumulate the required work experience necessary to take a certification examination.

The purpose of the adopted §137.5 is to establish certification standards for case managers used by insurance carriers for non-network workers' compensation claims. Case management requirements for certified network claims are governed by Insurance Code §1305.303 and §10.81 of this title (regarding Quality Improvement Program). The certification categories adopted in §137.5 are consistent with those set out for workers' compensation health care networks under §10.81 and reflect a desire to harmonize the requirements for certified case managers that provide services to injured employees.

New §137.5(a) provides that the rule is applicable to all case management services provided by an insurance carrier under the Labor Code. Pursuant to Labor Code §§412.041(i), 412.0125(b)(4), 413.021(a) and 501.002(a) this rule is also applicable to the State Office of Risk Management (SORM). The Division states that §137.5(a) shall become effective September 1, 2011 to allow system participants ample time to implement these certification requirements.

New §137.5(b) elaborates on the limitations of the rule, indicating it does not apply to case management services provided by a certified workers' compensation network, by certain political subdivisions, or by a health care provider subject to §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

New §137.5(c) establishes a requirement for a case manager to obtain certification from a national accrediting agency in one of six certification categories. These are the same requirements and certification categories that currently apply to case managers who perform case management services for claims in certified workers' compensation networks under §10.81 of this title. The six certification categories are case management, case management administration, continuity of care, disability management, occupational health, or rehabilitation case management.

New §137.5(d) requires an insurance carrier to use a case manager who is appropriately certified in accordance with this section when conducting evaluations to determine if case management services are required for an injured employee's case in accordance with the provisions of the Labor Code, including Labor Code §413.021(a).

New §137.5(e) requires the use of either a certified case manager or a skilled, non-certified case manager that meets the requirements of §137.5(f) when providing any other case management services to an injured employee other than those specified in §137.5(d).

New §137.5(f) defines the eligibility requirements for skilled, non-certified case managers to provide services other than those identified in subsection (d) of this title.

New §137.5(g) allows a skilled, non-certified case manager to provide supervised case management services for an aggregate total of no more than 24 months unless the skilled, non-certified case manager becomes certified in accordance with §137.5(c).

New §137.5(h) requires insurance carriers to verify and document that the case managers they use are complying with the requirements of §137.5(d), (e) and (f).

New §137.5(i) provides that an adjuster may not serve as a case manager for an injured employee's claim.

New §137.5(j) clarifies that case managers shall be reimbursed according to their contractual agreement with the insurance carrier and not according to adopted fee guidelines in Division rules.

New §137.5(k) provides that an insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and Division rules if the requirements of this section are not met.

General: Commenters support the proposed rule requiring insurance companies to utilize case managers who are certified when conducting evaluations to determine if case management services are required or when providing case management services. Certification is the preferred way to demonstrate that a case manager possesses the proper qualifications which are education, skills, knowledge, and experience required to render appropriate services, delivered according to sound principles, including evidence based practice.

Agency Response: The Division appreciates the supportive comments and agrees that certification of a case manager improves the professional standards for the oversight of coordinated care of injured employees.

General: Commenters offer numerous interpretations of Labor Code §413.021 in comparison with the proposed rule. One commenter states that adoption of the proposed rules may exceed the Commissioner's rule making authority, and it is questionable public policy because the proposed rule restricts the available pool of competent and trained individuals who could perform case management. The commenter further states the statute does not call for case management services, if necessary, to be performed solely by case managers who are certified, and if the legislature intended this, it could have done so. Another commenter opines that the proposed rule exceeds the statutory authority to regulate certain case management activity as provided in Labor Code §413.021. Another commenter states that there is no statutory authority to require that all case management services be performed by a certified case manager. Section 413.021 and Senate Bill 1814 only specify that the insurance carrier's evaluation "to determine if skilled case management is necessary . . ." shall be performed by appropriately certified case managers, as necessary, and the statute does not specify any other case management service that must be performed by a "certified" case manager, and further does not specify that a "certified" case manager must perform this evaluation in all claims. The commenter further opines that there is no statutory authority for the requirement that skilled case managers become certified case managers within 18 months, and consequently suggests the proposed rule conflicts with the statute.

Agency Response: The Division disagrees that the adopted rule exceeds the Commissioner's rulemaking authority. As noted in the preamble, the Legislative goal for the workers' compensation system is that the injured employee will receive return-to-work services as appropriate. In reaching that goal, the Legislature's intent is for the workers' compensation system to encourage the safe and timely return of injured employees to work. The Legislature has given the Commissioner broad rulemaking authority to promulgate rules. If there is ambiguity in the statutory language, as there seems to be based on the interpretations proposed by the various commenters, the Commissioner has rulemaking authority to promulgate rules as long as the rule is in harmony with the statutory objectives. One of the general objectives of the workers' compensation statutes is to return injured employees back to work quickly and safely.

Currently, certified case managers are required to be used to provide medical case management services that are treated by workers' compensation health care networks certified by the Department. Insurance carriers are also required by statute to use case managers who are appropriately certified to conduct evaluations regarding the need for case management services for non-network claims. With the agreement of participating employers, insurance carriers are also required to provide employers with return-to-work coordination services to assist in an employee's return-to-work. Part of return-to-work coordination services consists of vocational case management.

In response to comments received for the proposed rule and as part of its determination that the Division wants the best return-to-work outcome for the injured employee, the Division has determined that requiring appropriately certified case managers when providing all case management activities is consistent with the Legislative intent to provide quality case management for all injured employees. That determination is also consistent with the cost-effective medical treatment and return-to-work principles established by using certified case managers for claims being treated in certified workers' compensation networks. Using appropriately certified case managers in all settings will better harmonize health care management and return-to-work services for injured employees within both the certified network and non-network systems. This rule will simplify and streamline regulatory oversight of the case management process. It will also further the implementation of the primary objective of the Workers' Compensation Act, which is returning injured employees to work. Under the adopted rule, insurance carriers will no longer be permitted to make determinations on a case-by-case basis of when to utilize a case manager who is either certified or not certified for a particular claim. That type of ad hoc assessment would essentially allow insurance carriers and their agents to circumvent the requirement for certified case management through random determination or through contract.

The Division has determined that a phase-in process, using skilled, non-certified case managers under the direct supervi-

sion of appropriately certified case managers as an interim step, which will allow the skilled, non-certified case managers the opportunity to accumulate sufficient work experience to sit for an appropriate certification examination. The change from the proposed 18-month period to achieve certification to an aggregate total of 24-months, beginning with the month the individual first performs case management related services after the effective date of the rule that is incorporated in the adopted rule is to allow those individuals now working as non-certified case managers to gain the work experience necessary to pursue certification if they desire to perform case management functions within the workers' compensation system.

The Division also disagrees that requiring the certification of case managers for all case management functions would decrease the pool of competent and trained individuals who could perform case management. The requirement to set certification standards for case managers was implemented in the certified workers' compensation health care network rules, 28 TAC Chapter 10, and has not resulted in a shortage of competent and trained individuals who perform case management functions within these certified networks. The Division anticipates a similar result in the present case. Additionally, by allowing an aggregate 24-month period for skilled, non-certified case managers to gain the work experience necessary to sit for an appropriate certification examination, the pool of competent, trained, and certified individuals would continue to grow. The adopted rule also clarifies that unless a case manager is certified in accordance with Division rules, the case manager is not permitted to provide any case management services unless those services are provided under the direct supervision of an appropriately certified case manager.

General: A commenter opines that the proposed rule does not apply to the State Office of Risk Management (SORM) since Labor Code §412.0125(b)(4) authorizes SORM to implement any appropriate services otherwise contemplated by Labor Code §413.021. If implemented as proposed, SORM anticipates increased costs for compliance.

Agency Response: The Division disagrees in part. Pursuant to Labor Code §§412.041(i), 412.0125(b)(4), 413.021(a) and 501.002(a) this rule is applicable to the SORM. Labor Code §412.0125 provides that as part of return-to-work coordination services, the SORM shall implement any other services provided under Labor Code §413.021 that will facilitate the reintegration of an injured employee. Labor Code §412.041(i) provides that the director of the SORM is subject to the rules, orders and decisions of the Commissioner of Workers' Compensation in the same manner as a private employer, insurer, or association. Labor Code §501.002(a) provides that specific chapters of the Labor Code apply and are included with regards to workers' compensation insurance coverage for state employees. Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rule making authority, under Labor Code Title 5. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act. The application of the rule to injured employees covered by SORM standardizes the case management services provided to injured state employees serviced by SORM with those of other injured employees, including injured state employees serviced by the other State of Texas insurance carriers, such as the Texas Department of Transportation, the University of Texas System and the Texas A&M University System. The Division agrees that as a regulated entity, SORM may encounter additional costs as a result of complying with the requirements of §137.5. The overall costs are dependent on the specific business practices currently utilized by SORM.

General: A commenter recommends that the Division withdraw the proposed rule. In the alternative, the commenter recommends the rule require that all case management be performed by either certified case managers or by persons under the direct supervision of a certified case manager.

Agency Response: The Division declines to withdraw the proposed rule and declines to make the recommended changes. The rule as proposed and adopted clarifies the appropriate certification requirements for case managers in their delivery of services for non-network claims, and consequently the Division declines to withdraw this rule which implements the certification requirements of Labor Code §413.021(a). As noted in Labor Code §413.021(a), as necessary, case managers who are appropriately certified shall be used when conducting evaluations to determine if case management services are required. Section 413.021(a) does not provide for evaluations to be conducted under the direct supervision of a certified case manager, and for this reason the evaluations may not be performed by a non-certified case manager. In addition, the Division interprets Labor Code §413.021(a) to mean that insurance carriers are required to utilize certified case managers to perform all case management functions. This interpretation harmonizes with the general objectives of the statute, which, in this circumstance, would be returning more injured employees back to work and having better return-to-work outcomes for injured employees through the use of case management services.

General: Some commenters assert there are fewer nurses available, both generally and more specifically, to provide workers' compensation case management services. The increased demand and dwindling pool of such case managers will result in increased workers' compensation expenses in the administration of the claim.

Agency Response: The Division disagrees. There is no requirement to utilize only nurse case managers for case management services. There are several case manager certifications recognized by adoption of these rules. The choice to utilize a case manager with a particular certification is the choice of the insurance carrier as is the reimbursement for the case manager. These costs are subject to a wide variety of factors which are unique to each situation. Additionally, the rule allows an extended implementation period to allow non-certified case managers time to obtain the necessary work experience to meet all the prerequisites in sitting for a case manager certification examination.

General: A commenter seeks clarification as to the existing number of certified case managers in the state since it appears to be that only a fraction are qualified.

Agency Response: The Division clarifies that the number of existing case managers who are certified, as reflected in totals gathered as a result of the Division surveying the certifying entities, is approximately 3,700.

General: A commenter asks if the Division can produce a guideline and train health providers as the Division does with fee guidelines, required medical examinations, designated doctor training and other seminars.

Agency Response: The Division notes that a specific case management guideline is not necessary at this time. However, the Division will integrate training concerning the implementation and application of this new adopted rule into its routine education and outreach efforts.

General: A commenter asks why there is no provision that the injured employees and treating doctors should comply and work with the case nurse. The commenter further states that injured employees or doctors will not meet with the case nurse.

Agency Response: The Division clarifies that the treating doctor is primarily responsible for the employee's health care for an injury and, except in an emergency, all health care must be approved or recommended by the employee's treating doctor. Additionally, the treating doctor is responsible for maintaining efficient utilization of health care. Although there is no specified requirement to facilitate communication, the Division expects system participants to act in the best interest of the injured employee in order to facilitate the injured employee's recovery and appropriate return to work. The Division further clarifies that complaints about system participants can be filed with the Division.

§137.5(a): A commenter opposes the proposed effective date, indicating that the legislative requirement passed in 2005 was that case managers be appropriately licensed. Consequently, the commenter questions how either case managers or insurance carriers can claim to have needed six years to comply with the legislative requirement, and suggests that in those instances where the insurance carrier determines that skilled case management is necessary, the insurance carrier should not be permitted to delay compliance with a statutory requirement created in 2005. The commenter recommends January 1, 2011 as a more reasonable effective date.

Agency Response: The Division disagrees with the recommendation of January 1, 2011 as the implementation date. Although a legislative requirement was enacted in 2005, that requirement was changed during the 2007 legislative session. Additionally, when proposed in December 2009, system participants requested that the then-proposed case management certification rules be withdrawn and additional system participant input be gathered prior to the posting of a subsequent rule proposal. Input from system participants led to revisions of the initial December 2009 rule proposal, including the proposed implementation date and phase-in period for currently non-certified case managers to obtain required work experience in order to sit for the case management certification examinations. Additionally, this measured approach allows for an orderly transition to the requirements of the adopted rule.

§137.5(b)(3): A commenter requests that the rule include a provision that employers and insurance carriers may continue to use licensed physicians for case management when acting on the request of the employer or insurance carrier, and recommends a revision to subsection (b)(3) to read: "provided by a licensed health care physician."

Agency Response: The Division disagrees. The requirements of Labor Code §413.021 allow the insurance carrier to select an individual with suitable qualifications to evaluate the injured employee's claim so long as that individual is appropriately certified as a case manager. In the adopted new §137.5, as in the certification requirements in certified workers' compensation networks under §10.81(f), there is no specific exception for physicians from the certification requirements. The provisions of §10.81(f) have never been read to require certification of licensed heath care providers working within the scope of practice for their license and the Division anticipates that §137.5 will be read in the same manner.

§137.5(d): A commenter requests subsection (d) be modified to require that all case management services be provided by a case manager certified in accordance §137.5(c). The commenter further requests that proposed subsections (d) through (h) be removed as these provisions are inconsistent with the statute.

Agency Response: The Division disagrees that only case managers appropriately certified be allowed to provide case management services upon the adoption of the rule. System participants have noted the need to allow for a transition period so non-certified case managers may obtain required work experience in order to sit for the case manager certification examinations. Additionally, this measured approach allows for an orderly transition to the requirements of the adopted rule. By allowing this period of time, the Division declines to delete subsections (d) through (h) of this section.

§137.5(d): A commenter believes the proposed requirement of §137.5(d), which is to utilize only case managers who are certified in accordance with subsection (c), is unnecessary and counter-productive. Further, the commenter states it would be more reasonable and efficient to allow such evaluations to be performed by skilled and competent personnel who are working under the direct supervision of a certified case manager since the statute requires such evaluations to be performed by certified case managers "as necessary." Another commenter suggests that a non-certified case manager, nurse case manager, or other similarly experienced or educated individual be allowed to assess the claim and determine if case management services would assist an injured employee.

Agency Response: The Division disagrees. The statute specifically requires that only case managers that are appropriately certified be used to make evaluations of the need for case management. The language of the statute would not be satisfied by using non-certified personnel acting under the supervision of a certified case manager to perform these evaluations.

§137.5(d) and (e): A commenter states that case management should only be performed by specialty trained nurses without exception.

Agency Response: The Division disagrees. The statute specifically requires that only case managers that are appropriately certified be used to make evaluations of the need for case management. An appropriately certified registered nurse could act as case manager; however, the statute does not require that a certified case manager be limited to registered nurses.

§137.5(e): A commenter opines that it is not the best practice to have the actual delivery of case management services to injured employees being provided by non-certified case managers.

Agency Response: The Division agrees in part. The Division notes that on or after September 1, 2011, all case managers providing case management services in the Texas workers' compensation system will be required to be certified in accordance with subsection (c). Non-certified case managers will be allowed to provide case management services under the direct supervision of a case manager appropriately certified for an aggregate total of 24 months after the non-certified individual first begins providing case management related services in order to accrue the necessary work experience to sit for a certification examination.

§137.5(e): A commenter states there is nothing in the amendments that appear to show any intent to require "certified" case managers to perform any function in the Texas workers' compensation system other than this "initial evaluation" for the possibility of providing return-to-work services. Use of the term "skilled" clearly implies that non-certified case managers may provide all case management services, except with respect to the "screening" of claims with the potential for lost time. While "skilled" is not a defined term, the use implies something other than "certified."

Agency Response: The Division agrees that there is no statutory definition of "skilled." However, in the statutory language and in the adopted rule, the term "skilled" is linked with the term "non-certified case manager." This suggests that a skilled, non-certified case manager possesses the skills and qualifications of certified case managers, other than the necessary work experience, to sit for a certification examination for case managers. It does not equate certified and non-certified case managers.

As for the requirement that appropriately certified case managers be used for all case management services and as noted in the preamble, the Commissioner has taken into consideration the expressed goals and intent of the Legislature for the Workers' Compensation Act to include returning more injured employees back to work and having better return-to-work outcomes for injured employees through the use of case management and comments received for the proposed rule and has promulgated rules that are harmonized to the general objectives of the statute. The Commissioner has also taken into consideration the general trend in the workers' compensation system to utilize appropriately certified case manager to provide case management to injured employees as seen in the workers' compensation health care networks and Labor Code §413.021(a).

The Division has determined that requiring appropriately certified case managers when providing all case management activities is consistent with the legislative intent and also is consistent with the cost-effective treatment and return-to-work principles established by using certified case managers in the workers' compensation network. Providing an indefinite exception for the ongoing use of skilled, non-certified case managers would not meet the statutory goals of the Legislature in providing cost-effective and necessary medical care to injured employees, because an indefinite exception would, by definition, not actually determine when to utilize certified case managers. Under the adopted rule, insurance carriers will not be permitted to make case-by-case determinations on when to utilize a case manager who is certified or not certified for a particular claim. The ad hoc assessment of when to utilize a certified case manager would essentially allow insurance carriers and their agents to circumvent the requirement for certified case management through random determination or contract. The requirements for using appropriately certified case managers in all settings will better harmonize health care management and return-to-work services for injured employees within both the network and non-network systems. The adopted rules will simplify and streamline regulatory oversight of the case management process while further implementing the primary objective of the Workers' Compensation Act which is returning injured employees to work.

§137.5(f): A commenter asks how the certification requirements apply to a non-certified LVN employee that is hired to perform case management duties for the employer.

Agency Response: The Division clarifies that upon implementation of the new rule, all case managers providing case management services in the Texas workers' compensation system will require certification in accordance with subsection (c). Under the adopted rule, skilled, non-certified case managers will be allowed to provide case management services under the direct supervision of a case manager appropriately certified for an aggregate total of 24 months after the non-certified individual first begins providing case management related services in order to accrue the necessary work experience to sit for a certification examination.

§137.5(f): A commenter asks what defines "skilled," and also seeks clarification if it is to be left to the discretion of the insurance carrier.

Agency Response: The Division notes that there is no stated definition of "skilled;" however, in the context of the proposed and adopted rule, the term "skilled" is linked with non-certified case manager. This suggests that a skilled, non-certified case manager possesses the skills and qualifications, other than the necessary work experience, to sit for a certification examination for case managers.

§137.5(f)(1) and (2): A commenter appreciates both the inclusion of rule provisions that provide for a time period for skilled, non-certified case managers to obtain the work experience required by the national certifying organizations that is a prerequisite to being eligible to apply to be certified, as well as mandates that non-certified case managers must work under the direct supervision of a certified case manager until such time the non-certified case manager becomes certified.

Agency Response: The Division appreciates the supportive comment.

§137.5(g): Two commenters note the potential loophole in proposed subsection (g) that does not prohibit insurance carriers from repeated replacements and use of non-certified individuals to perform skilled case management. A commenter inquires how the Division will know when a particular case manager began their apprenticeship under a credentialed case manager and suggests that the proposed language of subsection (g) leaves room for an individual to "hop over to another mentor for 24 or 36 more months." The commenter asks how the Division will enforce the 24 or 36 month rule. Another commenter also observes that an insurance carrier could circumvent the requirement by using a series of non-certified case managers for consecutive 18-month periods since there is no proposed prohibition against an insurance carrier continuously replacing a non-certified individual whose 18 months have expired.

Agency Response: The Division clarifies that the 24-month period as adopted in the rule is an aggregate period of time consisting of the actual time that an individual spends performing case management related services under the supervision of a case manager appropriately certified. The 24 months are not required to be contiguous. A period of employment where the individual does not provide case management related services does not count toward the 24 month aggregate total. The 24-month period does not restart if the individual changes employers or supervisors. The Division retains the authority to audit parties subject to the rule, including insurance carriers and case managers to ensure compliance with Division rules.

§137.5(g): Commenters observe that the 18-month limitation on employment of skilled, non-certified case managers is too short, which will not allow the necessary time to gain the work experience for the appropriate examination that in some cases is only offered twice a year, and will reduce the number of qualified persons available to provide services. One commenter fur-

ther opines that due to the arbitrary designation of the 18 month deadline, some injured employees will have case management services terminated prematurely or transferred to a practitioner who is not familiar with the case and does not have a working relationship with the injured employee.

Agency Response: The Division agrees, in part. After review of the certification requirements of the categories listed in subsection (c) of this section and the comments submitted, the Division has determined that 24 months is adequate time to meet the work experience requirements necessary to sit for a case management certification examination and the adopted rule has been revised accordingly. The Division disagrees, however, that injured employees will have case manager services terminated or transferred to a practitioner who is not familiar with the case since the skilled, non-certified case manager and the case are to be directly supervised by the appropriately certified case manager, which is a requirement of subsection (f)(2) of this section.

§137.5(g): A commenter requests the Division consider the cost of obtaining a certification plus the additional educational time and failure to pass on the first examination when adopting this subsection with time limitations to acquire a certification.

Agency Response: The Division clarifies that numerous considerations have been taken into account as a result of system participant input since the Division's initial case manager certification rule proposal of December 2009. Allowing an extended implementation period to permit skilled, non-certified case managers time to obtain the necessary work experience, under the direct supervision of an appropriately certified case manager, in order to meet all the prerequisites in sitting for a certification examination is one example of such factors the Division considered and adopted as part of this rule. However, consideration for the potential failure to pass a certification examination is not a factor the Division must accommodate for purposes of implementing the legislative requirements that case managers be appropriately certified. While the requirements to become certified as a case manager may have some affiliated costs, these requirements and their consequential costs are mandated by statute, not the adopted rule. New §137.5 implements the legislative goal of requiring appropriately certified case managers so injured employees receive appropriate case management services.

§137.5(g): A commenter recommends that case managers with tenure should be grandfathered, and also recommends a preparatory class covering key workers' compensation issues.

Response: The Division declines to make the recommended change and notes that accommodations are already included in the proposed and adopted new rule for those case managers who are skilled and eligible to provide case management services if they meet all of the requirements to sit for a case manager certification examination, with the exception of work experience. To the extent that "tenured" case managers might have the work experience necessary to take one or more of the case manager certification examinations, they would only be qualified in part and would still be required to take and pass the certification exam after an aggregate 24-month period of performing case management services after the effective date of the rule. Concerning the commenter's suggestion that a preparatory class covering the key workers' compensation issues be made available, the Division notes that there are numerous educational resources available on the Division's website that will facilitate learning the laws and rules of the Texas workers' compensation system (http://www.tdi.state.tx.us/wc/indexwc.html).

§137.5(g): Commenters state subsection (g) of the proposed rule act to limit services to the injured employees of Texas. Some commenters recommend the inclusion of language in subsection (g) that allows for: "working under the supervision of a qualified and credentialed case manager" for a period of 48 months so that qualified case managers can gain the experience needed to sit for the exams. In the alternative, some commenters advise the minimal acceptable time frame is 24 months if it is not feasible to add the provision of 48 months. Another commenter suggests subsection rule language be based on URAC standards, which is 24 months if employed full time, and 36 months if employed part-time. The commenter expresses concern for the part-time individual who will not meet the 18-month limitation.

Response: The Division agrees in part. The Division notes that input from system participants led to revisions of the initial December 2009 rule proposal, including the proposed implementation date and phase-in period for currently non-certified case managers to obtain required work experience in order to sit for the case management certification examinations. After further review of the certification requirements of the categories listed in subsection (c) of this section and the comments received, the Division has determined that employment as a skilled non-certified case manager under the supervision of a certified case manager for an aggregate 24-month period, beginning with the month in which the individual first performs case management related services after the effective date of the rule is adequate time to meet the work experience requirements necessary to sit for a case manager certification examination. This measured approach allows for a sufficient period of time and an orderly transition to the requirements of the adopted rule.

§137.5(h): Commenters oppose the requirement imposed on insurance carriers to verify and document the compliance requirements of the rule for those case managers employed by a vendor, as well as independent case managers who are not directly employed by the insurance carrier. Some insurance carriers do not have ready access to the licensing and certification status of such skilled and certified case managers, and do not have managerial control over these individuals. Commenters suggest this is a burden and risk placed on the insurance carriers, which is not good for the injured employees as it may delay case management services. Some of the commenters offer alternative recommended language for subsection (g): "Insurance carriers shall provide verification and documentation information for case managers employed by the carrier. Independent case managers and case management vendor companies contracted by insurance carriers shall provide this verification and documentation information to the division, upon request. An independent case manager and/or case management vendor company contracted by insurance carriers who fails to comply with subsections (d), (e), and (f) of this section may be subject to all appropriate sanctions and penalties provided for by the Texas Labor Code."

Response: The Division disagrees that obtaining the certification status of case managers is unduly burdensome or risky for the insurance carrier. The Division notes that a requirement of insurance carriers to verify the licensure of its agents, adjusters, third party administrators or utilization review agents, for example, is one of the basic tenants of claims services, and further notes that each insurance carrier has the discretion to hire their own case managers or make a business decision to utilize a vendor or independent case manager to provide case management services. If an insurance carrier chooses the latter, the insurance carrier, as a general business practice, has the latitude to require verification proof of certification from that vendor or inde-

pendent case manager the same way it does for the other types of licensed or certified entities listed previously.

§137.5(k): A commenter recommends substitute language for subsection (k) as follows: "If the requirements of this section are not met for case managers employed by the carrier, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and division rules. If the requirements of this section are not met by independent case managers contracted by insurance carriers, the independent case manager or company employing the independent case manager may be liable for sanctions in accordance with Labor Code §402.072 and administrative violations in accordance with Labor Code §415.021 and division rules."

Response: The Division declines to make the recommended change as requiring verification and proof of case manager certification, as previously noted, is determined by the Division to be the responsibility of each insurance carrier that chooses to contract with a vendor of case management services or an independent case manager.

For: Commission for Case Manager Certification

For, with changes: American Insurance Association, GENEX Services, Insurance Council of Texas

Against: Office of Injured Employee Counsel

Neither for or Against: City of Laredo, Kinetic Clinic, Parker & Associates, Property Casualty Insurers Association of America, State Office of Risk Management, TARPPS, and VIA Metropolitan Transit

The new section is adopted under Labor Code §§413.021, 401.011(5-a), 413.011(e) and (g), 412.0125, 412.041(i), 501.002(a), 402.00111, and 402.061.

Pursuant to Labor Code §413.021, an insurance carrier shall evaluate a compensable injury in which the injured employee sustains an injury that could potentially result in lost time from employment as early as practicable to determine if skilled case management is necessary for the injured employee's case. As necessary, case managers who are appropriately certified shall be used to perform these evaluations. Additionally, a claims adjuster may not be used as a case manager. Labor Code §401.011(5-a) defines case management as a "collaborative process of assessment, planning, facilitation, and advocacy for options and services to meet an individual's health needs through communication and application of available resources to promote quality, cost-effective outcomes." Pursuant to Labor Code §413.011(e) and (g), the Commissioner may adopt rules relating to return-to-work guidelines and disability management that are designed to improve return-to-work outcomes through appropriate management of work-related injuries or conditions. The Commissioner by rule may identify claims in which application of disability management activities is required and prescribe at what point in the claim process a treatment plan is required.

The determination may be based on any factor considered relevant by the Commissioner. Labor Code §412.0125 provides that as part of return-to-work coordination services, SORM shall implement any other services provided under Labor Code §413.021 that will facilitate the reintegration of an injured employee. Labor Code §412.041(i) provides that the director of SORM is subject to the rules, orders and decisions of the Commissioner of Workers' Compensation in the same manner as a private employer, insurer, or association. Labor Code §501.002(a) provides that specific chapters of the Labor Code apply and are included with regards to workers' compensation insurance coverage for state employees. Labor Code §402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rule making authority, under Labor Code Title 5. Labor Code §402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

§137.5. Case Manager Certification.

(a) This section applies to all case management services as defined by Labor Code §401.011(5-a) that are provided under Labor Code Title 5 to injured employees by an insurance carrier on or after September 1, 2011.

(b) This section does not apply to case management services:

(1) subject to Insurance Code Chapter 1305;

(2) subject to Labor Code §504.053(b)(2); or

(3) of a health care provider subject to §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(c) Case managers who are certified must be certified by an established accredited organization including the National Commission for Certifying Agencies, the American Board of Nursing Specialties, or other national accrediting agencies with similar standards for case management certification. Case managers must be certified in one or more of the following areas:

(1) case management;

(2) case management administration;

(3) continuity of care;

(4) disability management;

(5) occupational health; or

(6) rehabilitation case management.

(d) When conducting evaluations to determine if case management services are required, insurance carriers shall utilize case managers who are certified in accordance with subsection (c) of this section.

(e) When providing case management services other than those specified in subsection (d) of this section, an insurance carrier shall utilize case managers who are:

(1) appropriately certified in accordance with subsection (c) of this section; or

(2) skilled, non-certified case managers as specified in subsection (f) of this section.

(f) Skilled, non-certified case managers are eligible to provide services other than those identified in subsection (d) of this section if:

(1) they meet all of the requirements of subsection (c) to sit for a case management certification examination, with the exception of work experience; and

(2) they are working under the direct supervision of an identified case manager that is certified in accordance with subsection (c) of this section in order to meet the experience requirements to sit for a case management certification examination.

(g) Individuals may only be employed or contracted as skilled, non-certified case managers as specified in subsection (f) of this section for an aggregate total of 24 months, beginning with the first month in

which the individual first performs case management related services that occurs after the effective date outlined in subsection (a) of this section. After accrual of the 24 months, these individuals shall not conduct case management services until a certification is obtained in accordance with subsection (c) of this section.

(h) Insurance carriers shall be responsible for verifying and documenting in writing compliance with the requirements of subsections (d), (e) and (f) of this section. Insurance carriers shall provide this verification and documentation information to the division upon request.

(i) Claims adjusters shall not be used as case managers. This does not prohibit claims adjusters from performing claims services that are within the scope of licensure in accordance with the Insurance Code Chapter 4101.

(j) Reimbursement policies and maximum allowable reimbursement rates set forth in the adopted fee guidelines under §134.204 of this title between the treating doctor and other health care providers does not apply to the reimbursement of case managers employed or contracted by insurance carriers under this section.

(k) If the requirements of this section are not met, the insurance carrier may be held liable for administrative violations in accordance with Labor Code provisions and division rules.

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 6, 2010.

TRD-201006877
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: September 1, 2011
Proposal publication date: September 17, 2010
For further information, please call: (512) 804-4703

♦ ♦ ♦

TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 1. GENERAL LAND OFFICE

CHAPTER 15. COASTAL AREA PLANNING
SUBCHAPTER A. MANAGEMENT OF THE BEACH/DUNE SYSTEM

31 TAC §15.31

The General Land Office (GLO) adopts amendments to §15.31, relating to Certification Status of the City of Corpus Christi Dune Protection and Beach Access Plan (Plan), without changes to the proposed text as published in the August 6, 2010, issue of the *Texas Register* (35 TexReg 6784) and the text of the rule as amended will not be republished.

The GLO adopts amendments to §15.31 relating to the certification status of the Plan, adopted on August 10, 1993 (1993 Plan), and amended by City Council of the City of Corpus Christi (the City) on April 15, 2003 (2003 Plan Amendments) and April 12, 2005 (2005 Plan Amendments).

The amendments to §15.31 add a new subsection (d) to certify as consistent with state law the amendments to the City of Corpus Christi Plan that were adopted by the City of Corpus Christi City Council, as Ordinance 028494 on February 9, 2010 (2010 Plan Amendments). The text of the 1993 Plan may be viewed in Chapter 10 on the web site at: http://library7.municode.com/default-now/home.htm?infobase=13945&doc_action=whatsnew. Appendices to the 1993 Plan, which includes Proposed Appendix XVIII, entitled Approximate Location of Bollards used to Separate the Pedestrian Safe Areas Vehicle-Free Areas and the Areas Set Aside for Vehicle Transit and Parking in the Vicinity of the Concrete Seawall and South Jetty of Packery Channel, can be found at the following web site: http://www.cctexas.com/files/g33/04122010%20BCC%20Appendices%2Epdf.

Information related to and appendices for the 1993 Plan are available from the City's Development Services Department as follows:

Physical copies of the updated 1993 Plan are available from the City of Corpus Christi Department of Public Works, 2406 Leopard Street, Suite 100, Corpus Christi, Texas 78408, phone number (361) 826-3240, and from the General Land Office's Archives Division, Texas General Land Office, P.O. Box 12873, Austin, Texas 78711-2873, phone number (512) 463-5277.

BACKGROUND

Pursuant to the Open Beaches Act (Texas Natural Resources Code, Chapter 61), the Dune Protection Act (Texas Natural Resources Code, Chapter 63), and the Beach/Dune Rules (31 TAC §§15.1 - 15.16, 15.21 - 15.36, 15.41 - 15.42) a local government with jurisdiction over Gulf Coast beaches must submit its dune protection and beach access plan and any amendments to such a plan to the GLO for certification. 31 TAC §15.3(o). The GLO reviews a local beach access and dune protection plan and, if appropriate, certifies that the plan is consistent with state law by adoption or amendment of a rule as authorized in Texas Natural Resources Code §61.011(d)(5) and §61.015(b). The certification by rule reflects the state's approval of the plan, but the text of the plan is not adopted by the GLO. 31 TAC §15.3(o)(4).

The City of Corpus Christi is a coastal city located on the south and west areas of Corpus Christi Bay, Nueces County, Texas. The City also extends to the east on Mustang Island as far north as the southern city limit of Port Aransas, and on North Padre Island as far south as the southern boundary of Padre Balli County Park and extending about 8,000 feet southward into Kleberg County.

The Gulf beaches and adjacent areas governed by the Plan are those areas seaward of the line of vegetation and landward of mean low tide within areas in Nueces County that have been incorporated by the City of Corpus Christi with respect to administration of the Open Beaches Act. Nueces County has not delegated the authority to the City of Corpus Christi for administration of the Dune Protection Act pursuant to Texas Natural Resources Code §63.011(a). With respect to administration of the Open Beaches Act, the Gulf beaches within the corporate limits of the City of Corpus Christi are governed by the City of Corpus Christi Dune Protection and Beach Access Plan (City's Plan), certified as consistent with state law in 31 TAC §15.31.

THE 2010 CITY OF CORPUS CHRISTI PLAN

On February 9, 2010, the City Council of the City of Corpus Christi adopted amendments to the City's 1993 Plan with Or-

dinance 028494 and submitted those amendments to the GLO with a request for certification. The amended plan authorizes restrictions on vehicular traffic on the Gulf beach seaward of portions of the concrete segment of the North Padre Island Seawall (Seawall), establishes a vehicle free area seaward of the Seawall when the distance between the toe of the seawall to the water is less than 150 feet in width, allows two-way vehicular traffic on the Gulf beach between the northern end of the Seawall and Padre Balli Park, establishes a vehicle-free area between the northern end of the concrete seawall and the Packery Channel jetty, commits the City Council to undertake efforts to restore and maintain the beach in front of the Seawall to a minimum width of 200 feet, and adds an appendix to the City's 1993 Plan that shows the approximate location of the bollards to be installed on the beach.

Section 10-73(e) of Section 10-73 the City's Plan, relating to Vehicular Operation, describes and authorizes restrictions on vehicular traffic on the Gulf beach seaward of portions of the concrete segment of the Seawall, and includes a prohibition on operating a vehicle within fifty (50) feet of the water's edge on any section of the Gulf beach within the incorporated city limits. However, this prohibition will not apply to: parking a vehicle at least 25 feet from the water's edge under Section 10-73(e)(3); and driving closer to 50 feet of the water's edge when the upper beach sand is too soft to allow safe vehicular transit, provided that the vehicle is not driven between a parked vehicle and the water under Section 10-73(e)(4).

The City deletes Section 10-73(f) of the City's Plan, which requires vehicular traffic to operate as one-way in a southerly direction between Whitecap Boulevard and Beach Access #4.

The City renames Section 10-77 to Vehicle-restricted Areas and Pedestrian Safe Areas.

The City amends Section 10-77(e) to require the city manager to establish a vehicle-restricted area seaward of the Seawall when the beach between the toe of the Seawall and the mean high tide line is less than 150 feet in width.

The City amends Section 10-77(e)(1) to require the city manager to temporarily restrict the operation of vehicles in front of the Seawall when and where the beach width is less than 150 feet.

The City amends Section 10-77(e)(2)(a, b, c, d, and e) to require the city manager to install rows of bollards parallel to the seawall to maintain vehicle transit and parking areas as follows: one row of bollards must preserve a 25-foot wide pedestrian safe area immediately adjacent to the Seawall; a second row of bollards located a minimum of 50 feet from the first row of bollards must allow two-way vehicle traffic seaward of the Seawall; the city manager must provide for approximately 79 head-in parking spaces, each having a width of 15 feet, seaward of and parallel to the first row of bollards; head-in parking areas may not be located across from walkways that provide access to the Seawall and beach from hotels, condominiums, parking lots, and other beach access points along the Seawall; the walkway areas should be marked as pedestrian crossings and may not exceed 80 feet in width, as measured parallel to the shoreline; and the bollards must be placed so as to maximize the area of pedestrian-safe beaches near the water in front of the Seawall, while still maintaining vehicle lanes.

The City amends Section 10-77(f) to require the city manager to mark vehicle-restricted and pedestrian safe areas with signs at each end of the vehicle-restricted and pedestrian safe areas to give notice of the vehicle-restricted or pedestrian safe areas and to prevent vehicles from entering the vehicle-restricted or pedestrian safe areas.

The City amends Section 10-77(g)(1, 2, 3, 4, and 5) to require the city manager to establish a pedestrian safe area on those portions of the Gulf beach between the north end of the Seawall and the south jetty of Packery Channel in accordance with the following design criteria: the bollards must be installed no farther than 50 feet landward of mean high tide for a distance of approximately 1550 feet from the north end of the Seawall to a point 600 feet from the south jetty; the bollards must be spaced to prevent the passage of vehicles between the bollards; at the northern end of the row of bollards parallel to the water, a perpendicular row of bollards with a chained opening must be installed that extends seaward to the line of mean low tide; at least two areas must be designated for boat launch access, and the bollards spaced to allow vehicles and boat trailers to pass through the row of bollards; and openings that are gated or chained must be installed in the bollards to allow vehicles to operate seaward of the bollard line only when the upper beach sand is too soft to allow safe vehicular access to the jetty.

The City adds Section 10-77(h) to add Appendix XVIII of the City of Corpus Christi, Texas, Dune Protection and Beach Access Regulations to illustrate the approximate location of the bollards that will separate the vehicle-free areas from the areas set aside for vehicle transit and parking in the vicinities of the Seawall and the south jetty of Packery Channel.

The City amends old Section 10-77(f) to become new Section 10-77(i) in which no vehicle-free area or pedestrian safe area may be implemented until the location and perimeter design has been submitted to and certified by the GLO as an amendment to the City's Beach Management and Construction Ordinance.

The City repeals Section 10-80(e) which requires vehicles traveling on the Gulf beach between the northern end of the Seawall and Padre Balli Park to travel in a southerly direction.

The City amends Section 10-81 by creating new Section 10-81(a) which continues to authorize the city to close portions of the beach to vehicle traffic for declared safety reasons during periods including, but not limited to, extreme high tides, such as storm tide and "spring" tide events, and when less than a 25-foot corridor along the beach is available for vehicular traffic.

The City adds Section 10-81(b) which, except for emergency vehicles, vehicles used to maintain the beach, or vehicles used to provide beach related services, prohibits driving on those portions of the beach seaward of the Seawall when the city manager has designated those portions of the beach seaward of the Seawall as vehicle-free under Section 10-77(e).

The City undertakes efforts to renourish the beach seaward of the Seawall in an expeditious manner in order to restore and maintain the beach to a minimum width of 200 feet.

The City amends the City's Dune Protection and Beach Access Regulations by adding a new Appendix XVIII entitled Approximate Location of Bollards Used to Separate the Pedestrian Safe Areas, Vehicle-free Areas, and the Areas Set Aside for Vehicle Transit and Parking in the Vicinity of the Concrete Seawall and South Jetty of Packery Channel. Figures 1 and 2 in Appendix XVIII show proposed locations of bollards for eroded beach conditions and renourished beach conditions, respectively.

The City's plan amendments comply with requirements of 31 TAC §15.7(h) relating to the preservation and enhancement of public beach use, in that: parking on the beach is adequate to

accommodate one car for each 15 linear feet of beach; where vehicles are prohibited from driving on and along the beach, ingress/egress access ways are no farther apart than 1/2 mile; signs explaining the nature and extent of vehicular controls, parking area, and access points, including access for disabled persons, are conspicuously posted; the City has adopted enforceable, written policy prohibiting the City's abandonment, relinquishment, or conveyance of any right, title, easement, right-of-way, street, path, or other interest that provides existing or potential beach access, unless an alternative equivalent or better beach access consistent with the 1993 Plan is first provided by the City; standards and procedures for emergency closings of the beach are included in Section 10-81 of the 1993 Plan; and beach access for disabled persons is preserved by: allowing a disabled person or a person transporting a disabled person to operate a golf cart on that part of the beach that is closed to vehicular traffic and by providing at least one ingress/egress access way accessible to golf carts for each area of the beach where vehicles are prohibited.

Pursuant to 31 TAC §15.7(i)(4) relating to the information contained in a vehicular control plan, an inventory and description of all existing vehicular access ways to and from the beach and existing vehicular use of the beach is included in Appendix VI of the 1993 Plan. All legal authority, including the City's ordinances that impose existing vehicular controls, is located in Chapter 10 of the 1993 Plan and the Texas Transportation Code. The City's short-term or long-range goals (which include a detailed description of the means and methods of upgrading the availability of public parking and access ways, including funding for such improvements) for restricting or regulating vehicular access and use are included in the City's Mustang-Padre Island Area Development Plan. Descriptions of how vehicular management relates to beach construction management, beach user fees, and dune protection within the City's jurisdiction are included in the City's 1993 Plan in Section 10-37 relating to Dedication of equivalent or better access, Section 10-86 relating to Beach user fees, and Section 10-87 relating to Use of fee revenue, respectively.

Accordingly, the GLO approves and certifies the City's 2010 Plan Amendment with no variances from the Beach/Dune Rules. Certification is contingent on the following condition: signs are conspicuously posted which explain the nature and extent of vehicular controls, parking areas, and access points, including access for disabled persons, and all of the above criteria are followed.

REASONED JUSTIFICATION

The justification for the adopted amendment certifying the 2010 Plan amendment concerning the authorization of restrictions on vehicular traffic on the Gulf beach seaward of portions of the concrete segment of the seawall is that beach users accessing the beach from the landward hotels, motels and condominiums will realize a safer crossing from the seawall to the water than what currently exists. The plan amendment concerning the establishment of a vehicle-free area when the distance between the toe of the Seawall and the water is less than 150 feet in width, is further justified because it increases beach users' safety relative to the current situation by allowing for safer pedestrian crossing from the seawall to the water. The justification for allowing two-way vehicular traffic on the Gulf beach between the northern end of the Seawall and Padre Balli Park include: eliminating any confusion caused by prohibiting traffic from traveling northward towards Whitecap Boulevard from Padre Balli Park if pertinent signage is not conspicuously posted; and allowing the beach between the Seawall and Padre Balli Park to be accessed from Whitecap Boulevard, eliminating the need for beach users to drive an additional distance southward to access the beach. The justification for establishing a vehicle-free area between the northern end of the Seawall and the Packery Channel jetty is that it would clearly demarcate those areas where beach users could have access to water from areas where vehicles could have limited access for tasks such as launching boats or unloading fishing gear or surfing equipment. The justification for committing the City Council to undertake efforts to restore and maintain the beach seaward of the Seawall to a minimum width of 200 feet includes creating and maintaining a wider beach, which would enhance the safety of pedestrian beach users by allowing a continuous 25-foot wide barrier constructed of bollards for the entire length of the Seawall, thus allowing pedestrians safe access to the upper beach. Also, the 200-foot wide beach would allow the lower beach to be defined with bollards while establishing a pedestrian-free area, allowing for two-way traffic and providing for head-in parking spaces between 50 and 25 feet from mean high tide line. The justification for adding an appendix to the City's plan is that it would clearly define those areas to be dedicated as pedestrian safe/vehicle-free zones at the upper and lower beaches and in the area between the northern end of the Seawall and the Packery Channel jetty and define those areas where vehicle traffic is allowed.

SUMMARY AND RESPONSE TO COMMENTS

One written comment was received by a local resident during the 30-day comment period specified in the notice of proposed rulemaking published in the August 6, 2010, issue of the *Texas Register.* The GLO gave due consideration to the comment received by the agency during the 30 day comment period.

The commenter objected to Plan Amendment on the basis that the Plan Amendment varied from the "original city proposal" by allowing persons to drive motor vehicles in an area closer to the water when the upper beach sand is too soft to permit the passage of vehicles and was too vague to be enforceable. The commenter provided four reasons to support these assertions: (1) an eleven year old boy was apparently killed in 2010 when hit by a truck driving on a neighboring beach which emphasized the danger of mixing cars and pedestrians in the area of the beach in front of the seawall; (2) that sand from recent dredging of Packery Channel was placed near the seawall which would make the seawall ineffective in stopping future storm surges and make the area near the seawall impassible, resulting in vehicles driving close to the water in front of the seawall; (3) the public will ignore the restrictions on driving close to the water when they subjectively believe the sand near the seawall is impassible; and (4) the City has a history of not enforcing the existing one-way traffic restrictions in front of the seawall and has an obligation to maintain two-way traffic in front of the seawall as the beach is a public roadway.

The GLO is not aware of the substance of the "original city proposal" and therefore is unable to comment on any variations between an original proposal and what was contained in Ordinance Number 028494 which was adopted by the Corpus Christi City Council. The GLO disagrees that the Plan Amendment is too vague to be enforceable. The GLO agrees that a danger exists in mixing motor vehicles and pedestrians in the area of the beach in front of the seawall when the beach area is narrow; however, the Plan Amendment will directly address this concern by requiring that the area in front of the seawall will be designated vehicle-restricted when the distance between mean low tide and the seawall is less than 150 feet. As the distance between mean low

tide and the seawall is currently less than 150 feet, the city manager will be required to designate this area as vehicle-restricted until such time as the beach nourishment is undertaken and the distance between mean low tide and the seawall is increased to more than 150 feet. No change was made based on these comments.

The GLO disagrees that placing sand dredged from Packery Channel will result in vehicles driving in an area close to the water in front of the seawall. The Plan Amendment requires that the City place bollards fifty feet from mean high tide and parallel to the water to create a pedestrian safe area from the north end of the seawall to Packery Channel. This pedestrian safe area may only be opened by the City to vehicular traffic when the upper beach is impassible. As this pedestrian safe area only extends from the north end of the seawall to Packery Channel and not in front of the seawall, the placement of sand in front of the seawall will have no effect on vehicular access to this area of the beach. No change was made based on these comments.

Finally, the GLO disagrees that the City has an obligation to maintain two-way traffic in front of the seawall. However, the Plan Amendment will allow for two-way traffic in front of the seawall but only when the beach width from mean low tide to the seawall is 150 feet or greater. The GLO believes that maintaining two-way traffic in front of the seawall may be dangerous for pedestrians when the beach width is narrower than 150 feet. No change was made based on these comments.

CONSISTENCY WITH CMP

The adoption of the amendment to §15.31 concerning Certification Status of City of Corpus Christi Dune Protection and Beach Access Plan is subject to the Coastal Management Program (CMP), 31 TAC §505.11(a)(1)(J), relating to the Actions and Rules Subject to the CMP. The GLO has reviewed these adopted actions for consistency with the CMP's goals and policies in accordance with the regulations of the Coastal Coordination Council (Council). The applicable goals and policies are found at 31 TAC §501.26, relating to Policies for Construction in the Beach/Dune System, and §501.27, relating to Policies for Development in Coastal Hazard Areas. The adopted actions are consistent with the GLO's Beach/Dune Rules that the Council has determined to be consistent with the CMP. Consequently, the GLO has determined that the adopted actions are consistent with applicable CMP goals and policies.

There were no comments from the public or council members on the consistency of the adopted rule during the comment period.

ENVIRONMENTAL REGULATORY ANALYSIS

The GLO has evaluated the adopted rulemaking action in light of the regulatory analysis requirements of Texas Government Code §2001.0225, and determined that the action is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute. "Major environmental rule" means a rule of which the specific intent 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. The adopted amendments are 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 adopted rule change implements legislative requirements in Texas Natural Resources Code §§61.011, 61.015(b), and 61.022(c), which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify that plans to impose or increase public beach access, parking, or use fees are consistent with state law.

STATUTORY AUTHORITY

The amendments are adopted under the Texas Natural Resources Code §§61.011, 61.015(b), 61.022(c), and 61.070, which provide the GLO with the authority to adopt rules to preserve and enhance the public's right to use and have access to and from the public beaches of Texas and to certify that plans to impose or increase public beach access, parking, or use fees are consistent with state law. In addition, Texas Natural Resources Code §63.121 provides the GLO with authority to adopt rules for protection of critical dune areas.

Texas Natural Resources Code §§61.011, 61.015, 61.022, and 61.070 are affected by the adopted amendments.

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 1, 2010.

TRD-201006827
Trace Finley
Deputy Commissioner, Policy and Governmental Affairs
General Land Office
Effective date: December 21, 2010
Proposal publication date: August 6, 2010
For further information, please call: (512) 475-1859

♦ ♦ ♦

TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 90. INTERMEDIATE CARE FACILITIES FOR PERSONS WITH MENTAL RETARDATION OR RELATED CONDITIONS SUBCHAPTER G. ABUSE, NEGLECT, AND EXPLOITATION; COMPLAINT AND INCIDENT REPORTS AND INVESTIGATIONS

40 TAC §90.211, §90.216

The Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts the repeal of §90.211, concerning definitions, and §90.216, concerning general provisions, in Chapter 90, Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions, without changes to the proposed text published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8096).

The repeal is adopted to eliminate rules that became unnecessary as a result of the transfer of responsibility for investigation of

abuse, neglect, and exploitation in licensed intermediate care facilities for persons with mental retardation or related conditions, which was effective June 1, 2010. Relevant definitions and general provisions are included in the rules of the Department of Family and Protective Services, which now conducts the investigations.

DADS received no comments regarding adoption of the repeal.

The repeal is adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Government Code, §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; and Texas Health and Safety Code, Chapter 252, which authorizes DADS to license and regulate intermediate care facilities for persons with mental retardation or related conditions.

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 6, 2010.

TRD-201006886
Kenneth L. Owens
General Counsel
Department of Aging and Disability Services
Effective date: December 26, 2010
Proposal publication date: September 3, 2010
For further information, please call: (512) 438-3734

♦ ♦ ♦

PART 5. TEXAS VETERANS LAND BOARD

CHAPTER 175. GENERAL RULES OF THE VETERANS LAND BOARD

The Veterans Land Board (Board) adopts revisions to §§175.2, 175.4, 175.22 and 175.57, without changes to the proposed text as published in the August 20, 2010, issue of the *Texas Register* (35 TexReg 7189) and will not be republished.

BACKGROUND AND INTRODUCTION

175.2. Loan Eligibility

This section outlines the eligibility requirements for a Veteran to be eligible for the Veterans Land Program as authorized by Title 7, Chapter 161 of the Texas Natural Resources Code relating to the Veterans Land Board. The change to this section eliminates the one-year residency requirement.

175.4. Land Description

This section describes requirements that the Land Description must meet in order for the land to be eligible for purchase under the Veterans Land Program. The change to this section eliminates the need for an original signature of the surveyor on the metes and bounds description and survey plats. A copy of the signature is now sufficient.

175.22. Duties and Responsibilities of Chairman, Executive Secretary, and Assistant Executive Secretary

This section describes the duties of the Commissioner, Chief Clerk, Executive Secretary and Assistant Executive Secretary of the General Land Office as they relate to the functions of the Veterans Land Board. This section previously made selection of an Executive Secretary mandatory, but the changes allow the Board to choose if they would like to select an Executive Secretary.

175.57. Title Insurance and Closing Requirements

The changes to this section allow exceptions in the mortgagee's title insurance policy to be only those that are acceptable to the board.

SUMMARY OF COMMENTS

No comments were received in response to the proposed amendments to §§175.2, 175.4, 175.22 and 175.57.

SUBCHAPTER A. GENERAL RULES AND CONTRACTING FINANCING

40 TAC §§175.2, 175.4, 175.22

STATUTORY AUTHORITY

The amendments are adopted under the Natural Resources Code, Title 7, Chapter 161, §§161.001, 161.061, 161.063, 161.218, 161.222, 161.233, 161.283, 161.503, and Chapter 162, §§162.001,162.003,162.011. These sections authorize the Board to adopt rules that it considers necessary and advisable for the Land Program and for the Veterans Housing 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 1, 2010.

TRD-201006823
Trace Finley
Deputy Commissioner, Policy and Governmental Affairs, General Land Office
Texas Veterans Land Board
Effective date: December 21, 2010
Proposal publication date: August 20, 2010
For further information, please call: (512) 475-1859

♦ ♦ ♦

SUBCHAPTER B. MORTGAGE FINANCING

40 TAC §175.57

STATUTORY AUTHORITY

The amendments are adopted under the Natural Resources Code, Title 7, Chapter 161, §§161.001, 161.061, 161.063, 161.218, 161.222, 161.233, 161.283, 161.503, and Chapter 162, §§162.001, 162.003, 162.011. These sections authorize the Board to adopt rules that it considers necessary and ad-

visable for the Land Program and for the Veterans Housing 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 1, 2010.

TRD-201006824

Trace Finley

Deputy Commissioner, Policy and Governmental Affairs, General Land Office

Texas Veterans Land Board

Effective date: December 21, 2010

Proposal publication date: August 20, 2010

For further information, please call: (512) 475-1859

♦ ♦ ♦

CHAPTER 176. VETERANS HOMES

40 TAC §176.7

The Veterans Land Board (Board) adopts revisions to §176.7 without changes to the proposed text as published in the August 20, 2010, issue of the *Texas Register* (35 TexReg 7191) and will not be republished.

BACKGROUND AND INTRODUCTION

176.7. Admission Requirements

Section 176.7 outlines the Admission Requirements to be admitted to a Texas Veterans Home. The change to this section amends the definition of "veteran" to include a person who satisfies the requirements of Title 40, Part 5, Chapter 175, §175.2(c)(1) of the Texas Administrative Code.

SUMMARY OF COMMENTS

No comments were received in response to the proposed amendment to §176.7.

STATUTORY AUTHORITY

The amendments are adopted under the Natural Resources Code, Title 7, Chapter 161, §§161.001, 161.061, 161.063, 161.218, 161.222, 161.233, 161.283, 161.503, and Chapter 162, §§162.001, 162.003, 162.011. These sections authorize the Board to adopt rules that it considers necessary and advisable for the Land Program and for the Veterans Housing 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 1, 2010.

TRD-201006825

Trace Finley

Deputy Commissioner, Policy and Governmental Affairs, General Land Office

Texas Veterans Land Board

Effective date: December 21, 2010

Proposal publication date: August 20, 2010

For further information, please call: (512) 475-1859

♦ ♦ ♦

CHAPTER 177. VETERANS HOUSING ASSISTANCE PROGRAM

40 TAC §§177.9 - 177.11

The Veterans Land Board (Board) adopts revisions to §§177.9 - 177.11 without changes to the proposed text as published in the August 20, 2010, issue of the *Texas Register* (35 TexReg 7191) and will not be republished.

BACKGROUND AND INTRODUCTION

177.9. Fees, Expenses, and Interest

Section 177.9 relates to all fees and interest rates charged in connection with the program by any party. Currently the board may require a down payment limited to 5%. The changes in this rule will allow the Veterans Land Board to charge a higher rate in the event that the Veterans participating lending institution requires a larger down payment.

177.10. Loan Security

Section 177.10 requires that a loan must be secured by a mortgage, deed of trust, or other lien prior to disbursement of funds. It requires that the security for the board's loan will be provided by a participation first lien mortgage with the board and participating lending institution joining as mortgagee, each reserving a share of the mortgage payment in proportion to each loan or a second lien and deed of trust securing the full amount. The change to this section allows for a first or second lien and deed of trust to secure the full amount of the board's loan.

177.11. Servicing Loans

Section 177.11 establishes the requirements for loan payment and servicing. The change to this section allows veterans to prepay their loans in accordance with the loan documents and in compliance with the requirements of the participating lending institution.

SUMMARY OF COMMENTS

No comments were received in response to the proposed amendments to §§177.9, 177.10. and 177.11.

STATUTORY AUTHORITY

The amendments are adopted under the Natural Resources code, Title 7, Chapter 161, §§161.001, 161.061, 161.063, 161.218, 161.222, 161.233, 161.283, 161.503, and Chapter 162, §§162.001, 162.003, 162.011. These sections authorize the Board to adopt rules that it considers necessary and advisable for the Land Program and for the Veterans Housing 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 1, 2010.

TRD-201006826

Trace Finley

Deputy Commissioner, Policy and Governmental Affairs, General Land Office

Texas Veterans Land Board

Effective date: December 21, 2010

Proposal publication date: August 20, 2010

For further information, please call: (512) 475-1859

♦ ♦ ♦

PART 20. TEXAS WORKFORCE COMMISSION

CHAPTER 807. CAREER SCHOOLS AND COLLEGES

The Texas Workforce Commission (Commission) adopts the following new section to Chapter 807, relating to Career Schools and Colleges, *without changes,* as published in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8480):

Subchapter A. General Provisions, §807.5

The Commission adopts amendments to the following sections of Chapter 807, relating to Career Schools and Colleges, *without changes,* as published in the September 17, 2010, issue of the *Texas Register* (35 TexReg 8480):

Subchapter A. General Provisions, §807.3

Subchapter B. Certificates of Approval, §807.11 and §807.16

Subchapter F. Instructors, §807.81

Subchapter H. Courses of Instruction, §807.122 and §§807.130 - 807.132

Subchapter I. Application Fees and Other Charges, §807.151

Subchapter L. Progress Standards, §807.223

Subchapter M. Attendance Standards, §807.245

Subchapter N. Cancellation and Refund Policy, §807.263

Subchapter P. Complaints, §807.301

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

PART I. PURPOSE, BACKGROUND, AND AUTHORITY

The purpose of the adopted Chapter 807 rule change is to address changes in the career school and college industry. To identify options for simplifying processes and eliminating duplicative regulation, Agency staff met with the Career Colleges and Schools of Texas, a group of industry representatives, to discuss amendments to Chapter 807, Career Schools and Colleges rules. The goal was to identify rule and process changes to:

--streamline the Commission's regulation of career schools and colleges; and

--eliminate requirements that do not improve student protections, but that unnecessarily restrict career schools and colleges' ability to respond to changing needs for training.

In addition, the adopted amendments to Chapter 807 are to:

--clarify exemption requirements based on changes in the Texas Higher Education Coordinating Board (THECB) rules, which now recognize national accrediting bodies that approve baccalaureate or higher-level degrees; and

--better inform students of regulations governing licensed career schools and colleges, and grievance processes available to students.

PART II. EXPLANATION OF INDIVIDUAL PROVISIONS WITH COMMENTS AND RESPONSES

(Note: Minor, nonsubstantive, editorial changes are made that do not change the meaning of the rules and, therefore, are not discussed in the Explanation of Individual Provisions.)

SUBCHAPTER A. GENERAL PROVISIONS

The Commission adopts the following amendments to Subchapter A:

§807.3. Memorandum of Understanding for Regulation of Schools

Section 807.3 deletes an incorrect reference to 40 TAC §800.205.

New §807.5. Exemptions

New §807.5 clarifies requirements for an exemption from the requirement for a certificate of approval to align with rule changes enacted by THECB (referred to as the Coordinating Board in this chapter). Texas Education Code, Chapter 61, allows THECB to authorize some career schools and colleges to offer baccalaureate or higher-level degrees. By rule, THECB recognizes certain national accrediting agencies that accredit career schools and colleges. If a career school or college is accredited by a recognized accreditor, the school or college can apply to THECB for a certificate of authorization to offer any degree program(s) up to, and including, a specific degree level cited in the certificate. This creates an opportunity for career schools and colleges in Texas with baccalaureate or higher-level degree programs to apply to the Commission for an exemption under Texas Education Code §132.002(a)(6).

The Commission's intent is to provide consistent and clear standards regarding the applicability of exemptions pursuant to Texas Education Code, Chapter 132.

New §807.5(1) - (5) sets forth that under the requirements of Texas Education Code §132.002(d), a career school or college application for an exemption from the provisions of Texas Education Code §132.002(a)(6) must provide evidence that:

(1) the school or college has been licensed for at least one year;

(2) the school or college has a certificate of authorization from THECB to grant baccalaureate or higher-level degrees or a letter from THECB indicating THECB approval is not required;

(3) the school or college is accredited by a THECB-recognized accrediting body;

(4) the school or college is in good standing with the designated accrediting body and not subject to:

(A) probation;

(B) a directive to show cause as to why accreditation should not be revoked; or

(C) any other action that, as defined by the accrediting agency, will prevent the school from seeking approval of its degree programs; and

(5) at least a simple majority (51 percent) of credits earned in the educational programs of the school or college are transferable to educational programs that are:

(A) at an equivalent or higher academic level (e.g., baccalaureate to baccalaureate or higher);

(B) at a junior college, college, or university supported entirely or partly by taxation from a local or state source; and

(C) within the same local/regional service area as the offered program, as determined by the Agency.

SUBCHAPTER B. CERTIFICATES OF APPROVAL

The Commission adopts the following amendments to Subchapter B:

§807.11. Original Approvals

Section 807.11(b) adds that schools must complete the Agency's application requirements within 180 days of receipt of the original application or the application may be considered withdrawn.

Section 807.11(c) states that a school's failure to respond to any Commission request for additional information within 30 days may result in withdrawal of the application by the Commission.

Section 807.11(d) requires that to reapply, a school shall submit:

(1) a complete application as required under §807.11(a); and

(2) an affidavit stating that the school will not reopen until it has been issued a Certificate of Approval.

§807.16. Degrees

Section 807.16 replaces the section title "Associate Degrees" with "Degrees" to align with THECB rules.

Section 807.16(a) removes the term "associate" because THECB now approves several levels of degrees.

Section 807.16(b) states that the Commission may recognize the approval to grant degrees upon receipt of notice issued by THECB and adds that additional notice by the school's accreditor also may be required. These changes are made to align with THECB rules.

SUBCHAPTER F. INSTRUCTORS

The Commission adopts the following amendments to Subchapter F:

§807.81. Instructor Qualifications

Section 807.81(a) replaces the term "program" with "course of instruction" to clarify that instructors for both programs and seminars must comply with this section.

Section 807.81(b)(1)(D) replaces the term "includes" with "is supplemented by" to further specify the requirements for a master's degree.

Section 807.81(b)(2)(A) adds the term "satisfactory completion of" to further specify the requirements for a bachelor's degree.

Section 807.81(b)(2)(D) replaces the term "includes" with "is supplemented by" to further specify the requirements for a bachelor's degree.

Section 807.81(b)(3)(B) replaces the term "includes" with "is supplemented by" to further specify the requirements for an associate's degree.

Section 807.81(b)(4) makes editorial changes to the language to align with the other subsections.

Section 807.81(b)(5) makes editorial changes to the language to align with the other subsections.

Section 807.81(c)(5) replaces the term "awareness course" with "seller training program" to align with terminology used by the Texas Alcoholic Beverage Commission.

Section 807.81(d) adds the term "proficiency" to address an editorial omission in the subsection.

SUBCHAPTER H. COURSES OF INSTRUCTION

The Commission adopts the following amendments to Subchapter H:

§807.122. General Information for Courses of Instruction

Section 807.122 adds new subsections (a) - (c) to reduce paperwork and allow flexibility in evaluating courses of instruction. The application process is modified for schools that are approved by an accrediting body recognized by the U.S. Secretary of Education and a variance to the general requirements is allowed, under certain conditions. Career schools and colleges must respond rapidly to changing market demands to improve their capability to compete with other educational institutions. Currently, courses in accredited career schools and colleges undergo two review and approval processes--first by the Agency and second by the appropriate accrediting agency--which delays the implementation of courses developed to meet students' changing needs.

Section 807.122(a) states that a school is not required to submit applications for additional courses of instruction or for course revisions to the Commission for approval, if the school:

(1) has been licensed for at least one year under current ownership;

(2) is accredited by an agency recognized by the U.S. Secretary of Education; and

(3) is in good standing with its designated accrediting agency and not subject to:

(A) probation;

(B) a directive to show cause as to why accreditation should not be revoked; or

(C) any other action, as defined by the accrediting agency, that would otherwise prevent the school from seeking approval to add or revise a course of instruction.

Section 807.122(b) requires that immediately upon receipt of the approval of the course of instruction from the accrediting agency, the school shall provide a copy to the Commission.

Section 807.122(c) sets forth that the Commission may require the school director of an accredited school to file applications for nondegree programs if there have been two substantiated complaints regarding programs in the previous year.

Section 807.122(h), formerly §807.122(e), replaces the term "programs" with "courses of instruction" to indicate that both programs and seminars must comply with this subsection.

Certain subsections have been relettered to accommodate additions.

§807.130. Admission Requirements Relating to Courses of Instruction

Section 807.130 replaces the section title "Admission Requirements Relating to Programs" with "Admission Requirements Relating to Courses of Instruction" to establish that both programs and seminars must comply with this section.

Section 807.130(a) and (b) replaces the term "program" with "course of instruction" to establish that both programs and seminars must comply with this section.

§807.131. School Responsibilities Relating to Courses of Instruction

Section 807.131 replaces the section title "School Responsibilities Regarding Programs" with "School Responsibilities Relating to Courses of Instruction" to establish that both programs and seminars must comply with this section.

Section 807.131(a) adds the requirement that schools must identify any portion of instruction "conducted by distance education."

Section 807.131(b)(2) adds the phrase "as established by the Commission" to clarify that the Commission establishes minimum employment rates in jobs related to the stated occupation.

§807.132. Course of Instruction Revisions

Section 807.132 replaces the section title "Course of Instruction Program" with "Course of Instruction Revisions" to establish that both programs and seminars must comply with this section.

Section 807.132(a) - (c) replaces the term "program" with "course of instruction" to establish that both programs and seminars must comply with this section.

SUBCHAPTER I. APPLICATION FEES AND OTHER CHARGES

The Commission adopts the following amendments to Subchapter I:

§807.151. Fee Schedule

Section 807.151(13) changes the fee for investigation of a complaint from $400 to $600 to conform with Texas Education Code §132.201(e).

SUBCHAPTER L. PROGRESS STANDARDS

The Commission adopts the following amendments to Subchapter L:

§807.223. Progress Requirements for Asynchronous Distance Education Schools

Section 807.223 replaces the section title "Progress Requirements for Distance Education Schools" with "Progress Requirements for Asynchronous Distance Education Schools" to clearly exclude synchronous distance education schools only from the requirements of this particular section.

Section 807.223(a) adds the term "asynchronous" to clearly exclude synchronous distance education schools only from the requirements of this particular section.

SUBCHAPTER M. ATTENDANCE STANDARDS

The Commission adopts the following amendments to Subchapter M:

§807.245. Leaves of Absence

Section 807.245 reduces paperwork, allows flexibility, and improves potential student outcomes by allowing courses of instruction eligible for payment from Title IV funds under 20 U.S.C. §1070 et seq. to adopt a leave of absence policy consistent with that of the U.S. Secretary of Education.

Section 807.245(c) adds the phrase "except as provided in subsection (d) of this section" to clarify the exception to the leave of absence policy set forth in this subsection.

Section 807.245(d) allows programs with a course time of more than 600 hours, and that are eligible for Title IV funding, to have a leave of absence policy consistent with the U.S. Department of Education policy at 34 C.F.R. §668.22(d).

Certain subsections have been relettered to accommodate additions to this section.

SUBCHAPTER N. CANCELLATION AND REFUND POLICY

The Commission adopts the following amendments to Subchapter N:

§807.263. Refund Requirements

Section 807.263 replaces the section title "Refund Requirements for Residence Schools" with "Refund Requirements" to clarify that the information contained in this section applies to all types of schools.

Section 807.263(e) removes the phrase "combination distance education-residence" to give students the same right to cancel as provided to other residence school students. More schools are offering hybrid programs, and having one distance education subject should not remove the student's right to cancel after a tour.

SUBCHAPTER P. COMPLAINTS

The Commission adopts the following amendments to Subchapter P:

§807.301. School Policy Regarding Complaints

Section 807.301 adds the requirement for schools to post critical information to enhance student awareness about the regulation of the school and the student grievance processes, as well as the Agency's role in the process. Currently, the Agency's Career Schools and Colleges unit receives frequent phone calls and written communications from students, indicating a lack of awareness of a school's grievance process and of their ability to file a complaint with the Agency. Adding this requirement will enable schools to facilitate greater awareness and more direct discussions with students by conveying grievance policy information to both current and prospective students in key locations at school facilities and on the school's Web site, in addition to providing materials to students as already required.

Section 807.301(5) requires that schools post a visible notice on the school's Web site and centrally located at or near the school's main entrance; in at least one of the student common areas (e.g., the student cafeteria and/or breakroom); in places where student solicitation, financial aid assistance, and enrollment activities take place; and other locations as necessary to respond to problems with career schools rule compliance, which states that:

(A) the school has a certificate of approval from the Agency, and provides the Agency-assigned school number;

(B) the school's programs are approved by the Agency and may also be approved by other state agencies or accrediting bodies,

and provides the name of any accrediting body and state agency, as applicable;

(C) students must address their concerns about an educational program by following the school's grievance process outlined in the school catalog;

(D) students who are dissatisfied with the school's response to their complaints can file a formal complaint with the Agency, as well as with the school's accrediting body, if applicable; and

(E) additional information on complaint procedures is located on the Agency's Career Schools and Colleges Web site.

No comments were received.

The Agency hereby certifies that the adoption has been reviewed by legal counsel and found to be within the Agency's legal authority to adopt.

SUBCHAPTER A. GENERAL PROVISIONS

40 TAC §807.3, §807.5

The rules are adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rules affect Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006783
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER B. CERTIFICATES OF APPROVAL

40 TAC §807.11, §807.16

The rules are adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rules affect Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006784
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER F. INSTRUCTORS

40 TAC §807.81

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006785
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER H. COURSES OF INSTRUCTION

40 TAC §§807.122, 807.130 - 807.132

The rules are adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rules affect Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006786

Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER I. APPLICATION FEES AND OTHER CHARGES

40 TAC §807.151

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006787
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER L. PROGRESS STANDARDS

40 TAC §807.223

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006788
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER M. ATTENDANCE STANDARDS

40 TAC §807.245

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006789
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER N. CANCELLATION AND REFUND POLICY

40 TAC §807.263

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006790

Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

SUBCHAPTER P. COMPLAINTS

40 TAC §807.301

The rule is adopted under Texas Labor Code §301.0015 and §302.002(d), which provide the Texas Workforce Commission with the authority to adopt, amend, or repeal such rules as it deems necessary for the effective administration of Agency services and activities.

The adopted rule affects Title 4, Texas Labor Code, particularly Chapters 301 and 302, as well as Texas Education Code, Chapter 132.

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 November 30, 2010.

TRD-201006791
Reagan Miller
Deputy Division Director, Workforce Policy and Service Delivery Branch
Texas Workforce Commission
Effective date: December 20, 2010
Proposal publication date: September 17, 2010
For further information, please call: (512) 475-0829

♦ ♦ ♦

REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the 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

State Securities Board

Title 7, Part 7

The State Securities Board (Agency), beginning December 2010, will review and consider for readoption, revision, or repeal Chapter 113, Registration of Securities; Chapter 114, Federal Covered Securities; Chapter 123, Administrative Guidelines for Registration of Open-End Investment Companies; Chapter 125, Minimum Disclosures in Church and Nonprofit Institution Bond Issues; Chapter 135, Industrial Development Corporations and Authorities; and Chapter 137, Administrative Guidelines for Regulation of Offers; in accordance with Texas Government Code, §2001.039. The rules to be reviewed are located in Title 7, Part 7, of the Texas Administrative Code.

The assessment made by the Agency at this time indicates that the reasons for readopting these chapters continue to exist.

The Agency's Board will consider, among other things, whether the reasons for adoption of these rules continue to exist and whether amendments are needed. Any changes to the rules proposed by the Agency's Board after reviewing the rules and considering the comments received in response to this notice will appear in the "Proposed Rules" section of the *Texas Register* and will be adopted in accordance with the requirements of the Administrative Procedure Act, Texas Government Code Annotated, Chapter 2001. The comment period will last for 30 days beginning with the publication of this notice of intention to review.

Comments or questions regarding this notice of intention to review may be submitted in writing, within 30 days following the publication of this notice in the *Texas Register,* to Kara Kennedy, General Counsel, P.O. Box 13167, Austin, Texas 78711-3167, or sent by facsimile to Ms. Kennedy at (512) 305-8310. Comments will be reviewed and discussed in a future Board meeting.

TRD-201006836
Denise Voigt Crawford
Securities Commissioner
State Securities Board
Filed: December 2, 2010

♦ ♦ ♦

Adopted Rule Reviews

Texas Appraiser Licensing and Certification Board

Title 22, Part 8

The Texas Appraiser Licensing and Certification Board (TALCB) adopts the review of §§153.1 - 153.18 of Chapter 153, Rules Relating to Provisions of the Texas Appraiser Licensing and Certification Act, in accordance with the Texas Government Code, §2001.039. The proposed notice of review was published in the March 5, 2010, issue of the *Texas Register* (35 TexReg 2021).

The agency made several amendments in conjunction with this review. The agency has determined that the reasons for the adoption of these chapters continue to exist.

No comments were received in response to the notice of the proposed rule review as published in the above-referenced issue of the *Texas Register.*

This concludes the review of Chapter 153, Rules Relating to Provisions of the Texas Appraiser Licensing and Certification Act.

TRD-201006962
Devon V. Bijansky
General Counsel
Texas Appraiser Licensing and Certification Board
Filed: December 8, 2010

♦ ♦ ♦

The Texas Appraiser Licensing and Certification Board (TALCB) adopts the review of §§153.19 - 153.37 of Chapter 153, Rules Relating to Provisions of the Texas Appraiser Licensing and Certification Act, in accordance with the Texas Government Code, §2001.039. The notice of proposed review was published in the June 11, 2010, issue of the *Texas Register* (35 TexReg 5081).

The agency made several amendments in conjunction with this review. The agency has determined that the reasons for the adoption of these sections continue to exist.

One comment was submitted in response to the notice of the proposed rule review as published in the above-referenced issue of the *Texas Register.* This commenter questioned the agency's authority under Chapter 1103, Texas Occupations Code (the Texas Appraiser Licensing and Certification Act) to adopt existing §153.20 related to enforcement action based on action in another state. The Board respectfully disagrees with this commenter, as the agency is authorized to adopt rules related to certification and licensing of appraisers and rules to ensure appraiser competency, professional conduct, and ethics; action against an appraiser in another state may be evidence of a lack of competency, professionalism, or ethics and is therefore appropriate to consider in evaluating fitness to act (or continue to act) as an appraiser in Texas.

This concludes the review of Chapter 153, Rules Relating to Provisions of the Texas Appraiser Licensing and Certification Act.

TRD-201006963
Devon V. Bijansky
General Counsel
Texas Appraiser Licensing and Certification Board
Filed: December 8, 2010

♦ ♦ ♦

The Texas Appraiser Licensing and Certification Board (TALCB) adopts the review of Chapter 155, Rules Relating to Standards of Practice, and Chapter 157, Rules Relating to Practice and Procedure, in accordance with the Texas Government Code, §2001.039. The proposed notice of review was published in the January 1, 2010, issue of the *Texas Register* (35 TexReg 113).

The agency made several amendments in conjunction with this review. The agency has determined that the reasons for the adoption of these chapters continue to exist.

No comments were received in response to the notice of the proposed rule review as published in the above-referenced issue of the *Texas Register.*

This concludes the review of Chapter 155, Rules Relating to Standards of Practice, and Chapter 157, Rules Relating to Practice and Procedure.

TRD-201006961
Devon V. Bijansky
General Counsel
Texas Appraiser Licensing and Certification Board
Filed: December 8, 2010

♦ ♦ ♦

Comptroller of Public Accounts

Title 34, Part 1

The Comptroller of Public Accounts adopts the review of Texas Administrative Code, Title 34, Part 1, Chapter 17, concerning Payment of Fees, Taxes, and Other Charges to State Agencies by Credit, Charge, and Debit Cards; Chapter 18, concerning Tobacco Settlement Permanent Trust Account; Chapter 19, concerning State Energy Conservation Office; and Chapter 20, concerning Texas Procurement and Support Services, pursuant to Government Code, §2001.039. The review assessed whether the reasons for adopting the chapters continue to exist.

The comptroller received no comments on the proposed review, which was published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8141).

Relating to the review of Chapter 17, the comptroller finds that the reasons for adopting Chapter 17 continue to exist and readopts the sections at this time without changes in accordance with the requirements of Government Code, §2001.039.

Relating to the review of Chapter 18, the comptroller finds that the reasons for adopting Chapter 18 continue to exist and readopts the sections at this time without changes in accordance with the requirements of Government Code, §2001.039. At a later date, §18.2 will be amended in separate rulemakings in accordance with the Texas Administrative Procedure Act.

Relating to the review of Chapter 19, the comptroller finds that the reasons for adopting Chapter 19 continue to exist and readopts the sections at this time without changes in accordance with the requirements of Government Code, §2001.039.

Relating to the review of Chapter 20, the comptroller finds that the reasons for adopting Chapter 20 continue to exist and readopts the sections at this time without changes in accordance with the requirements of Government Code, §2001.039. At a later date, all existing rules in Subchapters A - H will be amended in separate rulemakings in accordance with the Texas Administrative Procedure Act.

This concludes the review of Texas Administrative Code, Title 34, Part 1, Chapters 17, 18, 19 and 20.

TRD-201006852
Ashley Harden
General Counsel
Comptroller of Public Accounts
Filed: December 2, 2010

♦ ♦ ♦

Texas Education Agency

Title 19, Part 2

The Texas Education Agency (TEA) adopts the review of 19 TAC Chapter 61, School Districts, Subchapter AA, Commissioner's Rules on School Finance; Subchapter BB, Commissioner's Rules on Reporting Requirements; Subchapter CC, Commissioner's Rules Concerning School Facilities; Subchapter DD, Commissioner's Rules Concerning Missing Child Prevention and Identification Programs; Subchapter EE, Commissioner's Rules on Reporting Child Abuse and Neglect; Subchapter FF, Commissioner's Rules Concerning High School Diplomas for Certain Veterans; Subchapter GG, Commissioner's Rules Concerning Counseling Public School Students; Subchapter HH, Commissioner's Rules Concerning Classroom Supply Reimbursement Program; Subchapter II, Commissioner's Rules Concerning High School Allotment; and Subchapter JJ, Commissioner's Rules Concerning Automatic College Admission, pursuant to the Texas Government Code, §2001.039. The TEA proposed the review of 19 TAC Chapter 61, Subchapters AA-JJ, in the August 6, 2010, issue of the *Texas Register* (35 TexReg 6841).

Relating to the review of 19 TAC Chapter 61, Subchapter AA, the TEA finds that the reasons for adopting §§61.1012, 61.1015, 61.1018, and 61.1019 continue to exist and readopts the rules. The TEA finds that the reasons do not exist for adopting §61.1011, Public Education Grant Supplemental Payments, and §61.1016, Delivery of Funds per House Bill 1, Rider 82, 2003. Because of changes in school finance law, the Public Education Grant supplemental payment described in §61.1011 is obsolete. Section 61.1016 provided for the administration of an allotment that is no longer available, and its provisions were applicable only to certain school years that have already passed. The TEA received no comments related to the review of Subchapter AA. At a later date, the TEA plans to propose the repeals of §61.1011 and §61.1016. In addition, the TEA plans to propose changes related to contracts and tuition for education outside a student's home district and additional state aid for ad valorem tax credits under the Texas Economic Development Act.

Relating to the review of 19 TAC Chapter 61, Subchapter BB, the TEA finds that the reasons for adopting Subchapter BB continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter BB. At a later date, the TEA plans to propose changes to update provisions for bus accident reporting.

Relating to the review of 19 TAC Chapter 61, Subchapter CC, the TEA finds that the reasons for adopting Subchapter CC continue to exist and readopts the rules. The TEA received a comment related to the review of Subchapter CC. Following is a summary of the public comment received and the corresponding response.

Comment. The Texas Library Association (TLA) commented that it supports 19 TAC §61.1036, School Facilities Standards for Construction on or after January 1, 2004, and that the rule should continue to

exist. The TLA commented that §61.1036(a)(8) should be modified to require that school libraries include access to online databases.

Agency response. The agency agrees that the rule should continue to exist. In response to the comment that access to online databases should be required, the agency offers the following clarification. Subsection (a)(8) already requires that school libraries include computer/online reference areas. The subsection does not address the specific resources to be provided in these areas.

At a later date, the TEA plans to propose changes to Subchapter CC to add references to certain bonds for the construction of school facilities, update references to the state information depository, provide for open-enrollment charter schools to apply for the new instructional facility allotment, remove references to a type of property value adjustment that no longer exists, and update cross-references to statute.

Relating to the review of 19 TAC Chapter 61, Subchapter DD, the TEA finds that the reasons for adopting Subchapter DD continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter DD. No changes are necessary as a result of the review.

Relating to the review of 19 TAC Chapter 61, Subchapter EE, the TEA finds that the reasons for adopting Subchapter EE continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter EE. No changes are necessary as a result of the review.

Relating to the review of 19 TAC Chapter 61, Subchapter FF, the TEA finds that the reasons for adopting Subchapter FF continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter FF. No changes are necessary as a result of the review.

Relating to the review of 19 TAC Chapter 61, Subchapter GG, the TEA finds that the reasons for adopting Subchapter GG continue to exist and readopts the rules.

The TEA received comments related to the review of 19 TAC Chapter 61, Subchapter GG. Following is a summary of the public comments received and the corresponding responses.

Comment. The Texas Counseling Association (TCA) commented that subsection (a) should be expanded to require counseling regarding higher education for elementary and middle or junior high school students as required by the Texas Education Code, §33.007, and to provide annual counseling on higher education for high school students. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(1) should be modified to accurately reflect the degree, certification, and training options within postsecondary education rather than specific fields of study. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(2) should be edited to more accurately describe the curriculum options and benefits associated with the more rigorous graduation plans. The TCA also submitted a recommended change to the rule text that specifies the types of graduation plans.

Agency Response. The agency disagrees with specifying the types of graduation plans in 19 TAC §61.1071. However, the agency agrees that §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(4) should be amended to reference "strategies to manage the cost of higher education" rather than "financial aid eligibility" to ensure that information on opportunities to reduce the cost of higher education such as dual enrollment, advanced placement courses, and extracurricular activities are provided to students and their parents or guardians. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(4) should be revised to add information on the timelines, cost, and consequences for dropping college courses. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(5) should be expanded to require that information and assistance on how to apply to college as well as how to apply for financial aid is provided. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(6) should be broadened to include resources from other state agencies in addition to the Texas Higher Education Coordinating Board and to delete references to specific programs that may no longer exist or may change over time. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(7) should be amended to add information on the academic requirements for ad-

mission to four-year institutions of higher education. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

Comment. The TCA commented that subsection (b)(8) should be revised to include provision of information on all state-based financial assistance programs and remove the delineation of requirements for the Texas Grant Program, which may change over time. The TCA also submitted recommended changes to the rule text.

Agency Response. The agency agrees that 19 TAC §61.1071 should be amended to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities. At a later date, the specific comment, including the suggested rule text changes, will be considered for possible inclusion in an amendment to §61.1071.

At a later date, the TEA plans to propose changes to Subchapter GG to reflect more current statutory language in areas such as higher education, curriculum, financial aid requirements, or best practices in counseling students on postsecondary opportunities.

Relating to the review of 19 TAC Chapter 61, Subchapter HH, the TEA finds that the reasons for adopting Subchapter HH continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter HH. At a later date, the TEA plans to propose changes to remove an expiration date and update language related to dispute resolution.

Relating to the review of 19 TAC Chapter 61, Subchapter II, the TEA finds that the reasons for adopting Subchapter II continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter II. No changes are necessary as a result of the review.

Relating to the review of 19 TAC Chapter 61, Subchapter JJ, the TEA finds that the reasons for adopting Subchapter JJ continue to exist and readopts the rules. The TEA received no comments related to the review of Subchapter JJ. No changes are necessary as a result of the review.

This concludes the review of 19 TAC Chapter 61.

TRD-201006957
Cristina De La Fuente-Valadez
Director, Policy Coordination
Texas Education Agency
Filed: December 8, 2010

♦ ♦ ♦

State Securities Board

Title 7, Part 7

Pursuant to the notice of proposed rule review published in the September 3, 2010, issue of the *Texas Register* (35 TexReg 8141), the State Securities Board (Board) has reviewed and considered for readoption, revision, or repeal, all sections of the following chapters of Title 7, Part 7, of the Texas Administrative Code, in accordance with Texas Government Code, §2001.039: Chapter 101, General Administration; Chapter 103, Rulemaking Procedure; and Chapter 104, Procedure for Review of Applications.

The Board considered, among other things, whether the reasons for adoption of these rules continue to exist. After its review, the Board finds that the reasons for adopting these rules continue to exist and readopts this chapter, without changes, pursuant to the requirements of the Texas Government Code.

As part of the review process, the Board is proposing to amend §§101.5, 101.6, and 104.6. Notices of the proposed amendments will be published in the "Proposed Rules" section of a future issue of the *Texas Register,* in accordance with the Administrative Procedure Act, Texas Government Code Annotated, Chapter 2001.

No comments were received regarding the readoption of Chapters 101, 103, or 104.

This concludes the review of 7 TAC Chapters 101, 103, and 104.

TRD-201006837
Denise Voigt Crawford
Securities Commissioner
State Securities Board
Filed: December 2, 2010

♦ ♦ ♦

TABLES & GRAPHICS

Graphic images included in rules are published separately in this tables and graphics section. Graphic images are arranged in this section in the following order: Title Number, Part Number, Chapter Number and Section Number.

Graphic images are 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: 19 TAC §109.1101(d)(1)

Financial Solvency Review Methodology

Critical Indicators for School Districts	Determination of Category Flags	Final Determination of School Districts to Review for Potential Financial Insolvency
Student-to-Staff Ratio Outside the Norm or Declining		
-If WADA-to-all-staff ratio less than 85% of mean ratio for group	Any yes causes a "Yes" flag for this category	
-If WADA-to-all-staff ratio declined by more than 7% from prior year		
-If enrollment-to-teacher ratio less than 85% of mean ratio for group		
-If enrollment-to-teacher ratio declined by more than 7% from prior year		
General Fund Expenditures Exceeding Revenues		• Any district with 3 or more flags
-If expenditures exceed revenues by more than 6%	Any yes causes a "Yes" flag for this category	• Any district with 2 or more flags and a fund balance less than 12.5% (1½ months) of the district's general fund expenditures
-If expenditures exceed revenues by more than 4% and exceeded revenues by more than 3% in the prior year		• Any district with the fund balance flag and one other flag
-If expenditures exceed revenues by any amount *and* the district has a prior year end-of-year fund balance that has declined from the year before and that is less than 4% of the district's general fund expenditures		• Any district with a fund balance less than 1% of general fund expenditures
Actual Expenditures Consistently Exceeding Budgeted Expenditures (Inability to Stay Within Budget)		
-If actual expenditures exceeded budgeted expenditures by more than 10% in the prior year	Any yes causes a "Yes" flag for this category	
-If actual expenditures exceeded budgeted expenditures by more than 6% in the prior year and actual expenditures exceeded budgeted expenditures by more than 4% two years prior		
Declining or Low General Fund Unreserved* Fund Balance		
-If the prior year end-of-year fund balance has declined from the year before and the fund balance is less than 6.25% of the district's general fund expenditures	Any yes causes a "Yes" flag for this category	
-If the prior year end-of-year fund balance has declined from the year before by more than 25% and the fund balance is less than 12.5% (1½ months) of the district's general fund expenditures		
-If the prior year end-of-year fund balance is less than 1% of the district's general fund expenditures		

**The term "unreserved" will be replaced by the term "assigned and unassigned," effective beginning with fiscal year 2010–2011 data.*

Financial Solvency Review Methodology

Critical Indicators for Open-Enrollment Charter Schools	Determination of Category Flags	Final Determination of Charter Schools to Review for Potential Financial Insolvency
Student-to-Staff Ratio Outside the Norm or Declining		
-If WADA-to-all-staff ratio less than 70% of mean ratio for group	Any yes causes a "Yes" flag for this category	• Any charter school with the net working capital balance flag and at least one other flag • Any charter school with a net working capital balance less than 1% of expenditures
-If WADA-to-all-staff ratio is less than mean ratio for group and WADA-to-all-staff ratio declined by more than 10% from prior year		
General Fund Expenditures Exceeding Revenues		
-If expenditures** exceed revenues by more than 8%	Any yes causes a "Yes" flag for this category	
-If expenditures exceed revenues by more than 6% and exceeded revenues by more than 4% in the prior year		
-If expenditures exceed revenues by more than 5% *and* the charter school has a prior year end-of-year net working capital balance* that has declined from the year before by more than 20% and that is less than 4% of general fund expenditures for the charter school		
Declining or Low Net Working Capital Balance*		
-If the prior year end-of-year net working capital balance has declined from the year before by more than 50% and the net working capital balance is less than 6% of the general fund expenditures for the charter school	Any yes causes a "Yes" flag for this category	
-If the prior year end-of-year net working capital balance is less than 1% of the general fund expenditures for the charter school		

** The net working capital balance (equivalent to a school district's general fund unreserved*** fund balance) is defined as current assets minus current liabilities.*

*** For charter schools, general fund expenditures do not include depreciation expenses.*

**** The term "unreserved" will be replaced by the term "assigned and unassigned," effective beginning with fiscal year 2010–2011 data.*

Financial Solvency Review Methodology

School District Mean Student-to-Staff Ratios

Group (Number of WADA or Enrolled Students)	Mean WADA-to-All-Staff Ratio	85% of Mean WADA-to-All-Staff Ratio	Mean Enrollment-to-Teacher Ratio	85% of Mean Enrollment-to-Teacher Ratio
Under 100	11.71	9.95	8.39	7.13
100 to 249	11.55	9.82	9.48	8.06
250 to 499	11.97	10.18	10.73	9.12
500 to 999	12.35	10.50	11.48	9.76
1,000 to 1,599	11.93	10.14	12.45	10.58
1,600 to 2,999	11.83	10.06	13.52	11.50
3,000 to 4,999	12.05	10.24	14.29	12.15
5,000 to 9,999	12.24	10.40	14.80	12.58
10,000 to 24,999	12.60	10.71	14.88	12.65
25,000 to 49,999	12.75	10.83	15.01	12.76
50,000 and Over	12.99	11.04	15.06	12.80

Charter School Mean Student-to-Staff Ratios

Group (Number of WADA)	Mean WADA-to-All-Staff Ratio	85% of Mean WADA-to-All-Staff Ratio
Under 100	12.87	10.94
100 to 249	12.93	10.99
250 to 499	14.25	12.11
500 to 999	15.16	12.89
1,000 to 1,599	14.92	12.68
1,600 to 2,999	15.56	13.22
3,000 to 4,999	16.32	13.87
5,000 to 9,999	16.96	14.42

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 issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Texas Department of Agriculture

Notice of No Incentive Awards Under the Texas Equine Incentive Program for Calendar Year 2011; Notice of Program Fee for Calendar Year 2011

Pursuant to 4 TAC Part 1, Chapter 17, Subchapter I, §17.507 (relating to Establishment of Incentive Awards), the Texas Department of Agriculture (the department) is providing notice that there will be no equine incentive awards for owners of eligible foals under the department's Texas Equine Incentive Program (TEIP) for the 2011 calendar year. As noted on the department's website, at the present time, the Texas Legislature has not granted the Department the necessary legislative authority to disperse TEIP funds. Based on current TEIP participation, it is anticipated that foals paid into the program as reflected in the 2010 breeding reports will begin to receive the first incentive payouts commencing in January 2013 if the legislative authority is granted.

Pursuant to 4 TAC Part 1, Chapter 17, Subchapter I, §17.504(b) (relating to Breeding Report; Program Fee), the department has set the program fee for the 2011 calendar year at $30 per mare bred.

Eligible breed associations and owners of eligible foals may obtain further information by contacting Amanda Lyles, TEIP Program Coordinator, P.O. Box 12847, Austin, Texas 78711.

TRD-201006934
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: December 7, 2010

♦ ♦ ♦

Office of the Attorney General

Notice of Settlement of a Texas Water Code Enforcement Action

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Water Code and the Texas Health and Safety Code. Before the State may settle a judicial enforcement action, pursuant to the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Code.

Case Title and Court: Settlement Agreement in *Harris County, Texas and State of Texas v. Joel Gonzalez, Eva Gonzalez, and Atlantic Waste, Inc.;* Cause No. 2009-47757; in the 333rd Judicial District, Harris County District Court.

Background: This suit alleges violations of the rules promulgated by the Texas Commission on Environmental Quality under the Texas Health and Safety Code related to the storage and processing of municipal solid waste. The Defendants are Joel Gonzalez, Eva Gonzalez, and Atlantic Waste, Inc. The suit seeks civil penalties, injunctive relief, attorney's fees, and court costs.

Nature of the Settlement: The settlement awards $25,000 in civil penalties to be divided between Harris County and the State of Texas, $6,000 in attorney's fees and court costs for the State of Texas, and $5,000 in attorney's fees and court costs for Harris County. The Judgment also awards injunctive relief against the Defendants.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment and written comments on the proposed settlement should be directed to Mark Steinbach, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, MC-018, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

For information regarding this publication, contact Zindia Thomas, Agency Liaison, at (512) 936-9901.

TRD-201006936
Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: December 7, 2010

♦ ♦ ♦

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. Requests for federal consistency review were deemed administratively complete for the following project(s) during the period of November 19, 2010, through November 26, 2010. 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 extends 30 days from the date published on the Coastal Coordination Council web site. The notice was published on the web site on December 8, 2010. The public comment period for this project will close at 5:00 p.m. on January 7, 2011.

FEDERAL AGENCY ACTIONS:

Applicant: Port of Bay City Authority of Matagorda County; Location: The project site is located in the Gulf Intracoastal Waterway (GIWW) on South Gulf Road, in Matagorda, Matagorda County, Texas. The project can be located on the U.S.G.S. quadrangle map titled: Matagorda, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone 14; Easting: 798383; Northing: 3178515. Project Description: The applicant proposes to construct a barge terminal

and commercial fishing vessel facility. Such activities include a 200-foot-wide entrance channel dredged to a depth of -12 feet (NAVD 88), a jetty platform, bulkhead, haul-out and repair area, stowing area, cold storage, barge and commercial fishing vessel basins, and above-ground storage and supply services. Construction includes site clearing, associated excavation and fill, construction of associated structures for mooring and berthing, construction of a levee along the east side of the property, shoreline and slope stabilization, and temporary construction measures as needed. The discharge of sand/silt fill material is proposed for the slope protection along the entrance channel and levee construction. Excavation of material is proposed for the construction of the barge and commercial fishing vessel basins. Approximately 85,000 cubic yards of material will be permanently discharged into jurisdictional waters of the U.S. In addition, approximately 404,000 cubic yards of material will be excavated as a result of this construction. Material will be placed on-site as needed and in the construction of the levee along the east side of the property. Any remaining material will be placed in an approved Dredged Material Placement Area (DMPA). Approximately 0.94 acres of jurisdictional waters of the U.S. will be permanently filled and 8.09 acres will be excavated. The project was previously coordinated by public notice on 1 June 2010. Direct impacts exceeding three acres mandate a re-issue of the notice with Tier II evaluation criteria, revised drawings and previous agency comments. CMP Project No.: 11-0195-F1. Type of Application: U.S.A.C.E. permit application #SWG-2010-00284Rev2 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Hilcorp Energy Company; Location: The project is located in wetlands and open water adjacent to Venado Creek, approximately 9.2 miles northeast of Port Lavaca, in Jackson County, Texas. The project can be located on the U.S.G.S. quadrangle map entitled: Point Comfort, Texas. Approximate UTM Coordinates in NAD 27 (meters): Zone 14; Easting: 734019; Northing: 3182226.7. Project Description: The applicant proposes to amend the Department of Army (DA) Permit No. SWG-2009-00678 for the expansion of the previously authorized area in order to accommodate two more exploratory wells. The applicant is thereby utilizing the built site and adding a minimum 200-foot-wide by 226-foot-long area drill pad in order to safely drill the wells, the Ramon Musquiz, Abstract No. 59, West Ranch Gas Unit 1, No. 18 Well and No. 19 Well. The previously authorized work has been completed as depicted on sheet 4 of 4 of the proposed amendment plans. This amendment will ultimately impact approximately 1 acre of additional jurisdictional waters of the United States, including wetlands. Specifically, approximately 0.4 acres of tidally-influenced, emergent wetlands/mudflats and 0.64 acres of open water will be filled for the installation of the additional exploratory wells. CMP Project No.: 11-0198-F1. Type of Application: U.S.A.C.E. permit application #SWG-2009-00678 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403) and §404 of the Clean Water Act (33 U.S.C.A. §1344).

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 or activity 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 on the applications listed above, including a copy of the consistency certifications or consistency determinations for inspection may be obtained from Ms. Kate Zultner, Consistency Review Specialist, Coastal Coordination Council, P.O. Box 12873, Austin, Texas 78711-2873, or via email at kate.zultner@glo.texas.gov. Comments should be sent to Ms. Zultner at the above address or by email.

TRD-201006861
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: December 3, 2010

♦ ♦ ♦

Comptroller of Public Accounts

Notice of Contract Award

The Comptroller of Public Accounts (Comptroller) announces this notice of award for fiscal note consulting services under Request for Proposals (RFP) 199a. The RFP was published in the September 10, 2010, issue of the *Texas Register* (35 TexReg 8425).

The contract was awarded to Tim S. Wooten, 409 Wilson Ranch Road. Cypress Mill, Texas 78663. The total amount of the contract is not to exceed $73,935.00. The term of the contract is December 1, 2010 through August 31, 2011, with option to renew for one additional one-year term.

TRD-201006867
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: December 3, 2010

♦ ♦ ♦

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, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/13/10 - 12/19/10 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/13/10 - 12/19/10 is 18% for Commercial over $250,000.

The monthly ceiling as prescribed by §303.005[3] for the period of 12/01/10 - 12/31/10 is 18% for Consumer/Agricultural/Commercial/credit through $250,000.

The monthly ceiling as prescribed by §303.005 for the period of 12/01/10 - 12/31/10 is 18% for Commercial over $250,000.

[1]Credit for personal, family or household use.

[2]Credit for business, commercial, investment or other similar purpose.

[3]For variable rate commercial transactions only.

TRD-201006938
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: December 7, 2010

♦ ♦ ♦

Deep East Texas Council of Governments

Request for Proposals - Capacity Building Training Consultant

I. Overview

The Deep East Texas Council of Governments (DETCOG) is now accepting bids for our OneStar NPO Capacity Building Project for a training consultant. Bid documents may be obtained at www.detcog.org.

II. Obtaining full Request for Proposals (RFP) and Submission Information

The full RFP can be obtained at http:detcog.org or by contacting:

Danielle Sells, Criminal Justice Director

Phone (409) 384-5704 ext. 253

Fax (409) 384-5391

E-mail: dsells@detcog.org

Submission is due to DETCOG no later than 5:00 p.m. on December 31, 2010.

TRD-201006862
Walter G. Diggles
Executive Director
Deep East Texas Council of Governments
Filed: December 3, 2010

♦ ♦ ♦

Request for Proposals - Purchase of Automated Fingerprint Identification Verification System

I. Overview

The Deep East Texas Council of Governments (DETCOG) is now accepting bids for our COPS Technology Program for the purchase of Automated Fingerprint Identification System - Verification System. Bid documents may be obtained at www.detcog.org.

II. Obtaining full Request for Proposals (RFP) and submission information

The full RFP can be obtained at http:detcog.org or by contacting:

Danielle Sells, Criminal Justice Director

Phone (409) 384-5704 ext.253

Fax (409) 384-5390

E-mail: dsells@detcog.org

Submission is due to DETCOG no later than 5:00 p.m. on December 31, 2010.

TRD-201006868
Walter G. Diggles
Executive Director
Deep East Texas Council of Governments
Filed: December 3, 2010

♦ ♦ ♦

Request for Proposals - Purchase of Live-Capture Single-Finger Identity Verification System

I. Overview

The Deep East Texas Council of Governments (DETCOG) is now accepting bids for our COPS Technology Program for the purchase of Live-Capture Single-Finger Identity Verification System. Bid documents may be obtained at www.detcog.org.

II. Obtaining full Request for Proposals (RFP) and submission Information

The full RFP can be obtained at http:detcog.org or by contacting:

Danielle Sells, Criminal Justice Director

Phone (409) 384-5704 ext.253

Fax (409) 384-5390

E-mail: dsells@detcog.org

Submission is due to DETCOG no later than 5:00 p.m. on December 31, 2010.

TRD-201006869
Walter G. Diggles
Executive Director
Deep East Texas Council of Governments
Filed: December 3, 2010

♦ ♦ ♦

Request for Proposals - Purchase of Live-Capture Single-Fingerprint Identification Systems

I. Overview

The Deep East Texas Council of Governments (DETCOG) is now accepting bids for our COPS Technology Program for the purchase of Live-Capture Single-Fingerprint (2-Finger) Identification Systems. Bid documents may be obtained at www.detcog.org.

II. Obtaining full Request for Proposals (RFP) and submission information

The full RFP can be obtained at http:detcog.org or by contacting:

Danielle Sells, Criminal Justice Director

Phone (409) 384-5704 ext.253

Fax (409) 384-5390

E-mail: dsells@detcog.org

Submission is due to DETCOG no later than 5:00 p.m. on December 31, 2010.

TRD-201006866
Walter G. Diggles
Executive Director
Deep East Texas Council of Governments
Filed: December 3, 2010

♦ ♦ ♦

Request for Proposals - Purchase of Mobile Identification Systems

I. Overview

The Deep East Texas Council of Governments (DETCOG) is now accepting bids for our COPS Technology Program for the purchase of Mobile Identification Systems. Bid documents may be obtained at www.detcog.org.

II. Obtaining full Request for Proposals (RFP) and submission Information

The full RFP can be obtained at http:detcog.org or by contacting:

Danielle Sells, Criminal Justice Director

Phone (409) 384-5704 ext.253

Fax (409) 384-5390

E-mail: dsells@detcog.org

Submission is due to DETCOG no later than 5:00 p.m. on December 31, 2010.

TRD-201006863
Walter G. Diggles
Executive Director
Deep East Texas Council of Governments
Filed: December 3, 2010

♦ ♦ ♦

Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (the Code), §7.075. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **January 17, 2011.** Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on January 17, 2011.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Alon USA, LP; DOCKET NUMBER: 2010-1640-AIR-E; IDENTIFIER: RN100250869; LOCATION: Big Spring, Howard County; TYPE OF FACILITY: petroleum refinery; RULE VIOLATED: 30 Texas Administrative Code (TAC) §122.145(2)(C), Federal Operating Permit (FOP) Number O-01505, General Terms and Conditions (GTC), and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit a semi-annual deviation report; PENALTY: $4,200; ENFORCEMENT COORDINATOR: Carlie Konkol, (512) 239-0735; REGIONAL OFFICE: 3300 North A Street, Building 4-107, Midland, Texas 79705-5406, (432) 570-1359.

(2) COMPANY: City of Ballinger; DOCKET NUMBER: 2010-1601-PWS-E; IDENTIFIER: RN101409928; LOCATION: Runnels County; TYPE OF FACILITY: public water supply (PWS); RULE VIOLATED: 30 TAC §290.46(d)(2)(B) and §290.110(b)(4), by failing to operate the disinfection equipment to maintain a minimum disinfectant residual of 0.5 milligrams per liter (mg/L) total chlorine; PENALTY: $343; ENFORCEMENT COORDINATOR: Katy Schumann, (512) 239-2602; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(3) COMPANY: City of Bellevue; DOCKET NUMBER: 2010-1287-MWD-E; IDENTIFIER: RN101720779; LOCATION: Clay County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0011235003, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with permitted effluent limitations for biochemical oxygen demand and total suspended solids; PENALTY: $3,240; ENFORCEMENT COORDINATOR: Martha Hott, (512) 239-2587; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(4) COMPANY: Best Petroleum Explorations, Inc.; DOCKET NUMBER: 2010-1878-WR-E; IDENTIFIER: RN106004435; LOCATION: Jack County; TYPE OF FACILITY: water rights; RULE VIOLATED: the Code, §11.081 and §11.121, by impounding, diverting, or using state water without a required permit; PENALTY: $350; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(5) COMPANY: Bownds Construction, Inc.; DOCKET NUMBER: 2010-1866-WQ-E; IDENTIFIER: RN105520324; LOCATION: Randall County; TYPE OF FACILITY: storm water; RULE VIOLATED: 30 TAC §281.25(a)(4), by failing to obtain a construction general permit; PENALTY: $700; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(6) COMPANY: Cerrito Gas Processing, L.L.C.; DOCKET NUMBER: 2010-1454-AIR-E; IDENTIFIER: RN102521150; LOCATION: Webb County; TYPE OF FACILITY: natural gas processing plant; RULE VIOLATED: 30 TAC §116.110(a)(1) and THSC, §382.085(b), by failing to obtain permit authorization; 30 TAC §106.512(2)(C)(i) and THSC, §382.085(b), by failing to replace the oxygen sensors on generator one and two; 30 TAC §101.211(a) and THSC, §382.085(b), by failing to notify the commission within ten days, or as soon as practicable, prior to any scheduled maintenance, startup, or shutdown activity that is expected to cause an unauthorized emission; and 30 TAC §101.201(a)(1)(B) and THSC, §382.085(b), by failing to report an emissions event within 24 hours after the discovery; PENALTY: $12,355; ENFORCEMENT COORDINATOR: Kirk Schoppe, (512) 239-0489; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(7) COMPANY: Henry M. Garza dba Cielo Azul Ranch; DOCKET NUMBER: 2010-0020-PWS-E; IDENTIFIER: RN101217792; LOCATION: Wimberley, Hays County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.46(f)(2), (3)(A)(i)(III), (ii)(III), (iv), (B)(v), and (D)(ii), by failing to provide facility records to commission personnel at the time of the record review; 30 TAC §290.46(i), by failing to adopt an adequate plumbing ordinance, regulations, or service agreement with provisions for proper enforcement to ensure that neither cross-connections nor other unacceptable plumbing practices are permitted; 30 TAC §290.121(a) and (b), by failing to maintain an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations; 30 TAC §290.47(e), by failing to issue a boil water notification within 24 hours of a water outage; 30 TAC §290.46(m)(6), by failing to initiate maintenance and housekeeping practices at the facility to ensure the good working condition and appearance of its facilities and equipment and by failing to maintain the service pump in good working condition; 30 TAC §290.43(c), by failing to maintain the exterior coating on the ground storage tanks in accordance with American Water Works Association standards; and 30 TAC §290.46(v), by failing to ensure that all electrical wiring is securely installed in compliance with a local or national electrical

code; PENALTY: $2,096; ENFORCEMENT COORDINATOR: Amanda Henry, (713) 767-3500; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(8) COMPANY: CIRCLE BAR TRUCK CORRAL, INC.; DOCKET NUMBER: 2010-1554-PST-E; IDENTIFIER: RN102010519; LOCATION: Ozona, Crockett County; TYPE OF FACILITY: facility with retail sales of fuel; RULE VIOLATED: 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for all underground storage tanks (USTs); 30 TAC §334.50(d)(1)(B)(ii) and the Code, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records at least once each month; and 30 TAC §334.50(d)(1)(B)(iii)(I) and the Code, §26.3475(c)(1), by failing to record inventory volume measurement for the regulated substance inputs, withdrawals, and the amount still remaining in the tank each operating day; PENALTY: $13,000; ENFORCEMENT COORDINATOR: Keith Frank, (512) 239-1203; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(9) COMPANY: Devon Gas Services, L.P.; DOCKET NUMBER: 2010-1284-AIR-E; IDENTIFIER: RN102700176; LOCATION: Rhome, Wise County; TYPE OF FACILITY: natural gas compressor station; RULE VIOLATED: 30 TAC §116.110(a) and THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization to operate facilities which emit air contaminants; PENALTY: $7,500; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(10) COMPANY: Enterprise Products Operating, LLC; DOCKET NUMBER: 2010-1465-AIR-E; IDENTIFIER: RN102323268; LOCATION: Mont Belvieu, Chambers County; TYPE OF FACILITY: hydrocarbon processing plant; RULE VIOLATED: 30 TAC §116.715(a), Flexible Permit Numbers 76070 and PSD-TX-1057, Special Condition (SC) Number 1, by failing to prevent unauthorized emissions; and 30 TAC §101.201(a)(2)(G) and THSC, §382.085(b), by failing to identify for each emissions point the estimated total quantities of the individually listed compounds or mixtures of air contaminants released during an emissions event; PENALTY: $6,448; ENFORCEMENT COORDINATOR: Roshondra Lowe, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(11) COMPANY: Greenacres Grocery, Inc.; DOCKET NUMBER: 2010-1597-PST-E; IDENTIFIER: RN101914679; LOCATION: Beaumont, Jefferson County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.244(1) and (3) and THSC, §382.085(b), by failing to conduct daily and monthly inspections of the Stage II vapor recovery system; and 30 TAC §115.246(1), (3), and (4) and THSC, §382.085(b), by failing to maintain all required Stage II records at the station and make them immediately available for review; PENALTY: $2,408; ENFORCEMENT COORDINATOR: Wallace Myers, (512) 239-6580; REGIONAL OFFICE: 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(12) COMPANY: H & H Iron and Metal, Inc.; DOCKET NUMBER: 2010-1262-MLM-E; IDENTIFIER: RN105710552; LOCATION: Corpus Christi, Nueces County; TYPE OF FACILITY: scrap metal recycling yard; RULE VIOLATED: 30 TAC §335.2(a) and §335.4(1) and the Code, §26.121, by failing to prevent unauthorized collection, handling, storage, processing, or disposal and by failing to manage industrial sold waste; and 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste; PENALTY: $8,250; ENFORCEMENT COORDINATOR: Gena Hawkins, (512) 239-2583; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5839, (361) 825-3100.

(13) COMPANY: Hanson Brick East, LLC; DOCKET NUMBER: 2010-1470-AIR-E; IDENTIFIER: RN102315827; LOCATION: Mineral Wells, Palo Pinto County; TYPE OF FACILITY: brick and structural clay tile manufacturing plant; RULE VIOLATED: 30 TAC §122.143(4) and §122.146(1) and (2), FOP Number O-01692, GTC and Special Terms and Conditions (STC) Number 6, and THSC, §382.085(b), by failing to timely submit the Title V permit annual compliance certification; PENALTY: $2,500; ENFORCEMENT COORDINATOR: Jorge Ibarra, (817) 588-5800; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(14) COMPANY: Houston Refining, LP; DOCKET NUMBER: 2010-1315-AIR-E; IDENTIFIER: RN100218130; LOCATION: Houston, Harris County; TYPE OF FACILITY: petroleum refinery; RULE VIOLATED: 30 TAC §101.20(3) and §116.715(a), Flexible Permit Numbers 2167 and PSD-TX-985, SC Number 1, and THSC, §382.085(b), by failing to properly replace a strainer in the 536 Crude Unit; PENALTY: $10,000; Supplemental Environmental Project (SEP) offset amount of $4,000 applied to Barbers Hill Independent School District-Alternative Fueled Vehicle and Equipment Program; ENFORCEMENT COORDINATOR: Miriam Hall, (512) 239-1044; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(15) COMPANY: INEOS USA, LLC; DOCKET NUMBER: 2010-1059-AIR-E; IDENTIFIER: RN100238708; LOCATION: Alvin, Brazoria County; TYPE OF FACILITY: petrochemical plant; RULE VIOLATED: 30 TAC §§101.20(1), 116.115(c), 116.715(a) and 115.722(c)(2), Permit Numbers 95 and 19868, SC Number 1 and 8.B., and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $70,000; SEP offset amount of $35,000 applied to Brazoria County - Brazoria County Vehicle and Equipment Program; ENFORCEMENT COORDINATOR: Miriam Hall, (512) 239-1044; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(16) COMPANY: George Philip Meyer; DOCKET NUMBER: 2010-1389-PST-E; IDENTIFIER: RN102042421; LOCATION: Eldorado, Schleicher County; TYPE OF FACILITY: USTs; RULE VIOLATED: 30 TAC §334.7(d)(3), by failing to notify the agency of any change or additional information regarding the USTs; 30 TAC §334.49(a) and the Code, §26.3475(d), by failing to provide proper corrosion protection for the UST system; 30 TAC §334.49(c)(2)(C) and the Code, §26.3475(d), by failing to inspect the impressed current cathodic protection system at least once every 60 days to ensure that the rectifier and other system components are operating properly; 30 TAC §334.49(c)(4)(C) and the Code, §26.3475(d), by failing to have the cathodic protection system inspected and tested for operability and adequacy of protection; 30 TAC §334.8(c)(5)(C), by failing to ensure that a legible tag, label, or marking with the tank number is permanently applied upon or affixed to either the top of the fill tube or to a nonremovable point in the immediate area of the fill tube; and 30 TAC §334.42(i), by failing to inspect at least once every 60 days, any sumps, manways, overfill containers, or catchment basins; PENALTY: $6,437; ENFORCEMENT COORDINATOR: Wallace Myers, (512) 239-6580; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7035, (325) 655-9479.

(17) COMPANY: MIMS MEAT COMPANY, INC. dba Mims Meat Company; DOCKET NUMBER: 2010-1483-PST-E; IDENTIFIER: RN101818029; LOCATION: Houston, Harris County; TYPE OF FACILITY: meat company with fleet refueling; RULE VIOLATED: 30 TAC §334.49(a)(1) and the Code, §26.3475(d), by failing to provide proper corrosion protection for the UST system; and 30 TAC §334.50(b)(1)(A) and the Code, §26.3475(c)(1), by failing to monitor USTs for releases; PENALTY: $4,500; ENFORCEMENT

COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(18) COMPANY: Brad Archer dba Mullins Mobile Home Park; DOCKET NUMBER: 2010-1472-PWS-E; IDENTIFIER: RN102682044; LOCATION: Denton, Denton County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.46(d)(2)(a) and §290.110(b)(4), by failing to operate the disinfection equipment to maintain a free chlorine residual of 0.2 mg/L throughout the distribution system; PENALTY: $180; ENFORCEMENT COORDINATOR: Andrea Linson-Mgbeoduru, (512) 239-1482; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(19) COMPANY: Noltex, L.L.C.; DOCKET NUMBER: 2010-1386-AIR-E; IDENTIFIER: RN101049581; LOCATION: La Porte, Harris County; TYPE OF FACILITY: chemical manufacturing plant; RULE VIOLATED: 30 TAC §§116.115(b)(2)(F), 117.310(c)(1), and 122.143(4), Standard Permit Number 88301, FOP Number O-01301, STC Number 8, and THSC, §382.085(b), by failing to comply with the permitted emission rate for nitrogen oxides, carbon monoxide, and volatile organic compounds; PENALTY: $6,200; ENFORCEMENT COORDINATOR: Nadia Hameed, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(20) COMPANY: PANOLA-BETHANY WATER SUPPLY CORPORATION; DOCKET NUMBER: 2010-1451-MLM-E; IDENTIFIER: RN101454726; LOCATION: Panola County; TYPE OF FACILITY: PWS; RULE VIOLATED: 30 TAC §290.41(c)(3)(J), by failing to provide a concrete sealing block; 30 TAC §290.46(f)(2), (3)(A)(vi), (B)(ii), and (D)(vii), by failing to provide facility records to commission personnel at time of an investigation; 30 TAC §290.46(m)(2), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the facility and its equipment; 30 TAC §290.46(s)(1), by failing to calibrate the flow measuring devices once every three years; 30 TAC §290.46(t), by failing to post a legible sign at each production, treatment, and storage facility that contains the name of the facility and an emergency telephone number; and 30 TAC §290.42(i) and the Code, §26.121(a), by failing to obtain a discharge permit prior to any discharge of wastewater; PENALTY: $3,014; ENFORCEMENT COORDINATOR: Katy Schumann, (512) 239-2602; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(21) COMPANY: Plant Process Equipment, Inc.; DOCKET NUMBER: 2010-1291-AIR-E; IDENTIFIER: RN102421054; LOCATION: League City, Galveston County; TYPE OF FACILITY: metal fabrication shop; RULE VIOLATED: 30 TAC §106.452(1)(A) and THSC, §382.085(b), by failing to comply with the conditions of standard exemption 102 for enclosed dry abrasive cleaning; and 30 TAC §116.110(a) and THSC, §382.0518(a) and §382.085(b), by failing to obtain a permit-by-rule authorization to conduct surface coating operations at the plant; PENALTY: $1,530; SEP offset amount of $612 applied to Galveston Bay Foundation - "Marsh Mania"; ENFORCEMENT COORDINATOR: Nadia Hameed, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(22) COMPANY: PPG Industries, Inc.; DOCKET NUMBER: 2010-1413-WR-E; IDENTIFIER: RN102522950; LOCATION: Wichita Falls, Wichita County; TYPE OF FACILITY: flat glass manufacturing; RULE VIOLATED: 30 TAC §297.11 and the Code, §11.121, by failing to obtain a water right authorization prior to diverting, storing, impounding, taking, or using state water; PENALTY: $1,620; ENFORCEMENT COORDINATOR: Merrilee Hupp, (512) 239-4490; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(23) COMPANY: Rhodia, Inc.; DOCKET NUMBER: 2010-1388-AIR-E; IDENTIFIER: RN100220581; LOCATION: Houston, Harris County; TYPE OF FACILITY: sulfuric acid manufacturing plant; RULE VIOLATED: 30 TAC §117.335(a) and §117.9020(2)(C)(i) and THSC, §382.085(b), by failing to conduct a stack test on the Regenerator II Preheater and submit the test report; PENALTY: $1,410; ENFORCEMENT COORDINATOR: Miriam Hall, (512) 239-1044; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(24) COMPANY: Richey Road Municipal Utility District; DOCKET NUMBER: 2010-1569-MWD-E; IDENTIFIER: RN102340767; LOCATION: Harris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: 30 TAC §305.125(1), TPDES Permit Number WQ0012378002, Effluent Limitations and Monitoring Requirements Number 1, and the Code, §26.121(a)(1), by failing to comply with the permitted effluent limitations for ammonia nitrogen; and 30 TAC §305.125(1) and (17) and §319.7(d) and TPDES Permit Number WQ0012378002, Monitoring and Reporting Requirements Number 1, by failing to timely submit the discharge monitoring report; PENALTY: $1,397; ENFORCEMENT COORDINATOR: Jennifer Graves, (956) 425-6010; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(25) COMPANY: RODOS ONE, LLC dba Cypresswood Shell; DOCKET NUMBER: 2010-1317-PST-E; IDENTIFIER: RN104192810; LOCATION: Spring, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form; 30 TAC §334.8(c)(5)(A)(i) and the Code, §26.3467(a), by failing to make available to a common carrier a valid, current delivery certificate; and 30 TAC §115.246(5) and THSC, §382.085(b), by failing to maintain Stage II records at the station; PENALTY: $5,775; ENFORCEMENT COORDINATOR: Cara Windle, (512) 239-2581; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(26) COMPANY: City of San Marcos; DOCKET NUMBER: 2010-1316-EAQ-E; IDENTIFIER: RN105937932; LOCATION: San Marcos, Hays County; TYPE OF FACILITY: construction site; RULE VIOLATED: 30 TAC §213.4(a)(1), by failing to obtain approval of a water pollution abatement plan prior to beginning a regulated activity over the Edwards Aquifer Recharge Zone; PENALTY: $3,750; ENFORCEMENT COORDINATOR: Jordan Jones, (512) 239-2569; REGIONAL OFFICE: 2800 South IH 35, Suite 100, Austin, Texas 78704-5700, (512) 339-2929.

(27) COMPANY: Texas Department of Transportation; DOCKET NUMBER: 2010-0588-WQ-E; IDENTIFIER: RN105812374; LOCATION: Eastland County; TYPE OF FACILITY: construction site; RULE VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations (CFR) §122.26(c), by failing to obtain authorization to discharge storm water associated with construction activities; PENALTY: $3,000; SEP offset amount of $2,400 applied to Texas Association of Resource Conservation and Development Areas, Inc. - Unauthorized Trash Dump Clean-Up; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3100; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(28) COMPANY: The Dow Chemical Company; DOCKET NUMBER: 2010-1279-AIR-E; IDENTIFIER: RN100225945; LOCATION: Freeport, Brazoria County; TYPE OF FACILITY: chemical manu-

facturing plant; RULE VIOLATED: 30 TAC §116.115(c), Air Permit Number 19041, SC Number 1, and THSC, §382.085(b), by failing to prevent unauthorized emissions; PENALTY: $10,000; SEP offset amount of $4,000 applied to Brazoria County - Brazoria County Vehicle and Equipment Program; ENFORCEMENT COORDINATOR: Roshondra Lowe, (713) 767-3500; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(29) COMPANY: Tiger Trailers, Inc.; DOCKET NUMBER: 2010-1642-AIR-E; IDENTIFIER: RN105908024; LOCATION: Cookville, Titus County; TYPE OF FACILITY: utility trailer manufacturing shop; RULE VIOLATED: 30 TAC §116.110(a) and THSC, §382.0518(a) and §382.085(b), by failing to obtain authorization prior to conducting soldering, brazing, welding, and surface coating operations; PENALTY: $750; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

TRD-201006937
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: December 7, 2010

♦ ♦ ♦

Enforcement Orders

An agreed order was entered regarding City of Gustine, Docket No. 2008-1819-MWD-E on November 22, 2010 assessing $65,133 in administrative penalties with $65,133 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An order was entered regarding Eun Bok Lee dba Lee's Chevron, Docket No. 2009-0052-PST-E on November 22, 2010 assessing $4,946 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rudy Calderon, Staff Attorney at (512) 239-0205, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Benbrook Texas Limited Partnership, Docket No. 2009-0628-MWD-E on November 22, 2010 assessing $21,200 in administrative penalties with $17,600 deferred.

Information concerning any aspect of this order may be obtained by contacting Evette Alvarado, Enforcement Coordinator at (512) 239-2573, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Enterprise Hydrocarbons L.P., Docket No. 2009-0778-AIR-E on November 22, 2010 assessing $7,920 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Xavier Guerra, Staff Attorney at (210) 403-4016, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Blue Sky Business Corporation dba Little Buddy 3, Docket No. 2009-1056-PST-E on November 22, 2010 assessing $3,983 in administrative penalties with $796 deferred.

Information concerning any aspect of this order may be obtained by contacting Clinton Sims, Enforcement Coordinator at (512) 239-6933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An order was entered regarding Neal Young, Docket No. 2009-1111-AIR-E on November 22, 2010 assessing $4,080 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Phillip M. Goodwin, Staff Attorney at (512) 239-0675, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding JERRY SPENCER, L.P. dba JJS Fastop 294, Docket No. 2009-1250-PST-E on November 22, 2010 assessing $20,200 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Phillip Goodwin, P.G., Staff Attorney at (512) 239-0675, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Creek Park Corporation, Docket No. 2009-1372-MWD-E on November 22, 2010 assessing $4,750 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Kari L. Gilbreth, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Wolfe City, Docket No. 2009-1387-MWD-E on November 22, 2010 assessing $7,990 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Samuel Short, Enforcement Coordinator at (512) 239-5363, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Eastex Sand & Materials, Inc., Docket No. 2009-1579-MSW-E on November 22, 2010 assessing $10,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Xavier Guerra, Staff Attorney at (210) 403-4016, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Salvador G. Gonzalez dba Gonzalez Dairy, Docket No. 2009-1604-AGR-E on November 22, 2010 assessing $6,600 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Merrilee Hupp, Enforcement Coordinator at (512) 239-4490, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Stiff Creek Mobile Home Park, L.P., Docket No. 2009-1675-PWS-E on November 22, 2010 assessing $6,904 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Marshall Coover, Staff Attorney at (512) 239-0620, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding AMK ENTERPRISES, LLC, Docket No. 2009-1844-MLM-E on November 22, 2010 assessing $2,550 in administrative penalties with $510 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254)

761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chilton Water Supply and Sewer Service Corporation, Docket No. 2009-1910-MWD-E on November 22, 2010 assessing $24,184 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, P.E., Enforcement Coordinator at (817) 588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Santos Barcenas dba Bucketz, Docket No. 2009-1963-PST-E on November 22, 2010 assessing $21,630 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Gary K. Shiu, Staff Attorney at (713) 422-8916, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Rodolfo Santillan, Docket No. 2010-0012-LII-E on November 22, 2010 assessing $250 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Steven M. Fishburn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Monticello Drive Estates, Inc., Docket No. 2010-0021-PWS-E on November 22, 2010 assessing $3,354 in administrative penalties with $670 deferred.

Information concerning any aspect of this order may be obtained by contacting Amanda Henry, Enforcement Coordinator at (713) 767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chemtrade Refinery Services, Inc., Docket No. 2010-0052-AIR-E on November 22, 2010 assessing $8,850 in administrative penalties with $1,770 deferred.

Information concerning any aspect of this order may be obtained by contacting Kirk Schoppe, Enforcement Coordinator at (512) 239-0489, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Kingwood Petroleum, LLC dba Kwik Pantry FFP 3361, Docket No. 2010-0135-PST-E on November 22, 2010 assessing $3,675 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Steven M. Fishburn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Hudson, Docket No. 2010-0152-MWD-E on November 22, 2010 assessing $8,249 in administrative penalties with $1,649 deferred.

Information concerning any aspect of this order may be obtained by contacting Jeremy Escobar, Enforcement Coordinator at (361) 825-3422, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding METRO MART INC., Docket No. 2010-0159-PST-E on November 22, 2010 assessing $4,663 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Phillip M. Goodwin, Staff Attorney at (512) 239-0675, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Rubens Taddei, Docket No. 2010-0170-LII-E on November 22, 2010 assessing $1,244 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Steven M. Fishburn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Jim Broom, Docket No. 2010-0179-PST-E on November 22, 2010 assessing $6,300 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Marshall Coover, Staff Attorney at (512) 239-0620, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding CLAUSSEN'S CREST (SAN ANTONIO) HOMEOWNERS' ASSOCIATION, INC. dba Iron Mountain Ranch Homeowners' Association, Docket No. 2010-0271-EAQ-E on November 22, 2010 assessing $6,000 in administrative penalties with $1,200 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Marhaba Partners Limited Partnership, Docket No. 2010-0291-MWD-E on November 22, 2010 assessing $2,400 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jordan Jones, Enforcement Coordinator at (512) 239-2569, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Julio Cesar Lozano, Docket No. 2010-0362-AGR-E on November 22, 2010 assessing $1,050 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting James Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Jimmy Perdew, Docket No. 2010-0395-MSW-E on November 22, 2010 assessing $1,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Marshall Coover, Staff Attorney at (512) 239-0620, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Dwayne Gray dba Personal Touch Detailing Service, Docket No. 2010-0407-PST-E on November 22, 2010 assessing $4,725 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Marshall Coover, Staff Attorney at (512) 239-0620, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Live Oak Resort, Inc., Docket No. 2010-0411-PWS-E on November 22, 2010 assessing $1,638 in administrative penalties with $327 deferred.

Information concerning any aspect of this order may be obtained by contacting Rebecca Clausewitz, Enforcement Coordinator at (210) 403-4012, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding To Nguyen and Quang Huynh dba John's Quik Stop, Docket No. 2010-0475-PST-E on November 22, 2010 assessing $6,592 in administrative penalties with $1,318 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Pace, Enforcement Coordinator at (817) 588-5933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Semere Ogbazgi dba Hampton Service Station and Tesfaslassie Ogbazgi dba Hampton Service Station, Docket No. 2010-0479-PST-E on November 22, 2010 assessing $3,508 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Phillip M. Goodwin, P.G., Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding George W. Jackson dba Fort Jackson Mobile Estates, Docket No. 2010-0531-PWS-E on November 22, 2010 assessing $2,701 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Peipey Tang, Staff Attorney at (512) 239-0654, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Travis E. Tindol, Jr., Docket No. 2010-0545-PST-E on November 22, 2010 assessing $7,208 in administrative penalties with $1,441 deferred.

Information concerning any aspect of this order may be obtained by contacting Theresa Hagood, Enforcement Coordinator at (512) 239-2540, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding CAMPBELL BUSINESS, INC. dba Conoco Campbell Stop, Docket No. 2010-0546-PST-E on November 22, 2010 assessing $7,105 in administrative penalties with $1,421 deferred.

Information concerning any aspect of this order may be obtained by contacting Clinton Sims, Enforcement Coordinator at (512) 239-6933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding THOMAS & DORIS HUTTO, INC. dba Hutto Garbage Service, Docket No. 2010-0558-MLM-E on November 22, 2010 assessing $14,475 in administrative penalties with $2,895 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator at (817) 588-5825, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SAHIL MANAGEMENT LTD. dba Shady Acres Trailer Park, Docket No. 2010-0572-PWS-E on November 22, 2010 assessing $580 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Amanda Henry, Enforcement Coordinator at (713) 767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Alberto Alba Villarreal, Docket No. 2010-0581-PST-E on November 22, 2010 assessing $5,183 in administrative penalties with $1,036 deferred.

Information concerning any aspect of this order may be obtained by contacting Philip Aldridge, Enforcement Coordinator at (512) 239-0855, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Ranglers Group Inc dba Ranglers, Docket No. 2010-0582-PST-E on November 22, 2010 assessing $9,179 in administrative penalties with $1,835 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Pace, Enforcement Coordinator at (817) 588-5933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ISSN ENTERPRISES, INC. dba Nick's Grocery, Docket No. 2010-0601-PST-E on November 22, 2010 assessing $23,787 in administrative penalties with $4,757 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator at (817) 588-5825, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding McWane, Inc. dba Tyler Pipe Company, Docket No. 2010-0620-AIR-E on November 22, 2010 assessing $73,168 in administrative penalties with $14,633 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator at (210) 403-4006, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Alcoa World Alumina LLC, Docket No. 2010-0633-AIR-E on November 22, 2010 assessing $20,700 in administrative penalties with $4,140 deferred.

Information concerning any aspect of this order may be obtained by contacting Rebecca Johnson, Enforcement Coordinator at (361) 825-3420, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Koch Pipeline Company, L.P., Docket No. 2010-0639-AIR-E on November 22, 2010 assessing $15,000 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Bynum, Docket No. 2010-0646-PWS-E on November 22, 2010 assessing $232 in administrative penalties with $46 deferred.

Information concerning any aspect of this order may be obtained by contacting Amanda Henry, Enforcement Coordinator at (713) 767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding PRITEN YOGESH PATEL, LLC dba Joe's Mart, Docket No. 2010-0650-PST-E on November 22, 2010 assessing $3,525 in administrative penalties with $705 deferred.

Information concerning any aspect of this order may be obtained by contacting Mike Pace, Enforcement Coordinator at (817) 588-5933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding TJSR, INC. dba Sunny Food Mart, Docket No. 2010-0670-PST-E on November 22, 2010 assessing $8,506 in administrative penalties with $1,701 deferred.

Information concerning any aspect of this order may be obtained by contacting Rajesh Acharya, Enforcement Coordinator at (512) 239-0577, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ExxonMobil Oil Corporation, Docket No. 2010-0671-AIR-E on November 22, 2010 assessing $19,200 in administrative penalties with $3,840 deferred.

Information concerning any aspect of this order may be obtained by contacting Raymond Marlow, Enforcement Coordinator at (409) 899-8785, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Cimarex Energy Co., Docket No. 2010-0679-AIR-E on November 22, 2010 assessing $6,536 in administrative penalties with $1,307 deferred.

Information concerning any aspect of this order may be obtained by contacting John Muennink, Enforcement Coordinator at (361) 825-3423, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RICHEY AND MONK GROCERY, INC. dba Thrif-Tee Food Center, Docket No. 2010-0686-PST-E on November 22, 2010 assessing $12,517 in administrative penalties with $2,503 deferred.

Information concerning any aspect of this order may be obtained by contacting Tate Barrett, Enforcement Coordinator at (713) 422-8968, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding David McKee, Docket No. 2010-0694-WR-E on November 22, 2010 assessing $13,115 in administrative penalties with $2,623 deferred.

Information concerning any aspect of this order may be obtained by contacting Jeremy Escobar, Enforcement Coordinator at (361) 825-3422, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding San Pedro Canyon Water Company, Docket No. 2010-0697-PWS-E on November 22, 2010 assessing $474 in administrative penalties with $94 deferred.

Information concerning any aspect of this order may be obtained by contacting Epifanio Villarreal, Enforcement Coordinator at (361) 825-3425, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Benedum Gas Partners, L.P. dba WTG Benedum Joint Venture, Docket No. 2010-0700-AIR-E on November 22, 2010 assessing $3,175 in administrative penalties with $635 deferred.

Information concerning any aspect of this order may be obtained by contacting Gena Hawkins, Enforcement Coordinator at (512) 239-2583, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding D.B. Western, Inc. - Texas, Docket No. 2010-0713-IWD-E on November 22, 2010 assessing $91,135 in administrative penalties with $18,227 deferred.

Information concerning any aspect of this order may be obtained by contacting Thomas Jecha, P.G., Enforcement Coordinator at (512) 239-2576, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ANJU ENTERPRISES, INC. dba Parkway Chevron, Docket No. 2010-0721-PST-E on November 22, 2010 assessing $14,023 in administrative penalties with $2,804 deferred.

Information concerning any aspect of this order may be obtained by contacting Elvia Maske, Enforcement Coordinator at (512) 239-0789, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Kingstreet Investments, LLC dba King Food Mart, Docket No. 2010-0746-PST-E on November 22, 2010 assessing $2,782 in administrative penalties with $556 deferred.

Information concerning any aspect of this order may be obtained by contacting Clinton Sims, Enforcement Coordinator at (512) 239-6933, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SOUTHERN TRI-STAR MARKETS, LTD. dba Texaco Food Mart, Docket No. 2010-0747-PST-E on November 22, 2010 assessing $11,516 in administrative penalties with $2,303 deferred.

Information concerning any aspect of this order may be obtained by contacting Tate Barrett, Enforcement Coordinator at (713) 422-8968, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Formosa Plastics Corporation, Texas, Docket No. 2010-0795-AIR-E on November 22, 2010 assessing $17,950 in administrative penalties with $3,590 deferred.

Information concerning any aspect of this order may be obtained by contacting John Muennink, Enforcement Coordinator at (361) 825-3423, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Stiff Creek Mobile Home Park, L.P., Docket No. 2010-0796-PWS-E on November 22, 2010 assessing $425 in administrative penalties with $85 deferred.

Information concerning any aspect of this order may be obtained by contacting Amanda Henry, Enforcement Coordinator at (713) 767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Premont, Docket No. 2010-0799-PWS-E on November 22, 2010 assessing $3,970 in administrative penalties with $794 deferred.

Information concerning any aspect of this order may be obtained by contacting Epifanio Villarreal, Enforcement Coordinator at (361) 825-3425, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Jewish Community Center of Houston, Texas, Docket No. 2010-0807-PWS-E on November 22, 2010 assessing $2,800 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Stephen Thompson, Enforcement Coordinator at (512) 239-2558, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Samir H. Bhatt dba Seven Days Drive In, Docket No. 2010-0810-PST-E on November 22, 2010 assessing $10,854 in administrative penalties with $2,170 deferred.

Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (713) 767-3682, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Veolia ES Technical Solutions, L.L.C., Docket No. 2010-0811-AIR-E on November 22, 2010 assessing $22,100 in administrative penalties with $4,420 deferred.

Information concerning any aspect of this order may be obtained by contacting Raymond Marlow, Enforcement Coordinator at (409) 899-8785, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Uni-Graphics Printing, Ltd dba The Printing Bureau, Docket No. 2010-0824-AIR-E on November 22, 2010 assessing $22,245 in administrative penalties with $4,449 deferred.

Information concerning any aspect of this order may be obtained by contacting James Nolan, Enforcement Coordinator at (512) 239-6634, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding WTG Jameson, LP, Docket No. 2010-0826-AIR-E on November 22, 2010 assessing $3,825 in administrative penalties with $765 deferred.

Information concerning any aspect of this order may be obtained by contacting James Nolan, Enforcement Coordinator at (512) 239-6634, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Gore's Inc. and Aaron Lee Speck dba Brown-Tex Feedlot, Docket No. 2010-0865-AGR-E on November 22, 2010 assessing $16,147 in administrative penalties with $3,229 deferred.

Information concerning any aspect of this order may be obtained by contacting Samuel Short, Enforcement Coordinator at (512) 239-5363, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Texas Department of Transportation, Docket No. 2010-0873-MWD-E on November 22, 2010 assessing $3,060 in administrative penalties with $612 deferred.

Information concerning any aspect of this order may be obtained by contacting Martha Hott, Enforcement Coordinator at (512) 239-2587, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Duvelsa Hernandez dba Lalos Mini Mart, Docket No. 2010-0877-PST-E on November 22, 2010 assessing $5,265 in administrative penalties with $1,053 deferred.

Information concerning any aspect of this order may be obtained by contacting Rajesh Acharya, Enforcement Coordinator at (512) 239-0577, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Luminant Generation Company LLC, Docket No. 2010-0890-AIR-E on November 22, 2010 assessing $2,025 in administrative penalties with $405 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Hope, Hardwork, And Happiness, Inc. dba HHH 25, Docket No. 2010-0898-PST-E on November 22, 2010 assessing $2,625 in administrative penalties with $525 deferred.

Information concerning any aspect of this order may be obtained by contacting Philip Aldridge, Enforcement Coordinator at (512) 239-0855, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding ISP Synthetic Elastomers LLC, Docket No. 2010-0916-AIR-E on November 22, 2010 assessing $6,325 in administrative penalties with $1,265 deferred.

Information concerning any aspect of this order may be obtained by contacting Audra Benoit, Enforcement Coordinator at (409) 899-8799, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Triangle Waste Solutions, LP, Docket No. 2010-0948-MSW-E on November 22, 2010 assessing $778 in administrative penalties with $155 deferred.

Information concerning any aspect of this order may be obtained by contacting Danielle Porras, Enforcement Coordinator at (713) 737-3682, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding DALLAS SNR, INC. dba Valero Food Mart 6, Docket No. 2010-0961-PST-E on November 22, 2010 assessing $3,803 in administrative penalties with $760 deferred.

Information concerning any aspect of this order may be obtained by contacting Theresa Hagood, Enforcement Coordinator at (512) 239-2540, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Kuraray America, Inc., Docket No. 2010-0962-AIR-E on November 22, 2010 assessing $2,700 in administrative penalties with $540 deferred.

Information concerning any aspect of this order may be obtained by contacting Miriam Hall, Enforcement Coordinator at (512) 239-1044, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Oak Grove Water Supply Corporation, Docket No. 2010-1004-PWS-E on November 22, 2010 assessing $357 in administrative penalties with $71 deferred.

Information concerning any aspect of this order may be obtained by contacting Amanda Henry, Enforcement Coordinator at (713) 767-3672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding SHIN-ETSU SILICONES OF AMERICA, INC., Docket No. 2010-1006-IWD-E on November 22, 2010 assessing $24,875 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting JR Cao, Enforcement Coordinator at (512) 239-2543, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding San Antonio Water System, Docket No. 2010-1007-MWD-E on November 22, 2010 assessing $32,700 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Evette Alvarado, Enforcement Coordinator at (512) 239-2573, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding B & J Water Company, Docket No. 2010-1009-PWS-E on November 22, 2010 assessing $356 in administrative penalties with $71 deferred.

Information concerning any aspect of this order may be obtained by contacting Stephen Thompson, Enforcement Coordinator at (512) 239-2558, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Cowtown RV Park, Ltd, Docket No. 2010-1022-MWD-E on November 22, 2010 assessing $2,146 in administrative penalties with $429 deferred.

Information concerning any aspect of this order may be obtained by contacting Jordan Jones, Enforcement Coordinator at (512) 239-2569, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Armortex, Inc., Docket No. 2010-1073-AIR-E on November 22, 2010 assessing $3,025 in administrative penalties with $605 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator at (210) 403-4006, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Eastland County Water Supply District, Docket No. 2010-1101-MWD-E on November 22, 2010 assessing $4,392 in administrative penalties with $878 deferred.

Information concerning any aspect of this order may be obtained by contacting JR Cao, Enforcement Coordinator at (512) 239-2543, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chai Express Inc., Docket No. 2010-1127-PST-E on November 22, 2010 assessing $3,118 in administrative penalties with $623 deferred.

Information concerning any aspect of this order may be obtained by contacting Jorge Ibarra, P.E., Enforcement Coordinator at (817) 588-5890, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Dril-Quip, Inc., Docket No. 2010-1189-MWD-E on November 22, 2010 assessing $3,360 in administrative penalties with $672 deferred.

Information concerning any aspect of this order may be obtained by contacting Samuel Short, Enforcement Coordinator at (512) 239-5363, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RELIANCE STORE, LLC dba Five Star Food Store, Docket No. 2010-0661-PST-E on November 22, 2010 assessing $5,684 in administrative penalties with $1,136 deferred.

Information concerning any aspect of this order may be obtained by contacting Tate Barrett, Enforcement Coordinator at (713) 422-8968, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-201006969
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 8, 2010

♦ ♦ ♦

Notice of a Proposed Pesticides General Permit Authorizing the Application of Pesticides into Waters of the United States

The Texas Commission on Environmental Quality (TCEQ or Commission) proposes to issue a new general permit (Proposed Texas Pollutant Discharge Elimination System Permit Number TXG870000) authorizing the application of biological pesticides or chemical pesticides that leave a residue in water when such applications are made into or over, including near waters of the United States. The proposed general permit applies to the entire state of Texas. This general permit is authorized by Section 402 of the Clean Water Act (CWA) and Chapter 26 of the Texas Water Code.

PROPOSED GENERAL PERMIT. The Executive Director has prepared a draft pesticides general permit and the pesticide use patterns covered under this permit include mosquito and other nuisance insect pests, vegetation and algae, nuisance animal, area-wide and forest canopy pest control.

The Executive Director has made a preliminary decision that the general permit, if issued, meets all statutory and regulatory requirements. The proposed permit will expire five years from the date of issuance in accordance with 30 TAC §205.5(a).

The Executive Director has reviewed this action for consistency with the goals and policies of the Texas Coastal Management Program (CMP) according to Coastal Coordination Council regulations, and has determined that the action is consistent with the CMP.

A copy of the proposed general permit and fact sheet are available for viewing and copying at the TCEQ Office of the Chief Clerk located at the TCEQ's Austin office, at 12100 Park 35 Circle, Building F. These documents are also available at the TCEQ's 16 regional offices and at the pesticides general permit TCEQ website http://www.tceq.state.tx.us/permitting/water_quality/stakeholders/pesticidegp_stakeholder_group.html.

PUBLIC COMMENT/PUBLIC MEETING. You may submit public comments about this general permit. In addition, the TCEQ will hold a public meeting on this general permit. A public meeting is not a contested case hearing. The public meeting will be held as follows: January 12, 2011, from 1:30 p.m. - 5:00 p.m. at the TCEQ Austin Office, 12100 Park 35 Circle, Building E, Room 201S.

All written public comments and public meeting requests must be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087 or electronically at www.tceq.state.tx.us/about/comments.html within 30 days from the date this notice is published in the *Texas Register* or at the end of public meeting, whichever is later.

APPROVAL PROCESS. After the comment period, the Executive Director will consider all the public comments and prepare a written response. The response will be filed with the TCEQ Office of the Chief Clerk at least ten days before the scheduled Commission meeting when the Commission will consider approval of the general permit. This commission meeting will be open to the public. The Commission will consider all public comments in making its decision and will either adopt the Executive Director's response or prepare its own response. The Commission will issue its written response on the general permit at the same time the Commission issues or denies the general permit. A copy of any issued general permit and response to comments will be made available to the public for inspection at the agency's Austin and regional offices. A notice of the Commissioners' action on the proposed general permit and a copy of its response to comments will be mailed to each person who made a comment. Also, a notice of the Commission's action on the proposed general permit and the text of its response to comments will be published in the *Texas Register.*

MAILING LIST. In addition to submitting public comments, you may request to be placed on a mailing list to receive future notices mailed by the Office of the Chief Clerk. You may request to be added to: (1) the mailing list for this specific general permit; (2) the mailing list for a specific county; and/or (3) the mailing list of a specific applicant name and permit number. Clearly specify which list(s) to which you wish to be added and send your request to TCEQ Office of the Chief Clerk at the address above. Unless you otherwise specify, you will be included only on the mailing list for this specific general permit.

AGENCY CONTACTS AND INFORMATION. If you need more information about this general permit or the permitting process, please call the TCEQ Office of Public Assistance, toll free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us.

Further information may also be obtained by calling the TCEQ's Water Quality Division, Concentrated Animal Feeding Operation Permits Team, at (512) 239-4671.

Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201006925
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 7, 2010

♦ ♦ ♦

Notice of Minor Amendment Radioactive Material License

APPLICATION. Waste Control Specialists LLC, P.O. Box 1129, Andrews, Texas 79714 has applied to the Texas Commission on Environmental Quality (TCEQ) for a minor amendment of radioactive material license R04100. Radioactive Material License R04100 authorizes Waste Control Specialists LLC of the disposal of low-level radioactive waste. Waste Control Specialists LLC submitted an application on January 12, 2010 to the TCEQ for amendment to Radioactive Material License R04100 to allow for the reconfiguration of the planned land disposal facility and engineering design, construction modification, and changes to the environmental monitoring program at the Waste Control Specialist LLC site. The planned land disposal facility is located at 9998 West Highway 176, Andrews, Texas 79714 - one mile north of State Highway 176; 250 feet east of the Texas and New Mexico State Line (30 miles west of Andrews, Texas) in Andrews County, Texas. The application was submitted to the TCEQ on January 12, 2010. The TCEQ Executive Director has completed the technical review of the application and prepared a draft amended license. The draft license amendment if approved, would establish the conditions under which the facility must operate. The Executive Director has made a preliminary decision that this license amendment, if issued, meets all statutory and regulatory requirements. The license amendment request, the Executive Director's technical summary, and amended draft license are available for viewing and copying at the TCEQ's central office in Austin, Texas and at Andrews County Public Library, 109 NW 1st Street, Andrews, Texas 79714.

PUBLIC COMMENT/PUBLIC MEETING. You may submit public comments or request a public meeting about this application. The purpose of a public meeting is to provide the opportunity to submit comments or to ask questions about the application. The TCEQ holds a public meeting if the Executive Director determines that there is a significant degree of public interest in the application or if requested by a local legislator. A public meeting is not a contested case hearing. After the deadline for submitting public comments, the Executive Director will consider all timely comments and prepare a response to all relevant and material, or significant public comments.

EXECUTIVE DIRECTOR ACTION. The application is subject to Commission rules which direct the Executive Director to act on behalf of the Commission and provide authority to the Executive Director to issue final approval on this application for a minor amendment after consideration of all timely comments submitted on the application.

MAILING LIST. If you submit public comments or a request for reconsideration of the Executive Director's decision, you will be added to the mailing list for this specific application to receive future public notices mailed by the Office of the Chief Clerk. In addition, you may request to be placed on: (1) the permanent mailing list for a specific applicant name and permit number; and/or (2) the mailing list for a specific county. If you wish to be placed on the permanent and/or the county mailing list, clearly specify which list(s) and send your request to TCEQ Office of the Chief Clerk at the address below.

All written public comments and requests must be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087 or electronically at www.tceq.state.tx.us/about/comments.html within ten days from the mailing date of this notice, or ten days after publication in the *Texas Register.*

AGENCY CONTACTS AND INFORMATION. If you need more information about this license application or the licensing process, please call the TCEQ Office of Public Assistance, toll free, at 1-800-687-4040. Si desea información en Español, puede llamar al 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.state.tx.us. Further information may also be obtained from Waste Control Specialists LLC at the address stated above or by calling Sheila Parker at 1-888-789-2783.

TRD-201006971
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 8, 2010

♦ ♦ ♦

Notice of Water Quality Applications

The following notice was issued on November 24, 2010 through December 3, 2010.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

BP PRODUCTS NORTH AMERICA INC which operates the Texas City Refinery, a petroleum refinery producing petrochemicals, has applied for a major amendment to TPDES Permit No. WQ0000443000 to add the discharge of storm water from the approximately 150-acre BP Land Treatment Farm storm water treatment basin and silt bed on an intermittent and flow variable basis via Outfall 002; revise the flow type from continuous to an intermittent and flow variable basis via Outfall 002; to authorize the discharge of storm water from the adjacent inactive approximately 114-acre Borden site containing a 33-acre phosphogypsum pile and three-sided mote on an intermittent and flow variable basis via new Outfall 009; to authorize the discharge of non-process area storm water and tank farm storm water on an intermittent and flow variable basis via new Outfall 010; remove Outfall 004; add a daily maximum flow limit of not to exceed 64,800,000 gallons per day at summation Outfall 006 and allow the reporting of the daily maximum flows at Outfalls 001 and 005, which are summed at Outfall 006;

add untreated storm water discharges from all areas of the refinery site, after routing of first flush to the wastewater treatment facility, on an intermittent and flow variable bases via Outfall 003; note the possible addition of a disinfection process located at Outfall 001 and/or Outfall 005; and allow for the use of a synthetic dilution water associated with the marine biomonitoring requirements. The current permit authorizes the discharge of treated process water, storm water, domestic sewage, groundwater from remediation project, effluent from the BP Amoco Products Texas City Refinery Land Farm, and effluent from the Borden Plant Site at a daily average flow not to exceed 23,000,000 gallons per day via Outfall 001; water treatment plant sludge settling pond effluent at a daily average dry weather flow not to exceed 200,000 gallons per day via Outfall 002; storm water runoff on an intermittent and flow variable basis via Outfall 003; cooling tower blowdown and nonprocess area storm water on an intermittent and flow variable basis via Outfall 004; treated process wastewater from the wastewater treatment plant on an intermittent and flow variable basis via Outfall 005; reporting Outfall 006 for the summation of Outfalls 001 and 005; and cooling tower blowdown at a daily average flow not to exceed 2,160,000 gallons per day via Outfall 007. The facility is located at 2401 Fifth Avenue South between 21st and 25th Streets in the City of Texas City, Galveston County, Texas 77592.

CLEAN HARBORS DEER PARK LLC which operates the Clean Harbors Deer Park Plant, has applied for a major amendment to TPDES Permit No. WQ0001429000 to authorize the relocation of Outfall 001 from Tucker Baylor to proposed Outfall 004 which will discharge directly into the Houston Ship Channel in Segment No. 1006 Houston Ship Channel Tidal of the San Jacinto River Basin; to transfer reporting requirements for purgeable and nonpurgeable organic halides from the Outfall 002 Effluent Limitation and Monitoring Requirements page to the Other Requirements Section of the permit; to remove the sanitary treatment plant requirements as listed in the Other Requirements Section, Item No. 3; to reduce the frequency of monitoring for phenol, chlorpyrifos, 1,2,-dichlorobenzene, hexachlorocyclohexane, 1,2,4-trichorobenzene, hexachlorobenzene, 2,4,5-trichlorophenol, pentachlorophenol, phenanchrene and benzidine from monthly to quarterly; and to increase the total silver daily average and daily maximum limitation at Outfall 001. The current permit authorizes the discharge of treated industrial wastes, incinerator scrubber water, treated domestic wastewater and treated storm water at a daily average flow not to exceed 2,880,000 gallons per day via Outfall 001 and the discharge of storm water on an intermittent and flow variable basis via Outfalls 002 and 003. The facility is located at 2027 Independence Parkway South, south of Tidal Road, west of State Highway 134, and east of and adjacent to Tucker Bayou in the City of Deer Park, Harris County, Texas 77571.

PREMIUM WATERS INC which proposes to operate Premium Waters Reverse Osmosis Plant, a water bottling manufacturing plant, has applied for a new permit, proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0004937000, to authorize the discharge of reverse osmosis reject water at a volume not to exceed a daily average flow of 100,000 gallons per day via Outfall 001. The facility is located approximately 1,700 feet west of the intersection of State Highway 170 and U.S. Highway 377, Tarrant County, Texas 76177.

CITY OF BURKBURNETT has applied for a renewal of TPDES Permit No. WQ0010002001, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 2,200,000 gallons per day. The facility is located on the east side of Kelly Street, just north of Third Street (State Highway 240) in the City of Burkburnett in Wichita County, Texas 76354.

CITY OF HAPPY has applied for a renewal of TPDES Permit No. WQ0010183001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 77,000 gallons per day. The facility is located approximately 1/2 mile south of Farm-to-Market Road 1075 and 1/2 mile east of Interstate Highway 27, east of the City of Happy in Swisher County, Texas 79042.

CITY OF AMARILLO has applied for a renewal of TPDES Permit No. WQ0010392003, which authorizes the discharge of treated domestic wastewater at an annual average flow not to exceed 12,000,000 gallons per day. The facility is located at 3,700 Southeast Loop 335, approximately four miles east-southeast of the intersection of State Highway Spur 335 (Hollywood Road) and Farm-to-Market Road 1541 (Washington Street) in Randall County, Texas 79118.

THE CITY OF LEFORS has applied for a renewal of TPDES Permit No. WQ0010411001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day. The facility is located approximately 1,300 feet south of State Highway 273, 2.5 miles west of the intersection of Farm-to-Market Road 291 and State Highway 273 south of the City of Lefors in Gray County, Texas 79054.

CITY OF LONGVIEW has applied for a renewal of TPDES Permit No. WQ0010589003, which authorizes the discharge of treated filter backwash effluent from a water treatment plant at a daily average flow not to exceed 4,200 gallons per day. The facility is located south of Farm-to-Market Road 2206 on the east side of Swinging Bridge Road and 600 feet south of Premier Road in the City of Longview in Gregg County, Texas 75606.

CITY OF CHILLICOTHE has applied for a renewal of TPDES Permit No. WQ0010639001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 113,000 gallons per day. The facility is located approximately 2.0 miles north-northeast of the intersection of Farm-to-Market Roads 91 and 924, and approximately 2.5 miles north of the intersection of Farm-to-Market Road 91 and U.S. Highway 287 in Hardeman County, Texas 79225.

CITY OF HONEY GROVE has applied for a renewal of TPDES Permit No. WQ0010710003, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 500,000 gallons per day. The facility is located approximately 2,000 feet west from Farm-to-Market Road 100 and approximately 3,000 feet north of U.S. Highway 82 in Fannin County, Texas 75446.

HARRIS COUNTY MUNICIPAL UTILITY DISTRICT NO 6 has applied for a renewal of TPDES Permit No. WQ0011273001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 750,000 gallons per day. The facility is located at 11702 Hollister Drive, approximately 2.0 miles north and 1.0 mile east of the intersection of Fairbanks-North Houston Road and Whiteoak Bayou, in Houston in Harris County, Texas 77064.

BEACON HOLDINGS CORPORATION has applied for a renewal of TPDES Permit No. WQ0013637001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 7,500 gallons per day. The facility is located approximately 500 feet southwest of the intersection of Farm-to-Market Road 350 and Farm-to-Market Road 3126 on the shoreline of Lake Livingston in Polk County, Texas 77351.

YFZ LAND LLC has applied for a renewal of TCEQ Permit No. WQ0014722001, which authorizes the disposal of treated domestic wastewater at a daily average flow not to exceed 100,000 gallons per day via surface irrigation of 125 acres of non-public access agricultural land. This permit will not authorize a discharge of pollutants into waters in the State. The wastewater treatment facility and disposal site

are located approximately six miles northeast of the intersection of U.S. Highway 277 and County Road 300 in Schleicher County, Texas 76936.

JMH HOMES HOUSTON LLC has applied for a new permit proposed Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014987001, to authorize the discharge of treated domestic wastewater at a daily average flow not to exceed 19,000 gallons per day. The facility was previously permitted under TPDES Permit No. 12626-001 which expired December 1, 2007. The facility is located at 6421 Hermann Road, approximately 1.5 miles south of Greens Bayou and 1.0 mile east of U.S. Highway 59 in Houston in Harris County, Texas 77050.

If you need more information about these permit applications or the permitting process, please call the TCEQ Office of Public Assistance, Toll Free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.TCEQ.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201006970
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 8, 2010

♦ ♦ ♦

Notice of Water Rights Application

Notices issued December 1, 2010 through December 3, 2010.

APPLICATION NO. 12433; Southwest Land Services Inc., P.O. Box 984, Leander, Texas 78646, Applicant, has applied for a Water Use Permit to construct and maintain a dam and reservoir complex consisting of nine component pools on an unnamed tributary of Dry Berry Creek, Brazos River Basin, for recreation purposes in Williamson County. Applicant also seeks a bed and banks authorization to maintain the proposed reservoir complex full with re-circulated groundwater. The application and partial fees were received on February 12, 2009. Additional information and partial fees were received on June 2, August 6, November 6, December 8, 2009, and March 4, March 12, and September 22, 2010. The application was declared administratively complete and accepted for filing on August 7, 2009. The Executive Director has completed the technical review of the application and prepared a draft permit. The draft permit, if granted, would include special conditions including, but not limited to, maintaining the reservoirs with an alternative source of water. The application, technical memoranda, and Executive Director's draft permit are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78753. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, within 30 days of the date of newspaper publication of the notice.

APPLICATION NO. 12496; Popek and Son, 2501 Marguerite Street, Bay City, Texas 77414, Applicant, has applied for a water use permit to use the bed and banks of an unnamed drainage ditch, tributary of Hardeman Slough, tributary of Caney Creek, Brazos-Colorado Coastal Basin, to convey 200 acre-feet of groundwater per year for subsequent diversion for agricultural purposes in Matagorda County. The application was received on September 3, 2009. Additional information and fees were received on November 24, December 4, December 15, 2009, February 18, 2010, and March 17, 2010. The application was declared administratively complete and accepted for filing with the Office of the Chief Clerk on April 8, 2010. The Executive Director completed the technical review of the application and prepared a draft permit. The draft permit, if granted, would include special conditions including, but not limited to maintenance of an alternate source of water. The application, technical memoranda, and Executive Director's draft permit are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78711-3087. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, within 30 days of the date of newspaper publication of the notice.

INFORMATION SECTION

To view the complete issued notice, view the notice on our web site at www.tceq.state.tx.us/comm_exec/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the web site, type in the issued date range shown at the top of this document to obtain search results.

A public meeting is intended for the taking of public comment, and is not a contested case hearing.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. 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) applicant's name and permit number; (3) the statement "[I/We] request a contested case hearing;" and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the TCEQ Office of the Chief Clerk at the address provided below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at 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 TCEQ can be found at our web site at www.tceq.state.tx.us. Si desea información en Español, puede llamar al 1-800-687-4040.

TRD-201006972
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 8, 2010

♦ ♦ ♦

Proposal for Decision

The State Office of Administrative Hearings issued a Proposal for Decision and Order to the Texas Commission on Environmental Quality on December 3, 2010 in the matter of the Executive Director of the Texas Commission on Environmental Quality, Petitioner v. Odessa Corporation dba Signature Mart 2; SOAH Docket No. 582-10-0598; TCEQ Docket No. 2008-1641-PST-E. The commission will consider the Administrative Law Judge's Proposal for Decision and Order regarding the enforcement action against Odessa Corporation dba Signature Mart 2 on a date and time to be determined by the Office of the Chief Clerk in Room 201S of Building E, 12100 N. Interstate 35, Austin, Texas. This posting is Notice of Opportunity to Comment on the Proposal for Deci-

sion and Order. The comment period will end 30 days from date of this publication. Written public comments should be submitted to the Office of the Chief Clerk, MC-105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. If you have any questions or need assistance, please contact Melissa Chao, Office of the Chief Clerk at (512) 239-3300.

TRD-201006973
LaDonna Castañuela
Chief Clerk
Texas Commission on Environmental Quality
Filed: December 8, 2010

♦ ♦ ♦

Department of Family and Protective Services

Notice of Consultant Contract Amendment

In accordance with Texas Government Code, Chapter 2254, the Texas Department of Family and Protective Services (DFPS) announces this notice of a consultant contract amendment for foster care remodeling consulting services.

The notice of request for proposals (DFPS RFP #530-0-33065) was published in the November 13, 2009, issue of the *Texas Register* (34 TexReg 8072). The notice of award was published in January 22, 2010, issue of the *Texas Register* (35 TexReg 524).

DFPS awarded one (1) contract to PDF Group, LLC, 5805 Shoal Creek, Austin TX 78757, as the Texas foster care remodeling consultant to begin on January 4, 2010, and end on January 3, 2011. DFPS will execute the following amendment to extend the contract:

Foster Care Remodeling Consultant Contract

Contractor Name: PDF Group, LLC

Contract #: 530-0-33065

Renewal #: 2011.01

The Texas Department of Family and Protective Services, hereinafter referred to as the Department, and PDF Group, LLC, hereinafter referred to as the Contractor, shall enter into a contract effective January 4, 2010 for the purpose of providing consultant services with a payment type of Fee for Service. This contract has not been renewed previously. The contract dated January 4, 2010, is referred to herein as the "Original Contract." The procurement #530-0-33065, which resulted in this contract, anticipated possible renewals and amendments of the contract, and no additional procurement process is necessary before entering into this renewal. The Department and the Contractor agree to amend the contract as follows:

I.

Budget. The Department shall reimburse the Contractor the appropriate rate as agreed in this renewal document.

II.

Renewal Period. Section 25 of the Original Contract is amended to include: January 4, 2011, through January 3, 2012.

III.

Section 9.1 of the Original Contract is deleted in its entirety and the following provision substituted for same:

9.1 Budget and Payment.

The Department shall reimburse the Contractor at a rate of $175 per hour, per consultant, plus travel expenses at state mileage, hotel and per diem rates for required project travel. Payments will be made upon receipt of a proper and verified invoice and after deducting any known previous overpayment made by the Department. The Contractor shall invoice DFPS consistent with the accepted payment methodology on a monthly basis using the Time Accounting Form provided by the Department. The payment methodology for this contract is unit rate, plus travel expenses. All resulting payments under this agreement shall be due and payable in Travis County, Texas.

IV.

Section 8.2.1 of the Original Contract is deleted in its entirety and the following provision substituted for same:

8.2.1 Project Plan. Contractor will submit a Project Plan within 90 days after January 4, 2011. The submitted Project Plan must include the following features:

V.

Section 8.2.2 and Section 8.2.2.1 of the Original Contract are deleted in their entirety and the following provisions substituted for same:

8.2.2 Project Status Reports.

8.2.2.1 Contractor will submit Status reports every 90 days. The first Status report is due 90 days after January 4, 2011.

VI.

Section 8.2.3 of the Original Contract is deleted in its entirety and the following provision substituted for same:

8.2.3 Implementation Plan. Contractor will submit an implementation Plan within 60 days after the submission of the Project Plan described in Section 8.2.1 of this Contract.

VII.

Section 8.4 of the Original Contract is amended by deleting the language indicated in the following section from the Original Contract:

8.4.10. Contractor will align management of the project with the work of DFPS contractors performing simulation modeling on various redesign scenarios.

VIII.

All other terms and conditions of the Original Contract not in conflict with this renewal are continued in full force and effect.

This renewal #2011.01 to contract #530-0-33065 is effective January 4, 2011, through January 3, 2012.

For information concerning this proposed renewal, please contact: Jessica Perry, Contracts Attorney, Department of Family and Protective Services at (512) 438-2857 or e-mail jessica.perry@dfps.state.tx.us.

TRD-201006978
Gerry Williams
General Counsel
Department of Family and Protective Services
Filed: December 8, 2010

♦ ♦ ♦

Office of the Governor

Request for Grant Applications for General Juvenile Justice and Delinquency Prevention Programs

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications for projects that support juvenile justice and delinquency prevention during the state fiscal year 2012 grant cycle.

Purpose: The purpose of the this program is to support programs that prevent violence in and around schools and to improve the juvenile

justice system and develop effective education, training, prevention, diversion, treatment, and rehabilitation programs in the area of juvenile delinquency.

Available Funding: This solicitation is funded from authorized state and federal sources and will be administered in accordance with regulations required by these sources.

(1) State funds are authorized under §102.056 of the Texas Code of Criminal Procedure, and §772.006 of the Texas Government Code designates CJD as the administering agency. The source of funding is a biennial appropriation by the Texas Legislature from funds collected through court costs and fees.

(2) Federal funding is authorized for these projects under the Juvenile Justice and Delinquency Prevention Act of 2002, Public Law 107-273. Congress has not finalized federal appropriations for federal fiscal year 2011. All awards are subject to the availability of appropriated federal funds and any modifications or additional requirements that may be imposed by law.

Standards: Grantees must comply with the standards applicable contained in the *Texas Administrative Code*, Title 1, Part 1, Chapter 3 (1 TAC Chapter 3) and the requirements of the federal statutes that authorize this funding.

Prohibitions: Grant funds may not be used to support the following services, activities, and costs:

(1) proselytizing or sectarian worship;

(2) lobbying;

(3) any portion of the salary of, or any other compensation for, an elected or appointed government official;

(4) vehicles or equipment for government agencies that are for general agency use;

(5) weapons, ammunition, explosives or military vehicles;

(6) admission fees or tickets to any amusement park, recreational activity or sporting event;

(7) promotional gifts;

(8) food, meals, beverages, or other refreshments unless the expense is for a working event where full participation by participants mandates the provision of food and beverages and the event is not related to amusement and/or social activities in any way;

(9) membership dues for individuals;

(10) any expense or service that is readily available at no cost to the grant project or that is provided by other federal, state or local funds (i.e., supplanting);

(11) fundraising;

(12) construction;

(13) medical services;

(14) transportation, lodging, per diem or any related costs for participants, when grant funds are used to develop and conduct training;

(15) legal services for adult offenders; and

(16) overtime pay.

Eligible Applicants:

(1) State agencies;

(2) Units of local government;

(3) Independent school districts;

(4) Nonprofit corporations;

(5) Indian tribes performing law enforcement functions;

(6) Crime control and prevention districts;

(7) Universities;

(8) Colleges; and

(9) Faith-based organizations. Faith-based organizations must be tax-exempt nonprofit entities as certified by the Internal Revenue Service.

Eligibility Requirements:

(1) Eligible applicants must have a DUNS (Data Universal Numbering System) number assigned to its agency, to request a DUNS number, go to http://fedgov.dnb.com/webform/displayHomePage.do; and

(2) Eligible applicants must be registered in the federal Central Contractor Registration (CCR) database located at http://www.ccr.gov and maintain an active registration throughout the grant period.

Eligible Activities:

(1) Alternatives to Detention

(2) Community Assessment Center

(3) Delinquency Prevention

(4) Diversion

(5) Gangs - Juvenile

(6) Gender Specific Services

(7) Graduated or Progressive Sanctions

(8) Job Training

(9) Juvenile Probation

(10) Juvenile Sex Offender Programs

(11) Mentoring

(12) Professional Therapy and Counseling

(13) Reentry of Offender into the Community

(14) School Based Delinquency Prevention

(15) Substance Abuse

(16) Training and Technology

(17) Youth Advocacy

(18) Youth Courts / Teen Courts

Project Period: Grant-funded projects must begin on or after September 1, 2011, and expire on or before August 31, 2012.

Application Process: Applicants must access CJD's grant management website at https://egrants.governor.state.tx.us to register and apply for funding.

Preference will be given to those applicants that demonstrate cost effective programs focused on proven or promising approaches to services provision.

Closing Date for Receipt of Applications: All applications must be certified via CJD's eGrants website on or before February 28, 2011.

Selection Process:

(1) For eligible local and regional projects:

(a) Applications will be forwarded by CJD to the appropriate regional council of governments (COG).

(b) The COG's criminal justice advisory committee will prioritize all eligible applications based on identified community and/or comprehensive planning, cost and program effectiveness.

(c) CJD will accept priority listings that are approved by the COG's executive committee.

(d) CJD will make all final funding decisions based on approved COG priorities, reasonableness of the project, availability of funding, and cost-effectiveness.

(2) All statewide applicants applying for funding may be invited to participate in a 15 - 20 minute presentation demonstrating the effectiveness of their program. The presentation will be conducted in Austin, Texas and scored by the Juvenile Justice Advisory Board. Each statewide applicant will receive instructions from CJD 30 days prior to the event.

Contact Information: If additional information is needed, contact the eGrants Help Desk at eGrants@governor.state.tx.us or (512) 463-1919.

TRD-201006965
David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 8, 2010

♦ ♦ ♦

Request for Grant Applications for General Victim Assistance - Direct Services Programs

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications for projects that provide services to victims of crime under the state fiscal year 2012 grant cycle.

Purpose: The purpose of this program is to provide services and assistance directly to victims of crime to speed their recovery and aid them through the criminal justice process. Services may include the following:

(1) responding to the emotional and physical needs of crime victims;

(2) assisting victims in stabilizing their lives after a victimization;

(3) assisting victims to understand and participate in the criminal justice system; and

(4) providing victims with safety and security.

Available Funding: Federal funding is authorized for these projects under the Victims of Crime Act of 1984 (VOCA) as amended, and under the Violence Against Women Act of 2005 (VAWA 2005) 42 U.S.C. 3796gg through 3796gg-5 as amended. Congress has not finalized federal appropriations for federal fiscal year 2011. All awards are subject to the availability of appropriated federal funds and any modifications or additional requirements that may be imposed by law.

Funding Levels: Minimum grant award - $5,000.

Required Match: Grantees, other than Native American Tribes, may be required to provide matching funds of at least twenty percent (20%) of total project expenditures. Native American Tribes may be required to provide a five percent (5%) match. This requirement may be met through either cash or in-kind contributions or a combination of both.

Standards: Grantees must comply with all statutes, requirements, and guidelines cited in the *Texas Administrative Code* (1 TAC Chapter 3) applicable to this funding.

Prohibitions: Grant funds may not be used to support the following services, activities, and costs:

(1) proselytizing or sectarian worship;

(2) lobbying and administrative advocacy;

(3) perpetrator rehabilitation and counseling or services to incarcerated individuals;

(4) needs assessments, surveys, evaluations, and studies;

(5) prosecution activities;

(6) reimbursing crime victims for expenses incurred as a result of the crime;

(7) most medical costs. Grantees may not use grant funds for nursing-home care (except for short-term emergency), home health-care costs, in-patient treatment costs, hospital care, or other types of emergency or non-emergency medical or dental treatment. Grant funds cannot support medical costs resulting from a crime, except for forensic medical examinations for sexual assault victims;

(8) relocation expenses. Grant funds may not support relocation expenses for crime victims such as moving expenses, security deposits on housing, rent, and mortgage payments;

(9) administrative staff expenses. Grantees may not use grant funds to pay salaries, fees and reimbursable expenses associated with administrators, board members, executive directors, consultants, coordinators, and other individuals unless the grantee incurs the expense while providing direct services to crime victims;

(10) costs of sending individual crime victims to conferences;

(11) activities exclusively related to crime prevention or community awareness;

(12) non-emergency legal representation such as for divorces or civil restitution recovery efforts;

(13) victim-offender meetings that serve to replace criminal justice proceedings;

(14) management and administrative training for executive directors, board members, and other individuals that do not provide direct services;

(15) training to persons or groups outside the applicant agency;

(16) indirect organization costs;

(17) any activities or related costs for diligent search;

(18) job skills training;

(19) alcohol and drug abuse treatment;

(20) fundraising activities;

(21) property loss. Grant funds may not be used to reimburse crime victims for expenses incurred as a result of a crime, such as insurance deductibles, replacement of stolen property, funeral expenses, lost wages, and medical bills;

(22) any portion of the salary of, or any other compensation for, an elected or appointed government official;

(23) purchase or leasing of vehicles;

(24) purchase of equipment for governmental agencies that are for general agency use;

(25) admission fees or tickets to any amusement park, recreational activity, or sporting event;

(26) promotional gifts;

(27) food, meals, beverages, or other refreshments unless the expense is for a working event where full participation by participants mandates

the provision of food and beverages and that event is not related to amusement and/or social activities in any way; and

(28) membership dues for individuals.

Eligible Applicants:

(1) State Agencies;

(2) Units of Local Government;

(3) Hospital Districts;

(4) Nonprofit Corporations with an active Charter Number from the Texas Secretary of State;

(5) Native American Tribes;

(6) Crime Control and Prevention Districts;

(7) Universities;

(8) Colleges;

(9) Community Supervision and Corrections Departments;

(10) Councils of Governments that offer direct services to victims of crime;

(11) Hospital and Emergency Medical Facilities that offer crisis counseling, support groups, and/or other types of victims services; and

(12) Faith-Based Organizations that provide direct services to victims of crime. Faith-based organizations must be tax-exempt nonprofit entities as certified by the Internal Revenue Service.

Eligibility Requirements:

(1) Eligible applicants must have a DUNS (Data Universal Numbering System) number assigned to its agency, to request a DUNS number, go to http://fedgov.dnb.com/webform/displayHomePage.do; and

(2) Eligible applicants must be registered in the federal Central Contractor Registration (CCR) database located at http://www.ccr.gov and maintain an active registration throughout the grant period.

Eligible Activities:

(1) Crisis Services;

(2) Forensic Interviews;

(3) Legal Advocacy;

(4) Multi-Disciplinary Teams and Case Coordination;

(5) Peer Support Groups;

(6) Professional Therapy and Counseling;

(7) Protective Order Assistance;

(8) Public Presentations (designed to help identify victims);

(9) Shelter; and

(10) Victim-Offender Meetings.

Program Requirements:

(1) Applicants agree to promote collaboration and coordination among local service systems that involve multiple disciplines and support a seamless delivery of a continuum of services that focus on each individual's return of physical, mental, and emotional health to the fullest extent possible while incorporating an emphasis on cultural competency in underserved populations. Applicants must explain how their organization is culturally competent when providing services to victims. Here are some guidelines to follow: Victim service providers must have the ability to blend cultural knowledge and sensitivity with victim restoration skills for a more effective and culturally appropriate recovery process. Cultural competency occurs when a) cultural knowledge, awareness and sensitivity are integrated into action and policy, b) the service is relevant to the needs of the community and provided by trained staff, board members, and management, and c) an advocate or organization recognizes each client is different with different needs, feelings, ideas and barriers.

(2) Applicants must certify that they will comply with the following requirements:

(a) Services to Victims of Crime - Applicant agrees to provide services to victims of crime which include: responding to the emotional and physical needs of crime victims; assisting victims in stabilizing their lives after victimization; assisting victims to understand and participate in the criminal justice system; and providing victims with safety and security.

(b) Effective Services - Applicant must demonstrate a record of providing effective services to crime victims. If the applicant cannot yet demonstrate a record of providing effective services, the applicant must demonstrate that at least 25 percent of its financial support comes from non-federal sources.

(c) Volunteers - Applicant agrees to use volunteers to support either the project or agency-wide services, unless CJD determines that a compelling reason exists to waive this requirement.

(d) Community Efforts - Applicant agrees to promote community efforts to aid crime victims. Applicants should promote, within the community, coordinated public and private efforts to aid crime victims. Coordination efforts qualify an organization to receive these funds, but are not activities that can be supported with these funds.

(e) Crime Victims' Compensation - Applicant agrees to assist crime victims in applying for crime victims' compensation benefits.

(f) Records - Applicant agrees to maintain daily time and attendance records specifying the time devoted to allowable victim services.

(g) Civil Rights Information - Applicant agrees to maintain statutorily required civil rights statistics on victims served by race, national origin, sex, age, and disability of victims served, within the timeframe established by CJD. This requirement is waived when providing services, such as telephone counseling, where soliciting the information may be inappropriate or offensive to the crime victim.

(h) Victims of Federal Crime - Applicant agrees to provide equal services to victims of federal crime. (Note: A Victim of a federal crime is a victim of an offense that violates a federal criminal statute or regulation; federal crimes also include crimes that occur in an area where the federal government has jurisdiction, such as Indian reservations, some national parks, some federal buildings, and military installations.)

(i) No Charge - Applicant agrees to provide grant-funded services at no charge to victims of crime.

(j) Confidentiality - Applicant agrees to maintain the confidentiality of client-counselor information and research data, as required by state and federal law.

(k) Discrimination - Applicant agrees not to discriminate against victims because they disagree with the State's prosecution of the criminal case.

(l) Forensic Medical Examination Payments - Health care facilities shall conduct a forensic medical examination of a victim of an alleged sexual assault if the victim arrived at the facility within 96 hours after the assault occurred and the victim consented to the examination. The victim is not required to participate in the investigation or prosecution of an offence as a condition of receiving a forensic medical examina-

tion, nor pay for the forensic examination or the evidence collection kit. In addition, if a health care facility does not provide diagnosis or treatment services for sexual assault victims, the facility is required to refer the victim to a facility that provides those services. A law enforcement agency that requests a forensic medical examination of a victim of sexual assault shall pay full cost of the examination. Crime Victim Compensation funds may be used to pay for forensic medical examinations performed by trained examiners except that such funds may not be used to pay for the examinations if victims of sexual assault are required to seek reimbursement for such examinations from their insurance carriers.

(m) Protection Orders - Victims applying for a protective order or their attorney may not bear the costs associated with the filing of an order of protections.

(n) Nondisclosure of Confidential or Private Information - Personally identifying information or individual information collected in connection with services requested, utilized, or denied may not be disclosed; or, individual client information may not be revealed without informed, written, reasonably time-limited consent of the person about whom information is sought. If release of information is compelled by statutory or court mandate, reasonable attempts to provide notice to victims affected by the disclosure of information will be made and steps necessary will be taken to protect the privacy and safety of the persons affected by the release of information.

Project Period: Grant-funded projects may begin on or after September 1, 2011, and expire on or before August 31, 2012.

Application Process: Applicants can access CJD's eGrants website at https://egrants.governor.state.tx.us to register and apply for funding.

Preferences: Preference will be given to applicants that promote comprehensive victim restoration while incorporating an emphasis on cultural competency in underserved populations. Applicants are also encouraged to streamline administrative and reporting processes by consolidating grant requests whenever possible in lieu of submitting multiple applications.

Closing Date for Receipt of Applications: All applications must be certified via CJD's grant management website on or before February 28, 2011.

Selection Process:

(1) For eligible local and regional projects:

(a) Applications are forwarded by CJD to the appropriate regional council of governments (COG).

(b) The COG's criminal justice advisory committee will prioritize all eligible applications based on identified community priorities and program effectiveness.

(c) CJD will accept priority listings that are approved by the COG's executive committee.

(d) CJD will make all final funding decisions based upon approved COG priorities, reasonableness of the project, availability of funding, and cost-effectiveness.

(2) For state discretionary projects, applications will be reviewed by CJD staff members or a group selected by CJD's Executive Director. CJD will make all final funding decisions based on eligibility, reasonableness of the project, availability of funding, and cost-effectiveness.

Contact Information: If additional information is needed, contact the eGrants Help Desk at eGrants@governor.state.tx.us or (512) 463-1919.

TRD-201006966

David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 8, 2010

♦ ♦ ♦

Request for Grant Applications for the Criminal Justice Programs Solicitation

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications for projects that reduce crime and improve the criminal justice system during the state fiscal year 2012 grant cycle.

Purpose: The purpose of this solicitation is to reduce crime and improve the criminal justice system.

Available Funding: This solicitation is funded from authorized state and federal sources and will be administered in accordance with regulations required by these sources.

(1) State funds are authorized under §102.056 of the Texas Code of Criminal Procedure; and §772.006 of the Texas Government Code designates CJD as the administering agency. The source of funding is a biennial appropriation by the Texas Legislature from funds collected through court costs and fees.

(2) Federal funds are authorized under the Edward Byrne Memorial Justice Assistance Grant Program (JAG) (42 U.S.C. 3751(a)). JAG funds are made available through a Congressional appropriation to the United States Department of Justice. Congress has not finalized federal appropriations for federal fiscal year 2011. All awards are subject to the availability of appropriated federal funds and any modifications or additional requirements that may be imposed by law.

Funding Levels:

Minimum amount is $10,000

Maximum: None

Match Requirement: None

Standards: Grantees must comply with the standards applicable to this funding source cited in the *Texas Administrative Code* (1 TAC Chapter 3), and all statutes, requirements, and guidelines applicable to this funding.

Prohibitions: Grant funds may not be used to support the following services, activities, and costs:

(1) supplanting or use of grant funds to replace any other existing federal, state or local funds;

(2) proselytizing or sectarian worship;

(3) lobbying;

(4) any portion of the salary of, or any other compensation for, an elected or appointed government official;

(5) vehicles or equipment for government agencies that are for general agency use;

(6) weapons, ammunition, explosives or military vehicles;

(7) admission fees or tickets to any amusement park, recreational activity or sporting event;

(8) promotional gifts;

(9) food, meals, beverages, or other refreshments unless the expense is for a working event where full participation by participants mandates the provision of food and beverages and the event is not related to amusement and/or social activities in any way;

(10) membership dues for individuals;

(11) fundraising;

(12) construction, renovation or remodeling;

(13) medical services;

(14) transportation, lodging, per diem or any related costs for participants, when grant funds are used to develop and conduct training; and

(15) legal services for adult offenders.

Eligible Applicants:

(1) State agencies;

(2) Units of local government;

(3) Independent school districts;

(4) Native American tribes;

(5) Crime control and prevention districts;

(6) Public universities;

(7) Public colleges;

(8) Hospital districts;

(9) Community supervision and corrections departments; and

(10) Councils of government.

Eligibility Requirements:

(1) Eligible applicants are limited to one application;

(2) Projects must focus on reducing crime and improving the criminal justice system;

(3) Eligible applicants must provide law enforcement, corrections, or judicial services;

(4) Eligible applicants operating a law enforcement agency must be current on reporting Part I violent crime data to the Texas Department of Public Safety for inclusion in the annual Uniform Crime Report (UCR) and must have been current for the three previous years;

(5) Eligible applicants must have a DUNS (Data Universal Numbering System) number assigned to its agency, to request a DUNS number, go to http://fedgov.dnb.com/webform/displayHomePage.do; and

(6) Eligible applicants must be registered in the federal Central Contractor Registration (CCR) database located at http://www.ccr.gov and maintain an active registration throughout the grant period.

Project Period: Grant-funded projects must begin on or after September 1, 2011 and expire on or before August 31, 2012.

Application Process: Applicants can access CJD's eGrants website at https://egrants.governor.state.tx.us to register and apply for funding.

Preferences: Preference will be given to applicants who demonstrate cost effective programs focused on a comprehensive and effective approach to services that compliment the criminal justice system.

Closing Date for Receipt of Applications: All applications must be submitted via CJD's eGrants website on or before February 28, 2011.

Selection Process:

(1) For eligible local and regional projects:

(a) Applications will be forwarded by CJD to the appropriate regional council of governments (COG).

(b) The COG's criminal justice advisory committee prioritizes all eligible applications based on identified community and/or comprehensive planning, cost and program effectiveness.

(c) CJD will accept priority listings that are approved by the COG's executive committee.

(d) CJD will make all final funding decisions based on COG priorities, reasonableness, availability of funding, and cost-effectiveness.

(2) For state discretionary projects, applications will be reviewed by CJD staff members or a review group selected by the executive director. CJD will make all final funding decisions based on eligibility, reasonableness, availability of funding, and cost-effectiveness.

Contact Information: If additional information is needed, contact the eGrants Help Desk at eGrants@governor.state.tx.us or (512) 463-1919.

TRD-201006964
David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 8, 2010

♦ ♦ ♦

Request for Grant Applications for Violent Crimes Against Women Criminal Justice and Training Projects - Domestic Violence, Sexual Assault, Dating Violence, and Stalking

The Criminal Justice Division (CJD) of the Governor's Office is soliciting applications for projects that promote a coordinated, multidisciplinary approach to improving the criminal justice system's response to violent crimes against women during the state fiscal year 2012 grant cycle.

Purpose: The purpose of this funding is to assist in developing and strengthening effective law enforcement, prosecution and court strategies to combat family violence, sexual assault, dating violence and stalking crimes against women and to develop and strengthen victim services in such cases.

Available Funding: Federal funding is authorized for these projects under the Violence Against Women Act of 2005 (VAWA 2005), 42 U.S.C. 3796gg through 3796gg-5 as amended. Congress has not finalized federal appropriations for federal fiscal year 2011. All awards are subject to the availability of appropriated federal funds and any modifications or additional requirements that may be imposed by law.

Funding Levels: Minimum grant award - $5,000.

Required Match: Grantees, other than Native American tribes and non-profit, non-governmental victim service providers, must provide matching funds of at least thirty-five percent (35%) of total project expenditures. This requirement may be met through either cash or in-kind contributions or a combination of both.

Standards: Grantees must comply with all statutes, requirements, and guidelines cited in the *Texas Administrative Code* (1 TAC Chapter 3) applicable to this funding.

Prohibitions: Grantees may not use grant funds or program income to support the following services, activities, and costs:

(1) proselytizing or sectarian worship;

(2) lobbying;

(3) any portion of the salary of, or any other compensation for, an elected or appointed government official;

(4) purchase or leasing of vehicles;

(5) admission fees or tickets to any amusement park, recreational activity, or sporting event;

(6) promotional gifts;

(7) food, meals, beverages, or other refreshments unless the expense is for a working event where full participation by participants mandates the provision of food and beverages and that event is not related to amusement and/or social activities in any way;

(8) membership dues for individuals;

(9) any expense or service that is readily available at no cost to the grant project or that is provided by other federal, state, or local funds (e.g., supplanting), including the Texas Crime Victims Compensation Fund;

(10) fundraising;

(11) overtime;

(12) cash payments to victims;

(13) legal assistance and representation in civil matters other than protective orders;

(14) legal defense services for perpetrators of violence against women;

(15) liability insurance on buildings;

(16) major maintenance on buildings;

(17) property loss. Grant funds may not be used to reimburse victims for expenses incurred as a result of a crime, such as insurance deductibles, replacement of stolen property, funeral expenses, lost wages, and medical bills;

(18) services for programs that focus on children and/or men;

(19) activities exclusively related to violence prevention, such as media campaigns to educate the general public about violence against women;

(20) criminal defense work, including women who assault, kill, or otherwise injure their abusers;

(21) to serve any person incarcerated for committing a crime of domestic violence, dating violence, sexual assault, or stalking;

(22) relocation expenses. Grant funds may not support expenses for victims of domestic violence, sexual assault, or stalking such as moving household goods to a new location in another state or acquiring furniture or housing in a new location;

(23) creation of a voucher program. Grant funds may not support the creation of a voucher program where victims are directly given vouchers for such services as housing or counseling; and

(24) grant funds may not be used to pay for the prosecution of child sexual abuse when the victim is now an adult.

Eligible Applicants:

(1) Community Supervision and Corrections Departments;

(2) Councils of Governments (COGs);

(3) Crime Control and Prevention Districts;

(4) Indian Tribal Governments;

(5) Nonprofit Corporations with an active Charter Number from the Texas Secretary of State;

(6) Senior Universities and Colleges;

(7) State Agencies; and

(8) Units of Local Government.

Eligibility Requirements:

(1) Eligible applicants must have a DUNS (Data Universal Numbering System) number assigned to its agency, to request a DUNS number, go to http://fedgov.dnb.com/webform/displayHomePage.do; and

(2) Eligible applicants must be registered in the federal Central Contractor Registration (CCR) database located at http://www.ccr.gov and maintain an active registration throughout the grant period.

Eligible Activities:

(1) Court Services/Improvements (including specialized courts except drug courts);

(2) Crisis Services;

(3) Forensic Interviews;

(4) Investigation;

(5) Legal Advocacy;

(6) Multi-Disciplinary Teams and Case Coordination;

(7) Peer Support Groups;

(8) Professional Therapy and Counseling;

(9) Prosecution;

(10) Protective Order Assistance;

(11) Public Presentations;

(12) Shelter;

(13) Training; and

(14) Victim-Offender Meetings.

Program Requirements:

(1) Applicants agree to promote collaboration and coordination among local service systems that involve multiple disciplines and support a seamless delivery of a continuum of services that focus on each individual's return of physical, mental, and emotional health to the fullest extent possible while incorporating an emphasis on cultural competency in underserved populations. Applicants must explain how their organization is culturally competent when providing services to victims. Here are some guidelines to follow: Victim service providers must have the ability to blend cultural knowledge and sensitivity with victim restoration skills for a more effective and culturally appropriate recovery process. Cultural competency occurs when (a) cultural knowledge, awareness and sensitivity are integrated into action and policy, (b) the service is relevant to the needs of the community and provided by trained staff, board members, and management, and (c) an advocate or organization recognizes each client is different with different needs, feelings, ideas and barriers.

(2) Applicant agrees to implement comprehensive strategies that are sensitive to the concerns and safety of the victims and hold offenders accountable for their crimes. Applicants must indicate the percentage of their project that benefits Victim Services, Law Enforcement, Prosecution, Courts or other areas. Program emphasis decisions should be made based on the beneficiary of the funded activities. For example, a victim services coalition who provides training to police throughout the state would fall under the "law enforcement" category because the training is to benefit law enforcement.

(3) Applicants must certify that they will comply with the following requirements:

(a) Forensic Medical Examination Payments - Health care facilities shall conduct a forensic medical examination of a victim of an alleged sexual assault if the victim arrived at the facility within 96 hours after the assault occurred and the victim consented to the examination. The

victim is not required to participate in the investigation or prosecution of an offence as a condition of receiving a forensic medical examination, nor pay for the forensic examination or the evidence collection kit. In addition, if a health care facility does not provide diagnosis or treatment services for sexual assault victims, the facility is required to refer the victim to a facility that provides those services. A law enforcement agency that requests a forensic medical examination of a victim of sexual assault shall pay full cost of the examination. Crime Victim Compensation funds may be used to pay for forensic medical examinations performed by trained examiners except that such funds may not be used to pay for the examinations if victims of sexual assault are required to seek reimbursement for such examinations from their insurance carriers.

(b) Polygraph Testing Prohibition - A peace officer or attorney representing the state may not require an adult or child victim of an alleged sex offense to submit to a polygraph examination or other truth telling device as a condition for proceeding with the investigation of such an offense. In addition, the refusal of a victim to submit to a polygraph or other truth telling examination will not prevent the investigation, charging, or prosecution of an alleged sex offense or on the basis of the results of a polygraph examination.

(c) Protection Orders - Neither victims applying for a protective order nor their attorney may bear the costs associated with the filing of an order of protections.

(d) Judicial Notification - Offenders involved in a protection order are not allowed to possess a firearm unless the offender is a peace officer who is actively engaged in employment as a sworn, full-time paid employee of a state agency or political subdivision.

(e) Criminal Charges - In connection with the prosecution of any misdemeanor or felony domestic violence offense, the victim may not bear the costs associated with the filing of criminal charges against a domestic violence offender, issuance or service of a warrant, or witness subpoena.

(f) Nondisclosure of Confidential or Private Information - Personally identifying information or individual information collected in connection with services requested, utilized, or denied may not be disclosed; or, reveal individual client information without informed, written, reasonably time-limited consent of the person about whom information is sought. If release of information is compelled by statutory or court mandate, reasonable attempts to provide notice to victims affected by the disclosure of information will be made and steps necessary will be taken to protect the privacy and safety of the persons affected by the release of information.

Project Period: Grant-funded projects must begin on or after September 1, 2011, and will expire on or before August 31, 2012.

Application Process: Applicants can access CJD's eGrants website at https://egrants.governor.state.tx.us to register and apply for funding.

Preferences: Preference will be given to applicants that promote comprehensive victim restoration while incorporating an emphasis on cultural competency in underserved populations. Applicants are also encouraged to streamline administrative and reporting processes by consolidating grant requests whenever possible in lieu of submitting multiple applications.

Closing Date for Receipt of Applications: All applications must be certified via CJD's grant management website on or before February 28, 2011.

Selection Process:

(1) For eligible local and regional projects:

(a) Applications will be forwarded by CJD to the appropriate regional council of governments (COG).

(b) The COG's criminal justice advisory committee will prioritize all eligible applications based on identified community priorities and program effectiveness.

(c) CJD will accept priority listings that are approved by the COG's executive committee.

(d) CJD will make all final funding decisions based on eligibility, approved COG priorities, reasonableness of the project, availability of funding, and cost-effectiveness.

(2) For state discretionary projects, applications will be reviewed by CJD staff members or a group selected by CJD's Executive Director. CJD will make all final funding decisions based on eligibility, reasonableness of the project, availability of funding, and cost-effectiveness.

Contact Information: If additional information is needed, contact the eGrants Help Desk at eGrants@governor.state.tx.us or (512) 463-1919.

TRD-201006967
David Zimmerman
Assistant General Counsel
Office of the Governor
Filed: December 8, 2010

♦ ♦ ♦

Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission (HHSC) intends to submit to the Centers for Medicare and Medicaid Services a request for a waiver program for mental health rehabilitative services. The proposed waiver program will be a selective contracting waiver under the authority of §1915(b) of the Social Security Act.

In an effort to ensure that specialized mental health services are provided in a manner consistent with evidence-based best-practices, the state is pursuing a 1915(b) fee-for-service selective contracting waiver. Providers will be required to provide services regardless of the individual's current level of functioning and Medicaid status. The waiver will operate in all Texas counties except Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties.

HHSC is requesting that the new waiver be approved for the period beginning July 1, 2011, through June 30, 2013. The proposed waiver maintains cost neutrality for waiver years 2011 through 2013.

To obtain copies of the proposed waiver amendment, interested parties may contact Christine Longoria by mail at Texas Health and Human Services Commission, P.O. Box 85200, mail code H-620, Austin, Texas 78708-5200, phone (512) 491-1152, fax (512) 491-1957, or by e-mail at Christine.Longoria@hhsc.state.tx.us.

TRD-201006947
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: December 7, 2010

♦ ♦ ♦

Department of State Health Services

Designation of Site Serving Medically Underserved Populations

The Department of State Health Services (department) is required under the Occupations Code, §157.052, to designate sites serving medically underserved populations. In addition, the department is required to publish notice of such designations in the *Texas Register* and to provide an opportunity for public comment on the designations.

Accordingly, the department has proposed designating the following as a site serving medically underserved populations: Texas A&M University Kingsville, Student Health and Wellness, 1210 Retama, Kingsville, Texas 78363. The designation is based on proven eligibility as a site serving a disproportionate number of clients eligible for federal, state or locally funded health care programs.

Oral and written comments on this designation may be directed to Brian King, Program Director, Health Professions Resource Center - Mail Code 1898, Center for Health Statistics, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347; telephone (512) 458-7261. Comments will be accepted for 30 days from the publication date of this notice.

TRD-201006838
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: December 2, 2010

♦ ♦ ♦

Designation of Site Serving Medically Underserved Populations

The Department of State Health Services (department) is required under the Occupations Code, §157.052, to designate sites serving medically underserved populations. In addition, the department is required to publish notice of such designations in the *Texas Register* and to provide an opportunity for public comment on the designations.

Accordingly, the department has proposed designating the following as a site serving medically underserved populations: Lamar University Student Health Center, 857 E. Virginia, Beaumont, Texas 77705. The designation is based on proven eligibility as a site serving a disproportionate number of clients eligible for federal, state or locally funded health care programs.

Oral and written comments on this designation may be directed to Brian King, Program Director, Health Professions Resource Center - Mail Code 1898, Center for Health Statistics, Department of State Health Services, P.O. Box 149347, Austin, Texas 78714-9347; telephone (512) 458-7261. Comments will be accepted for 30 days from the publication date of this notice.

TRD-201006890
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: December 6, 2010

♦ ♦ ♦

Licensing Actions for Radioactive Materials

The Department of State Health Services 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 TX" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Abilene	Abilene Diagnostic Clinic PLLC	L05101	Abilene	20	11/19/10
Anderson	National Oilwell Varco, L.P.	L06094	Anderson	04	11/12/10
Austin	St. David's Healthcare Partnership, L.P., L.L.P. dba St. David's Medical Center	L00740	Austin	108	11/17/10
Austin	Austin Texas Radiation Oncology Group, P.A. dba Austin Cancer Centers	L01761	Austin	64	11/23/10
Austin	Austin Nuclear Pharmacy, Inc.	L05591	Austin	12	11/23/10
Austin	Seton Healthcare dba Dell Children's Medical Center of Central Texas	L06065	Austin	22	11/15/10
Cedar Park	Cedar Park Health System, L.P. dba Cedar Park Regional Medical Center	L06140	Cedar Park	05	11/12/10
Cedar Park	Cedar Park Health System, L.P. dba Cedar Park Regional Medical Center	L06140	Cedar Park	06	11/17/10
Cleburne	Texas Health Harris Methodist Hospital Cleburne	L02039	Cleburne	41	11/18/10
Cleveland	Cleveland Regional Medical Center, L.P.	L02055	Cleveland	42	11/19/10
College Station	TDI Brooks International, Inc.	L06139	College Station	04	11/18/10
Conroe	Sadler Clinic/Montgomery County Management Company	L04899	Conroe	30	11/29/10
Corpus Christi	Mcturbine, Inc.	L04341	Corpus Christi	11	11/23/10
Dallas	The University of Texas Southwestern Medical Center at Dallas	L00384	Dallas	106	11/16/10
Dallas	Methodist Hospitals of Dallas	L00659	Dallas	81	11/19/10
Dallas	Baylor University Medical Center	L01290	Dallas	99	11/15/10
Dallas	Mallinckrodt Inc.	L03580	Dallas	72	11/23/10
Dallas	Texas Oncology, P.A. dba Sammons Cancer Center	L04878	Dallas	42	11/15/10
Deer Park	Shell Chemical, L.P.	L04933	Deer Park	24	11/16/10
El Paso	Western Refining Company, L.P.	L02669	El Paso	20	11/17/10
Fort Worth	John Peter Smith Hospital	L02208	Fort Worth	73	11/15/10
Fort Worth	Sterigenics US, L.L.C.	L03851	Fort Worth	38	11/22/10
Glen Rose	Glen Rose Medical Foundation, Inc. dba Glen Rose Medical Center	L03225	Glen Rose	27	11/29/10
Harlingen	Texas Oncology, P.A. dba South Texas Cancer Center Harlingen	L00154	Harlingen	40	11/18/10
Houston	Cardinal Health	L01911	Houston	145	11/12/10
Houston	Texas Southern University	L03121	Houston	28	11/24/10
Houston	Memorial Hermann Healthcare System dba Hermann Hospital	L04655	Houston	42	11/15/10
Houston	Methodist Health Centers dba Methodist Willowbrook Hospital	L05472	Houston	36	11/17/10
Houston	Cardinal Health	L05536	Houston	27	11/12/10
Houston	University General Hospital, L.P.	L06018	Houston	06	11/17/10
Houston	Statewide Maintenance Company dba Diamond G Inspection, Inc.	L06229	Houston	02	11/22/10
Houston	The Methodist Hospital Research Institute	L06331	Houston	01	11/19/10
Huntsville	Sam Houston State University	L00873	Huntsville	20	11/18/10
Lubbock	Covenant Health System dba Covenant Medical Center - Lakeside	L01547	Lubbock	95	11/17/10
Lubbock	University Medical Center	L04719	Lubbock	116	11/19/10

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED):

Location	Name	License #	City	Amend-ment #	Date of Action
McAllen	Valley Heart Consultants	L05330	McAllen	13	11/23/10
New Braunfels	Cemex, Inc.	L02809	New Braunfels	31	11/16/10
Orange	Tin, Inc. dba Temple Inland	L01029	Orange	57	11/23/10
Plano	North Texas Regional Cancer Center	L05357	Plano	15	11/15/10
Queen City	International Paper Company	L01686	Queen City	37	11/30/10
San Antonio	South Texas Radiology Imaging Centers	L00325	San Antonio	189	11/24/10
San Antonio	Southwest Foundation for Biomedical Research	L00468	San Antonio	54	11/16/10
San Antonio	Accord Medical Management, L.P. dba Nix Health Care System	L03531	San Antonio	32	11/24/10
San Antonio	The University of Texas Health Science Center at San Antonio	L05217	San Antonio	14	11/12/10
Stafford	Aloki Enterprise, Inc.	L06257	Stafford	09	11/30/10
Sugar Land	US Imaging, Inc. dba Fort Bend Imaging	L04459	Sugar Land	35	11/25/10
The Woodlands	Opexa Therapeutics, Inc.	L05592	The Woodlands	11	11/17/10
Throughout TX	Texas Department of Transportation	L00197	Austin	153	11/17/10
Throughout TX	IRISNDT, Inc.	L04769	Deer Park	92	11/12/10
Throughout TX	Gray Wireline Service Inc.	L03541	Fort Worth	36	11/19/10
Throughout TX	The Dow Chemical Company	L00451	Freeport	89	11/15/10
Throughout TX	Vulcan Construction Materials, L.P.	L05382	Helotes	08	11/10/10
Throughout TX	Wood Group Logging Services, Inc.	L05262	Houston	40	11/29/10
Throughout TX	Q Pro, Inc. dba Q Pro Technical Services	L05980	Houston	07	11/17/10
Throughout TX	Marco Inspection Services, L.L.C.	L06072	Kilgore	34	11/16/10
Throughout TX	E&P Wireline Services, L.L.C.	L05738	Midland	20	11/16/10
Throughout TX	American X-Ray & Inspection Services, Inc. dba AXIS, Inc.	L05974	Midland	27	11/18/10
Throughout TX	Martin Marietta Materials Southwest, Ltd.	L04768	San Antonio	09	11/17/10
Throughout TX	INTEC	L05150	San Antonio	15	11/10/10
Throughout TX	Schlumberger Technology Corporation	L00764	Sugar Land	118	11/15/10
Tyler	Mother Frances Hospital	L01670	Tyler	161	11/24/10
Waco	Baylor University	L00343	Waco	30	11/17/10
Webster	CHCA Clear Lake, L.P. dba Clear Lake Regional Medical Center	L01680	Webster	78	11/23/10

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout TX	City of Abilene	L05459	Abilene	08	11/18/10
Throughout TX	Professional Service Industries	L04947	Austin	21	11/17/10
Throughout TX	Professional Service Industries	L04944	Harlingen	12	11/29/10
Throughout TX	Vulcan Construction Materials, L.P.	L05382	Helotes	09	11/17/10
Throughout TX	IHI Southwest Technologies, Inc.	L05278	San Antonio	16	11/17/10

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Arlington	Diagnostic Health Centers of Texas, L.P. dba Diagnostic Health Arlington	L05033	Arlington	25	11/12/10
Throughout Tx	Integrated Production Services, Inc.	L06051	Iowa Park	07	11/18/10
Tomball	Tomball Imaging, L.L.P.	L06137	Tomball	01	11/17/10
Tyler	Allens Nutech, Inc. dba Nutech, Inc.	L05511	Tyler	12	11/16/10

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of 25 Texas Administrative Code (TAC) Chapter 289, regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a 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 person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - Mail Code 2835, P.O. Box 149347, Austin, TX 78714-9347. For information call (512) 834-6688.

TRD-201006926
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: December 7, 2010

♦ ♦ ♦

Texas Department of Insurance

Company Licensing

Application to change the name of AIG MEXICO SEGUROS INTER-AMERICANA, S.A. DE C.V. to CHARTIS SEGUROS MÉXICO, S.A. DE C.V., a Mexican casualty company. The home office is in Benito Juárez, México.

Application for admission to the State of Texas by ALLIED EASTERN INDEMNITY COMPANY, a foreign fire and/or casualty company. The home office is in Lancaster, Pennsylvania.

Application for admission to the State of Texas by EASTERN ADVANTAGE ASSURANCE COMPANY, a foreign fire and/or casualty company. The home office is in Lancaster, Pennsylvania.

Application to change the name of EMPLOYEES LIFE INSURANCE COMPANY to SWBC LIFE INSURANCE COMPANY, a domestic life, accident and/or health company. The home office is in San Antonio, Texas.

Any objections must be filed with the Texas Department of Insurance, within 20 calendar days from the date of the *Texas Register* publication, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, M/C 305-2C, Austin, Texas 78701.

TRD-201006968
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: December 8, 2010

♦ ♦ ♦

Panhandle Regional Planning Commission

Legal Notice

The Panhandle Regional Planning Commission (PRPC) is seeking quotes for Customized Learning Materials Kits suitable for use in a regulated day-care setting. Kits will be designed to include materials suitable for children in age groups of 0-17 months, 18-35 months, 3-5 years and 6 years and older. All kits, at a minimum, must target the seven interest areas from the Texas Rising Star (TRS) Provider Certification guidelines of blocks, dramatic play, manipulatives, stories/language, music, art, and discovery/science.

This project is funded by an American Recovery and Reinvestment Act (ARRA) grant and intended to assist area child care providers in serving children in a quality setting. To that end, selected providers in the area will be awarded kits as described above. A copy of the Request for Quotes (RFQ) can be obtained Monday through Friday, 8:00 a.m. to 5:00 p.m., at 415 West Eighth Ave., Amarillo, Texas 79101 or by contacting Leslie Hardin, PRPC's Workforce Development Facilities Coordinator at (806) 372-3381 or lhardin@theprpc.org. Proposals must be received at PRPC by 3:00 p.m. on Friday, January 7, 2011.

TRD-201006977
Leslie Hardin
Facilities Training, Support Coordinator
Panhandle Regional Planning Commission
Filed: December 8, 2010

♦ ♦ ♦

Texas State Board of Examiners of Psychologists

Public Hearing

The Texas State Board of Examiners of Psychologists will hold a public hearing to receive comments regarding proposed revisions to 22 Texas Administrative Code (TAC) Chapter 465, Rules of Practice, §465.38, Psychological Services for Public Schools, under the requirements of Texas Government Code Annotated §2001.029.

The Texas State Board of Examiners of Psychologists will hold a public hearing in Austin on Friday, January 14, 2011 at 10:00 a.m. in the William P. Hobby Building, 333 Guadalupe, Tower 3, Room 100, Austin, Texas 78701. The hearing is structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. Open discussion will not be permitted during the hearing; however, Texas State Board of Examiners of Psychologists staff members will briefly discuss the proposal at the beginning of the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Mr. Brian Creath at (512) 305-7700. Requests should be made no later than 5:00 p.m. on Monday, January 10, 2011.

Written comments may be submitted to Brenda Skiff, Texas State Board of Examiners of Psychologists, 333 Guadalupe, Suite 2-450, Austin, Texas 78701, or faxed to (512) 305-7701. Electronic comments may be emailed to brenda.skiff@tsbep.state.tx.us. Comments must be received by 5:00 p.m. on January 14,

2011. Copies of the proposed rulemaking can be obtained at *http://info.sos.state.tx.us/pls/pub/regviewctx$.startup*. For additional information, contact Brenda Skiff at (512) 305-7700.

TRD-201006924
Sherry L. Lee
Executive Director
Texas State Board of Examiners of Psychologists
Filed: December 6, 2010

♦ ♦ ♦

Public Utility Commission of Texas

Announcement of Application for State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on December 1, 2010, for a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of PRIDE Network, Inc. for a State-Issued Certificate of Franchise Authority, Project Number 38939.

PRIDE Network, Inc. requested the CFA service area as shown on the map attached to application as Exhibit A.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 38939.

TRD-201006888
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 6, 2010

♦ ♦ ♦

Notice of Application for Service Area Exception

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on December 6, 2010, for an amendment to certificated service area for a service area exception within Smith County, Texas.

Docket Style and Number: Application of Upshur Rural Electric Cooperative Corporation to Amend a Certificate of Convenience and Necessity for Electric Service Area Exception within Smith County. Docket Number 38955.

The Application: Upshur Rural Electric Cooperative Corporation (URECC) filed an application for a service area boundary exception to allow URECC to provide service to a specific customer located within the certificated service area of Cherokee County Electric Cooperative, Inc. (CCECA). CCECA has provided a letter of concurrence for the proposed change.

Persons wishing to comment on the action sought or intervene should contact the Public Utility Commission of Texas no later than December 30, 2010 by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 38955.

TRD-201006954
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 7, 2010

♦ ♦ ♦

Notice of Application to Amend a Certificate of Convenience and Necessity for a Proposed Transmission Line

Notice is given to the public of the filing with the Public Utility Commission of Texas (commission) an application on December 6, 2010, to amend a certificate of convenience and necessity for a proposed transmission line in Bowie County, Texas.

Docket Style and Number: Application of Southwestern Electric Power Company to Amend a Certificate of Convenience and Necessity for a Proposed Transmission Line within Bowie County. Docket Number 38838.

The Application: The application of Southwestern Electric Power Company (SWEPCO) for a proposed transmission line is designated the NW Texarkana 345-kV Transmission Line Project. This 345-kV project is located in the Southwest Power Pool (SPP). The purpose of the proposed transmission line is to transmit power from the new Turk Power Station into the SPP transmission power grid to the loads requesting transmission service. Portions of this load are located in Texas. The proposed project is presented with a preferred route and four alternate routes. Any route presented in the application could, however, be approved by the commission. The preferred proposed line will be approximately 6.5 miles in length. The total estimated cost for the project is $5,207,935. The estimated date to energize facilities is July 13, 2012.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. The deadline for intervention in this proceeding is January 20, 2011. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 38838.

TRD-201006953
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 7, 2010

♦ ♦ ♦

Notice of Application to Amend Certificated Service Area Boundaries

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application filed on December 1, 2010, for an amendment to certificated service area boundaries within Cameron County, Texas.

Docket Style and Number: Application of the Brownsville Public Utilities Board (BPUB) to Amend a Certificate of Convenience and Necessity for Service Area Boundaries within Cameron County (Carlos Macias). Docket Number 38941.

The Application: The application encompasses an area of land which is singly certificated to American Electric Power Company (AEP), formerly known as Central Power & Light (CP&L), and is within the corporate limits of the City of Brownsville. BPUB received a letter request

from Carlos Macias requesting BPUB to provide electric utility service to his home. The estimated cost to BPUB to provide service to this proposed area is $3,524.94. If the application is granted the area would be dually certificated for electric service.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas no later than December 30, 2010, by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) 1-800-735-2989. All comments should reference Docket Number 38941.

TRD-201006889
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 6, 2010

♦ ♦ ♦

Texas Department of Transportation

Aviation Division - Request for Proposal for Professional Engineering Services

The City of Dallas, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional services firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional services as described below:

Airport Sponsor: City of Dallas Dallas Executive Airport. TxDOT CSJ No. 11MPDALAS. Scope: update the Airport Master Plan which includes, but is not limited to, information regarding existing and future conditions, proposed facility development to meet existing and future demand, constraints to development, develop an aviation forecast, anticipated capital needs, financial considerations, management structure and options as well as an updated Airport Layout Plan. The Airport Master Plan should be tailored to the individual needs of the airport.

There is no DBE requirement for this project. TxDOT Project Manager is Daniel Benson.

Interested firms shall utilize the Form AVN-551, titled "Aviation Planning Services Proposal." The form may be requested from TxDOT Aviation Division, 125 East 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-551, firms are encouraged to download Form AVN-551 from the TxDOT web site as addressed above. Utilization of Form AVN-551 from a previous download may not be the exact same format. Form AVN-551 is a PDF Template.

Please note:

Five completed, unfolded copies of Form AVN-551 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **January 11, 2011, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluating consultants for airport planning projects can be found at http://www.txdot.gov/business/projects/aviation.htm. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

If there are any procedural questions, please contact Edie Stimach, Grant Manager, or Daniel Benson, Project Manager for technical questions at 1-800-68-PILOT (74568).

TRD-201006858
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 2, 2010

♦ ♦ ♦

Aviation Division - Request for Proposal for Professional Engineering Services

The City of Dallas, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below.

Airport Sponsor: City of Dallas. TxDOT CSJ No.: 1118DALAS. Scope: Provide engineering/design services to construct light duty perimeter road; install perimeter fencing; construct asphalt airfield service road; construct new hangar access taxiway; and drainage improvements.

The DBE Goal is 3%. TxDOT Project Manager is Clayton Bridwell.

To assist in your proposal preparation the criteria, 5010 drawing, and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Dallas Executive Airport."

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT Aviation Division, 125 East 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT web site as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Five completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **January 11, 2011 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluation of engineering proposals can be found at http://www.txdot.gov/business/projects/aviation.htm. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Edie Stimach, Grant Manager. For technical questions, please contact Clayton Bridwell, Project Manager.

TRD-201006859
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 2, 2010

♦ ♦ ♦

Aviation Division - Request for Proposal for Professional Engineering Services

The City of Arlington, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Arlington Municipal Airport during the course of the next five years through multiple grants.

Current Project: City of Arlington. TxDOT CSJ No.: 1102ARLNG. Scope: Provide engineering/design services to relocate ASOS, relocate segmented circle; install Medium Intensity Taxiway Lights; install Runway exit/hold signs; adjust underground utilities; construct west parallel and stub taxiways; site prep for westside taxiway.

The DBE goal for the current project is 9%. TxDOT Project Manager is Harry Lorton.

Future scope work items for engineering/design services within the next five years may include the following:

1. Construct entrance roads
2. Construct access roads
3. Concrete joint repairs apron, runway, taxiways
4. Rehabilitate and mark Runway 16-34
5. Install apron lighting
6. Construct hangar access taxiway
7. Extend west parallel taxiway
8. Construct west side apron

The City of Arlington reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your proposal preparation the criteria, 5010 drawing, and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Arlington Municipal Airport." The proposal should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT Aviation Division, 125 East 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT web site as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Five completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **January 11, 2011, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Edie Stimach.

The consultant selection committee will be composed of local government members. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluation of engineering proposals can be found at http://www.txdot.gov/business/projects/aviation.htm. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Edie Stimach, Grant Manager. For technical questions, please contact Harry Lorton, Project Manager.

TRD-201006860

Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 2, 2010

♦ ♦ ♦

Aviation Division - Request for Proposal for Professional Engineering Services

Aransas County, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Aransas County Airport during the course of the next five years through multiple grants.

Current Project: Aransas County. TxDOT CSJ No.: 1116ROCKP. Scope: Provide engineering/design services to construct deer/hog resistant fencing with cattle guard.

The DBE goal for the current project is 6%. TxDOT Project Manager is Harry Lorton.

Future scope work items for engineering/design services within the next five years may include the following:

1. Improve Runway 14 R.S.A.
2. Construct New Hangar Taxiway
3. Mill and Overlay Hangar Area
4. Construct Run-up Pads Runway 14 and 32
5. Taxiway Lighting Runway 18-36

Aransas County reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your proposal preparation the criteria, 5010 drawing and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Aransas County Airport." The proposal should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT Aviation Division, 125 E. 11th Street, Austin, Texas 78701-2483, phone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT web site at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT web site as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

Five completed, unfolded copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than January 18, 2011 at 4:00 p.m. Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Sheri Quinlan.

The consultant selection committee will be composed of Aviation Division staff members and one local government member. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The criteria for evaluation of engineering proposals can be found at http://www.txdot.gov/business/projects/aviation.htm. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Sheri Quinlan, Grant Manager. For technical questions, please contact Harry Lorton, Project Manager.

TRD-201006974
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 8, 2010

♦ ♦ ♦

Notice Affording Opportunity for Public Hearing

Pursuant to 43 Texas Administrative Code Chapter 2, Subchapter A, §2.18(b), the Texas Department of Transportation's (department) Maintenance Division undertook an environmental review of the department's nine maintenance programs: 1) bridge; 2) customer service; 3) debris and spills; 4) drainage; 5) ferries; 6) enhancement; 7) pavement; 8) roadside appurtenances; and 9) traffic pavements and markings. The department's maintenance programs help the department to provide a safe and functional roadway system, ensure clean and aesthetically pleasing highways and facilities, and improve the value and prolong the functional lifespan of the department infrastructure. The department's environmental review of the programs as documented in the Draft Environmental Assessment describes the purpose of and need for each of the nine maintenance programs; program alternatives; direct, indirect, and cumulative environmental consequences of the programs; and identifies best management practices that when implemented avoid, minimize, or compensate for any adverse environmental impacts resulting from the department maintenance program activities.

The Draft Environmental Assessment is on file and available for review at the department Maintenance Division office located at 150 East Riverside Drive, Austin, Texas 78704. Anyone may request that a public hearing be held covering the social, economic, and environmental effects of the project by sending a written request to Dennis Markwardt, Maintenance Division, Texas Department of Transportation, 150 East Riverside Drive, Austin, Texas 78704 postmarked on or before January 18, 2011. Persons may contact Mr. Markwardt at (512) 416-3093 with any questions.

TRD-201006975

Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 8, 2010

♦ ♦ ♦

Public Hearing Notice - Statewide Public Involvement Plan

The Texas Department of Transportation (department) will hold a public hearing on Wednesday, January 19, 2011, at 10:00 a.m. at the Texas Department of Transportation, 200 East Riverside Drive, Room 1A-2, Austin, Texas to receive public comments on the Statewide Public Involvement Plan (PIP). The PIP reflects the department's documented public involvement process for providing reasonable public access to technical and policy information used in the development of the long-range statewide transportation plan and Statewide Transportation Improvement Program (STIP). The PIP includes the Transportation Planning and Programming (TPP) Division's public involvement process, as well as those of the department's districts.

Title 23, Code of Federal Regulations, §450.210 requires that the State's public involvement process establish continuous public involvement opportunities, provide reasonable public access to technical and policy information used in the development of the long-range statewide transportation plan and STIP, and provide adequate public notice of public involvement activities and time for public review and comment at key decision points.

A copy of the proposed Statewide PIP will be available for review, at the time the notice of hearing is published, at each of the department's district offices, at the department's Transportation Planning and Programming Division offices located in Building 118, Second Floor, 118 East Riverside Drive, Austin, Texas, and on the department's web site at:

http://www.txdot.gov/

Persons wishing to review the Statewide PIP may do so online or contact the Transportation Planning and Programming Division at (512) 486-5033.

Persons wishing to speak at the hearing may register in advance by notifying Lori Morel, Transportation Planning and Programming Division, at (512) 486-5033 not later than Tuesday, January 18, 2011, or they may register at the hearing location beginning at 10:00 a.m. on the day of the hearing. Speakers will be taken in the order registered. Any interested person may appear and offer comments or testimony, either orally or in writing; however, questioning of witnesses will be reserved exclusively to the presiding authority as may be necessary to ensure a complete record. While any persons with pertinent comments or testimony will be granted an opportunity to present them during the course of the hearing, the presiding authority reserves the right to restrict testimony in terms of time or repetitive content. Groups, organizations, or associations should be represented by only one speaker. Speakers are requested to refrain from repeating previously presented testimony. Persons with disabilities who have special communication or accommodation needs or who plan to attend the hearing may contact the Government and Public Affairs Division, at 125 East 11th Street, Austin, Texas 78701-2483, (512) 463-9957. Requests should be made no later than three days prior to the hearing. Every reasonable effort will be made to accommodate the needs.

Further information on the Statewide PIP may be obtained from Lori Morel, Transportation Planning and Programming Division, 118 East Riverside Drive, Austin, Texas 78704, (512) 486-5033. Interested parties who are unable to attend the hearing may submit comments to James L. Randall, P.E., Director, Transportation Planning and Programming Division, 118 East Riverside Drive, Austin, Texas 78704. In order to be considered, all written comments must be received at the Transportation Planning and Programming office by Monday, February 14, 2011, at 4:00 p.m.

TRD-201006976
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: December 8, 2010

♦ ♦ ♦

The Texas A&M University System

Notice of Contract Award

Texas A&M University announces the following contract award:

The notice of request for proposals (RFP 11-0001) was published in the October 8, 2010, issue of the *Texas Register* (35 TexReg 9163).

The contractor will conduct a hotel and conference center feasibility study for Texas A&M University.

The contract was awarded to Colliers PKF, 1010 Lamar, Suite 400, Houston, Texas 77002. The total amount of the contract is $35,000. The term of the contract is December 1, 2010 through January 19, 2011.

TRD-201006865
Rex Janne
Executive Director, Department of Procurement Services
The Texas A&M University System
Filed: December 3, 2010

♦ ♦ ♦

How to Use the Texas Register

Information Available: The 14 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 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.

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

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 35 (2010) is cited as follows: 35 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 "35 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 35 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 at: 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 website information, call the Texas Register at (512) 463-5561.

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 and Parts (using Arabic 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 (800-356-6548), and West Publishing Company (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 ***Index of Rules***. The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with the ***Texas Register*** page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
40 TAC §3.704.....950 *(P)*