TEXAS REGISTER

Volume 36 Number 27 *July 8, 2011* *Pages 4201 – 4472*

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 12887
Austin, TX 78711-3824
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IN ADDITION

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.)

Requests for Opinions

RQ-0977-GA

Requestor:

Mr. Don Sloan, President

Bandera County River Authority and Groundwater District

Post Office Box 177

Bandera, Texas 78003

Re: Whether certain kinds of electronic communication among members of the board of directors of a river authority constitute a violation of the Open Meetings Act, chapter 551, Government Code (RQ-0977-GA)

Briefs requested by July 25, 2011

RQ-0978-GA

Requestor:

The Honorable Jo Anne Bernal

El Paso County Attorney

500 East San Antonio, Room 503

El Paso, Texas 79901

Re: Whether a member of the El Paso County Ethics Commission who is a practicing attorney or former judge may be appointed to serve as the review officer of a preliminary screening committee (RQ-0978-GA)

Briefs requested by July 25, 2011

RQ-0979-GA

Requestor:

Mr. Scott Sayers, Chairman

Texas State Cemetery Committee

900 Navasota

Austin, Texas 78702

Re: Jurisdiction of the Texas State Cemetery over a state highway, the majority of which is located within the boundaries of the Cemetery (RQ-0979-GA)

Briefs requested by July 26, 2011

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

TRD-201102447
Jay Dyer
Deputy Attorney General
Office of the Attorney General
Filed: June 29, 2011

♦ ♦ ♦

Emergency Rules include new rules, amendments to existing rules, and the repeals of existing rules. A state agency may adopt an emergency rule without prior notice or hearing if the agency finds that an imminent peril to the public health, safety, or welfare, or a requirement of state or federal law, requires adoption of a rule on fewer than 30 days' notice. An emergency rule may be effective for not longer than 120 days and may be renewed once for not longer than 60 days (Government Code, §2001.034).

TITLE 22. EXAMINING BOARDS

PART 8. TEXAS APPRAISER LICENSING AND CERTIFICATION BOARD

CHAPTER 153. RULES RELATING TO PROVISIONS OF THE TEXAS APPRAISER LICENSING AND CERTIFICATION ACT

22 TAC §§153.1, 153.5, 153.16, 153.17, 153.27

The Texas Appraiser Licensing and Certification Board (TALCB) adopts on an emergency basis amendments to 22 TAC §153.1, Definitions; §153.5, Fees; §153.16, Provisional License; §153.17, Renewal or Extension of Certification and License or Renewal of Trainee Approval; and §153.27, Certification and Licensure by Reciprocity.

The amendments are adopted on an emergency basis to resolve conflicts between the agency's rules and new provisions of the Appraiser Licensing and Certification Act (Chapter 1103, Texas Occupations Code), as amended by House Bill 2375, which became immediately effective when it was signed into law on May 27, 2011. An urgent public necessity requires emergency action to resolve conflicts between existing rules and new statutory provisions, as follows: (1) Section 153.1 is being amended because subsection (a)(44), the definition of "Provisional License," includes references to §1103.208 of the Texas Occupations Code, the repeal of which abolished the provisional license category (although current provisional licensees may continue to hold such licenses until expiration), and §153.16, which is being amended herein in accordance with the repeal of Texas Occupations Code §1103.208. (2) Section 153.5 is being amended because subsection (a)(10) currently provides for renewal fees of double the usual renewal fee to renew a certification or license more than 90 days but less than one year after expiration, while new Texas Occupations Code §1103.2111 only requires payment of double the usual fee to renew more than 90 days but less than six months after expiration. (3) Section 153.16 is being amended to repeal provisions regarding application for a provisional license (as discussed above). (4) Section 153.17 is being amended to delete references to renewal of a provisional license. (5) Section 153.27 is being amended to delete a reference to certification or licensure only for appraisers from states that have entered into reciprocal agreements with Texas, as Chapter 1103 now requires, based on a requirement of the Dodd-Frank Wall Street Reform and Consumer Protection Act, that the TALCB honor reciprocity with appraisers from all states that are in good standing with the Appraiser Subcommittee.

The amendments are adopted on an emergency basis under Texas Occupations Code, §1103.151, which authorizes the TALCB to adopt rules relating to certificates and licenses, §1103.152, which authorizes the TALCB to adopt rules relating to appraiser certificate and license categories, and §1103.156, which authorizes the TALCB to adopt reasonable fees to administer the chapter.

The statute affected by this emergency adoption is Texas Occupations Code, Chapter 1103. No other statute, code or article is affected by the emergency adoption.

§153.1. Definitions.

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

(1) - (43) (No change.)

(44) Provisional License--A license issued [~~under the Texas Appraiser Licensing and Certification Act, Section 103.208, and §153.16 of this title (relating to Provisional License),~~] to individuals who have met the educational and examination requirements for licensing but who have not met the experience requirements.

(45) - (60) (No change.)

§153.5. Fees.

(a) The Board shall charge and the commissioner shall collect the following fees:

(1) - (9) (No change.)

(10) a fee equal to two times the timely renewal fee for the late renewal of a license or certification more than 90 days but less than six months [~~one year~~] after expiration;

(11) - (23) (No change.)

(b) - (d) (No change.)

§153.16. Provisional License.

[~~(a) In order to obtain a provisional license, a person must satisfy all requirements for a license with the exception of the experience requirement and must:~~]

[~~(1) make a diligent and good faith effort to find a sponsor; and~~]

[~~(2) submit to the Board two affidavits declining sponsorship signed by appraisers eligible to sponsor trainees.~~]

[~~(b)~~] Persons practicing under this section must maintain a current log of appraisal activities performed on a form prescribed by the board.

§153.17. Renewal or Extension of Certification and License or Renewal of Trainee Approval.

(a) (No change.)

(b) General Certification, Residential Certification, and State License[~~, and Provisional License~~].

(1) A certified or licensed appraiser may renew the certification or license by timely filing the prescribed application for renewal, paying the appropriate fees to the board and, unless renewing on inactive status, satisfying ACE requirements. [~~Provisional licensees must also provide a copy of an appraisal log and experience affidavit, on forms prescribed by the board, for the period of licensure being renewed.~~]

(2) - (3) (No change.)

(c) - (f) (No change.)

§153.27. Certification or Licensure by Reciprocity.

(a) A person who is licensed or certified as an appraiser under the laws of a state whose appraiser program has not been disapproved by the ASC [~~having reciprocity at the level of the person's license in the other state~~] may apply for a Texas license or certification at that same level by completing and submitting to the board the application for licensure or certification or license by reciprocity and paying to the board the fee.

(b) - (c) (No change.)

This agency hereby certifies that the emergency adoption 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 June 23, 2011.

TRD-201102371
Devon V. Bijansky
General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: June 23, 2011
Expiration date: October 20, 2011
For further information, please call: (512) 465-3938

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PART 23. TEXAS REAL ESTATE COMMISSION

CHAPTER 537. PROFESSIONAL AGREEMENTS AND STANDARD CONTRACTS

22 TAC §§537.20, 537.28, 537.30 - 537.32, 537.37

The Texas Real Estate Commission is renewing the effectiveness of the emergency adoption of amendments to §§537.20, 537.28, 537.30 - 537.32, and 537.37, for a 60-day period. The text of the amended sections was originally published in the March 4, 2011, issue of the *Texas Register* (36 TexReg 1409).

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102402
Loretta R. DeHay
General Counsel
Texas Real Estate Commission
Original effective date: March 1, 2011
Expiration date: August 27, 2011
For further information, please call: (512) 465-3926

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PROPOSED RULES

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 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER J. PURCHASED HEALTH SERVICES

DIVISION 4. MEDICAID HOSPITAL SERVICES

The Texas Health and Human Services Commission (HHSC) proposes the repeal of §355.8052, concerning Medicaid Inpatient Hospital Reimbursement; and proposes new §355.8052, concerning Medicaid Inpatient Hospital Reimbursement, in Chapter 355, Reimbursement Rates.

Background and Justification

HHSC proposes to repeal current §355.8052 and replace it with new §355.8052 describing the prospective payment system applicable to Medicaid inpatient hospital payments. The proposed methodology establishes a statewide base standard dollar amount (SDA) that is intended to address the effects of the current hospital-specific rate methodology, which can result in different payments to similarly situated hospitals for the same or similar services. Teaching hospitals and trauma-designated hospitals are eligible for increases to the statewide base SDA, in recognition of the high-cost functions of those groups of providers. Increases to the statewide base SDA are also available based on wage differences related to the geographic area in which each prospectively-paid inpatient hospital is located.

The proposed rule implements the requirements of the 2012-13 General Appropriations Act (Article II, Health and Human Services Commission, H.B. 1, Rider 67 and Rider 61(b)(17), 82nd Legislature, Regular Session, 2011), which direct HHSC to develop a statewide SDA and authorize HHSC to consider high-cost hospital functions and services, including regional differences. The proposed rule also reflects direction in Article II regarding inpatient hospital rates, including HHSC Rider 61(b)(29), related to appropriate payments to outlier hospitals, HHSC Rider 67, related to mitigation of disproportionate losses up to September 1, 2012, and Special Provisions, Section 16(b)(5), related to reducing hospital rates by eight percent. The proposed rule also reflects legislative direction in Article IX, General Provisions, Section 18.19, related to the use of trauma fund receipts for Medicaid reimbursement purposes.

Under the current methodology, which HHSC proposes to repeal, HHSC calculates a hospital-specific SDA for each prospectively-paid Medicaid inpatient hospital. The hospital-specific SDA is calculated based on each hospital's charges, converted to cost, for providing Medicaid services. Hospital-specific SDAs are grouped into payment divisions and assigned a payment division SDA, which is multiplied by relative weight for the diagnosis-related group (DRG) to determine the reimbursement amount. In recent years, this methodology has come under scrutiny as having the potential to reward inefficient and high-cost providers.

A statewide SDA, combined with appropriate adjustments for certain high-cost functions and services (called "add-ons" in the proposed rule), provides each hospital the incentive to manage its costs and, if the hospital desires, expand its services to include one or more of the high-cost services. For example, a hospital may choose to earn an increased SDA by obtaining a trauma designation or achieving a higher-level trauma designation, or it may choose to become a teaching hospital or take steps to increase its Medicare education adjustment factor.

To facilitate the transition to a statewide SDA, the Texas Legislature authorized HHSC to use up to $20 million in general revenue funds during the first year that the statewide rate is in effect to mitigate the fiscal impact to hospitals that are disproportionately impacted by the proposed transition to a statewide rate. The proposed rule describes the methodology used to identify the disproportionately impacted hospitals and to mitigate the impact to that group of hospitals.

The Legislature also authorized the transfer of funds to HHSC from the Trauma Facilities and Emergency Medical Services account administered by the Department of State Health Services in order to support the establishment and maintenance of trauma and emergency care facilities across the state by maximizing the availability of federal funds to reimburse trauma hospitals. The proposed methodology assures that reimbursements to a hospital using those funds will not be less than the amount the hospital otherwise would have received for uncompensated trauma care from the Trauma Facilities and Emergency Medical Services account.

HHSC modified the calculation of day and cost outliers by reducing the reimbursement percentage from 70 percent to 60 percent.

The proposed rule also notes that HHSC may, consistent with other administrative rules, adjust rates to accommodate available appropriated funds. HHSC will adjust rates pursuant to this authority to account for the eight percent hospital rate reduction specified in the 2012-13 General Appropriations Act.

HHSC anticipates that the proposed rule will be in effect for inpatient hospital reimbursement only for state fiscal year 2012. HHSC anticipates promulgating a new rule for inpatient reimbursements beginning in state fiscal year 2013, following the

next rebasing process and the transition to the all-patient refined diagnosis-related groups.

The methodology described in the proposed rule does not apply to children's hospitals, state-owned teaching hospitals, freestanding psychiatric hospitals, or hospitals in counties with 50,000 or fewer persons and certain other hospitals. The methodologies for reimbursing those hospitals are described in §§355.8054, 355.8056, and 355.8060 and in proposed §355.8055, which was published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4013).

Section-by-Section Summary

Current §355.8052 is repealed in its entirety. The provisions in current §355.8052(i) concerning rural and certain other hospitals are being relocated to proposed new §355.8055, which was published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4013).

Proposed new §355.8052(a) generally describes the reimbursement method and clarifies that the prospective payment system applies to inpatient hospital payments for fiscal year 2012 or until HHSC implements a new reimbursement methodology.

Proposed new §355.8052(b) lists the types of hospitals that are exceptions to the prospective payment system described in the proposed rule and identifies the rules describing reimbursement methodologies for those hospitals.

Proposed new §355.8052(c) defines the terms used in the proposed rule and in other inpatient hospital reimbursement rules.

Proposed new §355.8052(d) describes the methodology used to calculate a statewide base SDA.

Proposed new §355.8052(e) lists the categories of add-ons to the statewide base SDA that a hospital may be eligible to receive. This subsection also describes the eligibility criteria for each category of add-on and the methodology used to calculate the amount of the add-on. This subsection also describes the procedure HHSC used to verify each hospital's add-on status and the potential consequences to a hospital for failing to confirm the accuracy of its add-on status.

Proposed new §355.8052(f) describes the methodology used to calculate a hospital's final SDA, including that HHSC may adjust the final SDA based on available appropriations. This subsection includes a description of the methodology used to identify hospitals that are disproportionately impacted by the transition to a statewide SDA and to mitigate the impact to those hospitals in state fiscal year 2012. The subsection describes the final SDA that will be assigned to military and out-of-state hospitals, to merged hospitals, and to other hospitals for which HHSC has no base-year claim data.

Proposed new §355.8052(g) describes the methodology used to calculate relative weights for each diagnosis-related group; to recalibrate mean length of stay; and to recalibrate day outlier thresholds.

Proposed new §355.8052(h) describes the methodology used to calculate the payment amount for Medicaid services. This subsection also describes the methodology for calculating day and cost outlier adjustments. Additionally, HHSC modified the calculation of day and cost outlier adjustments by reducing the reimbursement percentage from 70 percent to 60 percent.

Proposed new §355.8052(i) describes the requirement that each hospital must submit cost reports at periodic intervals and provides that information from these reports is used in rebasing rate years to recalculate the base SDA.

Fiscal Note

Greta Rymal, Deputy Executive Commissioner for Financial Services, has determined that, for the first five years the proposed repeal and new section are in effect, there are foreseeable implications relating to costs or revenues of state government.

The effect on state government for the first five years the proposed repeal and new section are in effect is an estimated reduction in cost of $219,176,376 all funds ($91,133,537 general revenue (GR)) in fiscal year (FY) 2012; $278,251,774 ($118,396,130 GR) in FY 2013; $289,677,812 ($123,460,683 GR) in FY 2014; $301,573,045 ($128,530,432 GR) in FY 2015; and $313,956,740 ($133,808,363 GR) in FY 2016.

In addition to the fiscal impact above, the estimated additional funding available from the Trauma Facilities and Emergency Medical Services account administered by the Department of State Health Services (dedicated general revenue and the associated federal revenue) for each of the first five years is: $57,478,019 all funds ($23,899,360 dedicated general revenue (GRD)) in fiscal year (FY) 2012; $59,838,277 ($25,461,187 GRD) in FY 2013; $62,295,456 ($26,550,323 GRD) in FY 2014; $64,853,536 ($27,640,577 GRD) in FY 2015; and $67,516,660 ($28,775,600 GRD) in FY 2016.

Ms. Rymal anticipates that there will not be an economic cost to persons who are required to comply with the repeal and new section. There is no anticipated negative impact on local employment.

Ms. Rymal anticipates that there may be implications relating to costs or revenues of local government. The proposed new rule may have an adverse economic effect on revenues of local governments that own hospitals because reimbursement for all prospective inpatient hospital services is subject to the legislative budget reduction. The change in reimbursement methodology was implemented to limit the impact for disproportionately impacted hospitals, including those owned by local governments. Hospitals owned by local governments in counties with fewer than 50,000 residents are not reimbursed under this section and are not impacted by the proposed methodology.

Small Business and Micro-business Impact Analysis

Under §2006.002 of the Government Code, a state agency proposing an administrative rule that may have an adverse economic effect on small businesses must prepare an economic impact statement and, generally, a regulatory flexibility analysis. The economic impact statement estimates the number of small businesses subject to the rule and projects the economic impact of the rule on small businesses. The regulatory flexibility analysis describes the alternative methods the agency considered to achieve the purpose of the proposed rule while minimizing adverse effects on small businesses. A regulatory flexibility analysis is not required if the proposed rule is required by a state or federal mandate.

Carolyn Pratt, Director of Rate Analysis, has determined that the proposed repeal and new section may have an adverse economic effect on small businesses as a result of lower reimbursement for all prospectively paid inpatient hospital services due to legislative budget reduction. The change in reimbursement methodology was implemented to limit the impact for disproportionately impacted hospitals.

It is unknown the number of small or micro-businesses subject to the rule that may be impacted by the amendment.

As noted above, a methodology is proposed to mitigate the impact for disproportionately impacted hospitals. Alternative methods to achieve the purpose of the proposed rule are not required because the content of the rule is mandated by state law.

Public Benefit

Carolyn Pratt has also determined that, for each year of the first five years the repeal and new section are in effect, the anticipated public benefit expected as a result of enforcing the repeal and new section is that the previous disparity in payment to similarly-situated hospitals for providing the same service will be reduced or eliminated. Additionally, the public will benefit from the establishment of financial incentives, in the form of increases to the statewide base SDA, for hospitals to reduce costs and to expand their provision of one or more of the high-cost services.

Regulatory Analysis

HHSC has determined that this proposal is not a "major environmental rule" as defined by §2001.0225 of the Texas Government Code. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of 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

HHSC has determined that this proposal does 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, does not constitute a taking under §2007.043 of the Texas Government Code.

Public Comment

Written comments on the proposal may be submitted to Chris Dockal, Rate Analysis, Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax to (512) 491-1467; or by e-mail to chris.dockal@hhsc.state.tx.us, within 30 days after publication of this proposal in the *Texas Register.*

1 TAC §355.8052

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

Statutory Authority

The repeal is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The repeal affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.8052. Inpatient Hospital Reimbursement.

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 June 27, 2011.

TRD-201102396
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 424-6900

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1 TAC §355.8052

Statutory Authority

The new rule is proposed under Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements.

The new rule affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

§355.8052. Inpatient Hospital Reimbursement.

(a) Application and general reimbursement method.

(1) The prospective payment system described in this section applies to inpatient hospital payments for state fiscal year 2012 or until the Health and Human Services Commission (HHSC) implements a new reimbursement methodology.

(2) HHSC calculates reimbursement for a covered inpatient hospital service, determined in subsection (h) of this section, by multiplying the hospital's final standard dollar amount (SDA), determined in subsection (f) of this section, by the relative weight for the appropriate diagnosis-related group, determined in subsection (g) of this section.

(b) Exceptions. The prospective payment system described in this section does not apply to the following types of hospitals for covered inpatient hospital services:

(1) In-state and out-of-state children's hospitals. In-state and out-of-state children's hospitals are reimbursed using the methodology described in §355.8054 of this division (relating to Children's Hospital Reimbursement Methodology).

(2) State-owned teaching hospitals. A state-owned teaching hospital is reimbursed in accordance with the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) principles using the methodology described in §355.8056 of this division (relating to State-Owned Teaching Hospital Reimbursement Methodology).

(3) Freestanding psychiatric hospitals. A freestanding psychiatric hospital is reimbursed under the methodology described in

§355.8060 of this division (relating to Reimbursement Methodology for Freestanding Psychiatric Facilities).

(4) Hospitals in counties with 50,000 or fewer persons and certain other hospitals. A hospital in a county with 50,000 or fewer persons based on the 2000 decennial census and certain other hospitals are reimbursed under the methodology described in §355.8055 of this division (relating to Reimbursement Methodology for Rural and Certain Other Hospitals).

(c) Definitions. When used in this section, and §§355.8054 - 355.8056 of this division, the following words and terms have the following meanings, unless the context clearly indicates otherwise.

(1) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(2) Add-on--An amount that is added to the base SDA to reflect high-cost functions and services or regional cost differences.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsection (d) of this section, for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year--For the purpose of this section, the base year is federal fiscal year 2008 (October 1, 2007 to September 30, 2008).

(5) Base year claims--All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by a hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;

(C) were not claims for patients who are covered by Medicare;

(D) were not Medicaid spend-down claims;

(E) were not claims associated with military hospitals, out-of-state hospitals, and hospitals described in subsection (b) of this section.

(6) Base year cost per claim--The cost for a base year claim that would have been paid to a hospital if HHSC reimbursed the hospital under methods and procedures used in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), without the application of the TEFRA target cap.

(7) Cost-of-Living Index--An adjustment applied to the base SDA and add-on amounts based on the Market Basket Index in effect in April 2009 to account for changes in cost of living.

(8) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(9) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(11) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(12) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the Medicare DRG system or as otherwise specified by HHSC.

(13) Final settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary, or in the case of children's hospitals, audited by HHSC.

(14) Final standard dollar amount (final SDA)--The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(15) Full-cost SDA--The sum of a hospital's base year costs per claim divided by the sum of the hospital's relative weights.

(16) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

(17) HHSC--The Texas Health and Human Services Commission or its designee.

(18) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(19) Interim payment--An initial payment made to a hospital that is later settled to Medicaid-allowable costs, for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(20) Interim rate--The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for a DRG hospital reimbursed under this section and §355.8055 of this division excludes the application of TEFRA target caps and the resulting incentive and penalty payments for a hospital's fiscal years ending on or after October 1, 2007.

(21) Market basket index--The Centers for Medicare and Medicaid Services (CMS) projection of the annual percentage increase in hospital inpatient operating costs.

(22) Mean length of stay (MLOS)--One factor used in determining the payment amount calculated for each DRG; for each DRG, the average number of days that a patient stays in the hospital.

(23) Medical education add-on--An adjustment to the base SDA for a teaching hospital to reflect higher patient care costs relative to non-teaching hospitals.

(24) Military hospital--A hospital operated by the armed forces of the United States.

(25) Out-of-state children's hospital--A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(26) Rebasing--Calculation of the base year cost per claim for each Medicaid inpatient hospital. For purposes of this section, HHSC is not rebasing.

(27) Relative weight--The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(28) State-owned teaching hospital--The following hospitals: University of Texas Medical Branch (UTMB); University of Texas Health Center Tyler; and M.D. Anderson Hospital.

(29) Teaching hospital--A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(30) TEFRA target cap--A limit set under the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) and applied to the cost settlement for a hospital reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to patients under age 21.

(31) Tentative settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(32) Texas provider identifier--A unique number assigned to a provider of Medicaid services in Texas.

(33) Trauma add-on--An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations.

(34) Trauma hospital--An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation under 25 Texas Administrative Code §157.125 (relating to Requirements for Trauma Facility Designation).

(35) Universal mean--Average base year cost per claim for all hospitals.

(d) Base standard dollar amount (SDA) calculations. HHSC will use the methodologies described in this subsection to determine a statewide base SDA.

(1) HHSC calculates the universal mean as follows:

(A) Use the base year cost per claim for each hospital.

(B) Sum the dollar amount for all hospitals' base year costs per claim.

(C) Divide the result in subparagraph (B) of this paragraph by the total number of base year claims to derive the universal mean.

(2) From the amount determined in paragraph (1)(B) of this subsection, HHSC sets aside an amount to recognize high-cost hospital functions and services and regional wage differences. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(A) The costs remaining after HHSC sets aside the amount for high-cost hospital functions and services will be used to determine the base SDA, as described in paragraphs (3) and (4) of this subsection.

(B) The costs HHSC sets aside will determine the funds available for distribution to hospitals that are eligible for one or more add-ons as described in subsection (e) of this section.

(3) HHSC divides the amount in paragraph (2)(A) of this subsection by the total number of base year claims.

(4) HHSC multiplies the amount calculated in paragraph (3) of this subsection by the cost-of-living index to derive the base SDA.

(e) Add-ons.

(1) A hospital may receive increases to the base SDA for any of the following:

(A) Geographic wage add-on, as described in paragraph (3) of this subsection.

(B) Medical education add-on, as described in paragraph (4) of this subsection.

(C) Trauma add-on, as described in paragraph (5) of this subsection.

(2) If a hospital becomes eligible for one or more add-ons during fiscal year 2012, the hospital will not receive an increased base SDA. A hospital may become eligible for add-on adjustments in subsequent fiscal years.

(3) Geographic wage add-on.

(A) Wage index. To determine a hospital's geographic wage add-on, HHSC first calculates a wage index for Texas as follows:

(i) HHSC identifies the Medicare wage index factor for each Core Based Statistical Area (CBSA) in Texas.

(ii) HHSC identifies the lowest Medicare wage index factor in Texas.

(iii) HHSC divides the Medicare wage index factor for each CBSA by the lowest Medicare wage index factor identified in clause (ii) of this subparagraph.

(iv) HHSC uses the result of the calculations in clause (iii) of this subparagraph to calculate each CBSA's add-on amount described in subparagraph (C) of this paragraph.

(B) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification, under the process described in paragraph (6) of this subsection.

(C) Add-on amount.

(i) HHSC calculates 62 percent of the base SDA to derive the labor-related portion of that rate, consistent with the Medicare labor-related percentage.

(ii) To determine the geographic wage add-on amount for each CBSA, HHSC multiplies the wage index factor determined in subparagraph (A)(iv) of this paragraph for that CBSA by the percentage labor share of the base SDA calculated in clause (i) of this subparagraph.

(4) Medical Education add-on.

(A) Eligibility. A teaching hospital is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in paragraph (6) of this subsection, that HHSC's determination of the hospital's eligibility and Medicare education adjustment factor for the add-on is correct.

(B) Add-on amount. HHSC multiplies the base SDA by the hospital's Medicare education adjustment factor to determine the hospital's medical education add-on amount.

(5) Trauma add-on.

(A) Eligibility.

(i) To be eligible for the trauma add-on, a hospital must be designated as a trauma hospital by the Texas Department of

State Health Services and be eligible to receive an allocation from the trauma facilities and emergency medical services account under Chapter 780, Health and Safety Code.

(ii) HHSC initially uses the trauma level designation associated with the physical address of a hospital's Texas Provider Identifier (TPI). A hospital may request that HHSC, under the process described in paragraph (6) of this subsection, use a higher trauma level designation associated with a physical address other than the hospital's TPI address.

(B) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(i) by 12.8 percent for hospitals with Level 1 trauma designation;

(ii) by 8.2 percent for hospitals with Level 2 trauma designation;

(iii) by 1.4 percent for hospitals with Level 3 trauma designation; or

(iv) by 1.3 percent for hospitals with Level 4 trauma designation.

(C) Reconciliation with other reimbursement for uncompensated trauma care. Subject to the General Appropriations Act and other applicable law:

(i) If a hospital's allocation from the trauma facilities and emergency medical services account administered under Chapter 780, Health and Safety Code, is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at the time funds are dispersed from that account to eligible trauma hospitals.

(ii) If a hospital's allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(6) Add-on status verification.

(A) Notification. HHSC will notify a hospital of its add-on status, as initially determined by HHSC, to identify the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. HHSC may post the information on HHSC's website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.

(B) HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification, in writing by regular mail, hand delivery or special mail delivery, from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(i) the hospital provides documentation of its eligibility for a different trauma designation or medical education percentage; or

(ii) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA.

(C) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(f) Final SDA.

(1) HHSC calculates a hospital's final SDA as follows:

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) Multiply the SDA determined in subparagraph (A) of this paragraph by the hospital's total relative weight of base year claims.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) Multiply the SDA determined for each hospital in subparagraph (A) of this paragraph by the percentage determined in subparagraph (D) of this paragraph.

(2) A hospital is assigned the SDA derived in paragraph (1)(E) of this subsection as its final SDA, except that:

(A) such SDA will be reduced to the full-cost hospital SDA, if it exceeds the amount of the full-cost hospital SDA; or

(B) such SDA may be increased as described in paragraph (3) of this subsection.

(3) Adjustment to mitigate hospitals for disproportionate losses. A hospital may be eligible for an increase to the SDA determined in paragraph (1)(E) of this subsection based on the following methodology:

(A) HHSC identifies the SDA the hospital was assigned following the most recent rebasing and for which the hospital received notification and an opportunity to request review. Under §355.201 of this title (relating to Establishment and Adjustment of Reimbursement Rates by the Health and Human Services Commission), authorizing HHSC to adjust rates to stay within available appropriated funds, HHSC:

(i) multiplied such SDA by 62.32 percent;

(ii) multiplied the result of clause (i) of this subparagraph by the hospital's total relative weights used in the most recent rebasing;

(iii) divided the result of clause (ii) of this subparagraph by the hospital's total relative weights that were recalculated excluding the claims associated with hospitals described in subsection (b)(4) of this section;

(iv) multiplied the result of clause (iii) of this subparagraph by 98 percent;

(v) multiplied the result of clause (iv) of this subparagraph by 87 percent.

(B) HHSC compares the SDA calculated in paragraph (1)(E) of this subsection to the SDA calculated in subparagraph (A)(v) of this paragraph.

(i) If the SDA calculated in paragraph (1)(E) of this subsection is less than the SDA calculated in subparagraph (A)(v) of this paragraph, the hospital is assigned an SDA equal to the SDA calcu-

lated in subparagraph (A)(v) of this paragraph, proportionately reduced as necessary to stay within appropriated funds identified to mitigate disproportionate losses.

(ii) The SDA calculated in clause (i) of this subparagraph will be reduced to the highest individual hospital SDA computed in subsection (e) of this section, if it exceeds that amount.

(4) For military and out-of-state hospitals, the final SDA is the base SDA multiplied by the percentage determined in paragraph (1)(D) of this subsection.

(5) For hospitals other than those identified in paragraph (4) of this subsection for which HHSC has no base year claim data, the final SDA is the base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in paragraph (1)(D) of this subsection.

(6) Merged hospitals.

(A) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.

(B) When each of the merging hospitals was reimbursed under this section before the merger, HHSC will assign to the merged entity the final SDA assigned to the hospital associated with the surviving Texas Provider Identifier and will reprocess all claims for the merged entity back to the date of the merger.

(C) When one or more of the merging hospitals was not reimbursed under this section before the merger, the surviving TPI will determine whether the merged entity will be reimbursed under this section or under a methodology described elsewhere in this division.

(D) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.

(7) Adjustments. HHSC may adjust a hospital's final SDA in accordance with §355.201 of this title.

(g) Diagnosis-related groups (DRGs) statistical calculations. HHSC adopts the classification of diagnoses defined in the Medicare DRG prospective payment system unless a revision is required based on Texas claims data or other factors, as determined by HHSC. HHSC recalibrates the relative weights, mean length of stay (MLOS), and day outlier threshold whenever the base SDAs are recalculated.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows:

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the base year costs per claim as determined in subsection (d) of this section;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG.

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows:

(A) Base year claims are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows:

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.

(F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than ten base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare MLOS and will calculate the day outlier threshold based on the Medicare MLOS and standard deviation.

(5) If one of the DRGs specific to an organ transplant has fewer than five base year claims, HHSC will assign the corresponding Medicare relative weight and Medicare MLOS and will calculate the day outlier threshold based on the Medicare MLOS and standard deviation. In addition, HHSC adds a relative weight to account for the cost of procuring the organ to the Medicare relative weight for the DRG. HHSC uses the organ procurement costs published by the Acquisition of Organ Procurement Organization (AOPO). To calculate the relative weight for procurement, HHSC divides the average cost of organ procurement by the universal mean for all claims.

(h) Reimbursements.

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsection (f) of this section by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

(2) The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.

(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday,

inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment.

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows:

(i) Determine whether the number of medically necessary days allowed for a claim exceeds:

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.

(ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim.

(iii) Multiply the DRG relative weight by the final SDA.

(iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsection (g)(2) of this section, to arrive at the DRG per diem amount.

(v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.

(vi) Multiply the result in clause (v) of this subparagraph by 60 percent.

(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows:

(i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.

(ii) Multiply the full DRG prospective payment by 1.5.

(iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.

(iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment.

(C) If an admission qualifies for both a day outlier and a cost outlier payment adjustment, HHSC pays the higher outlier payment.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

(4) A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows:

(i) Multiply the DRG relative weight by the final SDA.

(ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsection (g)(2) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:

(I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or

(II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.

(i) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports in rebasing rate years to recalculate base SDAs and to complete cost settlements for children's hospitals, rural and certain other hospitals, and state-owned teaching hospitals as outlined in §§355.8054 - 355.8056 of this division.

(3) HHSC may require a hospital to provide additional data in a format and at a time specified by HHSC.

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 June 27, 2011.

TRD-201102397
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 424-6900

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TITLE 4. AGRICULTURE

PART 1. TEXAS DEPARTMENT OF AGRICULTURE

CHAPTER 7. PESTICIDES

SUBCHAPTER H. STRUCTURAL PEST CONTROL SERVICE

DIVISION 2. LICENSES

4 TAC §7.127

The Texas Department of Agriculture (the department) proposes amendments to §7.127, concerning fees for structural pest control applicants, licensees and continuing education providers. These amendments are necessary to comply with changes made to the structural pest control program by the 82nd Texas Legislature. The Legislature has required that all of the costs of administering this program be entirely offset by revenue generated for the program and has authorized the agency to collect fees accordingly. In order to meet this Legislative mandate, the department has first reviewed programs for cost savings and efficiencies, then restructured programs, as needed, to provide the best service possible at a reasonable cost to the regulated industry. The proposed amendments to §7.127 will increase structural pest control fees by an average of 57% so that the new leaner and more cost-efficient program may be implemented, under the cost recovery requirement imposed by the 82nd Legislature.

The amendments to §7.127 increases the fees for an original business license from $180 to $280; for a renewal business license from $180 to $280; for an original certified applicator license from $85 to $135; for a renewal certified applicator license from $80 to $125; for an original technician license from $65 to $100; for a renewal technician license from $60 to $95; for administering exams from $50 to $75; and for a continuing education course from $40 to $60. The amendments to §7.127 also change the times that late fees will be charged to be consistent with other licensing programs and deletes the proration amounts for licenses since licenses are no longer prorated.

Jimmy Bush, Assistant Commissioner for Pesticides, has determined that for the first five-year period the proposed amendments are in effect, there will be fiscal implications for state government due to the increase in fees collected. There will be an estimated increase in state revenue of $1,070,252 annually. The charging of a fee is necessary to enable the continued operation of a leaner, cost-efficient program due to a new Legislative requirement that this program generate revenue to completely offset its costs. The ability of the department to enforce statutory requirements will be impacted if the department does not assess a fee that recovers the full cost of the program. There is no anticipated fiscal impact for local governments as a result of administering or enforcing the rule amendments, as proposed.

Mr. Bush has also determined that for each year of the first five year the proposed amendments are in effect, the public benefit anticipated as a result of administering the proposed amendments will be achieving effective recovery of the costs to administering the Structural Pest Control Program, thereby allowing the department to provide consumer protection. The anticipated costs to micro-businesses, small businesses or individuals required to comply with the amendments would affect an estimated 18,299 structural pest control applicants, licensees and continuing education course providers.

Comments on the proposal may be submitted to Jimmy Bush, Assistant Commissioner for Pesticides, Texas Department of Agriculture, P.O. Box 12847, Austin, Texas 78711. Comments must be received no later than 30 days from the date of publication on the proposal in the *Texas Register.*

The amendments to §7.127 are proposed under Occupations Code, §1951.201, which designates the department as the sole authority in the state for licensing persons engaged in the business of structural pest control, and provides the department with the authority to establish fees under Chapter 1951 in amounts reasonable and necessary to cover the costs of administering the department's programs and activities under Chapter 1951.

The code affected by the proposal is the Occupations Code, Chapter 1951.

§7.127. Fees.

[~~(a)~~] Applicants, licensees and continuing education providers will be charged the following fees:

(1) $280 [~~$180~~] for an original business license;

(2) $280 [~~$180~~] for renewal of a business license;

(3) $135 [~~$85~~] for an original certified applicators license;

(4) $125 [~~$80~~] for renewal of a certified applicators license;

(5) $100 [~~$65~~] for an original technician license;

(6) $95 [~~$60~~] for an renewal of a technician license;

(7) $30 for duplicate business license, certified applicator license or technician license when the original has been lost or destroyed;

(8) $30 for reissuing a business license, certified applicators license or technician license due to a name change in the license;

(9) $75 [~~$50~~] for administering exams in each category;

(10) a renewal fee for applications received 90 days or less [~~1 day to 30 days~~] after expiration date equal to 1-1/2 times the normally required renewal fee;

(11) a renewal fee for applications received greater than 90 days but less than one year [~~31 to 60~~] days after expiration date equal to 2 times the normally required renewal fee; and

(12) $60 [~~$40~~] for continuing education course.

[~~(b) The following fees are based on increments of six (6) months.~~]

[~~(1) Business License Fees~~]

[(A) Issued for 1 day - 6 months $92.50]

[(B) Renewed for 1 day - 6 months $90.00]

[(C) Issued for 7 - 12 months $180.00]

[(D) Renewal for 7 - 12 months $180.00]

[(E) Issued for 13 - 18 months $267.50]

[(F) Renewal for 13 - 18 months $270.00]

[(2) Certified Applicator License Fees]

[(A) Issued for 1 day - 6 months $45.00]

[(B) Renewed for 1 day - 6 months $40.00]

[(C) Issued for 7 - 12 months $85.00]

[(D) Renewal for 7 - 12 months $80.00]

[(E) Issued for 13 - 18 months $125.00]

[(F) Renewal for 13 - 18 months $120.00]

[(3) Technician License Fees]

[(A) Issued for 1 day - 6 months $35.00]

[(B) Renewed for 1 day - 6 months $30.00]

[(C) Issued for 7 - 12 months $65.00]

[(D) Renewal for 7 - 12 months $60.00]

[(E) Issued for 13 - 18 months $95.00]

[(F) Renewal for 13 - 18 months $90.00]

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 June 27, 2011.

TRD-201102400
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 463-4075

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TITLE 10. COMMUNITY DEVELOPMENT

PART 1. TEXAS DEPARTMENT OF HOUSING AND COMMUNITY AFFAIRS

CHAPTER 5. COMMUNITY AFFAIRS PROGRAMS

SUBCHAPTER I. WEATHERIZATION ASSISTANCE PROGRAM DEPARTMENT OF ENERGY AMERICAN RECOVERY AND REINVESTMENT ACT (WAP ARRA)

10 TAC §§5.900 - 5.905

The Texas Department of Housing and Community Affairs (the "Department") proposes amendments to 10 TAC Chapter 5, Subchapter I, §§5.900 - 5.905, Weatherization Assistance Program Department of Energy American Recovery and Reinvestment Act (WAP ARRA), concerning the deobligation and reobligation of funds. The amended sections are proposed in order to alter the exceptions through which subrecipients will not receive a deobligation notice. Other amended sections modify the documentation the subrecipient must submit when notified of possible deobligation.

The proposed amendments are necessary in order to require a higher level of production and expenditures before a subrecipient is exempted from deobligation; and once deobligation has been initiated, the amendments require subrecipients to submit information that offers a more definitive indication of a subrecipient's ability to meet contractual expectations.

Mr. Timothy K. Irvine, Acting 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 governments as a result of enforcing or administering the amended sections as proposed.

Mr. Irvine has also 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 section will be enhanced compliance with formalized policy, all contractual and statutory requirements.

There will be no effect on small businesses or persons. There is no anticipated economic cost to persons who are required to comply with the section as proposed. The amended sections as proposed will not impact local employment.

The public comment period will be held between July 9, 2011 to July 20, 2011 to receive input on the proposed amendments and a public hearing will be held. Information on the public hearing may be found in the "In Addition" section of this issue of the *Texas Register* and may also be found at http://www.tdhca.state.tx.us. Written comments may be submitted to Texas Department of Housing and Community Affairs 2011 Rule Comments, P.O. Box 13941, Austin, Texas 78711-3941, by e-mail to tdhcarulecomments@tdhca.state.tx.us, or by fax to (512) 475-4624. ALL COMMENTS MUST BE RECEIVED BY 5:00 P.M. JULY 20, 2011.

The amendments are proposed pursuant to the authority of the Texas Government Code, Chapter 2306 which provides the Department with the authority to adopt rules governing the administration of the Department and its programs.

The proposed amendments affect no other code, article or statute.

§5.900. Deobligation and Reobligation of Funds for Department of Energy Weatherization Assistance Program under the American Recovery and Reinvestment Act.

Under the American Recovery and Reinvestment Act of 2009 (ARRA), the Texas Department of Housing and Community Affairs (the "Department") is receiving funding from the U.S. Department of Energy for the Weatherization Assistance Program (WAP). The Department is adopting rules to establish the processes and criteria to be used for the Deobligation of WAP ARRA funds committed to a Subrecipient pursuant to the Department's required plan submitted to and approved by the U.S. Department of Energy, together with all amendments thereto, and the subsequent Reobligation of those funds. [These sections will also apply to any New Providers of WAP ARRA Funds.] The Department is adopting these sections in order to assure the timely and appropriate use of WAP ARRA funds; compliance with federal accountability, transparency, and programmatic requirements; and that WAP

ARRA funds are expended by required deadlines. Unless otherwise specified herein, all definitions and requirements under 10 TAC Chapter 5, Subchapters E, F, and G of this chapter apply to WAP ARRA.

§5.901. Definitions.

(a) Awarded Funds--The amount of Weatherization Assistance Program under the American Recovery and Reinvestment Act (WAP ARRA) [~~WAP ARRA~~] funds awarded by the Department in accordance with the WAP ARRA [~~Weatherization Assistance Program under the American Recovery and Reinvestment Act (WAP ARRA)~~] Plan (the "Plan") to Subrecipients [~~or New Providers~~] of WAP ARRA funds. [~~The amount of funds awarded reflects the full multi-year amount of WAP ARRA funds awarded to the Subrecipient or New Provider and not only the amount reflected in a contract.~~]

(b) Deobligation--The partial or full removal of unexpended Awarded Funds from a Subrecipient [~~or New Provider~~]. Partial Deobligation is the removal of some portion of the full Awarded Funds from a Subrecipient [~~or New Provider~~], leaving some remaining balance of Awarded Funds to be administered by the Subrecipient [~~or New Provider~~]. Full Deobligation is the removal of the full amount of Awarded Funds from a Subrecipient [~~or New Provider~~].

(c) Department--The Texas Department of Housing and Community Affairs.

(d) Executive Director--The Executive Director of the Texas Department of Housing and Community Affairs.

(e) Expenditure--Funds having been drawn from the Department through the Contract System. For purposes of this rule, expenditure will include draws requested through the system.

~~[(f) New Provider--An entity to which the Department has contractually obligated WAP ARRA funds subsequent to March 12, 2010.]~~

(f) [~~(g)~~] Plan--The Department's required plan for the administration of WAP ARRA submitted to and approved by the U.S. Department of Energy, together with all approved amendments thereto from time to time in effect.

(g) [~~(h)~~] Production Schedule--A Production schedule signed by the applicable Executive Director/Chief Executive Officer of the Subrecipient [~~or New Provider~~], approved by the Department, and meeting the requirements of this definition. The Production Schedule shall include a total estimated number of units to be completed with all Awarded Funds, based on the average per unit cost for the Subrecipient [~~or New Provider~~]; the estimated monthly and quarterly unit production; and the estimated monthly and quarterly expenditure targets for all Awarded Funds reflecting achievement of the criteria identified in §5.902 of this chapter (relating to Criteria for Deobligation of Fund Award). The Production Schedule should reflect delays that should reasonably be anticipated, and unit production estimates may vary significantly from month to month. The Production Schedule shall reflect by month estimated numbers for the total units to be produced. The Production Schedule is a requirement applicable to all WAP ARRA contracts administered by the Subrecipient [~~or New Provider~~]. The Production Schedule must demonstrate how all Awarded Funds will be expended by required ARRA deadlines. The Production Schedule as defined herein may differ significantly from the WAP ARRA plan production schedule submitted by the Department to the U.S. Department of Energy. In the case of any such conflict, the applicable Subrecipient [~~or New Provider~~] is required to comply with the Production Schedule.

(h) [~~(i)~~] Reobligation--The reallocation of deobligated WAP ARRA funds to current Subrecipients [~~and/or New Providers~~].

(i) [~~(j)~~] Subrecipient--An entity to which the Department contractually obligated WAP ARRA funds [~~prior to March 12, 2010~~]. Subrecipients may have one or more contracts for WAP ARRA funds and reference to Subrecipient herein may include only one, some, or all of those contracts.

(j) [~~(k)~~] Unit Production--A unit is considered "produced" for purposes of this rule when the unit is considered a final unit and the post-weatherization inspection and all other requirements have been satisfied. Subrecipients are required to maintain a financial system that provides reconciliation between the general ledger and the monthly report submitted to the Department as part of the required financial system, subrecipients are required to maintain documentation to support that they have made timely payment of invoices or related liabilities within forty-five (45) days from the end of the corresponding report period; a unit is not considered produced until all invoices directly associated with weatherization measures in the unit are entered into that system.

(k) [~~(l)~~] WAP ARRA--The allocation of funds provided to the Department from the American Recovery and Reinvestment Act of 2009 for the Department of Energy Weatherization Assistance Program.

§5.902. Criteria for Deobligation of Fund Award.

(a) The criteria noted in this section will prompt the Deobligation process under this rule. If the criteria are met, then notification and ensuing processes will apply as further described in this rule.

(b) The criteria for Deobligation for a Subrecipient are as follows:

(1) Subrecipient fails to provide the Department with a Production Schedule by the 7th day of each month [~~April 1, 2010~~]. The Production Schedule must be signed by the Subrecipient Executive Director/Chief Executive Officer and approved by the Department;

~~[(2) By April 15, 2010, no unit production has occurred;]~~

~~[(3) By June 30, 2010, less than 20% of total expected unit production has occurred based on the Production Schedule, or less than 15% of total Awarded Funds have been expended;]~~

~~[(4) By August 31, 2010, less than 35% of total expected unit production has occurred based on the Production Schedule, or less than 25% of total Awarded Funds have been expended;]~~

~~[(5) By October 31, 2010, less than 40% of total expected unit production has occurred based on the Production Schedule, or less than 40% of total Awarded Funds have been expended;]~~

~~[(6) By December 31, 2010, less than 50% of total expected unit production has occurred based on the Production Schedule, or less than 50% of total Awarded Funds have been expended;]~~

(2) [~~(7)~~] The Subrecipient fails to submit a required monthly report explaining any variances between the Production Schedule and actual results on Production Schedule criteria; or

(3) [~~(8)~~] The Subrecipient's monthly report, as required under the contract between the Department and the Subrecipient, for Subrecipients whose monthly production target is 50 units or greater reflects unit production that is 5% or more below the unit production amount to be completed, or for Subrecipients whose monthly production target is less than 50 units the monthly report reflects unit production that is 10% or more below the unit production amount to be completed, as of the end of the month according to the Production Schedule, or expenditure of funds is 5% or more below the amount of Awarded Funds to be expended as of the end of the month according to the Production Schedule; [~~and~~]

(4) [(9)] The Subrecipient's [Subrecipent's] quarterly report, as required under the contract between the Department and the Subrecipient, for Subrecipients whose monthly production target is 50 units or greater reflects that unit production is 5% or more below the unit production amount to be completed, or for Subrecipients whose monthly production target is less than 50 units the monthly report reflects unit production that is 10% or more below the unit production amount to be completed, as of the end of the quarter according to the Production Schedule, or expenditure of funds is 5% or more below the amount of Awarded Funds to be expended as of the end of the quarter according to the Production Schedule;[.]

[(c) The criteria for Deobligation for a New Provider are as follows:]

[(1) The New Provider fails to provide a Production Schedule as described in this rule and required under the contract between the Department and the New Provider within fifteen (15) days of contract execution. The Production Schedule must be approved by the New Provider Executive Director/Chief Executive Officer;]

[(2) The New Provider fails to submit a required monthly report explaining any variances between the Production Schedule and actual results on Production Schedule criteria;]

[(3) The New Provider's monthly report, as required under the contract between the Department and the New Provider, reflects unit production that is 5% or more below the unit production amount to be completed as of the end of the month according to the Production Schedule, or expenditure of funds is 5% or more below the amount of Awarded Funds to be expended as of the end of the month according to the Production Schedule;]

[(4) The New Provider's quarterly report, as required under the contract between the Department and the New Provider, reflects that unit production is 5% or more below the unit production amount to be completed as of the end of the quarter according to the Production Schedule, or expenditure of funds is 5% or more below the amount of Awarded Funds to be expended as of the end of the quarter according to the Production Schedule; and]

[(5) The New Provider fails to meet any other production or expenditure targets based on the Production Schedule as required under the contract between the Department and the New Provider.]

(5) [(d)] At any time, a Subrecipient [or New Provider] fails to notify the Department of any adverse audit, inspection or internal control finding;[.]

(6) [(e)] At any time a Subrecipient [or New Provider] has recurrent findings or inspections reflecting work quality that do not conform fully to program requirements, lack of adequate and satisfactory inspections, inadequate assessments or that insufficient quality control efforts are in place;[.]

(7) [(f)] At any time a Subrecipient [or New Provider] has unresolved WAP ARRA monitoring findings, violates their contract, and fails to implement timely all necessary changes identified during a monitoring visit; or[.]

(8) [(g)] At any time the Department believes a Subrecipient [or New Provider] is at significant risk of not expending WAP ARRA Awarded Funds in accordance with the Production Schedule or is at significant risk of not providing appropriate and thorough controls on the expenditure of WAP ARRA funds.

§5.903. Corrective Action Notice [Notification and Action Plan].

(a) At any time that a Subrecipient [or New Provider] believes they may be at risk of meeting one of the criteria noted in §5.902 of this chapter (relating to Criteria for Deobligation of Fund Award), or of not achieving their Production Schedule goals, notification must be provided to the Department unless excepted under subsection (i) [(m)] of this section.

(b) A written "Corrective Action Notice" ["Notification of Possible Deobligation"] will be sent to the Executive Director of the Subrecipient [or New Provider] as soon as a criterion included in §5.902 of this chapter is [at risk of being] met. Written notice will be sent electronically and by mail. The notice will include an explanation of the criteria met.

[(c) Within fifteen (15) days of the date of the "Notification of Possible Deobligation" referenced in subsection (b) of this section, a Mitigation Action Plan must be submitted to the Department by the Subrecipient or New Provider in the format prescribed by the Department unless excepted under subsection (m) of this section.]

[(d) A Mitigation Action Plan is not limited to but must include:]

[(1) Explanation of why one or more of the criteria under §5.902 of this chapter occurred setting out all fully relevant facts.]

[(2) Explanation of how the criteria under §5.902 of this chapter will be immediately, permanently, and adequately mitigated. For example, if production or expenditures are insufficient, the explanation would need to address how production or expenditures will be increased in the short- and long-term to restore projected full and timely execution of the contract with respect to all Awarded Funds.]

[(3) If applicable because of failure to produce Unit Production or Expenditure targets under the existing Production Schedule, a detailed narrative of how the production schedule will be revised, going forward, to assure achievement of sufficient, achievable Unit Production and Expenditures to ensure timely and compliant full utilization of all Awarded Funds.]

[(4) An explanation of how remaining criteria under §5.902 of this chapter will be avoided. For example, if Unit Production criteria for June 30, reflected under §5.902(b) of this chapter were not met, then explanation will need to include how the ensuing criteria will be met and the criteria under §5.902(c) of this chapter, avoided.]

[(5) If relating to a Unit Production or expenditure criteria, a description of activities currently being undertaken including an accurate description of the number of units in progress, broken down by number of units that have been qualified, audited, assessed, contracted, inspected, and invoiced and as reflected in an updated Production Schedule.]

[(6) Provide any request for a reduction in Awarded Funds, reasons for the request, desired Awarded Fund and revised Production Schedule reflecting the reduced Awarded Fund.]

[(e) At any time after sending a Notification of Deobligation, the Department or a third-party assigned by the Department may monitor, conduct onsite-visits or other assessment or engage in any other oversight of the Subrecipient or New Provider that is believed appropriate by the Department under the facts and circumstances.]

[(f) The Department or a third-party assigned by the Department will review the Mitigation Action Plan, and where applicable, assess the Subrecipient's or New Provider's ability to meet the revised Production Schedule or remedy other concern.]

[(g) After the Department's receipt of the Mitigation Action Plan, the Department will provide the Subrecipient or New Provider a written Corrective Action Notice indicating the Department's determination, which may include one or more of the criteria identified in

§5.904 of this chapter (relating to Deobligation and Other Mitigating Actions) or other acceptable solutions or remedies.]

(c) [(h)] The Subrecipient [or New Provider] has seven (7) calendar days from the date of the Corrective Action Notice to appeal the Corrective Action Notice to the Executive Director. To evidence the current production capacity of the Subrecipient, appeals must include:

(1) The number of pending income-qualified Applications the Subrecipient has;

(2) The number of assessed units pending audits/Priority List assignment the Subrecipient has and the addresses of those units;

(3) The number of audited/Priority List assigned units pending work orders the Subrecipient has and the addresses of those units; and corresponding copies of audits if requested; and

(4) The number of units in progress of weatherization the Subrecipient has and the addresses of those units as well as estimated dates of completion.

(d) Appeals may include:

(1) Request for the full Fund Award;

(2) Request for only partial Deobligation of the full Awarded Fund if full Deobligation was indicated in the Corrective Action Notice;

(3) Request for other lawful action consistent with the timely and full completion of the contract and Production Schedule for all Awarded Funds.

(e) [(i)] In the event that an appeal is submitted to the Executive Director, the Executive Director may grant extensions or forbearance of targets included in the Production Schedule, continued operation of a contract, authorize Deobligation, or take other lawful action that is designed to ensure the timely and full completion of the contract for all Awarded Funds.

(f) [(j)] In the event the Executive Director denies an appeal, the Subrecipient will have the opportunity to have their appeal presented at the next Department Board meeting for which the matter may be posted in accordance with law and submitted for final determination by the Board.

(g) [(k)] In the event an appeal is not submitted within seven (7) calendar days from the date of the Corrective Action Notice, the Corrective Action Notice will automatically become final [without need of any further action or notice by the Department,] and the Department will amend/terminate the contract with the Subrecipient [or New Provider] to effectuate the Corrective Action Notice.

(h) [(l)] Prior to full deobligation or reobligation of a Contract or Fund Award, a public hearing will be held. To the extent an appeal is filed and heard by the Board under subsection (f) [(j)] of this section, this public hearing requirement will be satisfied by the publicly posted Board meeting for which the appeal appears on the agenda.

(i) [(m)] Corrective Action Notice [Notification of deobligation] will not be required to be sent to a Subrecipient [or New Provider, and a Mitigation Action Plan will not be required to be provided to the Department,] if all [any one or more] of the following are satisfied:

(1) The total cumulative unit production for the Subrecipient [or New Provider], based on the monthly report as reported in the Community Affairs contract system, is at least 95% [85%] of the total cumulative number of units to be completed as of the end of the month according to the Subrecipient's forecast unit production within the Production Schedule for the time period applicable (i.e. cumulative through the month for which reporting has been made); and[.]

(2) The total cumulative expenditures for the Subrecipient [or New Provider], based on the monthly report as reported in the Community Affairs contract system, is at least 95% [85%] of the total cumulative estimated expenditures to be expended as of the end of the month according to the Subrecipient's forecast expenditures within the Production Schedule for the time period applicable (i.e. cumulative through the month for which reporting has been made); and[.]

(3) The Subrecipient's[, or New Provider's,] monthly reports as reported in the Community Affairs contract system, for the prior two months, as required under the contract between the Department and the Subrecipient, reflects unit production that is 95% [90%] or more of the unit production amount to be completed as of the end of the month according to the Subrecipient's forecast unit production within the Production Schedule.

§5.904. Deobligation and Other Mitigating Actions.

(a) When one or more of the criteria in §5.902 of this chapter (relating to Criteria for Deobligation of Fund Award) have been met, the Department will issue a Corrective Action Notice, as described in §5.903 of this chapter (relating to Corrective Action Notice [Notification and Action Plan]), recommending one or more of the actions in subsections (b) - (d) of this section.

(b) Partial or Full Deobligation of Awarded Funds. Deobligation may be made [dependent upon identification of a temporary or permanent replacement provider] as described in §5.905 of this chapter (relating to Reobligation).

(c) Month-to-month monitoring, site visits, assessments and/or oversight by the Department or a third-party assigned by the Department.

(d) Other mitigating action that may improve the performance of the Subrecipient [or New Provider] and ensure the delivery of services to the service area, consistent with the timely and full completion of contract and expenditure of Awarded Funds.

(e) In the event of Deobligation, the Subrecipient will place no further orders, or enter into further subcontracts for services, materials, or equipment. However, to the extent possible, the Department will allow continued delivery of eligible services to those customers whose unit has been assessed prior to the delivery of notice of Deobligation. In the event of Deobligation, the Subrecipient will identify any such customers and negotiate with the Department regarding the delivery of services to those customers.

§5.905. Reobligation.

(a) While it may not be possible in all circumstances, it is the Department's primary goal to ensure that Deobligated Awarded Funds be expended in the existing geographic service area of the Deobligated Subrecipient. [or New Provider. So that Awarded Funds released through Deobligation can be recommitted to the geographic service area, the Department may immediately take the actions in paragraphs (1) and (2) of this subsection:]

[(1) Identify and reach agreements for increasing funding with Subrecipients who are capable of achieving unit production and expenditures in adjacent or non-adjacent geographic regions on a temporary or permanent basis; and/or]

[(2) Identify, initiate and complete the procurement process with one or more New Providers of weatherization services that can service one or more geographic service areas.]

[(b)] In the event that no qualified provider can be identified to serve a geographic service area where a Subrecipient [or New Provider] has been Deobligated, the Department will consider the geographic re-

allocation of Awarded Funds for only the remainder of the WAP ARRA contract, to other existing Subrecipients [~~or New Providers~~].

(b) [~~(c)~~] Unless otherwise determined by the Executive Director, Subrecipients [~~or a New Provider~~] will only qualify for Reobligation of Awarded Funds if they meet the criteria in paragraphs (1) - (5) of this subsection:

(1) If applicable, they have achieved 95% or more of monthly unit and expenditure Production Schedule targets for the previous three months;

(2) Subrecipients must have achieved 30% of total Production Schedule goals by August 31, 2010;

(3) Subrecipients must have [~~Have~~] no significant outstanding unresolved monitoring findings;

(4) Subrecipients must have [~~Have~~] had no significant unit quality or other concerns; and

(5) Subrecipients must [~~Can~~] demonstrate available capacity or expedited capacity building to administer additional Awarded Funds in a timely and appropriate manner.

(c) [~~(d)~~] Awards of Reobligation. Awarded Funds to existing Subrecipients [~~Subrecipents or New Providers~~] will be based upon ability to meet Unit Production and Expenditures requirements as assessed by Department staff and other criteria consistent with ARRA, Department or state weatherization policy objectives. Priority will be given to serving priority populations as required by the Department of Energy.

(d) [~~(e)~~] Subrecipients [~~and New Providers~~] may request an increase in their Awarded Funds with the Department or may be approached by the Department.

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 June 24, 2011.

TRD-201102375
Timothy K. Irvine
Acting Director
Texas Department of Housing and Community Affairs
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 475-3916

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TITLE 13. CULTURAL RESOURCES

PART 8. TEXAS FILM COMMISSION

CHAPTER 121. TEXAS MOVING IMAGE INDUSTRY INCENTIVE PROGRAM

13 TAC §§121.1 - 121.12, 121.14, 121.15

The Texas Film Commission proposes amendments to Title 13, Part 8, Chapter 121, §§121.1 - 121.12 and §121.14; and new §121.15, concerning Texas Moving Image Industry Incentive Program.

The proposed amendment to §121.1 removes stand-alone Visual Effects Projects from program eligibility due to low utilization, increases the cash grant percentage available to Digital Interactive Media Productions in light of their favorable economic impact, introduces the necessity for Applicants receiving $300,000 or more in cash grants to provide a CPA Audit Opinion upon submission of their Expended Budgets and clarifies the funds appropriated in the 2012-2013 fiscal biennium.

The proposed amendment to §121.2 removes defined terms which were not referenced elsewhere in the chapter or which were referenced only once, to add defined terms which were referenced but undefined in the chapter and which merited a full definition for ease of reference in other locations in the chapter, and supplements and/or clarifies existing defined terms.

The proposed amendment to §121.3 removes stand-alone Visual Effects Projects from program eligibility due to low utilization, and in light of the introduction of new defined terms in §121.2, which now feature much of the removed content of §121.3, collapses and shortens §121.3 and makes it clearer to the reader as a consequence.

The proposed amendment to §121.4 further clarifies the unavailability of cash grants to public service announcements which advance a public policy or political position, allows award shows which are broadcast on national network television to a national audience to participate in the program and makes clarifying language refinements.

The proposed amendment to §121.5, in light of the introduction of new defined terms in §121.2, which now feature some of the removed content of §121.5, collapses and shortens portions of §121.5 and makes it clearer to the reader as a consequence; utilizes terms which are now defined in §121.2; clarifies eligibility for shipments originating in Texas, airline travel and rental cars; clarifies restrictions on capital expenditures and location fees; defines terms which had previously only been utilized in a defined fashion once in §121.5; and clarifies the eligibility of certain internal billed items for commercial producers, among other useful, clarifying changes.

The proposed amendment to §121.6 increases the cash grant percentage available to Digital Interactive Media Productions in light of their favorable economic impact.

The proposed amendment to §121.7 utilizes defined terms now that they are established in §121.2 and provides greater detail concerning the calculation of additional percentages for multiple locations for days spent shooting in Underutilized or Economically Distressed Areas.

The proposed amendment to §121.8 removes stand-alone Visual Effects Projects from program eligibility due to low utilization, clarifies the Content Document requirement for a Digital Interactive Media Production, utilizes defined terms now that they are established in §121.2, to clarify disqualifications in certain circumstances and adds a provision describing the applicability of the Texas Public Information Act.

The proposed amendment to §121.9 utilizes defined terms now that they are established in §121.2, clarifies that preliminary award determinations may only be made if appropriated funds are available, clarifies the requirements concerning return of grant agreements, clarifies the ability to adjust encumbered grant award amounts, clarifies the requirement that a parent or guardian sign a Declaration of Texas Residency in the event of a minor cast or crew member and adds a provision concerning use of the Texas Film Commission logo.

The proposed amendment to §121.10 utilizes defined terms now that they are established in §121.2, cross-references certain other definitions by rule and adds disqualification provisions re-

lating to notification of production commencement and voluntary disqualification by an Applicant.

The proposed amendment to §121.11 utilizes defined terms now that they are established in §121.2, clarifies that the Applicant shall assemble its own submission, references the CPA Audit Opinion required by this chapter, requires additional information in the cast and crew list and removes stand-alone Visual Effects Projects from program eligibility due to low utilization, plus other useful, clarifying revisions.

The proposed amendment to §121.12 utilizes defined terms now that they are established in §121.2, clarifies that debts may not be owed to the State of Texas and specifies that the Compliance and Oversight Division shall conduct the final compliance audit.

The proposed amendment to §121.14 utilizes defined terms now that they are established in §121.2.

The proposed new §121.15 adds a requirement that if the estimated grant amount reflected in the grant agreement referenced in §121.9(d)(1) equals or exceeds $300,000, an Applicant must submit to the Texas Film Commission a CPA Audit Opinion, paid for by the Applicant and conducted by an independent Certified Public Accountant licensed to practice in the State of Texas with no relationship to the Applicant.

Evan E. Fitzmaurice, Director of the Texas Film Commission, has determined that for the first five-year period there will be no fiscal implications for state or to local governments as a result of enforcing or administering the proposed amendments and new section.

Mr. Fitzmaurice has also determined that for each year of the first five-years the proposed amendments and new section are in effect the public benefit anticipated as a result of the proposal is greater participation in the program, ease of administration of the program, more certainty for Applicants and higher percentages to Digital Interactive Media Production in recognition of their economic impact on the State of Texas. Other than small compliance costs to those Applicants required to furnish the CPA Audit Opinion, no economic costs are anticipated to persons who are required to comply with the proposal. There will be no impact on small businesses or micro-businesses as compared to large businesses.

Written comments on the proposed amendments and new section may be hand delivered to the Office of the Governor, General Counsel Division, 1100 San Jacinto, Austin, Texas 78701, mailed to P.O. Box 12428, Austin, Texas 78711-2428, or faxed to (512) 463-1932 and should be addressed to the attention of Michael Bryant, Assistant General Counsel. Comments must be received within 30 days of publication of the proposal in the *Texas Register.*

The amendments and new rule are proposed pursuant to the Texas Government Code, §485.022, which directs the Texas Film Commission to develop a procedure for the submission of grant applications and the awarding of grants; and Texas Government Code, Chapter 2001, Subchapter B, which prescribes the standards for rulemaking by state agencies.

No other codes, statutes, or articles are affected by this proposal.

§121.1. Background and Purpose.

(a) Background.

(1) The Texas Moving Image Industry Incentive Program offers grants based upon eligible expenditures within the state by the Applicant. Subject to this subchapter and Chapter 485 of the Texas Government Code:[.]

(A) Feature Films and[,] Television Programs [and ~~Visual Effects Projects for Feature Films and Television Programs~~] that choose the Texas Spend Option are eligible to receive grants of up to 15% of total eligible in-state spending;[.]

(B) Feature Films and[,] Television Programs [and ~~Visual Effects Projects for Feature Films and Television Programs~~] that choose the Texas Wage Option are eligible to receive grants of up to 25% of eligible Wages [~~wages~~] paid to Texas Residents; [~~residents.~~]

(C) Digital Interactive Media Productions [~~(Video Games), Commercials, Educational or Instructional Videos, Reality Television Projects and Visual Effects Projects for Commercials and Educational or Instructional Videos~~] are eligible to receive grants of up to 15% of eligible in-state spending paid to Texas Residents; and [~~equal to 5% of total eligible in-state spending.~~]

(D) Commercials, Educational or Instructional Videos and Reality Television Projects are eligible to receive grants equal to 5% of total eligible in-state spending.

(2) Grants are available upon submission of all required documentation by the Applicant to the Texas Film Commission (including submission of the CPA Audit Opinion to the State of Texas, if required by this chapter), initial verification by the Texas Film Commission Incentive staff and a compliance audit by the Office of the Governor's Compliance and Oversight Division. [~~project completion. Both live-action and animated projects are eligible.~~] These grants are in addition to the [~~state's existing~~] Sales Tax Exemptions described in Texas Tax Code §151.318 and §151.3185 and the Texas Comptroller of Public Accounts Administrative Rule, 34 TAC §3.300.

(3) The State of Texas has allocated $15,000,000 [~~$30,000,000~~] for fiscal year 2012 (September 1, 2011 to August 31, 2012) [~~2010 (September 1, 2009 to August 31, 2010)~~] and $15,000,000 for fiscal year 2013 (September 1, 2012 to August 31, 2013) [~~$30,000,000 for fiscal year 2011 (September 1, 2010 to August 31, 2011)~~] for the Texas Moving Image Industry Incentive Program. Applicants will not be eligible [~~able~~] to receive funding until after September 1, 2011 [~~2009~~]. This chapter shall apply to grants under the Texas Moving Image Industry Incentive Program from funds allocated to the program by the State of Texas for fiscal year 2012 (September 1, 2011 to August 31, 2012) and fiscal year 2013 (September 1, 2012 to August 31, 2013).

(4) Amounts expended in each segment of the Texas Moving Image Industry Incentive Program, which segments include: Television Programs (including solely for this purpose Reality Television Projects), Feature Films, Digital Interactive Media Productions, and Commercials, Educational and Instructional Videos, shall not exceed 40 percent of funds allocated to the program by the State of Texas for combined fiscal years 2012 (September 1, 2011 to August 31, 2012) and 2013 (September 1, 2012 to August 31, 2013).

(b) Purpose.

(1) The Texas Moving Image Industry Incentive Program was implemented to increase employment opportunities for Texas industry professionals, tourism and to [~~as well as~~] boost economic activity in Texas cities and the overall Texas economy. Rather than Texas being an exporter of talent, Texas can now attract a wide range of projects from traditional film and commercial productions to the technology driven animation[~~, visual effects and video game~~] productions and Digital Interactive Media Productions.

(2) The Texas Moving Image Industry Incentive Program [~~This program~~] allows for growth of the indigenous segments of production. It is an important goal of this program to have Texas' talented workforce stay in Texas and realize real professional growth in the industry. The [~~incentive~~] program increases the value of the Texas workforce and the viability of the small businesses that rely on production activity, increasing Texas' capacity to take on more production activity and increasing Texas competitive edge.

(3) The Texas Moving Image Industry Incentive Program [~~This program~~] is not intended for [~~on-going events or~~] productions that are permanently located in the State of Texas including[~~. This includes~~], but [~~is~~] not limited to, news productions, sports productions and religious service productions.

§121.2. Definitions.

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

(1) Applicant--

(A) For Feature Films, Television Programs, Reality Television Projects or Educational or Instructional Videos [~~feature films, television programs, reality television projects, educational or instructional videos, or visual effects projects for feature films, television programs, or educational or instructional videos~~], either the Production Company [~~production company~~] producing the project or the owner of the copyright.

(B) For commercials [~~and visual effects projects for commercials,~~] the Production Company [~~production company~~], advertising agency, or client; provided, however, that if an advertising agency or client applies as the Applicant, but a Production Company expends the funds in the state in connection with a project, a chain of downstream payment from the Applicant to the Production Company actually expending the funds must be evidenced in connection with the submission of the Expended Budget.

(C) For Digital Interactive Media Productions [~~video games~~], the game developer or game publisher.

~~[(2) Assignee--A third party designated by the applicant as the recipient of the grant.]~~

(2) [~~(3)~~] Business day--A day other than Saturday, Sunday or a legal Federal holiday.

(3) CPA Audit Opinion--An outside examination report and audit opinion letter concerning an Applicant's Expended Budget, conducted pursuant to §121.15 of this chapter.

(4) Cast--Actors paid by the Applicant to perform roles [~~An actor paid by the applicant or production company for performing a role~~] in Texas, including, but not limited to, featured actors, extras, stunt performers, voice-over talent, hosts, judges, announcers and roles or performers that appear on a recurring basis, but excluding talk show guests, game or contest show contestants, Reality Series participants, documentary subjects or interviewees, musicians performing as part of a music performance production, and litigants and witnesses in court room reality programs.

(5) Commercial--A commercial is defined as any live-action or animated production; that is an individual commercial, more than one commercial created in a contiguous production period for the same client, music video or infomercial; that is made for the purpose of entertaining or promoting a product, service, or idea; and that is produced for distribution via broadcast, cable or any digital format including but not limited to cable, satellite, Internet, or mobile electronic device.

(6) Crew--Workers paid by the Applicant to perform work in Texas that is directly contracted and credited for a specific position, but excluding musicians performing as part of a music performance production. An individual may work in more than one position on a production. Executive Producers and/or permanent salaried employees of an Applicant for a Commercial project who are listed on Call Sheets or Production Reports, but who are not paid Wages and who do not perform services on the project other than producing services, shall not be counted in Crew calculations for Texas Residency purposes. Vendors serving a traditional crew function and providing personal services, but who are paid as independent contractors rather than through payroll, will be counted in Texas Residency Crew calculations and should provide a Declaration of Texas Residency.

(7) Declaration of Texas Residency Form--A document promulgated by the Texas Film Commission to be utilized by Applicants in order to prove the residency status of each Texas Resident Crew or Cast member.

(8) Digital Interactive Media Production--Software that provides a user or users with a game to play for the purpose of entertainment or education, including for military or medical simulation training, and which is created for a game console, personal computer, handheld console, mobile electronic machine or an electronic device used by a business or consumer solely for bona fide amusement purposes that rewards the player exclusively with non-cash merchandise prizes or a representation of value redeemable for those items, as outlined in Texas Penal Code, §47.01.

(9) Educational or Instructional Video--An Educational or Instructional Video is defined as any live action or animated production; that is an Educational or Instructional Video or more than one Educational or Instructional Video created in a contiguous production period for the same client; and that is produced for exhibition in an educational or instructional setting.

(10) Episodic Television Series--A Television Program consisting of multiple episodes of a single season.

(11) Expended Budget--The final verifying documentation submitted by an Applicant to the Texas Film Commission at the completion of a project that shows the total eligible in-state spending and includes all documentation considered by the Texas Film Commission to be necessary to show compliance with the requirements of the Texas Moving Image Industry Incentive Program.

(12) Feature Film--A Feature Film is defined as any live-action or animated for-profit production, narrative or documentary that is produced for distribution in theaters or via any digital format, including, but not limited to DVD, Internet, or mobile electronic device.

(13) Filming Day--A day of Production as defined in paragraph (18) of this section.

(14) Physical Production--The period encompassing Pre-Production, Production, and Postproduction.

(15) Postproduction--The period of Physical Production that occurs after the end of Production, as defined in paragraph (18) of this section; including but not limited to, editing, music, sound, visual effects and animation.

(16) Pre-Production--The period of Physical Production that occurs before the start of Production as defined in paragraph (18) of this section.

(17) Principal Start Date--

(A) For a live action Feature Film, Television Program, Reality Television Project, Educational or Instructional Video or Commercial project, this is the first day of principal photography.

(B) For a Digital Interactive Media Production or animated project, this is the first day of Production.

(18) Production--

(A) For a live action Feature Film, Television Program, Reality Television Project, Educational or Instructional Video or Commercial project, this is the period of Physical Production between the first and last days of principal photography, inclusive.

(B) For a Digital Interactive Media Production or animated project, this is the period of Physical Production between the end of Pre-Production and the completion of the project.

(19) Production Company--A film production company, television production company, Digital Interactive Media Production developer, commercial production company or animation production company or post-production company.

(20) Qualifying Application--A Qualifying Application has the meaning provided in §121.8(a)(1) of this chapter.

(21) Reality Series--A Reality Television Project consisting of multiple episodes of a single season.

(22) Reality Television Project--A Reality Television Project is any live action, for-profit production based upon unscripted content (including, but not limited to: a reality series; a contest or game show, to include individual episodes; or a talk show, to include individual episodes) that is produced for distribution via broadcast, cable or any digital format, including, but not limited to, satellite, Internet and mobile electronic device.

(23) Television Program--A Television Program is defined as any live-action or animated for-profit production, narrative or documentary (including, but not limited to: an Episodic Television Series; a miniseries; a television movie; a television pilot; a television episode; an interstitial Television Program; or a musical performance that is more than 30 minutes in length) that is produced for distribution via broadcast, cable or any digital format, including, but not limited to, satellite, Internet and mobile electronic device (including a short episode or series of episodes, either narrative or documentary, that is distributed initially as an Internet download or stream).

(24) Texas Resident--An individual who is a permanent resident of Texas for at least 120 days prior to the Principal Start Date of the project and who has completed a Declaration of Texas Residency Form.

(25) Texas Spend Option--Feature Film and Television Program Applicants may choose a total spending option that will take into account all eligible in-state spending (including eligible Wages paid to Texas Residents) in their application pursuant to §121.8 of this chapter to preliminarily determine their grant amount.

(26) Texas Wage Option--Feature Film and Television Program Applicants may choose a Wages only option that will only take into account eligible Wages paid to Texas Residents in their application pursuant to §121.8 hereof to preliminarily determine their grant amount.

(27) Underutilized and Economically Distressed Area--

(A) Underutilized Area--An area of the state that receives less than 15 percent of the total film and television production in the state during a fiscal year as determined by the Texas Film Commission. Areas determined by the Texas Film Commission to receive in excess of 15 percent of the total film and television production in the state will be deemed to include the area within a thirty mile radius from that area's largest municipality's city hall.

(B) Economically Distressed Area--An area within the above-determined thirty mile radius where the median household income does not exceed 75 percent of the median household income as determined by the Texas State Data Center, University of Texas San Antonio.

(28) Wages--Compensation paid to an individual for work performed. Payment methods may include, but are not limited to, direct payments, payments through an agent or agency, payments through a loan-out company or payments through a payroll service. Wages may include, but are not limited to, gross wages, per diems (if signed for by the recipient), employer paid Social Security (Old Age, Survivors, and Disability Insurance (OASDI)) payments, employer paid Medicare (MEDI) payments, employer paid Federal Unemployment Insurance (FUI) payments, employer paid Texas State Unemployment Insurance (SUI) payments, employer paid Pension, Health and Welfare payments and employer paid Vacation and Holiday payments. Only the first $1,000,000 in aggregate wages and/or compensation per person will constitute eligible Wage expenditures.

~~[(5) Crew--An individual worker paid by the applicant or production company for work performed in Texas that is directly contracted and credited for a specific position. An individual may work in more than one position on a production.]~~

~~[(6) Digital interactive media production--A video game.]~~

~~[(7) Eligible projects--Feature films, television programs, reality television projects, commercials, educational or instructional videos, visual effects projects and video games that meet the qualifying requirements described in §121.3 of this chapter.]~~

~~[(8) Episodic television series--A television program consisting of multiple episodes of a single season.]~~

~~[(9) Expended budget--The final verifying documentation submitted by an applicant at the completion of a project that shows the total eligible in-state spending and includes all documentation considered necessary to show compliance with the requirements of the incentive program.]~~

~~[(10) Filmed--The creation or digital manipulation of a moving image project; the actual production activity for various industry segments:]~~

~~[(A) For a live action feature film, television program, reality television, educational or instructional video, or commercial project, the production of the project involving the capture of images by a camera.]~~

~~[(B) For an animated feature film, television program, commercial, or educational or instructional video project, the creation of computer generated digital images or the use of a camera to film with stop motion or time lapse photography.]~~

~~[(C) For a video game, the use of computers and software to create interactive digital images and visual effects.]~~

~~[(D) For a visual effects project, the finishing of a feature film, television program, commercial, or educational or instructional video with the creation of visual effects including, but not limited to, editing, visual effects, sound effects, music or animation.]~~

~~[(11) Filming day--A day of production as defined in paragraph (29) of this section.]~~

[(12) Game console--An electronic device or machine used by consumers primarily for the purpose of playing video games, including, but not limited to, the Nintendo Wii, the Sony PlayStation 3, the Sony PlayStation 2 and the Microsoft Xbox360.]

[(13) Goods and services--Physical products and services domiciled and used in Texas that are directly attributable to the production of a project including, but not limited to, contractors, subcontractors and service providers, and product or equipment purchases, rentals and leases.]

[(14) Handheld console--A portable electronic device used by a consumer primarily for the purpose of playing video games, including, but not limited to, the Sony PlayStation Portable, the Nintendo DS, the Nintendo DSi, the Nintendo Game Boy Advanced and the Nintendo Game Boy Color.]

[(15) Ineligible projects--Projects that do not qualify for the grant, as stated in §121.4 of this chapter.]

[(16) In-state spending (Texas spend)--The eligible amount of money spent in Texas during pre-production, production and post-production of the project.]

[(17) Interstitial television program--Short television programming shown between regularly scheduled programs or events.]

[(18) Loan-out company--A company controlled by the loaned-out employee.]

[(19) Mobile electronic--A portable electronic device used by a consumer for the purpose of mobile computing and communication, including, but not limited to, personal digital assistants (PDAs) and mobile phones.]

[(20) Moving image project--An eligible project as defined in §121.3 of this chapter.]

[(21) Music performance production--Productions featuring musical performances that are more than 30 minutes in length.]

[(22) Music video--Productions featuring musical performances that are less than 30 minutes in length.]

[(23) Pass through company--A company or person that acts as an agent or broker for companies or persons outside of Texas to provide goods, services or labor for the purpose of taking advantage of the Texas Moving Image Industry Incentive Program.]

[(24) Personal computer--An electronic device or machine used by a consumer for a variety of applications, including playing games. Games for this platform include those which play on the computer's CPU, as well as web and online game applications that are played using the personal computer.]

[(25) Physical production--The period encompassing pre-production, production, and postproduction.]

[(26) Postproduction--The period of physical production that occurs after the end of production, as defined in paragraph (29) of this section; including but not limited to, editing, music, sound, visual effects and animation.]

[(27) Pre-production--The period of physical production that occurs before the start of production as defined in paragraph (29) of this section.]

[(28) Principal start date--]

[(A) For a live action feature film, television program, reality television, educational or instructional video or commercial project, this is the first day of principal photography.]

[(B) For a video game or animated project, this is the first day of production.]

[(C) For a visual effects project, this is the first day of the stand alone finishing process including, but not limited to, the editing, visual effects, sound, music or animation created for feature films, television programs, commercials or educational or instructional videos.]

[(29) Production--]

[(A) For a live action feature film, television program, reality television, educational or instructional video or commercial project, this is the period of physical production between the first and last days of principal photography, inclusive.]

[(B) For a video game or animated project, this is the period of physical production between the end of pre-production and the creation of the gold master or completion of the project.]

[(C) For a visual effects project, this is the stand alone finishing process including, but not limited to, the editing, visual effects, sound, music or animation created for a feature film, television program, commercial, or educational or instructional video project.]

[(30) Production company--A film production company, television production company, video game developer, commercial production company, animation production company, visual effects production company or postproduction company.]

[(31) Reality series--A reality television project consisting of multiple episodes of a single season.]

[(32) Series of commercials--More than one commercial created in a contiguous production period for the same client.]

[(33) Series of educational or instructional videos--More than one educational or instructional video created in a contiguous production period for the same client.]

[(34) Stand-alone arcade machine--An electronic device used by a business or consumer solely for bona fide amusement purposes that reward the player exclusively with non-cash merchandise prizes or a representation of value redeemable for those items, as outlined in Texas Penal Code, §47.01.]

[(35) Texas resident--An individual who is permanently domiciled in Texas for at least 120 days prior to the principal start date of the project, unless enrolled as a full-time student at a Texas Institution of Higher Education, as defined by Texas Education Code, §61.003; and has completed a Declaration of Texas Residency Form.]

[(36) Texas spend option--Feature films, television programs and visual effects projects for feature films and television programs may choose a total spending provision to determine their grant amount that will include all eligible in-state spending (including eligible wages paid to Texas residents).]

[(37) Texas wage option--Feature films, television programs and visual effects projects for feature films and television programs may choose a wages only provision to determine their grant amount that will only include eligible wages paid to Texas residents.]

[(38) Underutilized and economically distressed area--]

[(A) Underutilized area--An area or municipality of the state that receives less than 15 percent of the total film and television production in the state during a fiscal year as determined by the Texas Film Commission. Areas or municipalities that receive in excess of 15 percent of the total film and television production in the state will be determined to include the area within a thirty mile radius from that area's largest municipality's city hall.]

[(B) Economically distressed area--An area within the above-determined thirty mile radius where the median household income does not exceed 75 percent of the median household income as determined by the Texas State Data Center, University of Texas San Antonio.]

[(39) Wages--Compensation paid to an individual for work performed. Payment methods may include, but are not limited to, direct payments, payments through an agent or agency, payments through a loan-out company or payments through a payroll service. Wages may include, but are not limited to, gross wages, per diems, employer paid Social Security (Old Age, Survivors, and Disability Insurance (OASDI)) payments, employer paid Medicare (MEDI) payments, employer paid Federal Unemployment Insurance (FUI) payments, employer paid State Unemployment Insurance (SUI) payments, employer paid Pension, Health and Welfare payments and employer paid Vacation and Holiday payments.]

[(40) Webisode--A short episode or series of episodes, either narrative or documentary, that is distributed initially as an Internet download or stream.]

§121.3. Eligible Projects.

(a) A project may be eligible for a grant under the Texas Moving Image Industry Incentive Program if it meets the stated minimum requirements [is a permitted project] listed in subsections (b) - (g)[(h)] of this section [that meets the minimum requirements].

(b) Feature Films.

(1) Feature Film Applicants must spend a minimum of $250,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the paid Crew and 70% of the paid Cast (including extras) must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that a sufficient number of qualified Crew and Cast (including extras) are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

(4) Animated or documentary Feature Films must have 70% of the combined total of paid Crew and paid Cast, including extras, be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that qualified Crew and Cast are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(1) A feature film is defined as any:]

[(A) live-action or animated for-profit production, narrative or documentary; and]

[(B) that is produced for distribution in theaters or via any digital format, including, but not limited to DVD, internet, or mobile electronic device.]

[(2) Minimum Requirements:]

[(A) Feature films must have minimum in-state spending of $250,000.]

[(B) 60% of the filming days must be completed in Texas.]

[(C) 70% of the total number of paid crew must be Texas residents unless it is determined and certified by the Texas Film Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

[(D) 70% of the total number of paid cast, including extras, must be Texas residents.]

[(E) Animated or documentary feature films must have 70% of the combined total of paid crew and cast, including extras, be Texas residents unless it is determined and certified by the Texas Film Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

[(F) For the purpose of calculating the 70% Texas resident ratio needed to qualify, certain individuals will be excluded from the Cast or Crew calculation. This includes, but is not limited to, individuals participating or appearing in the following manner:]

[(i) Documentary subjects or interviewees; or]

[(ii) Musicians performing as part of a music performance production.]

(c) Television Programs.

(1) Television Program Applicants must spend a minimum of $250,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the paid Crew and 70% of the paid Cast, including extras, must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that a sufficient number of qualified Crew and Cast (including extras) are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

(4) Animated or documentary Television Programs must have 70% of the combined total of paid Crew and paid Cast, including extras, be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that qualified Crew and Cast are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(1) A television program is defined as any:]

[(A) live-action or animated for-profit production, narrative or documentary, including, but not limited to:]

[(i) an episodic television series;]

[(ii) a miniseries;]

[(iii) a television movie ("MOW");]

[(iv) a television pilot;]

[(v) a television episode;]

[(vi) an interstitial television program;]

[(vii) a music performance production; or]

[(viii) a webisode;]

[(B) that is produced for distribution via broadcast, cable or any digital format, including, but not limited, to cable, satellite, internet, or mobile electronic device.]

[(2) Minimum Requirements:]

[(A) Television programs must have minimum in-state spending of $250,000.]

[(B) 60% of the filming days must be completed in Texas.]

[(C) 70% of the total number of paid crew must be Texas residents unless it is determined and certified by the Texas Film

Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

[(D) 70% of the total number of paid cast, including extras, must be Texas residents.]

[(E) Animated or documentary television programs must have 70% of the combined total of paid crew and cast, including extras, be Texas residents unless it is determined and certified by the Texas Film Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

[(F) For the purpose of calculating the 70% Texas resident ratio needed to qualify, certain individuals will be excluded from the Cast or Crew calculation. This includes, but is not limited to, individuals participating or appearing in the following manner:]

[(i) Documentary subjects or interviewees;]

[(ii) Musicians performing as part of a music performance production; or]

[(iii) Litigants and witnesses in court room programs.]

(d) Reality Television Projects.

(1) Reality Television Project Applicants must spend a minimum of $250,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the combined total of paid Crew and paid Cast, including extras, must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that a sufficient number of qualified Crew and Cast (including extras) are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(1) A reality television project is defined as any:]

[(A) live action for-profit production using unscripted content including, but not limited to:]

[(i) a reality series;]

[(ii) a contest or game show, to include individual episodes; or]

[(iii) a talk show, to include individual episodes;]

[(B) that is produced for nationally syndicated distribution via broadcast, cable or any digital format, including, but not limited, to cable, satellite, internet, or mobile electronic device.]

[(2) Minimum Requirements:]

[(A) Reality television projects must have minimum in-state spending of $250,000.]

[(B) 60% of filming days must be completed in Texas.]

[(C) 70% of the combined total of crew and cast, including extras, must be Texas residents.]

[(D) For the purpose of calculating the 70% Texas resident ratio needed to qualify, certain individuals will be excluded from the Cast or Crew calculation. This includes, but is not limited to, individuals participating or appearing in the following manner:]

[(i) Talk show guests;]

[(ii) Game or contest show contestants;]

[(iii) Reality series participants;]

[(iv) Documentary subjects or interviewees; or]

[(v) Litigants and witnesses in court room reality programs.]

(e) Commercials.

(1) Commercial Applicants must spend a minimum of $100,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the combined total of paid Crew and paid Cast, including extras, which are paid by the Applicant, must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that a sufficient number of qualified Crew and Cast (including extras) are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(1) A commercial is defined as any:]

[(A) live-action or animated production;]

[(B) that is an individual commercial, series of commercials, music video, infomercial, or interstitial advertisement;]

[(C) that is made for the purpose of entertaining or promoting a product, service, or idea; and]

[(D) that is produced for distribution via broadcast, cable or any digital format including but not limited to cable, satellite, internet, or mobile electronic device.]

[(2) Minimum Requirements:]

[(A) Commercials must have minimum in-state spending of $100,000.]

[(B) 60% of the filming days must be completed in Texas.]

[(C) 70% of the combined total of paid crew and cast, including extras, which are paid by the incentive applicant or production company, must be Texas residents.]

(f) Digital Interactive Media Productions.

(1) Digital Interactive Media Production Applicants must spend a minimum of $100,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the combined total of paid Crew and paid Cast which are paid by the Applicant must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that qualified Crew and Cast are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(f) Video Games.]

[(1) A video game is defined as any:]

[(A) piece of software that provides a user or users with a game to play for the purpose of entertainment or education, such as for military or medical simulation training; and]

[(B) that is created for a game console, personal computer, handheld console, mobile electronic or stand-alone arcade machine.]

[(2) Minimum Requirements:]

[(A) Video games must have minimum in-state spending of $100,000.]

[(B) 60% of the filming days must be completed in Texas.]

[(C) 70% of the combined total of paid crew and cast which are paid by the incentive applicant or production company, must be Texas residents unless it is determined and certified by the Texas Film Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

(g) Educational or Instructional Videos.

(1) Educational or Instructional Video Applicants must spend a minimum of $100,000 in in-state spending.

(2) 60% of the Filming Days must be completed in Texas.

(3) 70% of the combined total of paid Crew and paid Cast, including extras, which are paid by the Applicant, must be Texas Residents unless it is determined and certified by the Texas Film Commission in writing that qualified Crew and Cast are not available and every effort has been made by the production to meet the requirement by the Principal Start Date.

[(1) An educational or instructional video is defined as any:]

[(A) live action or animated production;]

[(B) that is an educational or instructional video or a series of educational or instructional videos; and]

[(C) that is produced for distribution in an educational or instructional setting.]

[(2) Minimum Requirements:]

[(A) Educational or instructional videos must have minimum in-state spending of $100,000.]

[(B) 60% of the filming days must be completed in Texas.]

[(C) 70% of the combined total of paid crew and cast, including extras, which are paid by the incentive applicant or production company, must be Texas residents.]

[(h) Visual Effects Projects.]

[(1) A visual effects project is defined as the stand alone finishing of:]

[(A) a live-action or animated feature film, television program, educational or instructional video, or commercial;]

[(B) that is completed with the inclusion of visual effects including, but not limited to, editing, visual effects, sound effects, music or animation; and]

[(C) that is produced for distribution in theaters, in educational or instructional settings, via broadcast, cable or any digital format, including but not limited to, cable, satellite, DVD, internet, or mobile electronic device.]

[(2) Minimum Requirements:]

[(A) Feature film and television program visual effects projects must have minimum in-state spending of $250,000.]

[(B) Commercial and educational or instructional video visual effects projects must have minimum in-state spending of $100,000.]

[(C) 60% of filming days must be completed in Texas.]

[(D) 70% of the combined total of paid crew and cast which are paid by the incentive applicant or production company must be Texas residents unless it is determined and certified by the Texas Film Commission that qualified crew are not available and every effort has been made by the production to meet the requirement by the principal start date.]

§121.4. Ineligible Projects.

(a) The following types of projects are not eligible for grants under this program:

(1) (No change.)

(2) news, current event or public access programming, political advertising (including Public Service Announcements which advance a public policy or political position) or programs that include weather or market reports;

(3) - (5) (No change.)

(6) awards shows (unless broadcast on national network television to a national audience), galas, [or] telethons or programs that solicit funds;

(7) - (8) (No change.)

(9) casino-type video games used in a Gambling Device, [directly used in a gambling device], as such term is defined pursuant to Texas Penal Code, §47.01; or

(10) (No change.)

(b) Not every project will qualify for a grant. The Texas Film Commission [State of Texas] is not required to act on any application and may deny an application or eventual payment on an application because of [make grants to projects that include] inappropriate content or content that portrays Texas or Texans in a negative fashion, as determined by the Texas Film Commission, in a moving image project. In determining whether to act on or deny an application, the Texas Film Commission shall consider general standards of decency and respect for the diverse beliefs and values of the citizens of Texas. As part of the preliminary application process, the Texas Film Commission will review the Content Document, as defined in §121.8(a)(1)(C) of this chapter, [content document,] and will advise the potential Applicant [applicant] on whether the content will preclude [exclude] the project from receiving a grant.

(c) Once an approved project has been completed, the Texas Film Commission will review the final content before issuing the grant, to determine if any substantial changes occurred [ensure that revisions made] during production to include [have not created an extreme difference from the] content described by subsection (b) of this section [as initially approved].

§121.5. Eligible and Ineligible In-State Spending.

(a) The following are eligible expenditures:

(1) Wages [and per diems] paid to Texas Residents [residents] for work performed in Texas, including additional compensation paid as part of a contractual or collective bargaining agreement.

[(A) For the purpose of calculating the grant amount only the first $1,000,000 in wages for each job position will be included.]

[(B) Eligible wages include, but are not limited to:]

[(i) payments for gross wages;]

[(ii) per diem payments;]

[(iii) employer paid Social Security (OASDI) payments;]

[(iv) ~~employer paid Medicare (MEDI) payments;]~~

[(v) ~~employer paid Federal Unemployment Insurance (FUI) payments;]~~

[(vi) ~~employer paid Texas State Unemployment Insurance (SUI) payments;]~~

[(vii) ~~employer paid pension, health and welfare payments; and]~~

[(viii) ~~employer paid vacation and holiday payments.]~~

(2) Additional compensation or reimbursements paid to Texas Residents [~~residents~~] including, but not limited to:

(A) mileage or car allowance;

(B) housing allowance; and

(C) box or kit rentals for use of personal equipment.

(3) Workers compensation insurance premiums for Texas Residents [~~residents~~], but only if the premiums are paid to a Texas-based insurance company or broker.

(4) Payroll company service fees for Texas Residents [~~residents~~], but only if paid to a Texas-based payroll company that processes payroll within Texas.

(5) Payments made to Texas domiciled entities, sole proprietorships or individuals [~~companies~~] for goods and services [~~domiciled and~~] used in Texas that are directly attributable to the Physical Production [~~physical production~~] of the moving image project. In the case of Digital Interactive Media Productions [~~video games~~] and animated projects, the amount attributable [~~attributed~~] to pre-production and research and development costs will be limited to an amount not to exceed 30% of the project's overall in-state spending.

(6) Payments for shipping on shipments originating in Texas (in the case of Federal Express, DHL or UPS shipments, the use of an Account Number of a Texas domiciled entity or sole proprietorship (where the address associated with the account number is printed) shall be conclusive proof of Texas origination for this purpose).

(7) Air travel to and from Texas on a Texas-based airline, including American Airlines[~~, Continental Airlines~~] and Southwest Airlines, or on a Texas-based air charter service, provided that an itemized receipt showing an itinerary and passenger name from the airline is provided confirming payment.

(8) Rentals[~~, leases and purchases~~] of vehicles registered and licensed in the State of Texas or rented[~~, leased or purchased~~] from a Texas domiciled entity or sole proprietorship, including, but not limited to, national rental car companies with a physical outlet in Texas [~~company or individual~~].

(9) Fees [~~Music that is specifically created for the project and fees~~] paid to Texas Residents [~~residents hired~~] to compose, orchestrate and perform [~~the~~] musicthat is specifically created for the project.

(10) Legal fees paid to Texas-based lawyers or law firms that are directly attributable to the Physical Production [~~physical production~~] of the moving image project.

(11) Internet purchases, but only if purchased from a Texas domiciled entity or sole proprietorship [~~Texas-based company~~] or a retailer with a physical store or outlet in Texas. Items purchased must be shipped directly to Texas.

(12) Capital expenditures for an individual item from a Texas domiciled entity or sole proprietorship under $1,000; spending on an individual capital item purchased for over $1,000 which item is not exhausted during the course of Production is acceptable Eligible Spending, so long as such item is sold at the end of the production and evidence of such sale is furnished to the Texas Film Commission; such documentation must show that only the difference between the purchase price and the sale price is submitted as Eligible Spending and a copy of the check or receipt for the sale should be included as back up with the original purchase documentation.

(13) Location Fees, if an executed Location Agreement by and between the Applicant and the location owner or owner's representative is provided to the Texas Film Commission with the Applicant's Expended Budget.

(b) The following are ineligible expenditures:

(1) Payments made to non-Texas domiciled entities, or if a sole proprietorship or individual, to non-Texas Residents [~~companies~~].

(2) Payments made for goods and services [~~not domiciled or~~] used in Texas.

(3) Payments made for goods and services that are not directly attributable to the Physical Production [~~physical production~~] of the moving image project.

(4) Payments made by Digital Interactive Media Production [~~video game~~] and animated projects for Pre-Production [~~pre-production~~] costs that exceed 30% of the project's overall in-state spending.

(5) Expenses related to distribution, publicity, marketing, or promotion of the project, including, but not limited to, promotional stills.

(6) Payments (other than properly allowable Location Fees) for facilities and automobiles that are part of a permanent/continuous business operation including, but not limited to, rental, lease or mortgage payments, utilities and insurance.

(7) Wages [~~and per diems~~] paid to non-Texas Residents [~~residents~~], including additional compensation paid as part of a contractual or collective bargaining agreement. [~~Wages include, but are not limited to:~~]

~~[(A) payments for gross wages;]~~

~~[(B) per diem payments;]~~

~~[(C) employer paid Social Security (OASDI) payments;]~~

~~[(D) employer paid Medicare (MEDI) payments;]~~

~~[(E) employer paid Federal Unemployment Insurance (FUI) payments;]~~

~~[(F) employer paid Texas State Unemployment Insurance (SUI) payments;]~~

~~[(G) employer paid pension, health and welfare payments; and]~~

~~[(H) employer paid vacation and holiday payments.]~~

(8) Payments made to a company, entity, association or person that acts as an agent or broker for companies, entities, associations or persons outside of Texas to provide goods, services or labor for the purpose of taking advantage of the Texas Moving Image Industry Incentive Program (also known as "pass-through" entities).

~~[(8) Payments made to pass-through companies.]~~

(9) (No change.)

(10) Additional compensation or reimbursements paid to non-Texas Residents [~~residents~~] including, but not limited to:

(A) - (C) (No change.)

(11) Workers compensation insurance payments for non-Texas Residents [~~residents~~].

(12) Payroll company service fees for non-Texas Residents or those paid to a non-Texas-based payroll company [~~residents~~].

(13) Payments for shipments originating outside of Texas (unless, in the case of Federal Express, DHL or UPS shipments, an Account Number of a Texas domiciled entity or sole proprietorship has been used for such shipments and such Account Number is printed on the invoices with the Texas address associated with the Account Number).

(14) - (16) (No change.)

(17) Payments for entertainment including, but not limited to, parties, event tickets, movies, hotel mini-bar items, meals unrelated to the Physical Production [~~physical production~~] of the project and personal gifts.

(18) (No change.)

(19) Capital expenditures for an individual item over $1,000 which item is not exhausted during the course of production, unless such purchase is from a Texas domiciled entity or sole proprietorship, the item is sold at the end of the production and evidence of such sale is furnished to the Texas Film Commission (such documentation must show that only the difference between the purchase price and the sale price is submitted as Eligible Spending and a copy of the check or receipt for the sale should be included as back up with the original purchase documentation).

(20) Payments to any business that sells alcohol or tobacco products reflected on receipts which are not itemized, even if the submitted item itself is otherwise eligible.

(21) On commercial productions where the Applicant is a production company rather than the client or ad agency, "talent handling fees," "overage fees" and "production fees," other than the Applicant's insurance fees from the actual column of the actual AICP budget (if it does not exceed the original, awarded bid and if a Texas-based insurance company or broker is used), editorial or post production fees from the actual column of the AICP budget (if such fees do not exceed the post production fees on the original, awarded bid), and any bona fide internal billing items which do not exceed the usual and customary cost of the goods or services, such as when production company employees work directly on the production using equipment and/or studio space owned by the Applicant that is "rented" to the production in lieu of using an outside vendor; to be included, however, these items must have been budgeted on the original, awarded bid.

(22) Any payments made other than by the Applicant, including, but not limited to, payments made on behalf of the Applicant by a third party.

(c) The Texas Film Commission reserves the right to determine which expenses are eligible or ineligible. [~~These lists are not all inclusive.~~]

§121.6. Grant Awards.

(a) Feature Films and[~~,~~] Television Programs must select [~~and Visual Effects Projects for Feature Films and Television Programs may choose to receive an incentive payment based on either~~] the Texas Spend Option or the Texas Wage Option for their projects[~~. Projects are required to choose an option~~] when submitting an application to the program. The selected option may be changed after the application is submitted, but not after the formal grant agreement has been signed. Grant awards will be calculated as follows:

(1) Texas Spend Option--[~~-~~] projects with total eligible in-state spending of:

(A) - (C) (No change.)

(2) Texas Wage Option--[~~-~~] projects with total eligible in-state spending of:

(A) At least $250,000 but less than $1 million will be eligible to receive a grant equal to 8% of eligible Wages [~~wages~~] paid to Texas Residents [~~residents~~].

(B) At least $1 million but less than $5 million will be eligible to receive a grant equal to 17% of eligible Wages [~~wages~~] paid to Texas Residents [~~residents~~].

(C) At least $5 million will be eligible to receive a grant equal to 25% of eligible Wages [~~wages~~] paid to Texas Residents [~~residents~~].

(b) Digital Interactive Media Productions with total eligible in-state spending of:

(1) At least $250,000 but less than $1 million will be eligible to receive a grant equal to 5% of eligible in-state spending.

(2) At least $1 million but less than $5 million will be eligible to receive a grant equal to 10% of eligible in-state spending.

(3) At least $5 million will be eligible to receive a grant equal to 15% of eligible in-state spending.

(c) Reality Television Projects, Commercials and Educational or Instructional Videos are eligible to receive a grant equal to 5% of total eligible in-state spending.

[~~(b) Reality Television Projects, Commercials, Video Games, Educational or Instructional Videos and Visual Effects Projects for Commercials and Educational or Instructional Videos are eligible to receive a grant equal to 5% of total eligible in-state spending.~~]

§121.7. Underutilized and Economically Distressed Areas.

(a) Projects, not to include projects choosing the Texas Wage Option but including Digital Interactive Media Productions, which[~~, that~~] complete at least 25% of their total Filming Days [~~filming days~~] in Underutilized [~~underutilized~~] or Economically Distressed Areas [~~economically distressed areas~~] may receive an additional 2.5% of total in-state spending. The additional 2.5% applies to all eligible spending in all areas of Texas; it is not restricted to the Underutilized or Economically Distressed-Area [~~underutilized or economically distressed-area~~] spending.

(b) Feature Filmsand[~~,~~] Television Programs [~~and Visual Effects Projects for Feature Films and Television Programs~~] that choose the Texas Wage Option and that complete at least 25% of their total Filming Days [~~filming days~~] in Underutilized [~~underutilized~~] or Economically Distressed Areas [~~economically distressed areas~~] may receive an additional 4.25% of eligible Wages [~~wages~~] paid to Texas Residents [~~residents~~]. The additional 4.25% applies to all eligible Wages [~~wages~~] paid to Texas Residents [~~residents~~]; it is not restricted to Wages [~~wages~~] paid for work only in the Underutilized or Economically Distressed Areas [~~underutilized or economically distressed area~~].

(c) In the event that multiple locations are utilized within a single Filming Day, in order to calculate the 25% of total Filming Days in Underutilized or Economically Distressed Areas necessary to receive an additional 2.5% or 4.25% of total in-state spending or Wages, as the case may be, the Texas Film Commission may pro-rate a given Filming Day by number of shot locations reflected on Production Reports fur-

nished by an Applicant to the Texas Film Commission. For example, if eight locations are utilized in a Filming Day, and five are located in Underutilized or Economically Distressed Areas, 5/8 of that Filming Day will count in calculating the 25% of total Filming Days necessary to become eligible for the additional grant percentage.

§121.8. Grant Application.

(a) Initial Submission.

(1) A Qualifying Application is defined to [~~must~~] include:

(A) A completed Qualifying Application Form for the Moving Image Industry Incentive Program;

(B) An itemized budget detailing only estimated Texas expenditures; and

(C) A Content Document [~~content document~~]:

(i) For Feature Films and[~~,~~] Television Programs (except Episodic Television Series) [~~and Visual Effects Projects for Feature Films and Television Programs~~], a full script.

(ii) For Episodic Television Series, the full script of the first episode to be filmed in Texas.

(iii) For Commercials[~~, Educational or Instructional Videos and Visual Effects Projects for Commercials~~] and Educational or Instructional Videos, the scripts, storyboards or detailed outlines/summaries of content.

(iv) For Digital Interactive Media Productions, a brief summary of game content providing sufficient detail concerning the themes, settings, story, characters and events to the Texas Film Commission upon which to base its preliminary content approval consideration. [~~Video Games, the game design document or a detailed outline/summary of game content.~~]

(v) For Reality Television Projects, a detailed outline/summary of program content.

(2) Qualifying Applications Forms for each type of project are available at the Texas Film Commission web site: http://governor.state.tx.us/film/ [~~http://www.governor.state.tx.us/divisions/film/~~], or by contacting the Texas Film Commission if Internet [~~internet~~] access is not available or special needs facilitation is required.

(3) Applications will not be accepted earlier than 30 calendar days prior to a project's Principal Start Date [~~principal start date~~].

(4) Applications must be received no later than 5:00 p.m. Central Time on the last Business Day [~~business day~~] prior to the Principal Start Date [~~principal start date~~].

(5) Only one application and Applicant [~~applicant~~] per project is allowed.

(6) Within 5 Business Days of the Principal Start Date indicated on the Qualifying Application form, an Applicant for a Feature Film, Television Program, Reality Television Project, Digital Interactive Media Production or Educational or Instructional Video must confirm with the Texas Film Commission in writing, to include e-mail, that the production began on time. If the start of the project is delayed for more than 30 days, an application may be discarded and the Applicant must reapply. If an Applicant fails to confirm that the production began on time within such 5 Business Day period, the Texas Film Commission may, at its sole election but with no obligation to do so, disqualify the application.

(b) The Office of the Governor, as a state agency, must comply with the Texas Public Information Act (the "Act"). In the event that a public information request related to the Applicant and/or the application is submitted to the agency, the Office of the Governor will promptly notify the Applicant of the request if current contact information is available, take all appropriate actions with the Attorney General of Texas to prevent release of confidential information, including asserting exemptions under the Act, and provide the Applicant with full information and opportunity to participate in such process if current contact information is available.

[~~(b) Additional Requirements.~~]

[~~(1) Within 5 business days of the principal start date indicated on the qualifying application form, an applicant for a Feature Film, Television Program, Reality Television Project, Video Game, Educational or Instructional Video or Visual Effects Project must confirm with the Texas Film Commission in writing, to include email, that production began on time. If the start of the project is delayed for more than 30 days, an application may be discarded and the production must reapply.~~]

[~~(2) Upon commencement of the production, an applicant may be required to submit a crew and vendor/services contact list to the Texas Film Commission. The applicant may also be required to show proof of the residency status of individuals hired to work on the project.~~]

§121.9. Processing and Review of Applications.

(a) (No change.)

(b) Initial Review.

(1) Each application will go through an initial review process when the Qualifying Application [~~qualifying application~~] has been received.

(A) If a project submits an application with required materials, and meets all qualifications, the Applicant [~~applicant~~] will receive an e-mail [~~email~~] notifying them that the Texas Film Commission has received their complete application and the preliminary award determination process will begin.

(B) If a project submits an application without the required materials, but initially appears to meet the minimum qualifications, the Applicant [~~applicant~~] will receive an e-mail [~~email~~] notifying them that their application requires additional materials or documentation, and that not receiving them in a timely manner may result in an application being disqualified.

(C) If a project submits an application with or without required materials and does not meet the minimum qualifications, the Applicant [~~applicant~~] will receive an e-mail [~~email~~] notifying them that they do not qualify for the Moving Image Industry Incentive Program [~~incentive program~~], but if minimum qualifications are met, the Applicant [~~applicant~~] may reapply before 5:00 p.m. Central Time on the last Business Day [~~business day~~] prior to the principal start date.

(2) (No change.)

(c) Preliminary Award Determination.

(1) During the preliminary award determination process, the Texas Film Commission will review the project's Qualifying Application [~~application~~] and budget to identify eligible expenditures and to determine if the Applicant [~~applicant~~] meets the minimum program requirements for in-state spending, Texas Filming Days [~~filming days~~] and Texas Residency [~~residency~~].

(2) The Texas Film Commission will also review the Content Document, as defined in §121.8(a)(1)(C) of this chapter, [~~project's content~~] to determine if it is appropriate.

(3) If the Qualifying Application [~~an application~~] meets all minimum program requirements as determined by the Texas Film Commission, and appropriated funds are then available at such time of determination, the Applicant [~~the applicant~~] will receive an e-mail [~~email~~] notifying them that the Qualifying Application [~~their application~~] has been approved.

(4) If a Qualifying Application [~~an application~~] does not meet all minimum program requirements as determined by the Texas Film Commission, the Applicant [~~applicant~~] will receive an e-mail [~~email~~] notifying them that their application does not qualify for the Moving Image Industry Incentive Program [~~incentive program~~].

(d) Grant Agreement.

(1) Upon Texas Film Commission approval of the Qualifying Application, a grant agreement will be executed between the Texas Film Commission and the Applicant [~~applicant~~]. The estimated grant amount will be based upon the Applicant's [~~applicant's~~] estimated in-state spending and election, as the case may be, of the Texas Spend Option or the Texas Wage Option, as applicable.

(2) The grant agreement must be returned to the Texas Film Commission [~~within 7 business days~~] with original signatures; failure to return could cause the Texas Film Commission to disqualify the project.

(3) Feature Films and[~~,~~] Television Programs [~~and Visual Effects Projects for Feature Films and Television Programs~~] that must choose between the Texas Spend Option and the Texas Wage Option to calculate their grant amount[~~,~~] will not be able to change the option selected once the grant agreement has been signed and returned to the Texas Film Commission.

(e) Periodic Tracking and Review. Once the grant agreement has been executed by both parties, the Texas Film Commission may periodically review production activity including, but not limited to, in-state spending, production locations and number of Texas Residents [~~residents~~] hired, and may require documentation for all of the above.

(f) Encumbrance of Funds.

(1) Upon Texas Film Commission approval of a Qualifying Application and receipt of a signed Grant Agreement, the Office of the Governor will encumber funds for the project.

(2) The amount encumbered for a project will be equal to the estimated grant amount on the Grant Agreement [~~plus a 10% contingency~~].

(3) To encumber funds, an Applicant [~~applicant~~] must have a Texas Payee Identification Number. Applicants without an existing Texas Payee Identification Number must submit a completed W-9 Form and a Texas Application for Payee Identification Number Form.

(4) Provided sufficient funds are then available, the [~~The~~] amount encumbered may [~~can~~] be adjusted by the Office of the Governor, at its sole election having no obligation to do so, if an Applicant [~~a project~~] amends the estimated Texas spending amount on their Qualifying Application, or ultimately submits spending documentation [~~application~~] so that it affects their estimated grant amount [~~by 10% or more~~].

(g) Verifying Texas Residency.

(1) In order to verify Texas Residency, the Applicant shall [~~The applicant will be required to~~] provide the Texas Film Commission with completed Declaration of Texas Residency Forms for each Texas Resident Crew and Cast member. [~~proof of the residency status of each Texas resident crew or cast member.~~]

(2) To be considered a Texas Resident, a Crew or Cast member must complete Sections I, II and III of the Declaration of Texas Residency Form. Section III must be completed with a valid Texas driver license, a valid Texas identification card or a current Texas voter registration. A full-time student of a Texas Institution of Higher Education, as defined by Texas Education Code §61.003, who does not have a Texas driver license, Texas identification card or Texas voter registration may complete Section III of the form with a current student identification card issued by a Texas Institution of Higher Education.

(3) A minor who does not have a Texas driver license, Texas identification card or Texas voter registration may have a Texas Resident parent or legal guardian complete Section III of the form, so long as such parent or legal guardian also signs Section III of the form, indicating such relationship to the minor.

(4) A representative of the Applicant must complete Section IV of the Declaration of Texas Residency Form.

~~[(2) The applicant can show proof of Texas residency by submitting completed Declaration of Texas Residency Forms for each crew or cast member.]~~

~~[(A) To be considered a Texas resident, a crew or cast member must complete section I, II and III of the Declaration of Texas Residency Form. Section III must be completed with a valid Texas driver license, a valid Texas identification card or a current Texas voter registration.]~~

~~*[(i)* A full-time student of a Texas Institution of Higher Education, as defined by Texas Education Code §61.003, who does not have a Texas driver license, Texas identification card or Texas voter registration may complete section III of the form with a current student identification card issued by a Texas Institution of Higher Education.]~~

~~*[(ii)* A minor who does not have a Texas driver license, Texas identification card or Texas voter registration may have a Texas resident parent or legal guardian complete section III of the form.]~~

~~[(B) A representative of the applicant or production company must complete section IV of the Declaration of Texas Residency Form.]~~

(h) Texas Film Commission Logo. Upon written request by an Applicant, having no obligation to do so, the Texas Film Commission may provide, having no obligation to do so, the Texas Film Commission logo to the Applicant so that the Applicant can include such logo in the closing credits of a Feature Film, Reality Series or Television Production.

§121.10. Disqualification of an Application

(a) A Qualifying Application [~~An application~~] may be disqualified at any time if a project does not meet the necessary requirements or if a Qualifying Application [~~an application~~] is incomplete. If a project is disqualified, the Applicant [~~applicant~~] will be notified by e-mail [~~email~~]. Qualifying Applications that have been disqualified may be resubmitted with the required changes or additional information, no earlier than 30 calendar days before the Principal Start Date [~~principal start date~~], and no later than 5:00 p.m. Central Time on the Business Day [~~business day~~] preceding the Principal Start Date [~~principal start date~~].

(b) In the case of a change in principal start or completion date, the Applicant [~~applicant~~] must notify the Texas Film Commission in writing, to include e-mail [~~email~~], of the new principal start or completion date, and must give the reason(s) for the change. If the start of

the project is delayed repeatedly or for more than 30 days, a Qualifying Application [an application] may be disqualified and the Applicant [production] must reapply.

(c) A Qualifying Application [An application] may also be disqualified for [the following] reasons including, but not limited to:

(1) Failure to submit required documents and notifications, or additional documents as requested or as required by this chapter;

(2) Failure to meet minimum requirements for in-state spending, number of Texas Residents [residents] hired, and/or percentage of Filming Days [filming days];

(3) (No change.)

(4) Inappropriate content as described in Texas Penal Code Annotated, §43.23 or content described by §121.4(b) of this chapter [that portrays Texas or Texans in a negative fashion];

(5) Lack of available funding; [or]

(6) Ineligible project as listed in §121.4 of this chapter;[.]

(7) Pursuant and subject to §121.8(a)(6) of this chapter, if an Applicant fails to confirm that the production began on time; or

(8) Voluntary notification in writing by the Applicant to the Texas Film Commission of the cancellation of the project.

§121.11. Confirmation and Verification of Texas Expenditures.

(a) The Applicant should collect, authenticate and assemble an Expended Budget and all final verifying documentation, including a CPA Audit Opinion if required by this chapter, and submit it to the Texas Film Commission within 60 days of completing Texas expenditures. [The Texas Film Commission will be responsible for collecting, authenticating and assembling final verifying documentation from the applicant for review.] The Texas Film Commission will perform the initial review, and a compliance audit will be performed by the Office of the Governor's Compliance and Oversight Division [Governor's Office Financial Services Division].

(b) [An expended budget should be received by the Texas Film Commission within 60 days of completing Texas expenditures.] The Expended Budget [expended budget] should be in a format acceptable to the Office of the Governor and should contain all final verifying documentation including, but not limited to:

(1) - (3) (No change.)

(4) Completed Declaration of Texas Residency Forms for all Texas Resident Crew and Cast members [resident crew and cast members];

(5) Crew and Cast [cast] lists that document Crew and Cast members, which also indicate whether such Crew and Cast members were paid or not (regardless of whether the Applicant was the source of payment), the absence of which indication shall create the presumption that such Cast and Crew were indeed paid; [non-Texas resident crew and cast members;]

(6) Call sheets, production reports or production calendars that document all production days; [and]

(7) The CPA Audit Opinion, if required by §121.15 of this chapter;

(8) Final content;

(A) Feature Films and Television Programs must submit a copy of the final script or final content for review.

(B) Commercials, Digital Interactive Media Productions, Reality Television Projects and Educational or Instructional Videos must submit final content (or online access to final content) for review.

(9) Additional documentation may be required including, but not limited to, the following:

(A) Financials, including all reports of expenditures.

(B) Proof of payment for expenditures.

(C) Feature Films and Television Programs that choose the Texas Wage Option and that spend less than $5 million in eligible Wages must provide expenditure reports documenting all eligible Texas spending (not just eligible Wage spending) in order to establish the percentage for calculating their grant amount (unless such percentages are established by expended Wages alone).

[(7) Final content.]

[(A) Feature films, television programs and visual effects projects for feature films and television programs must submit a copy of the final script or final content for review.]

[(B) Commercials, video games, reality television projects, educational or instructional videos and visual effects projects for commercials and educational or instructional videos must submit final content for review.]

[(8) Additional documentation may be required including, but not limited to, the following:]

[(A) Financials, including all reports of expenditures.]

[(B) Proof of payment for expenditures.]

[(C) Feature Films, Television Programs and Visual Effects Projects for Feature Films and Television Programs that choose the Texas Wage Option and that spend less than $5 million in eligible wages must provide expenditure reports documenting all eligible Texas spending (not just eligible wage spending) in order to establish the percentage for calculating their grant amount.]

(c) It is the responsibility of the Applicant to ensure that the final verifying documentation submitted in the Expended Budget is correct and complete. Once the Expended Budget is accepted for review by the Texas Film Commission, the Applicant will not be able to submit additional information unless requested to do so by the Office of the Governor.

[(c) An expended budget submitted in a format unacceptable to the Office of the Governor may be returned to the applicant for revision. The Texas Film Commission should receive the revised expended budget within 14 days of its return to the applicant.]

[(d) It is the responsibility of the applicant to ensure that the final verifying documentation submitted in the expended budget is correct and complete. Once the expended budget is accepted for review by the Texas Film Commission, the applicant will not be able to submit additional information unless requested to do so by the Office of the Governor.]

§121.12. Disbursement of Funds.

(a) Disbursement of funds will not occur until the Applicant [applicant or production company] has paid all financial obligations incurred to [in] the State of Texas, and a final compliance audit has been completed and approved.

(b) In the event of unpaid financial obligations to [in] the State of Texas, the Office of the Governor will determine whether or not to withhold grant disbursement, pending settlement.

(c) Payment Assignment.

(1) An Applicant [~~applicant~~] can assign payment of the grant to a third party.

(2) To assign payment the Applicant [~~applicant~~] must submit:

(A) (No change.)

(B) An assignment agreement completed and signed by the Applicant [~~applicant~~] and assignee.

§121.14. Revocation and Recapture of Incentives.

(a) An Applicant's [~~applicant's~~] eligibility for funds can be revoked after the project is completed for reasons such as obscene or inappropriate content, failure to meet minimum qualification requirements, failure to provide requested documentation, providing false information, or inability to complete the project.

(b) If an Applicant [~~applicant~~] has already received the grant and is determined to not meet a requirement in any way, the State of Texas can require that the Applicant [~~applicant~~] refund any sum of the grant money paid to the Applicant [~~applicant~~] by the State of Texas.

§121.15. CPA Audit Opinion.

(a) If the estimated grant amount reflected in the grant agreement referenced in §121.9(d)(1) of this chapter equals or exceeds $300,000, an Applicant must submit to the Texas Film Commission a CPA Audit Opinion, paid for by the Applicant and conducted by an independent Certified Public Accountant licensed to practice in the State of Texas with no relationship to the Applicant.

(b) The auditor conducting the CPA Audit and providing the CPA Audit Opinion must furnish the CPA Audit Opinion to the Applicant on the auditor's letterhead, dated as of the date of completion but no later than 60 days of the Applicant completing Texas expenditures.

(c) The CPA Audit must be conducted in accordance with auditing standards generally accepted in the United States of America, and the auditor must have sufficient knowledge of accounting principles and practices generally recognized in the film and television industry. The CPA is to perform an examination level attestation complete with the CPA Audit Opinion and audit.

(d) The CPA Audit Opinion shall take the following form, including the Notes thereafter:
Figure: 13 TAC §121.15(d)

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 June 21, 2011.

TRD-201102302
Michael Bryant
Assistant General Counsel
Texas Film Commission
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 463-9200

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TITLE 16. ECONOMIC REGULATION

PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

CHAPTER 80. LICENSED COURT INTERPRETERS

16 TAC §§80.10, 80.20, 80.22, 80.23

The Texas Department of Licensing and Regulation (Department) proposes amendments to existing rules at 16 Texas Administrative Code (TAC) Chapter 80, §§80.10, 80.20, 80.22 and 80.23, regarding the licensed court interpreter program.

These proposed rule changes are necessary to implement House Bill 4445, 81st Legislature, Regular Session, 2009, which amended Texas Government Code, Title 2, Subtitle D, Chapter 57, by creating a basic designation license and master designation license for licensed court interpreters.

The proposed rule changes were recommended by the Licensed Court Interpreter Advisory Board at its meeting on June 24, 2011.

§80.10

The proposal amends §80.10 by adding definitions for a basic designation license and a master designation license. The definitions create two levels of licensed court interpreter competency based upon oral examination results. Interpreters who score at least 60% on each part of the oral examination will be issued the basic designation license and will be permitted to interpret in court proceedings in justice courts and municipal courts that are not courts of record. Interpreters who score at least 70% on the oral examination will be issued the master designation license and will be permitted to interpret in court proceedings in all courts in the state.

§80.20

The proposal amends §80.20 by adding subsection (c) to clarify that all licensing requirements, including examination requirements, must be completed within one year of the application date. Subsection (d) specifies that any examination taken by an applicant before September 1, 2013, will be considered by the Department for purposes of issuing a basic designation license. The proposed amendment insures that an applicant who previously scored at least 60% on the oral examination will not be required to re-test in order to receive a basic designation license.

§80.22

The proposal amends §80.22 by adding subsection (c) to specify the examination score an applicant must make in order to be eligible for either a basic designation license or a master designation license. Section 80.22 also makes cheating on an examination grounds for denial, suspension, or revocation of a license and/or the imposition of an administrative penalty.

§80.23

The proposal amends §80.23 by adding subsection (d) to clarify that late license renewals are governed by the Chapter 60 of the Texas Administrative Code, Title 16, which sets out the procedural rules of the Department.

William H. Kuntz, Jr., Executive Director, has determined that for the first five-year period the proposed rules are in effect there will be no foreseeable implications relating to cost or revenues of the state or local government as a result of enforcing or administering the proposed rules.

Mr. Kuntz also has determined that for each year of the first five-year period the amendments are in effect, the public will benefit by an increase in the number of licensed court interpreters who will be able to provide interpreting services in justice and municipal court proceedings that are not courts of record.

There will be no adverse economic effect on small or micro-business or to persons who are required to comply with the rules as proposed.

Since the agency has determined that the rules will have no adverse economic effect on small business preparation of an Economic Impact Statement and a Regulatory Flexibility Analysis as detailed under Texas Government Code §2006.002 is not required.

Comments on the proposal may be submitted by mail to Caroline Jackson, Legal Assistant Team Lead, General Counsel's Office, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or by facsimile to (512) 475-3032, or electronically to erule.comments@license.state.tx.us. The deadline for comments is 30 days after publication in the *Texas Register.*

The amendments are proposed under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 57, which authorize the Department's governing body, the Texas Commission of Licensing and Regulation, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department.

The statutory provisions affected by the proposal are those set forth in Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 57. No other statutes, articles, or codes are affected by the proposal.

§80.10. Definitions.

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

(1) Dishonorable--Lacking in integrity, indicating an intent to deceive or take unfair advantage of another person, or bringing disrepute to the profession of court interpretation.

(2) Unethical--Conduct that does not conform to generally accepted standards of conduct for professional court interpreters.

(3) Basic Designation--Permits the interpreter to interpret court proceedings in justice courts and municipal courts that are not municipal courts of record, other than a proceeding before the court in which the judge is acting as a magistrate.

(4) Master Designation--Permits the interpreter to interpret court proceedings in all courts in this state, including justice courts and municipal courts.

§80.20. Licensing Requirements--General.

(a) Prior to performing court interpretation services, a person first must obtain a court interpreter license from the Department with a language endorsement for each language that the applicant will interpret.

(b) A person seeking to be licensed as a court interpreter must :

(1) file an application with the Department using Department forms; [~~for this purpose and must~~]

(2) pay a non-refundable license application filing fee; [~~at the time the application is filed with the Department.~~]

(3) satisfy the examination requirements of §80.22; and

(4) complete all requirements, including satisfying the examination requirements within one year of the date of the application.

(c) Until September 1, 2013, the Department shall consider examinations taken up to two years prior to the filing of the application for purposes of awarding a Basic Designation license.

§80.22. License Requirements--Examination.

(a) Each applicant must pass all parts of a Department approved language examination [~~before the applicant will be licensed as a court interpreter for that language~~].

(b) An applicant must pass the written examination with a score of 80%.

(c) An applicant must pass all three parts of the oral examination according to the following:

(1) an applicant scoring at least 60% on each part of the oral examination is eligible for a Basic Designation license.

(2) an applicant scoring at least 70% on each part of the oral examination is eligible for a Master Designation license.

(d) An applicant taking an examination must comply with the Department's examination requirements under 16 Texas Administrative Code Chapter 80, Subchapter E.

(e) Cheating on an examination is grounds for denial, suspension, or revocation of a license and/or an administrative penalty.

§80.23. Licensing Requirements--Renewal.

(a) A complete application for license renewal and all required fees must be filed by the expiration date, or the application will be considered late and the license will expire.

(b) Non-receipt of a license renewal notice from the Department does not exempt a person from any requirements of this chapter.

(c) A person shall not perform work requiring a license under Chapter 57 of the Texas Government Code with an expired license.

(d) Late renewals are governed by §60.83 of this title (relating to Late Renewal 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 June 27, 2011.

TRD-201102403
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 463-7348

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PART 8. TEXAS RACING COMMISSION

CHAPTER 321. PARI-MUTUEL WAGERING
SUBCHAPTER A. MUTUEL OPERATIONS

The Texas Racing Commission (Commission) proposes amendments to 16 TAC §§321.1, 321.35, 321.41, and 321.42. The sections proposed for amendment relate to: pari-mutuel wagering definitions; claims for payment on winning pari-mutuel tickets and vouchers; cashing of outstanding tickets; and cashing of outstanding vouchers. The proposed amendments will enable racetrack associations to pay patrons, under limited circumstances, for winning pari-mutuel tickets or vouchers that have been lost or destroyed.

Chuck Trout, Executive Director, has determined that for the first five-year period the amendment is in effect there will be no fiscal implications for state or local government as a result of enforcing the amendments.

Mr. Trout has also determined that for each year of the first five years the amended rules are in effect the following statements regarding the anticipated public benefit will apply:

The proposed amendment to §321.1, Definitions and General Provisions, defines "Player Tracking System" to mean a system that provides detailed information about the pari-mutuel play activity of patrons who volunteer to participate. Player Tracking Systems will facilitate the payment of lost or destroyed tickets and vouchers by demonstrating that particular patrons purchased those tickets and vouchers.

The proposed amendment to §321.35, Claim for Payment, establishes the process by which a patron may file a claim for a lost ticket or voucher. The amendment also establishes the criteria that an association must follow in determining whether to pay a claim, and the process a patron may use to appeal if the association does not pay a claim.

The proposed amendment to §321.41, Cashing Outstanding Tickets, provides that an association will not be held liable for a lost or destroyed ticket if it is cashed in accordance with amended §321.35.

The proposed amendment to §321.42, Cashing Outstanding Vouchers, provides that an association will not be held liable for a lost or destroyed voucher if it is cashed in accordance with amended §321.35.

The rule will have no adverse economic effect on small or micro-businesses, and therefore preparation of an economic impact statement and a regulatory flexibility analysis is not required.

There are no negative impacts upon employment conditions in this state as a result of the proposed amendments.

All comments or questions regarding the proposed amendments may be submitted in writing within 30 days following publication of this notice in the *Texas Register* to Carolyn Weiss, Assistant to the Executive Director, at P.O. Box 12080, Austin, Texas 78711-2080, telephone (512) 833-6699, or fax (512) 833-6907.

DIVISION 1. GENERAL PROVISIONS

16 TAC §321.1

The amendment is proposed under Texas Revised Civil Statutes Annotated Article 179e, §11.01, which requires the Commission to adopt rules to regulate pari-mutuel wagering on greyhound and horse racing.

The amendment implements Texas Revised Civil Statutes Annotated Article 179e.

§321.1. Definitions and General Provisions.

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

(1) - (12) (No change.)

(13) Player Tracking System--a system that provides detailed information about pari-mutuel play activity of patrons who volunteer to participate. The system can be used to customize highly specific promotions and tailor rewards to encourage incremental visits by patrons. The system should be able to produce customized informational reports based on such parameters as type of wager, type of race, favorite race meet, or other parameters deemed helpful by the association in supporting the patron.

(14) [~~(13)~~] Remote site--a racetrack or other location at which wagering is occurring that is linked via the totalisator system to a racetrack facility for pari-mutuel wagering purposes.

(15) [~~(14)~~] Report--a summary of betting activity.

(16) [~~(15)~~] Resultant--the profit-per-dollar wagered in a pari-mutuel pool computation.

(17) [~~(16)~~] Ticketless Electronic Wagering (E-wagering)--a form of pari-mutuel wagering in which wagers are placed and cashed through an electronic ticketless account system operated through a licensed totalisator vendor in accordance with §11.04 of this Act. Wagers are automatically debited and credited to the account holder.

(18) [~~(17)~~] TIM--ticket-issuing machine.

(19) [~~(18)~~] TIM-to-Tote network--a wagering network consisting of a single central processing unit and the TIMs at any number of remote sites.

(20) [~~(19)~~] Totalisator system--a computer system that registers and computes the wagering and payoffs in pari-mutuel wagering.

(21) [~~(20)~~] Totalisator operator--the individual assigned to operate the totalisator system at a racetrack facility.

(22) [~~(21)~~] Tote-to-tote network--a wagering network in which each wagering location has a central processing unit.

(23) [~~(22)~~] User--a totalisator company employee authorized to use the totalisator system in the normal course of business.

(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 June 24, 2011.

TRD-201102392
Mark Fenner
General Counsel
Texas Racing Commission
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 833-6699

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DIVISION 3. MUTUEL TICKETS AND VOUCHERS

16 TAC §§321.35, 321.41, 321.42

The amendments are proposed under Texas Revised Civil Statutes Annotated Article 179e, §11.01, which requires the Commission to adopt rules to regulate pari-mutuel wagering on greyhound and horse racing.

The amendments implement Texas Revised Civil Statutes Annotated Article 179e.

§321.35. Claim for Payment.

(a) Claims on pari-mutuel tickets or vouchers presented for payment.

(1) An association shall accept a claim for payment if the association has withheld payment or has refused to cash a pari-mutuel ticket or a voucher presented for payment. The claim for payment must

be [~~made~~] on a form prescribed by the association and approved by the executive secretary. [~~signed by the claimant.~~]

(2) The original of the claim must be signed by the claimant and shall be promptly forwarded to the Commission.

[~~(b) If a claim is made for payment of a mutilated ticket that does not contain the information required under §321.29 of this title (relating to Mutuel Tickets), the~~]

(3) The association shall make a recommendation to accompany the claim forwarded to the Commission. The recommendation must state whether or not the [~~mutilated~~] ticket or voucher can [~~has sufficient elements to~~] be positively identified as a winning ticket or voucher.

[~~(c) If a claim is made for payment of a mutilated voucher that does not contain the information required under §321.31 of this title (relating to Vouchers), the association shall make a recommendation to accompany the claim forwarded to the Commission. The recommendation must state whether or not the mutilated voucher has sufficient elements to be positively identified as an outstanding voucher.~~]

(4) [~~(d)~~] If a claim is made for the payment of a mutuel ticket or a voucher, the executive secretary shall investigate the claim and may:

(A) [~~(1)~~] order the association to pay the claim;

(B) [~~(2)~~] deny the claim; or

(C) [~~(3)~~] enter any other order the executive secretary determines appropriate.

(b) Claims on pari-mutuel tickets or vouchers that have been lost or destroyed.

(1) An association may cash a lost or destroyed ticket voucher if the ticket or voucher has not been previously cashed and the claimant can:

(A) demonstrate ownership via the use of the claimant's unique and personally identifiable player tracking account at the association where the transaction was made on the claimant's account; or

(B) can provide the mutuel manager sufficient information whereby the transaction can be positively verified through wagering system logs.

(2) If an association refuses to pay a claim for a lost or destroyed ticket or voucher, the claimant may file a claim for payment with the Commission. The claim for payment must be on a form prescribed by the association and approved by the executive secretary.

(A) The original of the claim must be signed by the claimant, and shall be promptly forwarded to the Commission.

(B) The association shall make a recommendation to accompany the claim forwarded to the Commission. The recommendation must state:

(i) whether or not the ticket or voucher can be positively verified as a winning transaction;

(ii) whether or not the ticket or voucher has been previously cashed, and date the ticket or voucher was cashed; and

(iii) why the association refused to pay the claimant.

(3) If a claim for payment is received by the executive secretary under paragraph (2) of this subsection, then the executive secretary shall investigate the claim and may:

(A) order the association to pay the claim;

(B) deny the claim; or

(C) enter any other order the executive secretary determines appropriate.

(c) An association shall be responsible for maintaining records and logs to validate claims for payments in this section. Records and logs must be maintained for 365 days.

(d) In the event a claim is made for a ticket that meets the criteria established in §321.41(a) of this chapter (relating to Cashing Outstanding Tickets), the claim must be approved by the executive secretary before the claim can be paid.

(e) In the event a claim is made for a voucher that meets the criteria established in §321.42(a) of this chapter (relating to Cashing Outstanding Vouchers), the claim must be approved by the executive secretary before the claim can be paid. [~~A claim may not be made for a lost or destroyed mutuel ticket or voucher.~~]

§321.41. Cashing Outstanding Tickets.

(a) - (d) (No change.)

(e) In the event a photostatic copy can not be provided, the association will not be held liable for:

(1) a reader cashed ticket if the association can produce documentation to support the ticket's existence; or[~~.~~]

(2) a ticket cashed in accordance with the executive secretary's approval under §321.35(b) or (d) of this chapter (relating to Claim for Payment).

§321.42. Cashing Outstanding Vouchers.

(a) - (d) (No change.)

(e) In the event a photostatic copy can not be provided, the association will not be held liable for:

(1) a reader cashed voucher if the association can produce documentation to support the voucher's existence; or[~~.~~]

(2) a voucher cashed in accordance with the executive secretary's approval under §321.35(b) or (d) of this chapter (relating to Claim for Payment).

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 June 24, 2011.

TRD-201102393
Mark Fenner
General Counsel
Texas Racing Commission
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 833-6699

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TITLE 22. EXAMINING BOARDS

PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 281. ADMINISTRATIVE PRACTICE AND PROCEDURES

SUBCHAPTER A. GENERAL PROVISIONS

22 TAC §281.2, §281.9

The Texas State Board of Pharmacy proposes amendments to §281.2, concerning Definitions, and §281.9, concerning Grounds for Discipline for a Pharmacy Technician or Pharmacy Technician Trainee. The proposed amendments to §281.2, if adopted, define confidential address of record, public address of record and diversion of dangerous drugs. The proposed amendments to §281.9 clarify the grounds for discipline for pharmacy technicians/trainees.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rules are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rules.

Ms. Dodson has determined that, for each year of the first five-year period the rules will be in effect, the public benefit anticipated as a result of enforcing the rules will ensure that licensees and registrants provide correct address information to the Board and ensure proper discipline for pharmacy technicians/trainees. There is no fiscal impact for individuals, small, large or micro-businesses, or to other entities which are required to comply with this section.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §§551.002, 554.051, and 555.001 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act. The Board interprets §555.001(d) as authorizing the agency to consider the home address and telephone number of a person licensed or registered by the Board, including a pharmacy owner as confidential and not subject to disclosure but each person licensed or registered must provide the Board with an address of record that is subject to disclosure.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§281.2. Definitions.

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

(1) Act--The Texas Pharmacy Act, Chapters 551 - 566, Texas Occupations Code, as amended.

(2) Administrative law judge--A judge employed by the State Office of Administrative Hearings.

(3) Agency--The Texas State Board of Pharmacy, and its divisions, departments, and employees.

(4) Administrative Procedure Act (APA)--Government Code, Chapter 2001, as amended.

(5) Board--The Texas State Board of Pharmacy.

(6) Confidential address of record--The home address required to be provided by each individual, who is a licensee, registrant, or pharmacy owner and where service of legal notice will be sent. The address is confidential, as set forth in §555.001(d) of the Act, and not subject to disclosure under the Public Information Act.

(7) [~~(6)~~] Contested case--A proceeding, including but not restricted to licensing, in which the legal rights, duties, or privileges of a party are to be determined by the board after an opportunity for adjudicative hearing.

(8) [~~(7)~~] Diversion of controlled substances--An act or acts which result in the distribution of controlled substances from legitimate pharmaceutical or medical channels in violation of the Controlled Substances Act or rules promulgated pursuant to the Controlled Substances Act or rules relating to controlled substances promulgated pursuant to this Act.

(9) Diversion of dangerous drugs--An act or acts which result in the distribution of dangerous drugs from legitimate pharmaceutical or medical channels in violation of the Dangerous Drug Act or rules promulgated pursuant to the Dangerous Drug Act or rules relating to dangerous drugs promulgated pursuant to this Act.

(10) [~~(8)~~] Executive director/secretary--The secretary of the board and executive director of the agency.

(11) [~~(9)~~] License--The whole or part of any agency permit, certificate, approval, registration, or similar form of permission required by law.

(12) [~~(10)~~] Licensee--Any individual or person to whom the agency has issued any permit, certificate, approved registration, or similar form of permission authorized by law.

(13) [~~(11)~~] Licensing--The agency process relating to the granting, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

(14) [~~(12)~~] Official act--Any act performed by the board pursuant to a duty, right, or responsibility imposed or granted by law, rule, or regulation.

(15) [~~(13)~~] Person--An individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership, association, or any other legal entity.

(16) [~~(14)~~] President--The president of the Texas State Board of Pharmacy.

(17) [~~(15)~~] Presiding Officer--The president of the Texas State Board of Pharmacy or, in the president's absence, the highest ranking officer present at a board [~~Board~~] meeting.

(18) Publicly available address of record--The alternate address required to be provided by each licensee, registrant, or pharmacy owner, which will be released to the public, as set forth in §555.001(d) of the Act, and is subject to disclosure under the Public Information Act.

(A) The alternate address must be a business address or other alternate address, such as the home address of the individual's relative, where mail can be received on a regular basis.

(B) A pharmacy must provide the physical address of the pharmacy to be used for this purpose.

(19) [~~(16)~~] Quorum--A majority of the members of the board appointed and serving on the board.

(20) [~~(17)~~] State Office of Administrative Hearings (SOAH)--The agency to which contested cases are referred by the Texas State Board of Pharmacy.

(21) [~~(18)~~] Sample--A prescription drug which is not intended to be sold and is intended to promote the sale of the drug.

(22) [~~(19)~~] Texas Public Information Act--Government Code, Chapter 552.

§281.9. Grounds for Discipline for a Pharmacy Technician or a Pharmacy Technician Trainee.

(a) (No change.)

(b) For the purposes of the Act, §568.003(a)(10), "negligent, unreasonable, or inappropriate conduct" shall include, but not be limited to:

(1) delivering or offering to deliver a prescription drug or device in violation of this Act, the Controlled Substances Act, the Dangerous Drug Act, or rules promulgated pursuant to these Acts;

(2) acquiring or possessing or attempting to acquire or possess prescription drugs in violation of this Act, the Controlled Substances Act, or Dangerous Drug Act or rules adopted pursuant to these Acts;

(3) failing to perform the duties of a pharmacy technician or pharmacy technician trainee in an acceptable manner consistent with the public health and welfare, which contributes to a prescription not being dispensed or delivered accurately;

(4) obstructing a board employee in the lawful performance of his duties of enforcing the Act;

(5) violating the provisions of an agreed board order or board order, including accessing prescription drugs with a revoked or suspended pharmacy technician or pharmacy technician trainee registration;

(6) physically abusing a board employee during the performance of such employees lawful duties; or

(7) failing [~~failure~~] to repay a guaranteed student loan, as provided in the Texas Education Code, §57.491.

(c) - (d) (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 June 21, 2011.

TRD-201102313
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER B. GENERAL PROCEDURES IN A CONTESTED CASE

22 TAC §281.30

The Texas State Board of Pharmacy proposes amendments to §281.30, concerning Notice and Service for Hearing. The proposed amendments, if adopted, clarify notice and service of hearing will be sent to the party's addresses including confidential and public address of record.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule.

Ms. Dodson has determined that, for each year of the first five-year period the rule will be in effect, the public benefit anticipated as a result of enforcing the rule will ensure that licensees and registrants receive proper notice of hearing. There is no fiscal impact for individuals, small, large or micro-businesses, or to other entities which are required to comply with this section.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§281.30. Notice and Service for Hearing.

The board may serve notice of a contested case hearing at the State Office of Administrative Hearings by sending it to the party's current publicly available address of record and the party's current confidential address of record if the confidential address of record is different from the party's publicly available address of record [~~last known address~~] as shown by the board's records.

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 June 21, 2011.

TRD-201102314
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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CHAPTER 283. LICENSING REQUIREMENTS FOR PHARMACISTS

22 TAC §§283.4, 283.7, 283.8

The Texas State Board of Pharmacy proposes amendments to §283.4, concerning Internship Requirements, §283.7, concerning Examination Requirements, and §283.8, concerning Reciprocity Requirements. The proposed amendments, if adopted, specify the application requirements for pharmacists and interns.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rules are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rules.

Ms. Dodson has determined that, for each year of the first five-year period the rules will be in effect, the public benefit anticipated as a result of enforcing the rules will ensure that licensees and registrants provide sufficient information on applications and are qualified to be licensed or registered with the Board. There is no fiscal impact for individuals, small, large or micro-businesses, or to other entities which are required to comply with these sections.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§283.4. Internship Requirements.

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

(c) College-/School-Based Internship Programs.

(1) Internship experience acquired by student-interns.

(A) An individual may be designated a student-intern provided he/she [~~meets all of the following requirements~~]:

(i) submits an [~~has made~~] application to the board that includes the following information:[~~;~~]

(I) name;

(II) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number;

(III) college of pharmacy and expected graduation date; and

(IV) any other information requested on the application.

(ii) - (iv) (No change.)

(B) - (C) (No change.)

(2) (No change.)

(3) Texas colleges/schools of pharmacy internship programs.

(A) - (G) (No change.)

(H) Individuals enrolled in the professional sequence of a Texas college/school of pharmacy whose professional degree program has been accredited by ACPE and approved by the board may be designated as a intern-trainee provided he/she [~~meets all of the following requirements~~]:

(i) submits an [~~has made~~] application to the board that includes the following information:[~~;~~]

(I) name;

(II) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number;

(III) college of pharmacy and expected graduation date; and

(IV) any other information requested on the application.

(ii) - (iii) (No change.)

(d) Extended-internship program.

(1) A person may be designated an extended-intern provided he/she has met one of the following requirements [~~has made application to the board and met one of the following requirements~~]:

(A) - (E) (No change.)

(2) In addition to meeting one of the requirements in paragraph (1) of this subsection, an applicant for an extended-internship must: [~~meet all requirements necessary in order for the Board to access the criminal history records information, including submitting fingerprint information and being responsible for all associated costs.~~]

(A) submit an application to the board that includes the following information:

(i) name;

(ii) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number;

(iii) any other information requested on the application; and

(B) meet all requirements necessary in order for the board to access the criminal history records information, including submitting fingerprint information and being responsible for all associated costs.

(3) - (6) (No change.)

(e) - (g) (No change.)

§283.7. Examination Requirements.

Each applicant for licensure by examination shall pass the Texas Pharmacy Jurisprudence Examination and the NAPLEX. The examination requirements shall be as follows:

(1) Prior to taking the required examination, the applicant shall:

(A) [~~shall~~] meet the educational and age requirements as set forth in §283.3 of this title (relating to Educational and Age Requirements); [~~and~~]

(B) [~~may be required to~~] meet all requirements necessary in order for the Board to access the criminal history record information, including submitting fingerprint information and being responsible for all associated costs; and[~~.~~]

(C) submit an application to the board that includes the following information:

(i) name;

(ii) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; and

(iii) any other information requested on the application.

(2) - (9) (No change.)

§283.8. Reciprocity Requirements.

(a) All applicants for licensure by reciprocity shall:

(1) [~~shall~~] meet the educational and age requirements specified in §283.3 of this title (relating to Educational and Age Requirements);

(2) [~~may be required to~~] meet all requirements necessary in order for the board [~~Board~~] to access the criminal history record information, including submitting fingerprint information and being responsible for all associated costs;

(3) [~~shall~~] complete the Texas and NABP applications for reciprocity. (Any fraudulent statement made in the application for reciprocity is grounds for denial of the application; if such application is granted, any fraudulent statement is grounds for suspension, revocation, and/or cancellation of any license so granted by the board. The Texas application includes the following information:[~~);~~]

(A) name;

(B) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; and

(C) any other information requested on the application.

(4) - (5) (No change.)

(b) - (e) (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 June 21, 2011.

TRD-201102315
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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CHAPTER 291. PHARMACIES
SUBCHAPTER A. ALL CLASSES OF PHARMACIES

22 TAC §§291.1, 291.6, 291.29

The Texas State Board of Pharmacy proposes amendments to §291.1, concerning Pharmacy License Application, §291.6, concerning Pharmacy License Fees, and §291.29, concerning Professional Responsibility of Pharmacists. The proposed amendments to §291.1, if adopted, clarify application requirements for pharmacies. The proposed amendments to §291.6, if adopted, raise pharmacy license fees based on expenses. The proposed amendments to §291.29 clarify requirements for prescriptions issued for a partner or family member in accordance with the Texas Medical Board rules and establish guidelines for prescriptions issued by practitioners practicing at pain management clinics.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the amendments to §291.1 and §291.29 are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rules. Ms. Dodson has determined that, for the first five-year period the amendments to §291.6 are in effect, there will be fiscal implications for state government as a result of enforcing or administering the amended rule as follows:

Revenue Increase

FY2012 = $16,004

FY2013 = $20,850

FY2014 = $20,850

FY2015 = $20,850

FY2016 = $20,850

There are no anticipated fiscal implications for local government.

Ms. Dodson has determined that, for each year of the first five-year period the amendments to §291.1 and §291.29 will be in effect, the public benefit anticipated as a result of enforcing the rules will ensure that registrants provide appropriate information on applications and pharmacists are aware of the professional responsibility requirements. There is no fiscal impact for individuals, small or large businesses, or to other entities which are required to comply with these sections.

Ms. Dodson has determined that, for each year of the first five-year period the amendments to §291.6 will be in effect, the public benefit anticipated as a result of enforcing the rule will be assuring that the Texas State Board of Pharmacy is adequately funded to carry out its mission. The effect on large, small or micro-businesses (pharmacies) will be the same as the economic cost to an individual, if the pharmacy chooses to pay the fee for the individual.

Economic cost to persons who are required to comply with the amended rule will be an increase of $6 for an initial license and an increase of $6 for the renewal of a license.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by these amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§291.1. Pharmacy License Application.

(a) To qualify for a pharmacy license, the applicant must submit an application including the following information:

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

(3) names, addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain

a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; [home addresses, dates of birth, phone numbers, and social security numbers] of all owners; if a partnership or corporation, for all managing officers, the name, title, addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; [home address, home phone number, date of birth, and social security number of all managing officers;]

(4) - (15) (No change.)

(b) Subsection (c) of this section applies to new pharmacy applications for Class A (Community), [pharmacies or] Class C (Institutional), or Class F (Freestanding Emergency Medical Care Center) pharmacies owned by a management company with the following exceptions.

(1) Subsection (c) of this section does not apply to a new pharmacy application submitted by an entity which already owns a pharmacy licensed in Texas.

(2) Subsection (c)(1) and (3) of this section do not apply to each individual owner or managing officer listed on a new pharmacy application if the individual possesses an active pharmacist license in Texas.

(c) If the pharmacy is to be licensed as a Class A (Community), [pharmacy or] Class C (Institutional), or Class F (Freestanding Emergency Medical Care Center) pharmacy owned by a management company, the applicant must submit copies of the following documents in addition to the information required in subsection (a) of this section:

(1) the birth certificate or passport of each individual owner, or, if the pharmacy is owned by a partnership or a closely held corporation:

(A) one of these documents for each managing officer; and

(B) a list of all owners of the corporation;

(2) an approved credit application from a primary wholesaler or other documents showing credit worthiness as approved by the board [Board]; and

(3) a current driver license or state issued photo ID card of each individual owner, or, if the pharmacy is owned by a partnership or a closely held corporation, a current driver license or state issued photo ID card for each managing officer.

(d) - (h) (No change.)

§291.6. Pharmacy License Fees.

(a) Initial License Fee.

(1) The fee for an initial license shall be $371 [Prior to December 1, 2011, the fee for an initial license shall be $452 for a two year registration and for processing the application and issuance of the pharmacy license as authorized by the Act §554.006. Effective December 1, 2011, the fee for an initial license shall be $365] for a two year registration and for processing the application and issuance of the pharmacy license as authorized by the Act §554.006.

(2) In addition, the following fees shall be collected:

(A) [prior to December 1, 2011, $15 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act §564.051; effective December 1, 2011,] $13 surcharge to fund a program to aid impaired pharmacists as authorized by the Act §564.051;

(B) $10 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(C) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

(3) New pharmacy licenses shall be assigned an expiration date and initial registration fee shall be prorated based on the assigned expiration date.

(b) Biennial License Renewal. The Texas State Board of Pharmacy shall require biennial renewal of all pharmacy licenses provided under the Act §561.002.

(c) Renewal Fee.

(1) The fee for biennial renewal of a pharmacy license shall be $371 [Prior to December 1, 2011, the fee for biennial renewal of a pharmacy license shall be $452 for processing the application and issuance of the pharmacy license as authorized by the Act §554.006. Effective December 1, 2011, the fee for biennial renewal of a pharmacy license shall be $365] for processing the application and issuance of the pharmacy license as authorized by the Act §554.006.

(2) In addition, the following fees shall be collected:

(A) [prior to December 1, 2011, $15 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act §564.051; effective December 1, 2011,] $13 surcharge to fund a program to aid impaired pharmacists as authorized by the Act §564.051;

(B) $10 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(C) $2 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

(d) Duplicate or Amended Certificates. The fee for issuance of an amended pharmacy license renewal certificate shall be $20.

§291.29. Professional Responsibility of Pharmacists.

(a) Pharmacist shall exercise sound professional judgment with respect to the accuracy and authenticity of any prescription drug order dispensed. If the pharmacist questions the accuracy or authenticity of a prescription drug order, the pharmacist shall verify the order with the practitioner prior to dispensing.

(b) A pharmacist shall make every reasonable effort to ensure that any prescription drug order, regardless of the means of transmission, has been issued for a legitimate medical purpose by a practitioner in the course of medical practice. A pharmacist shall not dispense a prescription drug if the pharmacist knows or should have known that the order for such drug was issued without a valid pre-existing patient-practitioner relationship as defined by the Texas Medical Board in 22 Texas Administrative Code (TAC) [§174.4 (relating to Use of the Internet in Medical Practice) and] §190.8 (relating to Violation Guidelines) or without a valid prescription drug order.

(1) A prescription drug order may not be dispensed or delivered by means of the Internet unless pursuant to a valid prescription that was issued for a legitimate medical purpose in the course of medical practice by a practitioner, or practitioner covering for another practitioner, who has conducted at least one in-person medical evaluation of the patient.

(2) A prescription drug order may not be dispensed or delivered if the pharmacist has reason to suspect that the prescription drug order may have been authorized in the absence of a valid patient-prac-

titioner relationship, or otherwise in violation of the practitioner's standard of practice to include that the practitioner:[.]

(A) did not establish a diagnosis through the use of acceptable medical practices for the treatment of patient's condition;

(B) prescribed prescription drugs that were not necessary for the patient due to a lack of a valid medical need or the lack of a therapeutic purpose for the prescription drugs; or

(C) issued the prescriptions outside the usual course of medical practice.

(3) Notwithstanding the provisions of this subsection and as authorized by the Texas Medical Board in 22 TAC §190.8, a pharmacist may dispense a prescription when a physician has not established a professional relationship with a patient if the prescription is for medications for:

(A) sexually transmitted diseases for partners of the physician's established patient; or

(B) a patient's family members if the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the Governor's office to be pandemic.

(c) If a pharmacist has reasons to suspect that a prescription was authorized solely based on the results of a questionnaire and/or in the absence of a documented patient evaluation including a physical examination, the pharmacist shall ascertain if that practitioners standard of practice allows that practitioner to authorize a prescription under such circumstances. Reasons to suspect that a prescription may have been authorized in the absence of a valid patient-practitioner relationship, or in violation of the practitioners standard of practice, include:

(1) the number of prescriptions authorized on a daily basis by the practitioner;

(2) a disproportionate number of patients of the practitioner receive controlled substances;

(3) [~~(2)~~] the manner in which the prescriptions are authorized by the practitioner or received by the pharmacy;

(4) [~~(3)~~] the geographical distance between the practitioner and the patient or between the pharmacy and the patient;

(5) [~~(4)~~] knowledge by the pharmacist that the prescription was issued solely based on answers to a questionnaire; [~~or~~]

(6) [~~(5)~~] knowledge by the pharmacist that the pharmacy he/she works for directly or indirectly participates in or is otherwise associated with an Internet site that markets prescription drugs to the public without requiring the patient to provide a valid prescription order from the patients practitioner; or[.]

(7) knowledge by the pharmacist that the patient has exhibited doctor-shopping or pharmacy-shopping tendencies.

(d) A pharmacist shall ensure that prescription drug orders for the treatment of chronic pain have been issued in accordance with the guidelines set forth by the Texas Medical Board in 22 TAC §170.3 (relating to Guidelines) [~~§174.4 (relating to Use of the Internet in Medical Practice)~~], prior to dispensing or delivering such prescriptions.

(e) A prescription drug order may not be dispensed or delivered if issued by a practitioner practicing at a pain management clinic that is not in compliance with the rules of the Texas Medical Board in 22 TAC §§195.1 - 195.4 (relating to Pain Management Clinics).

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 June 21, 2011.

TRD-201102316
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER B. COMMUNITY PHARMACY (CLASS A)

22 TAC §291.32, §291.33

The Texas State Board of Pharmacy proposes amendments to §291.32, concerning Personnel, and §291.33, concerning Operational Standards. The proposed amendments to §291.32, if adopted, allow a pharmacist-in-charge to be the pharmacist-in-charge of more than one Class A pharmacy if the pharmacies are not open simultaneously or in the event of an emergency. The proposed amendments to §291.33, if adopted, clarify the requirements for documenting patient counseling; outline the prescription labeling requirements for drugs dispensed pursuant to partner therapy; and outline the procedures for returning undelivered prescription medication to stock.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rules.

Ms. Dodson has determined that, for each year of the first five-year period the rules will be in effect, the public benefit anticipated as a result of enforcing the rules will ensure that a pharmacist-in-charge adequately supervises a pharmacy during an emergency situation; only authorized individuals are allowed to access the pharmacy during an emergency; patient counseling is adequately documented; prescriptions dispensed for partner therapy are appropriately labeled; proper procedures are followed for undelivered medications that are returned to stock; and proper beyond-use dating is on prescription labels for patient med-paks. There is no fiscal impact for individuals, small, large or micro-businesses, or to other entities which are required to comply with these sections.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§291.32. Personnel.

(a) Pharmacist-in-charge.

(1) General.

(A) Each Class A pharmacy shall have one pharmacist-in-charge who is employed on a full-time basis, who may be the pharmacist-in-charge for only one such pharmacy; provided, however, such pharmacist-in-charge may be the pharmacist-in-charge of:

(i) more than one Class A pharmacy, if the additional Class A pharmacies are not open to provide pharmacy services simultaneously; or

(ii) during an emergency, up to two Class A pharmacies open simultaneously if the pharmacist-in-charge works at least 10 hours per week in each pharmacy for no more than a period of 30 consecutive days.

(B) The pharmacist-in-charge shall comply with the provisions of §291.17 of this title (relating to Inventory Requirements).

(2) (No change.)

(b) - (e) (No change.)

§291.33. Operational Standards.

(a) Licensing requirements.

(1) - (4) (No change.)

(5) A Class A pharmacy shall notify the board in writing within ten days of closing, following the procedures in §291.5 of this title (relating to Closing a Pharmacy [~~Closed Pharmacies~~]).

(6) - (12) (No change.)

(b) Environment.

(1) (No change.)

(2) Security.

(A) - (C) (No change.)

(D) Only persons designated either by name or by title including such titles as "relief" or "floater" pharmacist, in writing by the pharmacist-in-charge may unlock the prescription department except in emergency situations. An additional key to or instructions on accessing the prescription department may be maintained in a secure location outside the prescription department for use during an emergency or as designated by the pharmacist-in-charge [~~for entry by another pharmacist~~].

(E) (No change.)

(3) (No change.)

(c) Prescription dispensing and delivery.

(1) Patient counseling and provision of drug information.

(A) (No change.)

(B) Such communication:

(i) shall be provided with each new prescription drug order;

(ii) shall be provided for any prescription drug order dispensed by the pharmacy on the request of the patient or patient's agent;

(iii) shall be communicated orally in person unless the patient or patient's agent is not at the pharmacy or a specific communication barrier prohibits such oral communication;

(iv) [~~effective, June 1, 2010,~~] shall be documented by recording the initials or identification code of the pharmacist providing the counseling in the prescription dispensing record as follows: [~~on either the original hard-copy prescription. in the pharmacy's data processing system or in an electronic logbook; and~~]

(I) on the original hard-copy prescription;

(II) in the pharmacy's data processing system;

(III) in an electronic logbook; or

(IV) in a hard-copy log containing the name of the patient, date of counseling, prescription number and initials or identification code of the pharmacist providing the counseling; and

(v) shall be reinforced with written information relevant to the prescription and provided to the patient or patient's agent. The following is applicable concerning this written information.

(I) Written information must be in plain language designed for the consumer and printed in an easily readable font size comparable to but no smaller than ten-point Times Roman.

(II) When a compounded product is dispensed, information shall be provided for the major active ingredient(s), if available.

(III) For new drug entities, if no written information is initially available, the pharmacist is not required to provide information until such information is available, provided:

(-a-) the pharmacist informs the patient or the patient's agent that the product is a new drug entity and written information is not available;

(-b-) the pharmacist documents the fact that no written information was provided; and

(-c-) if the prescription is refilled after written information is available, such information is provided to the patient or patient's agent.

(IV) The [~~Effective January 1, 2011, the~~] written information accompanying the prescription or the prescription label shall contain the statement "Do not flush unused medications or pour down a sink or drain." A drug product on a list developed by the Federal Food and Drug Administration of medicines recommended for disposal by flushing is not required to bear this statement.

(C) - (I) (No change.)

(2) - (6) (No change.)

(7) Labeling.

(A) At the time of delivery of the drug, the dispensing container shall bear a label in plain language and printed in an easily readable font size, unless otherwise specified, with at least the following information:

(i) name, address and phone number of the pharmacy;

(ii) unique identification number of the prescription that is printed in an easily readable font size comparable to but no smaller than ten-point Times Roman;

(iii) date the prescription is dispensed;

(iv) initials or an identification code of the dispensing pharmacist;

(v) name of the prescribing practitioner;

(vi) name of the patient or if such drug was prescribed for an animal, the species of the animal and the name of the owner that is printed in an easily readable font size comparable to but no smaller than ten-point Times Roman. The name of the patient's partner or family member is not required to be on the label of a drug

prescribed for a partner for a sexually transmitted disease or for a patient's family members if the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the Governor's office to be pandemic;

(vii) instructions for use that is printed in an easily readable font size comparable to but no smaller than ten-point Times Roman;

(viii) quantity dispensed;

(ix) appropriate ancillary instructions such as storage instructions or cautionary statements such as warnings of potential harmful effects of combining the drug product with any product containing alcohol;

(x) if the prescription is for a Schedules II - IV controlled substance, the statement "Caution: Federal law prohibits the transfer of this drug to any person other than the patient for whom it was prescribed";

(xi) if the pharmacist has selected a generically equivalent drug pursuant to the provisions of the Act, Chapters 562 and 563, the statement "Substituted for Brand Prescribed" or "Substituted for 'Brand Name'" where "Brand Name" is the actual name of the brand name product prescribed;

(xii) the name of the advanced practice nurse or physician assistant and the name of the supervising physician, if the prescription is carried out or signed by an advanced practice nurse or physician assistant in compliance with Subtitle B, Chapter 157, Occupations Code;

(xiii) the name of the pharmacist who signed the prescription for a dangerous drug under delegated authority of a physician as specified in Subtitle B, Chapter 157, Occupations Code, and the name of the supervising physician;

(xiv) the name and strength of the actual drug product dispensed that is printed in an easily readable font size comparable to but no smaller than ten-point Times Roman, unless otherwise directed by the prescribing practitioner;

(I) The name shall be either:

(-a-) the brand name; or

(-b-) if no brand name, then the generic name and name of the manufacturer or distributor of such generic drug. (The name of the manufacturer or distributor may be reduced to an abbreviation or initials, provided the abbreviation or initials are sufficient to identify the manufacturer or distributor. For combination drug products or non-sterile compounded drug products having no brand name, the principal active ingredients shall be indicated on the label.)

(II) Except as provided in clause (xi) of this subparagraph, the brand name of the prescribed drug shall not appear on the prescription container label unless it is the drug product actually dispensed.

(xv) [~~effective June 1, 2010,~~] if the drug is dispensed in a container other than the manufacturer's original container, the date after which the prescription should not be used or beyond-use-date. Unless otherwise specified by the manufacturer, the beyond-use-date shall be one year from the date the drug is dispensed or the manufacturer's expiration date, whichever is earlier. The beyond-use-date may be placed on the prescription label or on a flag label attached to the bottle. A beyond-use-date is not required on the label of a prescription dispensed to a person at the time of release from prison or jail if the prescription is for not more than a 10-day supply of medication; and

(xvi) [~~effective January 1, 2011,~~] either on the prescription label or the written information accompanying the prescription, the statement "Do not flush unused medications or pour down a sink or drain." A drug product on a list developed by the Federal Food and Drug Administration of medicines recommended for disposal by flushing is not required to bear this statement.

(B) - (D) (No change.)

(8) Returning Undelivered Medication to Stock.

(A) As specified in §431.021(w), Health and Safety Code, a pharmacist may not accept an unused prescription or drug, in whole or in part, for the purpose of resale or re-dispensing to any person after the prescription or drug has been originally dispensed, or sold except as provided in §291.8 of this title (relating to Return of Prescription Drugs). Prescriptions that have not been picked up by or delivered to the patient or patient's agent may be returned to the pharmacy's stock for dispensing.

(B) A pharmacist shall evaluate the quality and safety of the prescriptions to be returned to stock.

(C) Prescriptions returned to stock for dispensing shall not be mixed within the manufacturer's container.

(D) Prescriptions returned to stock for dispensing should be used as soon as possible and stored in the dispensing container. The expiration date of the medication shall be the lesser of one year from the dispensing date on the prescription label or the manufacturer's expiration date if dispensed in the manufacturer's original container.

(E) At the time of dispensing, the prescription medication shall be placed in a new prescription container and not dispensed in the previously labeled container unless the label can be completely removed. However, if the medication is in the manufacturer's original container, the pharmacy label must be removed so that no confidential patient information is released.

(d) - (g) (No change.)

(h) Customized patient medication packages.

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

(3) Label.

(A) The patient med-pak shall bear a label stating:

(i) the name of the patient;

(ii) the unique identification number for the patient med-pak itself and a separate unique identification number for each of the prescription drug orders for each of the drug products contained therein;

(iii) the name, strength, physical description or identification, and total quantity of each drug product contained therein;

(iv) the directions for use and cautionary statements, if any, contained in the prescription drug order for each drug product contained therein;

(v) if applicable, a warning of the potential harmful effect of combining any form of alcoholic beverage with any drug product contained therein;

(vi) any storage instructions or cautionary statements required by the official compendia;

(vii) the name of the prescriber of each drug product;

~~*[(viii)* the date of preparation of the patient med-pak and the beyond-use date assigned to the patient med-pak (which such beyond-use date shall not be later than 60 days from the date of preparation);]~~

(viii) [~~(ix)~~] the name, address, and telephone number of the pharmacy;

(ix) [~~(x)~~] the initials or an identification code of the dispensing pharmacist;

(x) [~~(xi)~~] [~~effective June 1, 2010,~~] the date after which the prescription should not be used or beyond-use-date. Unless otherwise specified by the manufacturer, the beyond-use-date shall be one year from the date the med-pak is dispensed or the earliest manufacturer's expiration date for a product contained in the med-pak if it is less than one-year from the date dispensed. The beyond-use-date may be placed on the prescription label or on a flag label attached to the bottle. A beyond-use-date is not required on the label of a prescription dispensed to a person at the time of release from prison or jail if the prescription is for not more than a 10-day supply of medication; and

(xi) [~~(xii)~~] [~~effective January 1, 2011,~~] either on the prescription label or the written information accompanying the prescription, the statement "Do not flush unused medications or pour down a sink or drain." A drug product on a list developed by the Federal Food and Drug Administration of medicines recommended for disposal by flushing is not required to bear this statement.

(xii) [~~(xiii)~~] any other information, statements, or warnings required for any of the drug products contained therein.

(B) If the patient med-pak allows for the removal or separation of the intact containers therefrom, each individual container shall bear a label identifying each of the drug product contained therein.

(C) The dispensing container is not required to bear the label specified in subparagraph (A) of this paragraph if:

(i) the drug is prescribed for administration to an ultimate user who is institutionalized in a licensed health care institution (e.g., nursing home, hospice, hospital);

(ii) no more than a 34-day supply or 100 dosage units, whichever is less, is dispensed at one time;

(iii) the drug is not in the possession of the ultimate user prior to administration;

(iv) the pharmacist-in-charge has determined that the institution:

(I) maintains medication administration records which include adequate directions for use for the drug(s) prescribed;

(II) maintains records of ordering, receipt, and administration of the drug(s); and

(III) provides for appropriate safeguards for the control and storage of the drug(s); and

(v) the dispensing container bears a label that adequately:

(I) identifies the:

(-a-) pharmacy by name and address;

(-b-) unique identification number of the prescription;

(-c-) name and strength of each drug product dispensed;

(-d-) name of the patient; and

(-e-) name of the prescribing practitioner of each drug product and if applicable, the name of the advanced practice nurse or physician assistant who signed the prescription drug order;

(II) [~~effective June 1, 2010,~~] the date after which the prescription should not be used or beyond-use-date. Unless otherwise specified by the manufacturer, the beyond-use-date shall be one year from the date the med-pak is dispensed or the earliest manufacturer's expiration date for a product contained in the med-pak if it is less than one-year from the date dispensed. The beyond-use-date may be placed on the prescription label or on a flag label attached to the bottle. A beyond-use-date is not required on the label of a prescription dispensed to a person at the time of release from prison or jail if the prescription is for not more than a 10-day supply of medication; and

(III) for each drug product sets forth the directions for use and cautionary statements, if any, contained on the prescription drug order or required by law.

(4) - (8) (No change.)

(i) (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 June 21, 2011.

TRD-201102317
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER F. NON-RESIDENT PHARMACY (CLASS E)

22 TAC §291.104

The Texas State Board of Pharmacy proposes amendments to §291.104, concerning Operational Standards. The proposed amendments, if adopted, delete the specific language regarding generic substitution since this language is repetitive of language in Chapter 309 and references the requirements in §309.3 and §309.7

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule.

Ms. Dodson has determined that, for each year of the first five-year period the rule will be in effect, the public benefit anticipated as a result of enforcing the rule will ensure proper dispensing of generic medications by Non-Resident (Class E) pharmacies to Texas residents. There is no fiscal impact for individuals, small or large businesses, or to other entities which are required to comply with this section.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§291.104. Operational Standards.

(a) Licensing requirements.

(1) A Class E pharmacy shall register with the board on a pharmacy license application provided by the board, following the procedures specified in §291.1 of this title (relating to Pharmacy License Application). [~~annually or biennially with the board on a pharmacy license application provided by the board.~~]

(2) - (14) (No change.)

(b) (No change.)

(c) Generic Substitution.

(1) Unless compliance would violate the pharmacy or drug laws or rules in the state in which the pharmacy is located a pharmacist in a Class E pharmacy may dispense a generically equivalent drug product and shall comply with the provisions of §309.3 of this title (relating to Generic Substitution) and §309.7 of this title (relating to Dispensing Responsibilities).[:]

~~[(1) a pharmacist in a Class E pharmacy may dispense a generically equivalent drug product if:]~~

~~[(A) the generic product costs the patient less than the prescribed drug product;]~~

~~[(B) the patient does not refuse the substitution; and]~~

~~[(C) the prescribing practitioner authorizes the substitution of a generically equivalent product; or]~~

~~[(D) the practitioner or practitioner's agent does not clearly indicate that the oral or electronic prescription drug order shall be dispensed as ordered; and]~~

~~[(2) Pharmacists shall use as a basis for the determination of generic equivalency as defined in the Subchapter A, Chapter 562 of the Act, the following.]~~

~~[(A) For drugs listed in the publication, pharmacists shall use Approved Drug Products with Therapeutic Equivalence Evaluations (Orange Book) and current supplements published by the Federal Food and Drug Administration, within the limitations stipulated in that publication, to determine generic equivalency. Pharmacists may only substitute products that are rated therapeutically equivalent in the Orange Book and have an "A" rating. "A" rated drug products include but are not limited to, those designated AA, AB, AN, AO, AP, or AT in the Orange Book.]~~

~~[(B) For drugs not listed in the Orange Book, pharmacists shall use their professional judgment to determine generic equivalency.]~~

(2) [~~(3)~~] The pharmacy must include on the prescription order form completed by the patient or the patient's agent information that clearly and conspicuously:

(A) states that if a less expensive generically equivalent drug is available for the brand prescribed, the patient or the patient's agent may choose between the generically equivalent drug and the brand prescribed; and

(B) allows the patient or the patient's agent to indicate the choice of the generically equivalent drug or the brand prescribed.

(d) - (f) (No change.)

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

Filed with the Office of the Secretary of State on June 21, 2011.

TRD-201102318
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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CHAPTER 295. PHARMACISTS

22 TAC §295.5

The Texas State Board of Pharmacy proposes amendments to §295.5, concerning Pharmacist License or Renewal Fees. The proposed amendments to §295.5, if adopted, will raise pharmacist license fees based on expenses.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the amendments are in effect, there will be fiscal implications for state government as a result of enforcing or administering the amended rule as follows:

Revenue Increase

FY2012 = $63,702

FY2013 = $85,042

FY2014 = $85,042

FY2015 = $85,042

FY2016 = $85,042

There are no anticipated fiscal implications for local government.

Ms. Dodson has determined that, for each year of the first five-year period the amendments will be in effect, the public benefit anticipated as a result of enforcing the amended rule will be assuring that the Texas State Board of Pharmacy is adequately funded to carry out its mission. The effect on large, small or micro-businesses (pharmacies) will be the same as the economic cost to an individual, if the pharmacy chooses to pay the fee for the individual.

Economic cost to persons who are required to comply with the amended rule will be an increase of $6 for an initial license and an increase of $6 for the renewal of a license.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8082. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §51.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as

authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§295.5. Pharmacist License or Renewal Fees.

(a) Biennial Registration. The Texas State Board of Pharmacy shall require biennial renewal of all pharmacist licenses provided under the Pharmacy Act, §559.002.

(b) Initial License Fee.

(1) The fee for the initial license shall be $200 [~~Prior to December 1, 2011, the fee for the initial license shall be $281 for a two year registration and for processing the application and issuance of the pharmacist license as authorized by the Act, §554.006. Effective December 1, 2011, the fee for initial license shall be $194~~] for a two year registration and for processing the application and issuance of the pharmacist license as authorized by the Act, §554.006.

(2) In addition, the following fees shall be collected:

(A) [~~prior to December 1, 2011, $13 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act, §564.051; effective December 1, 2011,~~] $11 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act, §564.051;

(B) $10 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(C) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

(3) New pharmacist licenses shall be assigned an expiration date and initial fee shall be prorated based on the assigned expiration date.

(c) Renewal Fee.

(1) The fee for biennial renewal of a pharmacist license shall be $200 [~~Prior to December 1, 2011, the fee for biennial renewal of a pharmacist license shall be $281 for processing the application and issuance of the pharmacist license as authorized by the Act, §554.006. Effective December 1, 2011, the fee for biennial renewal of a pharmacist license shall be $194~~] for processing the application and issuance of the pharmacist license as authorized by the Act, §554.006.

(2) In addition, the following fees shall be collected:

(A) [~~prior to December 1, 2011, $13 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act, §564.051; effective December 1, 2011,~~] $11 surcharge to fund a program to aid impaired pharmacists and pharmacy students as authorized by the Act, §564.051;

(B) $10 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(C) $2 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

(d) - (e) (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 June 21, 2011.

TRD-201102319
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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CHAPTER 297. PHARMACY TECHNICIANS AND PHARMACY TECHNICIAN TRAINEES

22 TAC §297.3, §297.4

The Texas State Board of Pharmacy proposes amendments to §297.3, concerning Registration Requirements. The proposed amendments to §297.3, if adopted, clarify application requirements for pharmacy technicians and pharmacy technician trainees. The proposed amendments to §297.4, if adopted, will raise pharmacy technician and pharmacy technician trainee fees based on expenses.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the amendments to §297.3 are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule. Ms. Dodson has determined that, for the first five-year period the amendments to §297.4 are in effect, there will be fiscal implications for state government as a result of enforcing or administering the amended rule as follows:

Revenue Increase

FY2012 = $23,394

FY2013 = $31,444

FY2014 = $31,444

FY2015 = $31,444

FY2016 = $31,444

There are no anticipated fiscal implications for local government.

Ms. Dodson has determined that, for each year of the first five-year period the amendments to §297.3 will be in effect, the public benefit anticipated as a result of enforcing the rule will ensure that registrants provide appropriate information on applications. There is no fiscal impact for individuals, small or large businesses, or to other entities which are required to comply with this section.

Ms. Dodson has determined that, for each year of the first five-year period the amendments to §297.4 will be in effect, the public benefit anticipated as a result of enforcing the rule will be assuring that the Texas State Board of Pharmacy is adequately funded to carry out its mission. The effect on large, small or micro-businesses (pharmacies) will be the same as the economic cost to an individual, if the pharmacy chooses to pay the fee for the individual.

Economic cost to persons who are required to comply with the amended rule will be an increase of $1 for an initial registration and an increase of $1 for the renewal of a registration.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§297.3. Registration Requirements.

(a) General.

(1) Individuals [~~Effective February 1, 2007, individuals~~] who are not registered with the Board may not be employed as or perform the duties of a pharmacy technician or pharmacy technician trainee.

(2) - (3) (No change.)

(b) Registration for pharmacy technician trainees. An individual may register as a pharmacy technician trainee only once and the registration may not be renewed.

(1) Each applicant for pharmacy technician trainee registration shall:

(A) [~~shall~~] have a high school or equivalent diploma (e.g., GED), or be working to achieve a high school or equivalent diploma. For the purposes of this subparagraph, an applicant for registration may be working to achieve a high school or equivalent diploma for no more than two years;

(B) [~~shall~~] complete the Texas application for registration that includes the following information:[~~; and~~]

(i) name;

(ii) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; and

(iii) any other information requested on the application.

(C) [~~may be required to~~] meet all requirements necessary in order for the Board to access the criminal history record information, including submitting fingerprint information and paying the required fees.

(2) - (3) (No change.)

(c) Initial registration for pharmacy technicians.

(1) Each applicant for pharmacy technician registration shall:

(A) - (B) (No change.)

(C) complete the Texas application for registration that includes the following information:[~~;~~]

(i) name;

(ii) addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; and

(iii) any other information requested on the application.

(D) - (E) (No change.)

(2) - (3) (No change.)

(d) Renewal.

(1) All applicants for renewal of a pharmacy technician registration shall:

(A) complete the Texas application for registration that includes the following information:[~~;~~]

(i) name;

(ii) a addresses, phone numbers, dates of birth, and social security numbers; however, if an individual is unable to obtain a social security number, an individual taxpayer identification number may be provided in lieu of a social security number along with documentation indicating why the individual is unable to obtain a social security number; and

(iii) any other information requested on the application.

(B) - (C) (No change.)

(2) (No change.)

(3) If the completed application and renewal fee are not received in the board's [~~boards~~] office on or before the last day of the assigned expiration month, the person's pharmacy technician registration shall expire. A person shall not practice as a pharmacy technician with an expired registration.

(4) - (6) (No change.)

(e) (No change.)

§297.4. Fees.

(a) Pharmacy technician trainee. The fee for registration shall be $42 and is composed of the following fees:

(1) $35 for processing the application and issuance of the pharmacy technician trainee registration as authorized by the Act, §568.005;

(2) $2 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(3) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

[~~(1) Prior to December 1, 2011, the fee for registration shall be $54 and is composed of the following fees:~~]

[~~(A) $46 for processing the application and issuance of the pharmacy technician trainee registration as authorized by the Act, §568.005;~~]

[~~(B) $3 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and~~]

[~~(C) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.~~]

[~~(2) Effective December 1, 2011, the fee for registration shall be $41 and is composed of the following fees:~~]

[~~(A) $34 for processing the application and issuance of the pharmacy technician trainee registration as authorized by the Act, §568.005;~~]

[(B) $2 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and]

[(C) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.]

(b) Pharmacy technician.

(1) Biennial Registration. The board shall require biennial renewal of all pharmacy technician registrations provided under Chapter 568 of the Act.

(2) Initial Registration Fee.

(A) The fee for initial registration shall be $65 [Prior to December 1, 2011, the fee for initial registration shall be $83] for a two year registration and is composed of the following fees:

(i) $57 [$75] for processing the application and issuance of the pharmacy technician registration as authorized by the Act, §568.005;

(ii) $3 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(iii) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

[(B) Effective December 1, 2011, the fee for initial registration shall be $64 for a two year registration and is composed of the following fees:]

[(i) $56 for processing the application and issuance of the pharmacy technician registration as authorized by the Act, §568.005;]

[(ii) $3 surcharge to fund the TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and]

[(iii) $5 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.]

(B) [(C)] The initial registration fee shall be prorated based on the assigned expiration date.

(3) Renewal Fee. The fee for biennial renewal of a pharmacy technician registration shall be $62 and is composed of the following:

(A) $57 for processing the application and issuance of the pharmacy technician registration as authorized by the Act, §568.005;

(B) $3 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and

(C) $2 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.

[(A) Prior to December 1, 2011, the fee for biennial renewal of a pharmacy technician registration shall be $80 and is composed of the following:]

[(i) $75 for processing the application and issuance of the pharmacy technician registration as authorized by the Act, §568.005;]

[(ii) $3 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and]

[(iii) $2 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.]

[(B) Effective December 1, 2011, the fee for biennial renewal of a pharmacy technician registration shall be $61 and is composed of the following:]

[(i) $56 for processing the application and issuance of the pharmacy technician registration as authorized by the Act, §568.005;]

[(ii) $3 surcharge to fund TexasOnline as authorized by Chapter 2054, Subchapter I, Government Code; and]

[(iii) $2 surcharge to fund the Office of Patient Protection as authorized by Chapter 101, Subchapter G, Occupations Code.]

(c) Duplicate or Amended Certificates. The fee for issuance of a duplicate or amended pharmacy technician trainee registration certificate or pharmacy technician registration renewal certificate shall be $20.

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 June 21, 2011.

TRD-201102320
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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CHAPTER 303. DESTRUCTION OF DRUGS

22 TAC §303.1

The Texas State Board of Pharmacy proposes amendments to §303.1, concerning Destruction of Dispensed Drugs. The proposed amendments, if adopted, clarify the requirements for the destruction of dispensed drugs with regard to controlled substances and change the title of Chapter 303.

Gay Dodson, R.Ph., Executive Director/Secretary, has determined that, for the first five-year period the rule is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the rule.

Ms. Dodson has determined that, for each year of the first five-year period the rule will be in effect, the public benefit anticipated as a result of enforcing the rule will ensure proper procedures for the destruction of dispensed prescriptions. There is no fiscal impact for individuals, small, micro, or large businesses, or to other entities which are required to comply with this section.

Comments on the proposed amendments may be submitted to Allison Benz, R.Ph., M.S., Director of Professional Services, Texas State Board of Pharmacy, 333 Guadalupe Street, Suite 3-600, Austin, Texas 78701, FAX (512) 305-8008. Comments must be received by 5:00 p.m., August 8, 2011.

The amendments are proposed under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this amendment: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§303.1. Destruction of Dispensed Drugs.

(a) Drugs dispensed to patients in health care facilities or institutions.

(1) Destruction by the consultant pharmacist. The consultant pharmacist, if in good standing with the Texas State Board of Pharmacy, is authorized to destroy dangerous drugs [~~and controlled substances~~] dispensed to patients in health care facilities or institutions. A consultant pharmacist may not destroy controlled substances unless allowed to do so by federal laws or rules of the Drug Enforcement Administration. Dangerous drugs may be destroyed provided[~~, providing~~] the following conditions are met.

(A) A written agreement exists between the facility and the consultant pharmacist.

(B) The drugs are inventoried and such inventory is verified by the consultant pharmacist. The following information shall be included on this inventory:

(i) name and address of the facility or institution;

(ii) name and pharmacist license number of the consultant pharmacist;

(iii) date of drug destruction;

(iv) date the prescription was dispensed;

(v) unique identification number assigned to the prescription by the pharmacy;

(vi) name of dispensing pharmacy;

(vii) name, strength, and quantity of drug;

(viii) signature of consultant pharmacist destroying drugs;

(ix) signature of the witness(es); and

(x) method of destruction.

(C) The signature of the consultant pharmacist and witness(es) to the destruction and the method of destruction specified in subparagraph (B) of this paragraph may be on a cover sheet attached to the inventory and not on each individual inventory sheet, provided the cover sheet contains a statement indicating the number of inventory pages that are attached and each of the attached pages are initialed by the consultant pharmacist and witness(es).

(D) The drugs are destroyed in a manner to render the drugs unfit for human consumption and disposed of in compliance with all applicable state and federal requirements.

(E) The actual destruction of the drugs is witnessed by one of the following:

(i) a commissioned peace officer;

(ii) an agent of the Texas State Board of Pharmacy;

(iii) an agent of the Texas Health and Human Services Commission, authorized by the Texas State Board of Pharmacy to destroy drugs;

(iv) an agent of the Texas Department of State Health Services, authorized by the Texas State Board of Pharmacy to destroy drugs; or

(v) any two individuals working in the following capacities at the facility:

(I) facility administrator;

(II) director of nursing;

(III) acting director of nursing; or

(IV) licensed nurse.

(F) If the actual destruction of the drugs is conducted at a location other than the facility or institution, the consultant pharmacist and witness(es) shall retrieve the drugs from the facility or institution, transport, and destroy the drugs at such other location.

(2) Destruction by a waste disposal service. A consultant pharmacist may utilize a waste disposal service to destroy dangerous drugs [~~and controlled substances~~] dispensed to patients in health care facilities or institutions. A consultant pharmacist may not use a waste disposal service to destroy controlled substances unless allowed to do so by federal laws or rules of the Drug Enforcement Administration. Dangerous drugs may be transferred to a waste disposal service for destruction[~~,~~] provided the following conditions are met.

(A) The waste disposal service is in compliance with applicable rules of the Texas Commission on Environmental Quality and United States Environmental Protection Agency relating to waste disposal.

(B) The drugs are inventoried and such inventory is verified by the consultant pharmacist prior to placing the drugs in an appropriate container, and sealing the container. The following information must be included on this inventory:

(i) name and address of the facility or institution;

(ii) name and pharmacist license number of the consultant pharmacist;

(iii) date of packaging and sealing of the container;

(iv) date the prescription was dispensed;

(v) unique identification number assigned to the prescription by the pharmacy;

(vi) name of dispensing pharmacy;

(vii) name, strength, and quantity of drug;

(viii) signature of consultant pharmacist packaging and sealing the container; and

(ix) signature of the witness(es).

(C) The consultant pharmacist seals the container of drugs in the presence of the facility administrator and the director of nursing or one of the other witnesses listed in paragraph (1)(E) [~~(1)(D)~~] of this subsection as follows:

(i) tamper resistant tape is placed on the container in such a manner that any attempt to reopen the container will result in the breaking of the tape; and

(ii) the signature of the consultant pharmacist is placed over this tape seal.

(D) The sealed container is maintained in a secure area at the facility or institution until transferred to the waste disposal service by the consultant pharmacist, facility administrator, director of nursing, or acting director of nursing.

(E) A record of the transfer to the waste disposal service is maintained and attached to the inventory of drugs specified in subparagraph (B) of this paragraph. Such record shall contain the following information:

(i) date of the transfer;

(ii) signature of the person who transferred the drugs to the waste disposal service;

(iii) name and address of the waste disposal service; and

(iv) signature of the employee of the waste disposal service who receives the container.

(F) The waste disposal service shall provide the facility with proof of destruction of the sealed container. Such proof of destruction shall contain the date, location, and method of destruction of the container and shall be attached to the inventory of drugs specified in subparagraph (B) of this paragraph.

(3) (No change.)

(b) (No change.)

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

Filed with the Office of the Secretary of State on June 22, 2011.

TRD-201102356
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 305-8028

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 19. AGENTS' LICENSING

The Texas Department of Insurance (Department) proposes amendments to §§19.1701 - 19.1717, 19.1719 - 19.1721, 19.1723, and 19.1724, concerning utilization review agents (URAs) for health care provided under a health benefit plan or health insurance policy (referred to hereafter as Subchapter R, collectively), and §§19.2001 - 19.2011, 19.2013, 19.2014, 19.2016, 19.2017, 19.2019 and 19.2020, and new §§19.2012, 19.2015, and 19.2021, concerning URAs for health care provided under workers' compensation insurance coverage (referred to hereafter as Subchapter U, collectively). These amendments and new sections are necessary to: (i) implement HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, which effectively revises the definitions of "adverse determination" and "utilization review" in the Insurance Code Chapter 4201 to include retrospective reviews and determinations regarding the experimental or investigational nature of a service; and (ii) make other changes necessary, as determined by the Department with the advice of the Utilization Review Advisory Committee (Advisory Committee), for clarity and effective implementation and enforcement of the Insurance Code Chapter 4201.

In conjunction with this proposal, the Department is proposing the repeal of §19.1718, concerning criminal penalties; §19.1722, concerning the utilization review advisory committee; §19.2012, concerning appeal of adverse determination of URAs; §19.2015, concerning retrospective review of medical necessity; §19.2018, concerning criminal penalties; and §19.2021, concerning non-involvement of independent review organizations, which is also published in this issue of the *Texas Register.*

HB 4290

HB 4290 amends 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.

Proposed amendments in §19.1703(40) and §19.2003(34), and §19.1703(45) and §19.2003(40), concerning the definitions of "retrospective review," and "utilization review" respectively, are necessary to accurately include "retrospective review" as a form of "utilization review," as provided in HB 4290.

Proposed §19.1703(40) and proposed §19.2003(34) define "retrospective utilization review" as a form of utilization review for health care services that have been provided to an enrollee or injured employee, respectively. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

Amendments are proposed to the definition of "utilization review" in §19.1703(45) and §19.2003(40) to include a system for prospective, concurrent, or *retrospective* review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or *retrospective* review to determine the experimental or investigational nature of health care services.

Because HB 4290 clarifies that utilization review includes retrospective review, the Department is also proposing in Subchapters R and U several more specific amendments and new provisions governing retrospective review. New requirements are proposed to §§19.1711(c), 19.1712(b), 19.1715, 19.1720(h)(2), 19.2011(c), 19.2012(b), 19.2015, and 19.2020(h)(2).

Proposed amendments in §19.1703(2) and §19.2003(2), §19.1703(16) and §19.2003(13), and §19.1703(45) and §19.2003(40), concerning the definitions of "adverse determination," "experimental or investigational," and "utilization review" respectively, are necessary to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services as utilization review.

The proposed amendments to §19.1703(2) define the term "adverse determination" as a determination by a URA made on behalf of any payor that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. These proposed amendments, which are necessary to implement HB 4290, incorporate determinations on whether health care services are experimental or investigational into the definition of "adverse determination." The amendments are also necessary to clarify that the term does not include a denial of health care services for which the enrollee should have sought prospective or concurrent utilization review.

The proposed amendments to §19.2003(2) define the term "adverse determination" as a determination by a URA made on be-

half of any payor that the health care services provided or proposed to be provided to an injured employee are not medically necessary or appropriate. The term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational. This revised definition clarifies that the term does not include a denial of health care services for which the injured employee should have sought prospective or concurrent utilization review.

The proposed revised definition also clarifies that for the purposes of Subchapter U an adverse determination does not include a determination that health care services are experimental or investigational. Though this clarification is inconsistent with the statutory definition of "adverse determination" under the Insurance Code §4201.002(1), it is consistent with the Labor Code §408.021 and §413.014, and pursuant to the Insurance Code §4201.054, in the event of such a conflict, the Labor Code Title 5 prevails.

The Labor Code §408.021 entitles an injured employee under both network coverage and non-network coverage to all medically necessary health care services. Although injured employees under non-network coverage are entitled to experimental and investigational services, those services must be preauthorized pursuant to the Labor Code §413.014, relating to preauthorization requirements, concurrent review and certification of health care.

Despite this difference in the definition of the term "adverse determination" under Chapter 4201 of the Insurance Code and Chapter 408 of the Labor Code, it is nevertheless necessary that Subchapter U contain provisions relating to the experimental or investigational nature of care in the context of utilization review. Even though the determination that a health care service is experimental or investigational does not in itself constitute an adverse determination, only a URA should make determinations that health care services are experimental or investigational, based on the definition of "utilization review."

Proposed amendments to §19.1703(16) and §19.2003(13) add a definition of the term "experimental or investigational." These proposed amendments are necessary to ensure a uniform application of the term.

Amendments are proposed to the definition of "utilization review" in §19.1703(45) and §19.2003(40) to include a system for prospective, concurrent, or retrospective review *to determine the experimental or investigational nature of health care services."* These amendments incorporate determinations on whether health care services are experimental or investigational into the definition of "utilization review."

Throughout Subchapters R and U, the Department has also added a reference to "experimental or investigational" in provisions relating to utilization review determinations of the medical necessity or appropriateness of health care services. These additions are necessary because determinations of the experimental or investigational nature of health care services are now also included in utilization review determinations. These changes result from the enactment of HB 4290 and are necessary to implement HB 4290.

Other Necessary Proposed Amendments

In addition to the need to implement HB 4290, the Department, with the advice of the Advisory Committee, has determined that other amendments are necessary for the effective compliance with and implementation and enforcement of the Insurance Code Chapter 4201. These other necessary proposed amendments are described in the remainder of this Introduction. The Insurance Code §4201.003 requires the Commissioner to appoint an advisory committee to advise the Commissioner on the development of rules regarding the administration of Chapter 4201. The Commissioner appointed representatives to the Advisory Committee, whose responsibilities are set forth in 28 TAC §19.1722. The Advisory Committee met in a series of public meetings to discuss implementation of the Insurance Code Chapter 4201 and submitted a final advisory report to the Commissioner. The Advisory Committee's discussions and final report were key in developing these proposed amendments and new sections.

There are several changes made throughout the text of Subchapters R and U based on the recommendation of the Advisory Committee. These changes include changing the word "patient" to the word "enrollee" throughout the text of Subchapter R as a clarifying change. Also, changing the word "patient" to the word "injured employee" throughout the text of Subchapter U is a clarifying change recommended by the Advisory Committee.

For both Subchapters R and U, the Advisory Committee also requested that the Department include a paragraph within specific sections to explain whether the section applies to a specialty URA. The Department has added the requested applicability provision in the relevant sections based on the Insurance Code §4201.452. Section 4201.452 provides that a specialty URA is not subject to §4201.151, relating to utilization review plan; §4201.152, relating to utilization review under direction of physician; §4201.206, relating to opportunity to discuss treatment before adverse determination; §4201.252, relating to Personnel; or §4201.356, relating to decision by physician required and specialty review. Therefore, those proposed provisions that implement any of these statutes do not apply to a specialty URA.

The Advisory Committee also recommended that when "medical necessity" or "medically necessary" is used throughout the rule text for both Subchapters R and U, a reference to "experimental or investigational" should also be added as applicable. This recommendation is consistent with HB 4290, which amends the definition of "utilization review" to include a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. For Subchapter R, references to "experimental or investigational" were also added in provisions addressing adverse determinations, as appropriate.

Additionally, the Department has determined with the advice of the Advisory Committee, that the text of Subchapters R and U should be consistent whenever possible for the benefit of both the regulated entities and consumers. Pursuant to the Insurance Code §4201.054, the Labor Code Title 5 prevails in the event of a conflict between the Insurance Code Chapter 4201 and the Labor Code Title 5. Pursuant to the Insurance Code §1305.351, Chapter 1305 of the Insurance Code prevails in the event of a conflict between the Insurance Code Chapter 4201 and the Insurance Code Chapter 1305. Because there are statutes that specifically govern utilization review for workers' compensation coverage, there are necessary inconsistencies between the Subchapter R rules and the Subchapter U rules in order to implement and maintain consistency with the relevant statutes. However, because there are URAs that may be subject to both Subchapters R and U, the Department recognizes the importance of consistency for ease of interpretation and com-

pliance. Additionally, uniform standards, to the extent possible, afford a more consistent and efficient utilization review process for enrollees and injured employees, who are equally entitled to the highest quality of utilization review, regardless of whether such review is conducted under a health benefit plan/health insurance policy or workers' compensation insurance coverage.

Proposed Nonsubstantive Editorial Corrections.

Additionally, there are numerous proposed nonsubstantive editorial revisions that are made throughout the text of both Subchapter R and Subchapter U. These nonsubstantive changes include updating statutory and rule citations, conforming to current nomenclature and agency style, reorganizing rule text, reformatting, amending for consistency and clarity, and correcting typographical and/or grammatical errors. For a more detailed description of the reorganization of the rule text, Figure: 28 TAC Chapter 19--Preamble shows existing sections that have been deleted, redesignated, moved, or replaced:

Figure: 28 TAC Chapter 19--Preamble

The following paragraphs include a description of all of the proposed amendments necessary to implement HB 4290 and to make the other changes that the Department, with the advice of the Advisory Committee, has determined are necessary for effective compliance with and effective implementation and enforcement of the Insurance Code Chapter 4201.

Subchapter R amendments and new sections.

Section 19.1701 addresses General Provisions. The proposed amendment to §19.1701(a) is necessary to change the existing provision relating to the statutory basis for the rules in Subchapter R to reflect that the new subchapter incorporates the most recent amendments to Chapter 4201 of the Insurance Code. The proposed amendment to §19.1701(b) amends the severability clause language to conform to current agency style. The addition of the word "medical" in §19.1701(c)(4) is a clarifying change. Proposed new §19.1701(d) provides that Subchapter U of 28 TAC Chapter 19 applies to utilization review performed under workers' compensation insurance coverage in lieu of the provisions of Subchapter R.

Section 19.1702 addresses Limitations on Applicability. The proposed amendments to §19.1702(a) delete existing subsection (a) and update the subsection to specify the applicability of Subchapter R to utilization review performed under a health benefit plan or a health insurance policy except as provided in the Insurance Code Chapter 4201. Existing §19.1702(b) is proposed for deletion because under these proposed rules only HMOs and insurers that conduct utilization review only for coverage for which they are the payors are exempt from obtaining certification. Section 19.1719 sets forth the responsibility of HMOs and insurers performing utilization review. The proposed amendments to §19.1702(b), which is existing §19.1702(c) relating to the non-applicability of Subchapter R, track statutory language. The Insurance Code §4201.051 provides that this chapter does not apply to a person who: (i) provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and (ii) does not determine whether a particular health care service provided or to be provided to an enrollee is: (a) medically necessary or appropriate; or (b) experimental or investigational. Section 19.1702(b)(2) is proposed to be deleted because the provision is no longer applicable under the proposed rules; personnel employed by a URA are governed by §19.1706 under the proposed rules. Existing §19.1702(b)(3) is proposed to be deleted because it is repetitive of §19.1702(a) in the proposed rules.

Section 19.1703 addresses Definitions. A proposed amendment to the definition of "adverse determination" in §19.1703(2) adds the phrase "made on behalf of any payor." The inclusion of the phrase "made on behalf of any payor" clarifies that the definition includes those payors that conduct utilization review in-house. The change is necessary to reflect the Department's position that the term "adverse determination" includes determinations made on behalf of all payors. The addition of the phrase "or are experimental or investigational" is necessary to implement HB 4290. HB 4290 amends the definition of "adverse determination" to include determinations by a URA that health care services provided or proposed to be provided to a patient are experimental or investigational. The final proposed amendment to §19.1703(2) adds the provision that the term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. This proposed amendment is necessary to clarify that adverse determinations do not include denials of health care services due to the enrollee's or health care provider's failure to request prospective or concurrent utilization review, if such prospective or concurrent utilization review was required.

The proposed amendments to the definition of "appeal" in §19.1703(3) are to improve clarity. The proposed amendments to the definition of "certificate" in §19.1703(4) are necessary to provide a more detailed and accurate definition that reflects that an insurance carrier or HMO can be certified or registered, but that a "certificate" is not issued to an insurance carrier or HMO that is registered as a URA under §19.1704. The proposed amendments to the definition of "complaint" in §19.1703(6) are necessary to clarify that a complaint does not include an expression of dissatisfaction with a specific adverse determination and also to replace the term "enrollee" with "complaining party" to include any party filing a complaint.

Proposed new §19.1703(7) is necessary to define the term "concurrent utilization review," which is a form of utilization review that is subject to these proposed rules. The proposed amendment to the definition of "declination" in §19.1703(8), replacing the word "carrier" with "benefit plan," is a clarifying change.

Proposed new §19.1703(12) is necessary to define the term "disqualifying association" to ensure a consistent application in identifying situations in which conflicts of interest may exist for health care providers performing utilization review.

Proposed new §19.1703(13) adds a definition of "doctor." This definition mirrors the definition of "doctor" in existing 28 TAC §19.2003(12). The definition of "doctor" tracks the statutory language in the Labor Code §401.011(17), which provides that "doctor" means a doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

Proposed new §19.1703(16) adds a definition of "experimental or investigational." This definition is consistent with Texas Labor Code §413.014(a), which provides "investigational or experimental service or device" means a health care treatment, 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 definition is also consistent with 28 TAC §134.600 and 28 TAC §12.5(12). Section 134.600, relating to injured employees non-emergency health care requir-

ing preauthorization, specifies "any investigational or experimental 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." Section 12.5(12), relating to definitions for rules regulating IROs, 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."

The proposed amendments to the definition of "health benefit plan" in §19.1703(17) are necessary for consistency with the Insurance Code §4201.002(4). Section 4201.002(4) defines "health benefit plan" as a plan of benefits, other than a health insurance policy, that: (i) defines the coverage provisions for health care for enrollees; and (ii) is offered or provided by a public or private organization.

Proposed new §19.1703(18) adds a definition of "health care facility." This definition mirrors the definition of "health care facility" in existing 28 TAC §19.2003(15). This definition is consistent with the Labor Code §401.011(20), which defines "health care facility" as "a hospital, emergency clinic, outpatient clinic, or other facility providing health care."

The proposed amendment to delete "inquiry" in existing §19.1703(18) is necessary because the term "inquiry" is not used in the rule text in the context that the definition contemplates. The term "inquiry" is only used in §19.1716(d), and in that context the term refers to *Department* inquiries, not inquiries that would be considered a request for information or assistance from a URA.

Proposed amendments to the definition of "health care provider" in §19.1703(19) update the definition to track the statutory language. The Insurance Code §4201.002(5) provides that the term "health care provider" means a person, corporation, facility, or institution that is: (i) licensed by a state to provide or is otherwise lawfully providing health care services; and (ii) eligible for independent reimbursement for those health care services.

Proposed new §19.1703(20) adds a definition of "health coverage." This definition is necessary to provide a uniform understanding and application of what constitutes "health coverage" in implementing the Subchapter R rules.

The proposed amendment to the definition of "health insurance policy" in §19.1703(21), replacing "company" with "corporation," is necessary to track the statutory definition more closely. The Insurance Code §4001.002(6) provides, "(6) 'Health insurance policy' means an insurance policy, including a policy written by a corporation subject to Chapter 842, that provides coverage for medical or surgical expenses incurred as a result of accident or sickness."

Proposed new §19.1703(22) adds a definition of "health maintenance organization or HMO," which references the statutory definition in the Insurance Code §843.002. Proposed new §19.1703(23) adds a definition of "insurance carrier or insurer." This definition is added for consistency with the proposed amendments to §19.2003(17). The definitions, however, are not identical, because the proposed §19.2003(17) definition references workers' compensation insurance, which is not applicable under §19.1703(23). Proposed new §19.1703(24) adds the term "legal holiday," which is defined in accordance with the definition of a "national holiday" as defined in the Government Code §662.003(a).

Proposed new §19.1703(26) adds a definition of the term "medical emergency." This definition tracks the statutory language of the Insurance Code §1305.004(13), which provides that the term 'medical emergency' means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy; or (ii) serious dysfunction of any body organ or part. This definition is necessary to uniformly implement the proposed Subchapter R rules.

Proposed new §19.1703(27) defines "medical records" as "The entire history of diagnosis and treatment, including but not limited to medical, mental health records as allowed by law, dental, and other health care records from all disciplines rendering care to an enrollee." Except for the inclusion of the phrase "mental health records as allowed by law," and the change of the term "injured employee" to "enrollee," this definition is based on the Insurance Code §1305.004(14), which defines the term "medical records" for purposes of the Workers' Compensation Health Care Network Act. Section 1305.004(14) defines "medical records" to mean the history of diagnosis and treatment for an injury, including medical, dental, and other health care records from each health care practitioner who provides care to an injured employee. The addition of the phrase "mental health records as allowed by law" was recommended by the Advisory Committee. This definition is necessary to uniformly implement the proposed Subchapter R rules.

Existing §19.1703(20), which defines "mental health medical record summary," is redesignated as §19.1703(28). A proposed amendment to the definition of "mental health therapist" in §19.1703(29) adds "as appropriate" to clarify that not all of the individuals licensed under subparagraphs (A) - (M) are authorized to diagnose, evaluate, or treat any mental or emotional condition or disorder. This addition was recommended by the Advisory Committee. Another amendment is proposed to delete existing subparagraph "(G) a person licensed as a chemical dependency counselor by the Texas Commission on Alcohol and Drug Abuse," also at the recommendation of the Advisory Committee. The proposed deletion of existing subparagraph (G) results in the proposed redesignation of existing subparagraphs (H) - (N) in §19.1703(29).

The proposed amendment to the existing definition of "mental or emotional condition or disorder" in §19.1703(30) deletes the phrase "revision of the" in reference to the Diagnostic and Statistical Manual of Mental Disorders ("Manual"). The proposed amendment is necessary for clarification because both new "editions" and new "revisions" of the Manual are published.

The proposed amendment to the existing definition of "nurse" in §19.1703(31) adds an "or" between "registered" and "professional," clarifying that both a registered nurse and a professional nurse are included in the definition. This proposed amendment is consistent with the definition of "nurse" in the Insurance Code §4201.002(8), which defines "nurse" as "a professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse."

The proposed deletion of the definition of "patient" in existing §19.1703(25) is necessary because the term "patient" is no longer used in the subchapter.

The proposed amendments to the definition of "payor" in §19.1703(32) are necessary to more closely track the statutory

language. The Insurance Code §4201.002(10) defines "payor" as (i) an insurer that writes health insurance policies; (ii) a preferred provider organization, health maintenance organization, or self-insurance plan; or (iii) any other person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to a person treated by a health care provider in this state under a policy, plan, or contract."

Proposed new §19.1703(33) adds a definition of "peer review." This definition, which was recommended by the Advisory Committee, is necessary for uniform implementation of the Subchapter R rules.

The definition of the term "preauthorization" in §19.1703(36) is proposed to be amended to add the descriptor "form of prospective utilization review by a payor or its utilization review agent of. . ." This addition results in the phrase "are medically necessary and appropriate" no longer being necessary because "utilization review" is proposed to be defined in §19.1703(45) as "A system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services...." Thus, the concept "medically necessary and appropriate" is already incorporated by reference to the terminology "utilization review."

A proposed amendment to the existing definition of "preferred provider" in §19.1703(37) changes the term "carrier" to "benefit plan" for clarity and uniform implementation.

A proposed amendment to the existing definition of "provider of record" in §19.1703(38) clarifies that a doctor as well as a physician or other health provider does not necessarily have to render care, treatment, or services to be considered the provider of record. An amendment is also proposed to the existing definition to replace the terminology "care, treatment, and services" with "health care services" for consistency with other usages of this phrase throughout the text. Proposed new §19.1703(39) adds a definition of the term "registration." Proposed amended §19.1719 sets forth the responsibility of an HMO and insurer performing utilization review, including the responsibility of those performing utilization review only for coverage for which they are the payor. HMOs and insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but are instead required to register. The proposed new definition clarifies that the registration process only applies to an HMO or insurer that performs utilization review solely for its own insureds or enrollees.

Proposed amendments to the existing definition of "retrospective review" in §19.1703(40) change the defined term to "retrospective utilization review" and incorporate the term "utilization review" into the definition, thereby removing the need to refer to "medical necessity and appropriateness" because the concept is included in the definition of the term "utilization review." The proposed addition of the phrase "that have been" in relation to health care services provided to an enrollee and the proposed deletion of the phrase "is performed for the first time subsequent to the completion of such health care services" are necessary for clarity and to avoid redundancy. The proposed addition of the phrase "or should have been previously conducted" in relation to what retrospective utilization review does not include is necessary for clarification.

Existing §19.1703(33), which defines "routine vision services," existing §19.1703(34), which defines "screening criteria," and existing §19.1703(35), which defines "single health care service plan" are redesignated as §19.1703(41), (42), and (43), respectively.

Proposed new §19.1703(44) adds a definition of "specialty utilization review agent." This definition is consistent with the Insurance Code §4201.451, which provides that for purposes of Subchapter J in Chapter 4201, relating to specialty URAs, the term "specialty utilization review agent" means a URA who conducts utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

The proposed amendments to the definition of the term "utilization review" in §19.1703(45) add the term "retrospective" review and the phrase "and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services" to the definition. The additions are necessary to implement HB 4290 which provides that utilization review applies to retrospective review and determinations of the experimental or investigational nature of health care services.

The addition of the phrase "holding a certificate of authority under the Insurance Code Chapter 4151" to subparagraph (C) of the existing definition of "utilization review agent" in §19.1703(46) clarifies the type of administrator to which the subparagraph refers. This amendment is necessary for uniform implementation of the Subchapter R rules.

Proposed amendments to the existing definition of "verification" in §19.1703(48) replace the term "carrier" with the term "benefit plan" throughout the definition for clarity and consistency. The amendment to change the word "title" to the word "subchapter" is necessary to conform to Department and Texas Register style. The proposed amendment to the definition of "working day" in §19.1703(49) is necessary to update the definition to clarify that "legal" holidays are as defined by the Government Code §662.003(a) and provide consistency with 28 TAC §102.3, relating to computation of time under the general provisions of TDI-DWC. Under 28 TAC §102.3(b), use of the term "day," rather than "working day" means a calendar day.

Section 19.1704 addresses Certification or Registration of Utilization Review Agents. An amendment is proposed to the title of existing §19.1704 to include "registration" of URAs in the title. Proposed new §19.1704(a), which is added to implement the Insurance Code §4201.101, provides that a person acting as or holding itself out as a URA must be certified or registered under the Insurance Code Chapter 4201 and 28 TAC Chapter 19, Subchapter R. Section 4201.101 provides that a URA may not conduct utilization review unless the Commissioner issues a certificate of registration to the agent under Subchapter C of Chapter 4201.

Proposed new §19.1704(a)(1) and (2) add new provisions and are necessary to address certification and registration requirements for HMOs and insurers. Proposed new §19.1704(a)(1) provides that, pursuant to §19.1719(a)(2) and (b)(3), if an HMO or insurer performs utilization review for an individual or entity subject to 28 TAC Chapter 19, Subchapter R, such HMO or insurer must have a valid certificate pursuant to the Insurance Code §4201.101 and §19.1704. This provision is consistent with the Insurance Code §4201.057(e) and §4201.058(c). The Insurance Code §4201.057(e) provides that an HMO that performs utilization review for a person or entity subject to the Insurance Code Chapter 4201, other than a person or entity for which the HMO is the payor, must obtain a certificate of registration under

Chapter 4201, Subchapter C, and shall comply with all of the provisions of Chapter 4201. The Insurance Code §4201.058(c) provides that an insurer that performs utilization review for a person or entity subject to the Insurance Code Chapter 4201, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Chapter 4201, Subchapter C, and shall comply with all of the provisions of Chapter 4201.

Proposed new §19.1704(a)(2) provides that, pursuant to §19.1719(a)(3) and (b)(4), if an HMO or insurer performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration pursuant to §19.1704.

Proposed new §19.1704(b) adopts by reference Form No. LHL005 (Utilization Review Agent (URA) Application) to be used for application for a certification or registration and for renewal of a certification or registration as a URA in this state.

Section 19.1704(c)(1) - (3), relating to application filing requirements, are in existing §19.1704(a), relating to where to file the application, with several amendments. The first proposed amendment to §19.1704(c) adds the title "Application Filing Requirements" for clarity and to conform to *Texas Register* style relating to subheadings. The second proposed amendment adds paragraph (1), entitled "Application for certification." Paragraphs (1) and (2) are necessary to distinguish between applications for *certification* and applications for *registration.* Paragraph (1)(A) provides that an application for certification of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (1)(B) provides that an application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19). Another proposed amendment to §19.1704(c) adds paragraph (2), entitled "Application for registration." Paragraph (2)(A) provides that an application for registration of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (2)(B) provides that the fee requirement specified by §19.802(b)(19) does not apply to an applicant for registration. These provisions are consistent with proposed §19.1719(a)(3) and (b)(4).

An additional proposed amendment to §19.1704(c) redesignates existing §19.1704(a) as paragraph (3), entitled "Where to obtain and file the application form." Proposed amendments to this paragraph reference Form No. LHL005 and update the address with which the form must be filed.

The proposed amendments to §19.1704(d) reorganize the information that is required in Form No. LHL005 and impose some additional requirements pursuant to the Commissioner's authority to promulgate forms under the Insurance Code §4201.104 and under the Commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201. Additionally, the proposed amendment to §19.1704(d)(1)(A) adds "or the experimental or investigational nature" to the requirement that the completed application include an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or appropriateness of health care. This addition is necessary to implement HB 4290, which includes in the definition of "adverse determination" a determination by a URA that health care services provided or proposed to be provided to a patient are experimental or investigational.

Proposed amendments to §19.1706(d) require the URA to provide to the Department the name, number, type, license number and state of licensure, and qualifications of the personnel either employed or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information.

Proposed new §19.1704(d)(3) adds a new requirement that the application form include copies of template letters for notification of determinations made in utilization review that comply with §19.1710 and §19.1712.

Existing §19.1704(c)(9) is proposed for deletion because these prohibitions are addressed in proposed §19.1706(b). The URA is also required to certify in the application Form No. LHL005 that it is compliant with Texas rules. Existing §19.1704(c)(11) is proposed for deletion because proposed new §19.1704(d)(4) sets forth the organizational information that Form No. LHL005 requires, including (i) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state; (ii) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and (iii) a letter of good standing from the Texas Comptroller of Public Accounts.

Existing §19.1704(c)(12) is proposed for deletion because the name and biographical information for each director, officer and executive of the applicant is required under proposed new §19.1704(d)(5). Additionally, proposed §19.1704(d)(5) adds a new requirement that the application form include the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant as required under 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement). This change is necessary because, in accordance with §1.502(c) and (e) of this title, the Department has developed guidelines relating to the matters which the Department will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction, which include criminal background checks for each director, officer, and executive of the applicant.

The amendments to existing §19.1704(e) propose changes to the application process and are proposed pursuant to the Commissioner's general rulemaking authority under the Insurance Code §4201.003(a). The proposed addition of the phrase "a complete" to modify "application" in subsection (e)(1) clarifies that the 60 day time period does not begin until after the application is complete. Another amendment to subsection (e)(1) clarifies that the Department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

An amendment is proposed to §19.1704(e)(2) to change the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days of the date of the Department's latest notice of the omissions or deficiencies. This proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process, providing the Department with information more quickly. This shorter time period will allow a more efficient application process, thereby making more URAs more quickly available to the Texas consumer.

Amendments are proposed to §19.1704(e)(3) to provide that before the end of the 15 working days specified in subsection (e)(2), the applicant may request in writing additional time to correct the omissions or deficiencies in the application. Under the pro-

posed amendments, the request for the additional time must be approved by the Department in writing for the requested extension to be effective.

Amendments are proposed to §19.1704(e)(4) to rename what is now called an "application file" a "charter file." This file must be maintained by the Department. Under the proposed amendments, the file must contain approved application documents and requests for additional time and responses from the applicant. These documents are in addition to the documents relating to notices of omissions or deficiencies that are required to be maintained under the existing rule. Also, under the proposed amendments, the requirement that the charter file contain documents relating to "any written materials generated by any person that was considered by the Department in evaluating the application" is proposed to be deleted. This proposed deletion is necessary because it is overly broad, requiring retention of documents that will not be useful for future reference.

Proposed amendments to §19.1704(f)(1), relating to two-year renewal, clarify the requirements for the renewal process. The Insurance Code §4201.103 provides that certification may be renewed biennially by filing, not later than March 1, a renewal form with the Commissioner accompanied by a fee in an amount set by the Commissioner. The Insurance Code §4201.104(a) authorizes the Commissioner to promulgate forms to be filed for a renewal certificate of registration. Proposed amendments to §19.1704(f)(2), relating to continued operation during Department review, provides that if a URA has filed the required information specified in subsection (f) and the fee required only for certification renewal with the Department on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is finally denied or issued by the Department.

Proposed new §19.1704(f)(3) specifies the requirements for renewal if the certification or registration has been expired for 90 days or less. Under proposed new §19.1704(f)(3), the URA may renew the certification or registration by filing a completed renewal application, fee as applicable for certification renewal, and the required information described in subsection (f). Proposed §19.1704(f)(3) prohibits the URA from operating from the time the certification or registration has expired until the time the Department has issued a renewal certification or registration. Proposed new §19.1704(f)(4) specifies the requirements if the certification or registration has been expired for longer than 90 days. Under proposed §19.1704(f)(4), the URA may not renew the certification or registration but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accordance with §19.1704. Under proposed §19.1704(f)(4), §19.1704(e), relating to original application requirements and process, applies to applications made under paragraph (4).

The proposed deletion of existing §19.1704(h)(1) - (4), relating to evidence required by an applicant for a certificate, is necessary because the requirements specified in this subsection are addressed in proposed §19.1704(d)(2) with substantive amendments to some of the existing requirements.

The proposed deletion of existing §19.1704(i), relating to requirements for filing of changes in original applications of URAs that received their certificates prior to the 1992 adoption date of Subchapter R, is necessary because the requirement is obsolete.

Section 19.1705 addresses General Standards of Utilization Review. Proposed amendments to §19.1705(a) require the utilization review plan to be approved by a physician, periodically updated, and include input from both primary and specialty physicians, doctors, or other health care providers. The Insurance Code §4201.151 provides that a URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a physician and conducted in accordance with standards developed with input from appropriate health care providers and approved by a physician. The proposed deletion of the components listed in existing §19.1705(1) - (3) that must be included in the utilization review plan is necessary because the Department establishes updated required components in proposed new subsections (b) - (g) of §19.1705 or the components are otherwise incorporated into other sections of the subchapter, and the retention of the provisions would therefore be repetitive.

Proposed new §19.1705(b) adds a statutorily required general standard of utilization review relating to special circumstances. It requires the utilization review determination to take into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. This requirement is consistent with the Insurance Code §4201.153, which requires that utilization review determinations be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria.

Proposed new §19.1705(c) adds a statutorily required prohibition related to performance tracking data. This provision is consistent with the Insurance Code §4201.556(a), which prohibits a URA from publishing data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

Proposed new §19.1705(d) adds statutorily required screening criteria provisions. It describes the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome focused, and that they comply with the Insurance Code §4201.153. The Insurance Code §4201.153(a) - (c) require: (a) that a URA use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers; (b) that a utilization review determination be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria; and (c) that screening criteria be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, proposed new §19.1705(d) requires that screening criteria recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to harmonize the Subchapter R screening criteria requirements with proposed §19.2005(d),

which incorporates requirements of the Labor Code. Pursuant to the Commissioner's authority in §4201.003 to adopt rules to implement Chapter 4201, the Department determined this conforming change is necessary in Subchapter R rules to implement the existing requirements for screening criteria in accordance with §4201.153 while maintaining screening criteria standards that are consistent with the screening criteria standards under Subchapter U.

Proposed new §19.1705(e) adds a statutorily required provision related to referral and determination of adverse determinations. It requires that adverse determinations be referred to an appropriate physician or doctor.

Proposed new §19.1705(e) also provides that, in addition to determination of medical necessity or appropriateness, adverse determinations must be referred to and may only be determined by an appropriate physician or doctor to determine the experimental or investigational nature of health care services. This requirement is the result of the enactment of HB 4290, 81st Legislature, Regular Session, effective September 1, 2009, that effectively revise the definition of "adverse determination" in the Insurance Code Chapter 4201 to include determinations regarding the experimental or investigational nature of a service.

Proposed new §19.1705(g) adds statutorily required provisions related to the URA's complaint system. It requires the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with the Insurance Code §4201.204, which requires in pertinent part that a URA (i) establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review; (ii) to include a requirement in the complaint procedure that the URA provide a written response to the complainant within 30 days; and (iii) maintain a record of each complaint until the third anniversary of the date the complainant filed the complaint. Additionally, proposed §19.1705(g) adds a new requirement that the written response include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. This information is necessary to inform the consumer that he or she has the right to file a complaint with the Department after the issuance of an adverse determination by the URA, and the process by which the consumer may speak to a Department representative regarding his or her claim to the URA.

Proposed new §19.1705(h) adds the Insurance Code §1369.056 requirement that the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of Subchapter R if: (i) the drug is not included in a drug formulary used by the group health benefit plan; and (ii) the enrollee's physician has determined that the drug is medically necessary. This subsection is proposed to implement the Insurance Code §1369.056 and Chapter 4201. Under the Insurance Code §1369.057, the Commissioner may adopt rules to implement Chapter 1369, Subchapter B, of the Insurance Code. The Commissioner also has authority under §4201.003 to adopt rules to implement Chapter 4201.

Proposed new §19.1705(i) provides that §19.1705 applies to a specialty URA except for subsection (a), relating to utilization review plan requirements. While a specialty URA is required to have a utilization review plan pursuant to §19.1720(c), the specialty URA is exempt from the requirements that the utilization review plan be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other health care providers, including practicing health care providers. The reason that the specialty URAs are not subject to these requirements is that these requirements are based on the Insurance Code §4201.151 and pursuant to the Insurance Code §4201.452, specialty URAs are not subject to §4201.151. Specialty URAs are required, pursuant to §19.1720(c), to use only a health care provider of the appropriate specialty. Under the Insurance Code §4201.453 and §19.2020, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Section 19.1706 addresses Requirements and Prohibitions Relating to Personnel. A proposed amendment to §19.1706(a)(1) replaces the term "Personnel" with "Physicians, doctors, and other health care providers" to clarify to whom this section applies. A new requirement is added in proposed new §19.1706(a)(2) to require personnel conducting utilization review to hold an unrestricted license or administrative license or to be otherwise authorized to provide health care by a licensing agency in the United States. This new requirement in proposed §19.1706(a)(2) was unanimously recommended by the Advisory Committee and is consistent with the provisions of the Insurance Code §4201.252(a). Section 4201.252(a) requires that "Personnel employed by or under contract with a URA to perform utilization review be appropriately trained and qualified."

A new prohibition is proposed in new §19.1706(c), relating to disqualifying associations. Proposed new §19.1706(c) prohibits a physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal. The subsection also clarifies that being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. Proposed new §19.1703(12) defines "disqualifying association." Both §19.1703(12) and §19.1706(c) are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of proposed new §19.1703(12) and §19.1706(c) is to prohibit the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal.

Proposed amendments to §19.1706(d) add requirements that the URA provide the name, license number and state of licensure of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information, in addition to the information that is currently required.

The deletion of existing §19.1706(e), which requires utilization review dental plans to be reviewed by a dentist currently licensed by a state licensing agency in the United States, is proposed to avoid unnecessary redundancy. Review of dental plans are governed by §19.1720, relating to specialty URAs.

Proposed amendments to newly designated §19.1706(e) add a new paragraph (2) to require the URA to maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review are licensed, qualified, and appropriately trained or experienced.

Proposed new §19.1706(f) adds a new requirement relating to training related to acquired brain injury treatment. It requires the URA to provide adequate training to personnel responsible for pre-certification, certification, and recertification of services or treatment related to acquired brain injury treatment. The basis for this requirement is the Insurance Code §1352.004. Section 1352.004 provides that "preauthorization" means the provision of a reliable representation to a physician or health care provider of whether a health benefit plan issuer will pay the physician or provider for proposed medical or health care services if the physician or provider provides those services to the patient for whom the services are proposed. The term includes precertification, certification, recertification, or any other activity that involves providing a reliable representation by the issuer to a physician or health care provider. Under §1352.004, the Commissioner is required by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan. The purpose of the training is to prevent denial of coverage in violation of §1352.003 and to avoid confusion of medical benefits with mental health benefits. The Commissioner is further required to prescribe by rule, in consultation with the Texas Traumatic Brain Injury Advisory Council, the basic requirements for the training. Although the Insurance Code §1352.004 contemplates the required training for a health benefit plan issuer and not for a URA specifically, proposed new §19.1706(e) will ensure that URA personnel will receive adequate training, as consistent with the intent of the Insurance Code §1352.004. The requirement that URA personnel receive the training is proposed under the Commissioner's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Newly designated §19.1706(g) is existing §19.1706(d), relating to the requirement that utilization review conducted by a URA be under the direction of a currently licensed physician, with minor nonsubstantive changes proposed for purposes of clarity and readability.

Proposed new §19.1706(h) provides that §19.1706 applies to a specialty URA except subsections (a), (d), (e) and (g). Specialty URA requirements relating to employed or contracted physicians, doctors, other health care providers, and personnel; information required to be filed with the Department; the URA's written procedures and maintenance of records; and the conducting of a utilization review under the direction of a physician, do not apply to specialty URAs because these specialty requirements are in proposed new §19.1720.

Section 19.1707 addresses Prohibition of Certain Activities and Procedures Related to Health Care Providers and Enrollees. Proposed new §19.1707(c) is necessary to provide that §19.1707 applies to a specialty URA.

Section 19.1708 addresses Utilization Review Agent Contact with and Receipt of Information from Health Care Providers. The proposed amendments to existing §19.1708 are nonsubstantive.

The proposed amendments to §19.1708(c) require the URA, when conducting utilization review, to request "all relevant and updated medical records" in order to complete the review. This proposed amendment is necessary to ensure that the URA utilizes the most recent and complete information possible to review the enrollee's treatment. While the treatment may vary on a case-by-case basis, the Department has determined that this proposed amendment will enable the most effective review to be conducted.

Proposed amendments to §19.1708(c) provide that the information required may include identifying information about the claim and about the treating physician, doctor, or other health care provider. This additional information is necessary to clarify the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records in order to complete the review. Proposed amendments add "and diagnostic testing" to include diagnostic testing in the type of information that the URA may request. This additional information is necessary to assist the URA in making an informed determination.

An amendment is proposed to existing §19.1708(c)(2) to replace the reference to "prospective and concurrent review" with the general term "utilization review." This change is necessary to specifically include retrospective review, which is a type of "utilization review" under proposed §19.1703(45).

Additionally, a proposed amendment to existing §19.1708(d) deletes the reference to "regarding the appropriateness of certification" and substitutes "regarding the appropriateness of health care." This change is necessary to correct an inadvertent error in the existing rule.

Proposed new §19.1708(g) is necessary to provide that §19.1708 applies to a specialty URA.

Section 19.1709 addresses On-Site Review by the Utilization Review Agent. Proposed amendments to §19.1709(c), relating to on-site review at a health care facility, change the references to hospital to a "health care facility." The broader term "health care facility," which includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care, is necessary for purposes of clarification and accuracy.

Proposed new §19.1709(d) provides that §19.1709 applies to a specialty URA.

Section 19.1710 addresses Notice of Determinations Made in Prospective and Concurrent Utilization Review. An amendment is proposed to the title of existing §19.1710, "Notice of Determinations Made by Utilization Review Agents," to clarify that the section regulates the notice of determinations in prospective and concurrent utilization review. Existing subsection (b) is reformatted as subsection (b)(1) with proposed amendments to clarify that the subsection notification requirements pertain only to favorable determinations.

Proposed new §19.1710(b)(2) adds a new requirement that a URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the federal Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction, based on the type of service in the preauthorization request. These standards apply under federal law to health insurers and HMOs and therefore already apply to health insurers and HMOs conducting utilization review. For consistency among all URAs, the Department has determined it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement will prevent different numbering systems based on whether the URA is subject to the federal regulations.

A proposed amendment to §19.1710(c) adds a new subheading to clarify that the subsection regulates notices of adverse determination. Newly designated §19.1710(c)(1) sets forth additional required notice elements to be included in the written notice of

an adverse determination sent to the enrollee and the provider of record in all instances of a prospective or concurrent utilization review. Some of the notice elements in §19.1710(c)(1) are required by the Insurance Code §4201.303(a); these requirements, which are listed in existing and redesignated §19.1710(c)(1)(A), (B), (C), and (F) and proposed new subparagraph (G) include: (i) the principal reasons for the adverse determination; (ii) the clinical basis for the adverse determination; (iii) a description of or the source of the screening criteria used as guidelines in making the adverse determination; (iv) a description of the procedure for the complaint and appeal process, including notice to the enrollee of the enrollee's right to appeal an adverse determination to an independent review organization and of the procedures to obtain that review; and (v) a description of the URA's appeal process.

The proposed amendments to add new notice requirements in proposed new paragraphs §19.1710(c)(1)(D), (E), (H), and (I) include: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination; (iii) the date and time the URA offered the opportunity to discuss the adverse determination and the date and time the discussion, if any, took place; and (iv) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), with instructions on how to submit the form. The Department has determined that these additional notice elements are necessary to provide important consumer information to the enrollee and the provider of record in the event that the adverse determination is appealed.

The additional notice element in proposed new §19.1710(c)(1)(D), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the enrollee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination required in proposed new §19.1710(c)(1)(E), is necessary for the enrollee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the enrollee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirement in proposed new §19.1710(c)(1)(G) and (I), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee of his or her additional options following an adverse determination. The information will inform the provider of record of what information is necessary for submission to the URA on behalf of the enrollee for the appeal of an adverse determination. The requirement in proposed new §19.1710(c)(1)(H) regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred, is also useful to inform the enrollee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA

Proposed new §19.1710(c)(2) adds a new requirement that mandates that the description of the URA's appeal process include a statement that explains the URA's process for circumstances involving an enrollee's life-threatening condition, and under the process, the enrollee must be provided an immediate independent review by an IRO and is not required to comply with procedures for an internal review of the adverse determination by a URA. This proposed provision is based on the requirement in the Insurance Code §4201.303(b).

Proposed new §19.1710(c)(3) requires that the release of medical information to an IRO included in the request for review by an IRO be signed by the enrollee or the enrollee's legal guardian. This requirement is based on the Insurance Code §4201.552, which prohibits a URA from disclosing individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the patient's prior written consent or except as otherwise required by law. Section 4201.552 also requires that if the prior written consent is submitted by anyone other than the patient who is the subject of the personal or confidential information requested, the consent must be dated and contain the patient's signature.

Existing §19.1710(d)(1) - (3) are proposed to be redesignated as §19.1710(c)(4)(A) - (C). Proposed amendments to §19.1710(c)(4)(A) - (C) specify required time frames for notification of an adverse determination and revise existing time frame requirements to be consistent with the Insurance Code §4201.304. Section 4201.304 requires a URA to provide notice of an adverse determination required under Subchapter G of Chapter 4201: (A) with respect to a patient who is hospitalized at the time of the adverse determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the adverse determination; (B) with respect to a patient who is not hospitalized at the time of the adverse determination, within three working days in writing to the provider of record and the patient; or (C) within the time appropriate to the circumstances relating to the delivery of the services to the patient and to the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider, the agent is required to provide the notice to the treating physician or other health care provider not later than one hour after the time of the request.

Existing §19.1710(e), which discusses notification of adverse determination for life-threatening conditions, is proposed to be deleted. Proposed §19.1721 (relating to Independent Review of Adverse Determinations) addresses these requirements, and therefore, the retention of this subsection is unnecessary.

Proposed new §19.1710(d) specifies the requirements relating to a notice of determination concerning an acquired brain injury. Under proposed §19.1710(d), a URA is required to comply with the notice requirements in subsection (b), relating to notification of favorable determinations, and subsection (c), relating to notice of adverse determinations. Additionally, in regard to a determination concerning an acquired brain injury as defined by §21.3102, the URA must not later than three business days af-

ter the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, provide notification of the determination through a direct telephone contact to the individual making the request. Proposed §19.1710(d) also provides that the subsection does not apply to a determination made pursuant to coverage under a small employer health benefit plan. This proposed provision is consistent with the Insurance Code §1352.006, relating to the determination of medical necessity and extension of coverage, which provides that (i) in §1352.006, the term "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document; (iv) to comply with the requirements of §1352.006 the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan.

Proposed new §19.1710(e) specifies that §19.1710 applies to specialty URAs.

Section 19.1711 addresses Requirements Prior to Issuing Adverse Determination. An amendment is proposed to the title of existing §19.1711, "Requirements Prior to Adverse Determinations," to clarify that the section regulates the requirements prior to the issuance of adverse determinations. Proposed new §19.1711(a) defines the term "reasonable opportunity," for purposes of §19.1711, as at least one documented good faith attempt to contact the provider of record requesting the services (i) no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or (ii) no less than five working days prior to issuing a retrospective utilization review adverse determination. This definition is necessary to provide guidance regarding what constitutes a "reasonable opportunity" to ensure uniform implementation of the §19.1711(b)(1) requirements relating to prospective or concurrent utilization review adverse determination and subsection (c)(1) requirements relating to retrospective utilization review adverse determination. The proposed definition is also used in proposed new §19.1712(a)(2)(E) and (b)(3) and §19.1720(h)(1)(A) and (2)(A), and it is necessary that all of these requirements are implemented on the basis of a uniform definition.

Proposed newly designated §19.1711(b) addresses requirements regarding any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services prior to issuing a prospective or concurrent utilization review adverse determination. An amendment is proposed to §19.1711(b)(1) to require the URA, prior to issuance of an adverse determination, to afford "the provider of record" a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician or doctor. The amendment changes the existing rule which addresses such discussion opportunities with a physician or dentist. The inclusion of dental plans in the existing rule is proposed for deletion because dental plans are specialty health services that are subject to the peer-to-peer discussion requirements under §19.1720, relating to specialty URAs. An amendment is also proposed to §19.1711(b)(1) to clarify that the discussion must include, *at a minimum,* the clinical basis for the URA's decision in addition to the discussion of the plan of treatment for the enrollee. This clarification indicates that the required discussion may also include other matters as deemed necessary by the URA and/or provider of record.

Proposed new §19.1711(b)(2) adds a new requirement that when the URA provides the reasonable opportunity required under §19.1711(b)(1), the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination. This requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the URA.

Proposed amendments to newly designated §19.1711(b)(3) provide more detailed requirements regarding these written procedures. The proposed amendments require the URA to maintain documentation detailing the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.1711(b)(4) adds a new requirement that the URA submit this required documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

Proposed new §19.1711(c) sets forth requirements prior to issuing retrospective review adverse determinations. The proposed new subsection imposes the same requirements for the peer-to-peer discussion regarding any instance in which a URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of a retrospective adverse determination as those requirements prior to the issuance of an adverse determination for prospective or concurrent utilization review specified in proposed §19.1711(b)(1), (3), and (4). Additional requirements are proposed in §19.1711(c)(2) for retrospective adverse determinations to (i) require that when the URA provides the reasonable opportunity required under §19.1711(c)(1), the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination; and (ii) require the URA to allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.1711, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

These proposed requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements that result from the enactment of HB 4290. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review" as a type of "utilization review." The Insurance Code §4201.206 provides that subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination. Because a "utilization review agent," as defined in the Insurance Code §4201.002, means "an entity that conducts utilization review...," and the term "utilization review" includes "retrospective review" as provided in §4201.002(13) of the Insurance Code, the §4201.206 provision requiring a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination prior to issuance of an adverse determination is applicable to URAs conducting retrospective review.

Proposed new §19.1711(d) provides that the §19.1711 requirements except subsections (b) and (c) apply to a specialty URA. The requirements under subsections (b) and (c) are not applicable because the underlying peer-to-peer requirement from which the other requirements are derived is based on the authority of the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.1720(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Section 19.1712 addresses Appeal of Adverse Determination. Existing §19.1712 contains three subsections: subsection (a) relating to maintenance and availability of the URA's written appeal procedures; subsection (b) relating to the required provisions that must be included in the appeal procedures; and subsection (c) relating to appeals involving life threatening conditions. All three of these subsections are reformatted to be part of a new subsection (a)(1) - (3). The proposed amendments to existing §19.1712(a) are nonsubstantive and are necessary for clarification, internal consistency of terminology, and to redesignate the subsection as §19.1712(a)(1). Proposed amendments to §19.1712(a)(2), which is existing §19.1712(b), are necessary to clarify that each URA is required to comply with its written procedures for appeals. Proposed amendments to §19.1712(a)(2) also revise the information that is required to be in the written procedures for appeals.

Proposed new §19.1712(a)(2)(A) requires the URA's written procedures for appeals to include a statement specifying the time frames for filing the written or oral appeal, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the enrollee adequate time to appeal an adverse determination and specifies a uniform time period for all enrollees to appeal an adverse determination. Under this provision, all enrollees will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review.

Existing §19.1712(b)(1) and (2) are proposed for deletion because the substantive requirements are moved to proposed new §19.1712(a)(2)(B) and (C). Proposed §19.1712(a)(2)(B) requires that the URA written appeal procedures include a provision that an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing. This provision is similar to the existing §19.1712(b)(1). Proposed §19.1712(a)(2)(C)(i) - (iv) contain the same requirements relating to an appeal acknowledgement letter to be sent by the URA to the appealing party that are specified in existing §19.1712(b)(2).

Existing §19.1712(b)(3) is proposed to be divided into two separate provisions and redesignated as §19.1712(a)(2)(D) and (F) with the following proposed amendments. A proposed amendment to §19.1712(a)(2)(D) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician who has not previously reviewed the case. This provision is consistent with the Insurance Code §4201.356(a), which provides that the procedures for appealing an adverse determination must provide that a physician makes the decision on the appeal, except as provided by §4201.356(b) relating to specialty provider reviews. A proposed amendment to §19.1712(a)(2)(F) clarifies that the notification of appeal under the subparagraph must be in writing.

Proposed new §19.1712(a)(2)(E) adds a new requirement to be included in the URA's written procedures for appeals. The URA's written procedures must include a provision that in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, the URA before issuance of an adverse determination must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The provision must require that the discussion include, at a minimum, the clinical basis for the URA's decision. This provision is consistent with the Insurance Code §4201.206, which provides that subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA is required to provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the agent's determination.

A proposed amendment to §19.1712(a)(2)(G) adds a requirement that the URA's written procedures for appeal must include a provision that an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification. The requirement for the follow-up letter is necessary to ensure that the appealing party receives prompt written documentation of the expedited appeal determination.

Existing §19.1712(b)(5), relating to procedures regarding the resolution of the appeal, is proposed to be redesignated as §19.1712(a)(2)(H). Proposed amendments to §19.1712(a)(2)(H) require the URA, after seeking review of the appeal of the adverse determination, to issue a response letter to the enrollee or an individual acting on behalf of the enrollee and the provider of record explaining the resolution of the appeal.

Proposed §19.1712(a)(2)(H)(i) - (vi) specify the elements of information that must be included in the response letter (i) a statement of the specific medical, dental, or contractual reasons for

the resolution, as required in existing §19.1712(b)(5)(A); (ii) the medical or clinical basis for such decision, including screening criteria; (iii) a description of or the source of the screening criteria that were utilized in making the determination; (iv) the professional specialty and state or states of licensure of the physician who made the determination; (v) a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) in addition to the existing rule requirement for a notice of the appealing party's right to seek review of the denied appeal by an IRO and the procedures for obtaining that review; and (vi) procedures for filing a complaint in accordance with the Insurance Code §4201.204 and as described in §19.1705(g). These requirements are necessary to provide the enrollee with important information concerning the basis for the determination and the opportunity and procedures for filing a request for an independent review of the adverse determination. This required information will also be helpful to the appealing party in preparing the request for independent review. The requirements in proposed §19.1712(a)(2)(H)(ii), (iv), and (v) are consistent with the Insurance Code §4201.359.

The requirement in proposed new §19.1712(a)(2)(H)(vi) relating to procedures for filing a complaint is consistent with the Insurance Code §4201.204, which requires the URA to establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review. The requirements in proposed §19.1712(a)(2)(H)(i) and (iii) are proposed under the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201. Existing §19.1712(b)(5)(A) is redesignated as proposed §19.1712(a)(2)(H)(i) and is similar to the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(1), proposed §19.1710(c)(1)(A), and proposed §19.1715(b)(2)(A). These provisions require the URA to include the principal reasons for the adverse determination in the notice of an adverse determination.

The requirement under new §19.1712(a)(2)(H)(iii) mirrors the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(3), proposed §19.1710(c)(1)(C), and proposed §19.1715(b)(2)(C). These provisions require the URA to include a description of or the source of the screening criteria that were utilized as guidelines in making the determination in the notice of an adverse determination.

Existing §19.1712(b)(6), relating to notification of the determination of the appeal, is proposed to be redesignated as §19.1712(a)(2)(I). It is proposed to be amended to provide that the URA's written appeal procedures must include a provision that the appeal must be resolved as soon as practical, but, in accordance with the Insurance Code §4201.359, in no case later than 30 days after the date the URA receives the written appeal or the one-page appeal form from the appealing party referenced in §19.1712(a)(2)(C).

Existing §19.1712(c), relating to immediate appeals for life-threatening conditions, is proposed to be redesignated as §19.1712(a)(3). No amendments are proposed to redesignated §19.1712(a)(3).

Proposed new §19.1712(b) governs appeals of retrospective review adverse determinations. Proposed subsection (b) requires the URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the requirements in paragraphs (1) - (3) of subsection (b). Proposed subsection (b)(1) requires that the appeal procedures must be in accordance with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims). Proposed subsection (b)(2) requires that an appeal of an adverse determination relating to retrospective utilization review must comply with §19.1715. Proposed subsection (b)(3) requires that in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity, as defined in §19.1711(a), to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.1712(c) addresses appeals of adverse determinations concerning acquired brain injuries. Under proposed §19.1712(c), a URA is required to make a determination concerning an acquired brain injury not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness. The notification of the determination must be provided through a direct telephone contact to the individual making the request. This provision is consistent with the Insurance Code §1352.006, which provides that (i) in §1352.006, "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document; (iv) to comply with these requirements, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan."

Proposed new §19.1712(d) provides that §19.1712 applies to a specialty URA except subsection (a)(2)(D), relating to the requirement that appeal decisions of prospective or concurrent adverse determinations must be made by a physician who has not previously reviewed the case; subsection (a)(2)(E), relating to the requirement that before issuing a prospective or concurrent adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician; and subsection (b)(3), relating to the requirement that before issuing a retrospective adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician. The requirement under subsection (a)(2)(D) is not applicable because §19.1720(i) governs appeal procedures specifically for specialty URAs. Section §19.1720(i) require the decision in any appeal of an adverse determination by a specialty URA to be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination. The requirements under subsections (a)(2)(E) and (b)(3) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance

Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.1720(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Section 19.1713 addresses Utilization Review Agent's Telephone Access. An amendment is proposed to existing §19.1713(c) to clarify that a URA must implement its written description that it provides to the Commissioner setting forth procedures when responding to post-stabilization care subsequent to emergency treatment as requested by a treating physician, doctor, or other health care provider of record. Another amendment is proposed to existing §19.1713(c) to clarify that the procedure must comply with the Insurance Code §4201.004. The Insurance Code §4201.004(b) requires a URA to provide to the Commissioner a written description of the procedures to be used when responding with respect to post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider.

Proposed new §19.1713(d) clarifies that §19.1713 does not apply to an HMO or preferred provider benefit plan that is subject to §19.1723 (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §19.1724 (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans), respectively. This exemption is necessary because §19.1723 and §19.1724 specify detailed telephone access requirements for HMOs or preferred provider benefit plans, respectively.

Proposed new §19.1713(e) provides that §19.1713 applies to a specialty URA.

Section 19.1714 addresses Confidentiality. Proposed §19.1714(a)(4), relating to requests for recorded personal information, requires the URA to respond to an individual's written request for access to recorded personal information about the individual within 10 *working* days, instead of 10 business days as provided in the existing rule. This amendment is proposed for clarity and uniformity of implementation; the term "working day" is defined in §19.1703(48), and the term "business day" is not defined.

Under proposed §19.1714(a)(12), which is existing subsection (m), the requirement that the information be retained for "at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened" is proposed for deletion. An amendment is proposed that requires the information to be retained for at least *four* years without the qualifier in the existing rule "if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened." These amendments (i) broaden the information that the URA must retain to include all information generated and obtained by a URA in the course of utilization review, and not just that information relating to cases for which an adverse decision was made or information relating to a case that may be reopened; and (ii) extend the period the information is to be retained from two to four years. These changes are necessary to broaden the type of information that is to be retained and to allow sufficient time for the Department to examine the information. The Department generally conducts URA examinations triennially but does not always examine each URA exactly every three years, so the requirement that the URA maintain information for four years will ensure that the Department has the opportunity to review such information. Additionally, nonsubstantive amendments are made to clarify that the URA is required to retain the information.

As previously discussed, proposed new §19.1714(b), relating to a URA's written procedures on confidentiality, is existing §19.1714(k) with proposed nonsubstantive amendments for clarification. These proposed amendments include the clarification that the confidentiality requirements pertain to both the information received by the URA from the enrollee, the enrollee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties.

Proposed new §19.1714(c) provides that §19.1714 applies to a specialty URA.

Section 19.1715 addresses Notice of Determination Made in Retrospective Review. The title of existing §19.1715 is changed from "Retrospective Review of Medical Necessity" to "Notice of Determination Made in Retrospective Review" to more accurately reflect the provisions in the section. Existing §19.1715(a) is proposed for deletion and to be replaced with a new §19.1715(a), relating to required notice, to require a URA to notify the enrollee, or an individual acting on behalf of the enrollee, and the enrollee's provider of record of a determination made in a retrospective review of medical necessity or appropriateness of health care service or the experimental or investigational nature of care. Proposed new §19.1715(b), relating to required procedures, requires the URA to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review to the enrollee and the provider of record, including the time frames for the notice of adverse determination.

Proposed §19.1715(b)(1) requires the notice of adverse determination to be in writing and sent to the provider of record, including the health care provider who rendered service, and the enrollee or the individual acting on behalf of the enrollee. This provision is consistent with the Insurance Code §4201.305, which provides that notwithstanding §4201.302 and §4201.304, if a retrospective utilization review is conducted, the URA is required to provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 days after the date on which the claim is received.

Proposed §19.1715(b)(2) requires the notice of adverse determination to include several notice elements of information, including some statutory requirements. These statutory requirements are included in proposed §19.1715(b)(2)(A), (B), (C), (F), and (G).

In addition to the notice elements required by the Insurance Code §4201.303, proposed §19.1715(b)(2)(D), (E), (H), and (I) also require the following information be included in the notice of adverse determination for retrospective utilization review: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination; (iii) the date and time the URA offered the opportunity to discuss the adverse determination, and the date and time that the discussion, if any, occurred; and (iv) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), with instructions on how to submit the form. These additional requirements are proposed pursuant

to the rulemaking authority in the Insurance Code §4201.003, which provides that the Commissioner may adopt rules to implement Chapter 4201 of the Insurance Code. The Department has determined that these additional notice elements are necessary to provide important consumer information to the enrollee and the provider of record in the event that the adverse determination is appealed.

The additional notice element in proposed new §19.1715(b)(2)(D), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the enrollee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and state(s) of licensure of the physician or doctor who made the adverse determination, required in proposed new §19.1715(b)(2)(E), is necessary for the enrollee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the enrollee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirement in proposed new §19.1715(b)(2)(G), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee of his or her additional options following an adverse determination. The information will inform the provider of record of what information is necessary for submission to the URA on behalf of the enrollee for the appeal of an adverse determination. The requirement in proposed new §19.1715(b)(2)(H) regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred, is also useful to inform the enrollee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Existing §19.1715(c), relating to prohibiting a URA from requiring the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder, is redesignated as §19.1715(b)(3). Redesignated §19.1715(b)(3) is retained with (i) proposed nonsubstantive editorial revisions and (ii) other necessary proposed amendments that are made throughout the text. Additionally, an amendment is proposed to §19.1715(b)(3) to provide that the provisions in this paragraph also apply when a retrospective review of the experimental or investigational nature of health care service is made in relation to health coverage. This amendment is necessary because of the enactment of HB 4290.

Proposed new §19.1715(c), relating to a determination concerning an acquired brain injury, requires a URA to make a determination concerning an acquired brain injury not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness. The URA is required to provide notification of the determination through a direct telephone contact to the individual making the request. The requirements do not apply to a determination made pursuant to coverage under a small employer health benefit plan. This proposed provision is consistent with the Insurance Code §1352.006, relating to the determination of medical necessity and extension of coverage, which provides that (i) in §1352.006, the term "utilization review" has the meaning assigned by §4201.002; (ii) notwithstanding Chapter 4201 or any other law relating to the determination of medical necessity under the Insurance Code, a health benefit plan is required to respond to a person requesting utilization review or appealing for an extension of coverage based on an allegation of medical necessity not later than three business days after the date on which the person makes the request or submits the appeal; (iii) the person must make the request or submit the appeal in the manner prescribed by the terms of the plan's health insurance policy or agreement, contract, evidence of coverage, or similar coverage document; (iv) to comply with the requirements of §1352.006, the health benefit plan issuer must respond through a direct telephone contact made by a representative of the issuer; and (v) §1352.006(b) does not apply to a small employer health benefit plan.

Proposed new §19.1715(d) provides that §19.1715 applies to specialty URAs.

Section 19.1716 addresses "Regulatory Requirements Subsequent to Certification or Registration." Proposed new §19.1716(a), relating to reporting of material changes in the application or latest renewal form, requires the URA to report to the Department, not later than the 30th day after the date on which the change takes effect, any material changes in such information. This provision implements the Insurance Code §4201.107, which provides that a URA shall report any material change to the information disclosed in a form filed under Subchapter C of Chapter 4201 not later than the 30th day after the date the change takes effect.

Proposed §19.1716(b)(1) requires that information related to complaints be included in the summary report but the proposed amendments clarify in the introductory paragraph that URAs must submit information related to *adverse determinations, appeals of adverse determinations, and any other related information requested by the Department in accordance with the Insurance Code §38.001.* This provision is proposed under the Insurance Code §4201.204(c) and the Insurance Code §38.001. The Insurance Code §4201.204(c) requires that a URA: (i) submit to the Commissioner a summary report of all complaints at the times and in the form specified by the Commissioner; and (ii) allow the Commissioner to examine the complaints and relevant documents at any time. The Insurance Code §38.001 authorizes the Department to address inquiries to a holder of an authorization relating to (i) the person's business condition; or (ii) any matter connected with the person's transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties.

Proposed new §19.1716(b)(2) requires the summary report to be provided in the form required by the Commissioner and requires the URA to permit the Commissioner or the Commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the Department. This provision is also proposed under the Insurance Code §4201.204(c).

A proposed amendment to §19.1716(b)(3)(B) clarifies that "successor codes and modifiers" are applicable as part of that re-

quirement. Existing §19.1716(c)(1) - (5), relating to complaints to the Department, is proposed for deletion because the Department has determined that the more detailed complaint procedure requirements in existing subsection (c)(1) - (5) are too restrictive and inconsistent with procedures that the Department follows for investigating and resolving other types of complaints.

Existing §19.1716(d), relating to the provision of evidence of corrective action, is proposed for deletion because the requirements under existing §19.1716(c)(4) and (5) that the URA's response include (i) corrective actions, if any, on the part of the URA which the commissioner or his or her designated representative finds appropriate and whether the URA has voluntarily agreed to take such action; and (ii) a time frame in which corrective actions should be completed, are proposed for deletion. Thus, evidence of such corrective action is no longer required. Proposed new §19.1716(d), relating to Department inquiries, reiterates the Department's authority in the Insurance Code §38.001 to address inquiries to a URA related to any matter connected with the URA transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties. Under §38.001, a URA to which such an inquiry is addressed must respond in writing not later than the 10th day after the date the inquiry is received.

An amendment is proposed to newly designated §19.1716(e)(1)(A), which is existing §19.1716(g)(1), to clarify that an on-site review by the Department may be scheduled or unscheduled. Under proposed new §19.1716(e)(1)(B), an on-site review will only be conducted during working days and normal business hours. Proposed new §19.1716(e)(1)(C) retains the provision in existing §19.1716(g)(3) that the URA is required to make available all records relating to its operation during the scheduled and unscheduled on-site review without a proposed substantive change. Existing §19.1716(g)(3) is proposed for deletion because this provision has been moved to proposed new §19.1716(e)(1)(C). Newly designated §19.1716(e)(2), which is existing §19.1716(g)(2), retains the provision that the URA will be notified of any scheduled on-site review by letter, with proposed nonsubstantive changes. The provision in proposed new §19.1716(e)(3), which is not in the existing rules, provides that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by the Department's designated representative upon arrival.

Existing §19.1716(f), relating to lists of URAs, is proposed for deletion because the Department now maintains a list of certified URAs on its website, which is available to individuals or organizations interested in obtaining information on the certification status of a URA. This list is updated in real-time. Existing §19.1716(g)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is proposed for deletion. The Department has determined that this provision is no longer necessary because of the Insurance Code §4201.601 which authorizes the Department to take certain steps if it is believed that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include authority to compel the production of necessary information if it is believed that the URA is in violation of the Insurance Code or rules relating to reasonable accessibility.

Proposed new §19.1716(f) provides that §19.1716 applies to specialty URAs.

Section 19.1717 addresses Administrative Violations. Existing §19.1717(e), relating to violations of provisions of the Insurance Code and Department rules other than those violations of Chapter 4201 and applicable rules, is proposed for deletion because the provisions in that subsection are included in revised existing §19.1717(a) and (d). The deletion of existing subsection (e) requires the redesignation of subsequent subsections. Additionally, an amendment is proposed to redesignated §19.1717(e), which is existing §19.1717(f) relating to commission of fraudulent or deceptive acts in obtaining or using a URA certification, to include the commission of fraudulent or deceptive acts in obtaining or using a URA registration. New proposed §19.1717(f) provides that §19.1717 applies to specialty URAs.

In conjunction with this proposal, existing §19.1718, concerning criminal penalties, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Section 19.1719 addresses Responsibility of HMOs and Insurers Performing Utilization Review. The proposed amendment to existing subsection (a)(1) provides that an HMO performing utilization review only for coverage for which it is the payor is subject to Subchapter R except for the *certification* requirements in §19.1704 of this title. This proposed provision is consistent with the Insurance Code §4201.057(c), which provides that as a condition of holding a certificate of authority to engage in the business of an HMO, an HMO that performs utilization review must: (i) comply with Chapter 4201, except Subchapter C, relating to certification; and (ii) submit to assessment of a maintenance tax under Chapter 258 of the Insurance Code to cover the costs of administering compliance with §4201.057(c).

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing §19.1719(a)(2), which requires an HMO performing utilization review for an individual or entity for which it is not the payor to have a valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.1704. This provision is consistent with the Insurance Code §4201.057(e), which provides that notwithstanding §4201.057(c)(1), an HMO that performs utilization review for a person or entity subject to Chapter 4201, for which the HMO is not the payor, must obtain a certificate of registration under Subchapter C of Chapter 4201 and must comply with all of the provisions of Chapter 4201.

Amendments are proposed to existing §19.1719(a)(3) to clarify that an HMO that performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor must have a valid registration pursuant to §19.1704 and to comply with the filing requirements under §19.1704. Under the proposed amendments to existing §19.1719(a)(3), the HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor. These proposed amendments are necessary for the Department to obtain additional information about HMOs conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing §19.1719(a)(4), which provides that an HMO, including an HMO that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under the Human Resources Code Chapter 32, is subject to the Insurance Code Chapter 4201 and Subchapter R.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to existing

§19.1719(a)(5), which requires an HMO to submit to assessment of maintenance taxes under the Insurance Code Chapter 258 to cover the costs of administering compliance of HMOs under Chapter 4201 of the Insurance Code.

Section 19.1719(b) in both the existing rules and the proposed rules addresses requirements for insurers performing utilization review. Existing §19.1719(b)(1), relating to the tax requirements to which such insurers are subject, is proposed to be redesignated as new §19.1719(b)(2). Proposed new §19.1719(b)(1) provides that an insurer performing utilization review under the Insurance Code Chapter 4201 is subject to Subchapter R, except, pursuant to the Insurance Code §4201.058, an insurer performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 if the insurer performs utilization review only for coverage for which it is the payor. Existing §19.1719(b)(2), to which insurers performing utilization review are subject, is proposed for deletion because it is obsolete. Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1719(b)(2) which requires that an insurer that delivers or issues for delivery a health insurance policy in Texas and that performs utilization review is subject to assessment of maintenance tax under the Insurance Code Chapter 257. These proposed provisions are consistent with the Insurance Code §4201.058, which provides that as a condition of holding a certificate of authority to engage in the business of insurance, an insurer that performs utilization review must: (i) comply with Chapter 4201, except Subchapter C, relating to certification; and (ii) submit to assessment of a maintenance tax under Chapter 257 of the Insurance Code to cover the costs of administering compliance with §4201.058(a).

New §19.1719(b)(3) requires an insurer performing utilization review for an individual or entity for which it is not the payor to have a valid certificate as provided under Chapter 4201 of the Insurance Code and in accordance with §19.1704 of this subchapter. This requirement is consistent with the Insurance Code §4201.058(c), which provides that notwithstanding §4201.058(a), an insurer subject to the Insurance Code that performs utilization review for a person or entity subject to Chapter 4201, other than a person or entity for which the insurer is the payor, must obtain a certificate of registration under Subchapter C of Chapter 4201 and is required to comply with all of the provisions of Chapter 4201.

Existing §19.1719(b)(4) pertains to requirements for registration of insurers and is proposed for deletion. Existing §19.1719(b)(3) is proposed to be redesignated as §19.1719(b)(4) and requires an insurer that performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor to have a valid registration pursuant to §19.1704 and to comply with the filing requirements under §19.1704. Under proposed §19.1719(b)(4), the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health coverage for which it is the payor. These proposed amendments are necessary for the Department to obtain additional information about insurers conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight.

Proposed new §19.1719(c) provides that §19.1719 applies to specialty URAs.

Section 19.1720 addresses Specialty Utilization Review Agent. Proposed new §19.1720(a) requires a specialty URA, in order to be certified or registered as a specialty URA, to submit to the Department the application and information required in §19.1704. Proposed §19.1720(b)(1) provides that a specialty URA is subject to the requirements of the Insurance Code Chapter 4201, except as specified in the proposed amendments. Proposed §19.1720(b)(2) provides that a specialty URA is subject to the requirements of Subchapter R, except for those requirements related to the statutes referenced in §19.1720(b)(1), including: §§19.1705(a); 19.1706(a), (d), (e), and (g); 19.1711(b) and (c); and 19.1712(a)(2)(D) and (E) and (b)(3). These amendments in §19.1720(b)(1) and (2) are consistent with the Insurance Code §4201.452, which provides that a specialty URA is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Proposed §19.1720(c) specifies requirements relating to the specialty URA's utilization review plan. These requirements are consistent with the Insurance Code §4201.453, which provides that a specialty URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Proposed new §19.1720(d) addresses requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Proposed §19.1720(d)(1) adds "physicians, doctors, and other health care providers" to existing §19.1720(f) to clarify that those individuals and entities employed by or under contract with the specialty URA must also be appropriately trained, qualified, and currently licensed. The phrase "if applicable," is proposed for deletion to clarify that the licenses of these individuals and entities should always be current.

Proposed new §19.1720(d)(2) requires personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by the Texas Medical Board or be otherwise authorized to provide health care services by a licensing agency in the United States. This requirement is based on an Advisory Committee recommendation and is necessary to ensure that all such personnel are appropriately trained and qualified to conduct specialty utilization review.

A new requirement is proposed in new §19.1720(e), relating to information required to be filed with the Department. Proposed new §19.1720(e) requires the specialty URA to provide the name, number, type, license number, and state of licensure and qualifications of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information. This requirement is necessary to enable the Department to monitor and ensure that appropriate personnel are conducting utilization review, which should result in a higher quality of utilization review for the enrollee. The Department has authority to require this information under the Insurance Code §4201.104, which requires the Commissioner to promulgate forms to be filed for a URA's initial certification and renewal certification. Additionally, the Insurance Code §4201.107 requires the URA to report to the Department any material changes to information disclosed in the application form.

Proposed new §19.1720(f) requires the specialty URA to: (i) develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced; and (ii) to maintain documentation demonstrating that physicians, doctors, and other health care providers that

are utilized to perform utilization review are licensed, qualified, and appropriately trained or experienced. The requirements are necessary to create a written record that the URA can provide to the Department upon request to enable the Department to determine whether the physicians, doctors, or other health care providers are licensed, qualified, and appropriately trained or experienced. The requirements should ultimately result in a higher quality of utilization review for the enrollee. These requirements are consistent with the Insurance Code §4201.454, which requires personnel who are employed by or under contract with a specialty URA to perform utilization review to be appropriately trained and qualified.

A proposed amendment to §19.1720(g) clarifies that the physician, doctor, or health care provider may be employed by or under contract to the specialty URA. This proposed amendment is necessary to avoid any ambiguity or misunderstanding regarding the type of business relationship that the URA may have with the directing physician, doctor, or other health care provider.

A new requirement is proposed in new §19.1720(h)(1)(B) to require that a discussion under subsection (h) prior to the issuance of an adverse determination include the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision required under subsection (h)(1)(A), as deemed necessary by the URA and/or provider of record. This requirement is consistent with the Insurance Code §4201.456, which provides that subject to the notice requirement of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA is required to provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the enrollee's treatment plan and the clinical basis for the agent's determination with a health care provider who is of the same specialty as the agent.

A new requirement in proposed new §19.1720(h)(1)(C) provides that when the specialty URA provides the reasonable opportunity required under §19.1720(h)(1)(A), the specialty URA must include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. This requirement is necessary to provide the provider of record with the necessary information in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA.

A new requirement is proposed in new §19.1720(h)(1)(D) to require the specialty URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.1720(h)(1)(E) requires the specialty URA to submit the subsection (h)(1)(D) documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

Proposed new §19.1720(h)(2)(A) requires a specialty URA, before issuing a retrospective review adverse determination, to provide the provider of record a reasonable opportunity to discuss the treatment provided to the enrollee with a health care provider of the same specialty as the URA. Proposed new §19.1720(h)(2)(B) requires the discussion to include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision as deemed necessary by the URA and/or provider of record.

New §19.1720(h)(2)(C) proposes new requirements that the reasonable opportunity required under §19.1720(h)(2)(A) include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. Under the proposed requirements, the specialty URA must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.1711, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

Proposed new §19.1720(h)(2)(D) requires that the specialty URA maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.1720(h)(2)(E) requires that the specialty URA submit the §19.1720(h)(2)(D) documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions. Both of these requirements are necessary to ensure that the proper consumer protection is afforded to enrollees who are using specialty URAs for utilization review.

The portion of existing §19.1720(i), relating to the requirement that the specialty review must be completed within 15 working days of receipt of the request, is proposed for deletion. This existing requirement mirrored the requirement under the Insurance Code §4201.356(b), which provided a process for requesting a particular type of specialty provider to review a case and required the specialty review to be completed within 15 working days. However, under the Insurance Code §4201.452, the Insurance Code §4201.356 does not apply to specialty URAs. The Insurance Code §4201.457 governs the appeal decisions

for specialty URAs. Therefore, the 15 working day requirement is not statutorily required and is proposed for deletion.

Section 19.1721 addresses Independent Review of Adverse Determinations. Existing §19.1721(a), (b), and (c) are re-formatted under a single subsection (a), relating to life-threatening conditions, with both proposed substantive and nonsubstantive amendments. Newly designated §19.1721(a)(1) addresses notification for life-threatening conditions. Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1721(a)(1)(A), which is in existing §19.1721(a); an amendment is also proposed to clarify that the notification of adverse determination subject to the time frames discussed in §19.1721(a)(1)(A) relate to notice of determinations made in *prospective and concurrent* utilization review.

Nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to newly designated §19.1721(a)(1)(B), which is also part of existing §19.1721(a). Also, an amendment is proposed to §19.1721(a)(1)(B) to add a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process and a copy of Form No. LHL009. This requirement is necessary to inform the enrollee of the process for independent review of the adverse determination in the event of life-threatening conditions. The provision of the copy of Form No. LHL009 will inform the enrollee of his or her additional options following an adverse determination and enable the enrollee to more quickly and efficiently request independent review.

Existing §19.1721(b) is proposed to be redesignated as §19.1721(a)(1)(C). Nonsubstantive editorial revisions are proposed to be redesignated §19.1721(a)(1)(C), which retains the existing §19.1721(b) prudent layperson standard for determining the existence of a life-threatening condition.

An amendment is proposed to §19.1721(a)(2) to clarify that a party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA is entitled to review of that determination or denial by an IRO. This provision is necessary to implement the Insurance Code §4201.360, which provides that notwithstanding any other law, in a circumstance involving an enrollee's life-threatening condition, the enrollee is: (i) entitled to an immediate appeal to an IRO as provided by Subchapter I of Chapter 4201; and (ii) not required to comply with procedures for an internal review of the URA's adverse determination.

Proposed deletions of existing §19.1721(c)(1) - (3) are necessary because the requirements to provide a notification of the independent review process, a copy of the Form No. LHL009, and a description of how to obtain independent review are moved to proposed §19.1721(a)(1)(B).

Existing §19.1721(d), (e), and (g) - (h) are redesignated as §19.1721(b)(1) - (5), relating to independent review involving life-threatening and non-life threatening conditions. Proposed §19.1721(b)(1) addresses the request for independent review. Proposed §19.1721(b)(1)(A) proposes an amendment to existing subsection (d) to require the URA to notify the Department within one working day from the date the request for an independent review is received. The existing requirement in §19.1721(d) is that the notification be made by the URA "upon receipt of the request." The proposed amendment will allow the URA additional time, as well as a reasonable amount of time, to notify the Department. A "working day" is defined by §19.1703(48). The Department has determined that this additional time is necessary to avoid impractical deadlines in situations such as when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Proposed §19.1721(b)(1)(B), which is part of existing §19.1721(e) with proposed amendments, requires the URA to provide the Department the completed Form No. LHL009 that is submitted to the URA by the party requesting independent review. The submission of this completed form is in lieu of the requirement in existing §19.1721(e) that the URA provide to the Department the "information contained in the form prescribed by the commissioner. . . ." This requirement is necessary to clarify that while the same information is required to be provided as in the existing rule, the information must be provided in a copy of the completed Form No. LHL009 itself. This should result in greater efficiency and less time for the URA and in quicker response time for the enrollee who is requesting the independent review. Proposed §19.1721(b)(1)(C) which is also part of existing §19.1721(e), requires the URA to submit the completed Form No. LHL009 via the Department's Internet website. This amendment is necessary to update the existing requirement that the information be submitted via modem or, in the event that the modem is unavailable, through facsimile.

Existing §19.1721(f) is proposed for deletion because the provision that the URA may access the Department on working days between 7:00 a.m. and 6:00 p.m. Central Time, Monday through Friday, is no longer accurate. This proposed amendment is necessary because Department staff is not available during all of those hours.

Existing §19.1721(g) is redesignated as §19.1721(b)(2), relating to the assignment of the independent review by the Department. The existing requirement that the Department must, within one working day of receipt of the request for independent review, randomly assign an IRO and notify the URA, IRO, the enrollee or individual acting on behalf of the enrollee, and the enrollee's provider of record is retained in the proposal with two proposed amendments in addition to nonsubstantive editorial revisions, which are discussed in the early part of this Introduction. The two proposed amendments add the "payor" and "any other providers listed by the URA as having records relevant to the review of the assignment" to those who must be notified by the Department. Existing §19.1721(h)(1) - (5) is redesignated as §19.1721(b)(3)(A) - (E), relating to the information required to be provided to the assigned IRO. Proposed §19.1721(b)(3) includes requirements that information in the possession of the health benefit plan be provided to the assigned IRO. No other substantive amendments are proposed to §19.1721(b)(3)(A) - (E); however, nonsubstantive editorial revisions, which are discussed in the early part of this Introduction, are proposed to these provisions.

Existing §19.1721(i) is redesignated as §19.1721(b)(4). An amendment is proposed to §19.1721(b)(4), relating to payor and URA compliance, to change the existing requirement that the URA must comply with the IRO's determination to provide that *the payor and* URA must comply with the IRO's determination. This amendment is necessary to require that all relevant parties are required to comply with the IRO's determination.

Existing §19.1721(j) and (k) are redesignated as §19.1721(b)(5)(A) and (B), relating to payment and recovery of costs for the independent review. Nonsubstantive editorial revi-

sions, which are discussed in the early part of this Introduction, are proposed to the redesignated §19.1721(b)(5)(A) and (B).

In conjunction with this proposal, existing §19.1722, concerning the utilization review advisory committee, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Section 19.1723 addresses Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans. An amendment is proposed to the title of existing §19.1723 to clarify that the section addresses preauthorization for HMOs and preferred provider benefit plans. In addition to proposed nonsubstantive editorial amendments throughout §19.1723, other amendments are proposed to existing §19.1723(b), (f)(2), and (d)(2), and a new subsection (k) is proposed. In existing §19.1723(b) and (f)(2), the term "business day" is changed to "working day." These changes are necessary for consistency with the defined term in §19.1703(49) and with other rule provisions that contain the "working day" requirement. An amendment is proposed to §19.1723(d)(2) to add a new requirement that the initial determination by an HMO or preferred provider benefit plan indicating whether proposed services are preauthorized within 24 hours of receipt of the request must be followed, within three working days, by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. This requirement is necessary to ensure that prompt written documentation of the adverse determination is provided to the relevant parties. Proposed new §19.1723(k) provides that §19.1723 applies to specialty URAs.

Section 19.1724 addresses Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans. An amendment is proposed to the title of existing §19.1724 to clarify that the section addresses verification for HMOs and preferred provider benefit plans. In addition to proposed nonsubstantive editorial amendments throughout §19.1724, other amendments are proposed to existing §19.1724(d), and a new subsection (n) is proposed. In existing §19.1724(d)(2), the term "business day" is changed to "working day." This change is necessary for consistency with the defined term in §19.1703(49) and with other rule provisions that contain the "working day" requirement. Proposed new §19.1723(n) provides that §19.1724 applies to specialty URAs.

Subchapter U amendments and new sections.

Section 19.2001 addresses General Provisions. The proposed amendment to §19.2001(a) is necessary to change the existing provision relating to the statutory basis for the rules in Subchapter U to reflect that the new subchapter incorporates the most recent amendments to Chapter 4201 of the Insurance Code and the most recent statutory provisions under the Insurance Code Chapter 1305 and the Labor Code Title 5. The proposed amendment to §19.2001(b) amends the severability clause language to conform to current agency style. The addition of the phrase "concerned before expenses are incurred" in §19.2001(c)(4) is a clarifying change.

Proposed new §19.2001(d) provides that Subchapter R of 28 TAC Chapter 19 applies to utilization review performed under a health benefit plan or health insurance policy.

Section 19.2002 addresses Limitations on Applicability. Proposed §19.2002(a) specifies the applicability of Subchapter U to utilization review performed under workers' compensation insurance coverage, except as provided in the Insurance Code Chapter 4201.

An amendment is proposed to add new §19.2002(b) to provide that health care providers performing peer reviews regarding the prospective, concurrent or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and requires such health care providers to comply with this subchapter, the Labor Code Title 5, and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to, 28 TAC Chapter 180 (relating to Monitoring and Enforcement). This new provision is needed for clarification that peer review can be a type of utilization review. Pursuant to the Insurance Code §4201.054(c), this new subsection further provides that if there is a conflict between Subchapter U and rules adopted by the Commissioner of Workers' Compensation, the rules adopted by the Commissioner of Workers' Compensation prevail. These required amendments are consistent with the Insurance Code §4201.054(a), which provides that except as provided by §4201.054, 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. Additionally, the Insurance Code §4201.054(c) provides that Title 5 of the Labor Code, prevails in the event of a conflict between Chapter 4201 and Title 5, Labor Code.

Proposed §19.2002(c) provides that Subchapter U does not apply to a person that only provides information to injured employees, their representatives or their physicians, doctors, or other health care providers about scope of coverage or benefits provided under workers' compensation insurance coverage but that does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. The proposed amendments are necessary to track the Insurance Code §4201.051, which provides that Chapter 4201 does not apply to a person who provides information to an enrollee about scope of coverage or benefits provided under a health insurance policy or health benefit plan; and who does not determine whether a particular health care service provided or to be provided to an enrollee is: (a) medically necessary or appropriate; or (b) experimental or investigational.

Section 19.2002(2) is proposed to be deleted because the provision is no longer applicable under the proposed rules; personnel employed by a URA are governed by §19.2006 under the proposed rules. Existing §19.2002(3)(A) - (D) are proposed to be deleted because none of the categories of reviews under existing §19.2002(3) pertain to workers' compensation coverage.

Section 19.2003 addresses Definitions. Proposed new §19.2003(1) adds a definition of an "administrator" because the term is used in the proposed amended rules. This definition is consistent with Subchapter R.

A proposed amendment to the definition of "adverse determination" in §19.2003(2) adds the phrase "made on behalf of any payor." The inclusion of the phrase "made on behalf of any payor" clarifies that the definition includes those payors that conduct utilization review in-house. The change is necessary to reflect the Department's position that the term "adverse determination" includes determinations made on behalf of all payors. Also, an amendment is proposed to the existing definition to clarify that the term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. This proposed amendment is necessary to clarify that adverse determinations do not include denials of health care services due to the injured employee's or health care provider's failure to request

prospective or concurrent utilization review, if such prospective or concurrent utilization review was required. Another amendment is proposed to clarify that for the purposes of Subchapter U, an adverse determination does not include a determination that health care services are experimental or investigational. The reasoned justification for this proposed amendment is discussed in detail in the earlier part of this Introduction under the subheading "HB 4290."

The proposed amendments to the definition of "appeal" in §19.2003(3) are necessary to update the existing definition and to clarify that the term "appeal" used in Subchapter U (i) refers to the URA's formal process in which an injured employee, an injured employee's representative, or the injured employee's provider of record may request reconsideration of an adverse determination; and (ii) also applies to reconsideration processes prescribed by the Labor Code Title 5 and applicable rules for workers' compensation.

The proposed amendments to the definition of "certificate" in §19.2003(4) are necessary to provide a more detailed and accurate definition that reflects that an insurance carrier can be certified or registered, but that a "certificate" is not issued to an insurance carrier that is registered as a URA under §19.2004.

Proposed new §19.2003(8) replaces the term "concurrent review" with the term "concurrent utilization review" which is defined as a form of utilization review that is subject to these proposed rules.

Proposed new §19.2003(11) is necessary to define the term "disqualifying association" to ensure a consistent application in identifying situations in which conflicts of interest may exist for health care providers performing utilization review.

Proposed new §19.2003(13) adds a definition of "experimental or investigational." This definition is consistent with the Labor Code §413.014(a), 28 TAC §134.600, and 28 TAC §12.5(12).

Proposed §19.2003(14)(F) is amended to include "a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device, including the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device," for consistency with the definition of "health care" in the Labor Code §401.011.

The proposed amendments to the definition of "health care provider" in §19.2003(16) update the definition to track the statutory language in the Insurance Code §4201.002(5).

Existing §19.2003(16) is proposed to be deleted because the definition of "injured employee" is not necessary and is arguably ambiguous because in the event that an injured employee's compensability is in dispute, the inclusion of the definition could result in confusion regarding whether that injured employee would be considered an injured employee for the purposes of this definition.

The proposed amendment to delete "inquiry" in §19.2003(17) is necessary because the term "inquiry" is not used in the rule text in the context that the definition contemplates. The term "inquiry" is only used in §19.2016(d), and in that context the term refers to *Department* inquiries, not inquiries that would be considered a request for information or assistance from a URA.

Proposed §19.2003(17) is amended to add "or insurer" to the term "insurance carrier," in order to indicate that the terms have the same meaning for purposes of Subchapter U. An amendment is proposed §19.2003(17)(A) to delete "an insurance company," replacing it with "a person authorized and admitted by the Texas Department of Insurance to do the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance." This language incorporates the definition of an "insurance company," which is defined in existing §19.2003(19) and is proposed for deletion. An amendment is also proposed to §19.2003(17) to include "a certified self-insurance group under Chapter 407A" in the definition. This proposed amendment is consistent with the Labor Code §401.011(27).

Proposed new §19.2003(18) adds the term "legal holiday," which is defined in accordance with the definition of a "national holiday" defined in the Government Code §662.003(a).

Proposed new §19.2003(21) adds a definition of "medical emergency." This definition tracks the Insurance Code §1305.004(13). This definition is necessary to uniformly implement the proposed Subchapter U rules.

The proposed amendment to §19.2003(22) adds "mental health records as allowed by law" to the definition of "medical records." The definition of the term "medical records" is primarily based on the definition in the Insurance Code §1305.004(14), which defines the term "medical records" for purposes of the Workers' Compensation Health Care Network Act. The addition, however, of the phrase "mental health records as allowed by law" to the statutory definition was recommended by the Advisory Committee. This proposed amendment is necessary to include certain mental health records in the implementation of the provisions of the Subchapter U rules relating to "medical records" in order to ensure the availability of mental health records when allowed. This amendment is proposed pursuant to the Commissioner's rulemaking authority under the Insurance Code §4201.003(a) to adopt rules to implement Chapter 4201.

Proposed new §19.2003(23) adds a definition of "mental health medical record summary." This term is defined in the existing Subchapter R rules, and the Advisory Committee recommended adding the definition to the Subchapter U rules for uniformity.

Proposed new §19.2003(24) defines "mental health therapist." This definition mirrors the definition in proposed §19.1703(29) and incorporates the Advisory Committee recommendation to add the qualifier "as appropriate" to indicate that not all of the individuals licensed under subparagraphs (A) - (M) are authorized to diagnose, evaluate, or treat any mental or emotional condition or disorder.

Proposed new §19.2003(25) adds a definition for the term "mental or emotional condition or disorder." This definition mirrors the definition in proposed §19.1703(30) and is added based on a recommendation of the Advisory Committee.

Proposed new §19.2003(27) adds a definition of "payor." This proposed definition provides that a "payor" for purposes of Subchapter U is any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits including workers' compensation benefits to an individual treated by a health care provider in this state under a policy, plan, or contract. This definition is consistent with the Insurance Code §4201.002(10)(C).

Proposed new §19.2003(28) adds a definition of "peer review." This definition, which was recommended by the Advisory Committee, is necessary for uniform implementation of the Subchapter U rules.

The definition of the term "preauthorization" in §19.2003(31) is proposed to be amended: "A form of prospective utilization review by a payor or its utilization review agent of health care services proposed to be provided to an injured employee." This proposed definition clarifies that preauthorization is a form of utilization review and is more consistent with the definition in proposed §19.1703(36).

Proposed new §19.2003(32) adds a definition of "provider of record." This definition mirrors the definition in proposed §19.1703(38) and is necessary to track the Insurance Code §4201.002(12). Section 4201.002(12) defines "provider of record" as the physician or other health care provider with primary responsibility for the care, treatment, and services provided to an enrollee. The term includes a health care facility if treatment is provided on an inpatient or outpatient basis.

Proposed new §19.2003(33) adds a definition of the term "registration." Proposed §19.2019 sets forth the responsibility of an insurer performing utilization review, including the responsibility of those performing utilization review only for coverage for which they are the payor. Insurers performing utilization review only for coverage for which they are the payors are not subject to certification requirements but are instead required to register. The proposed new definition clarifies that the registration process only applies to an insurer that performs utilization review solely for its own insureds or injured employees.

Proposed amendments to the existing definition of "retrospective review" in redesignated §19.2003(34) change the defined term to "retrospective utilization review" and incorporate the term "utilization review" into the definition, thereby removing the need to refer to "medically reasonable and necessary" because the concept is included in the definition of the term "utilization review." The proposed addition of the sentence "Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted" is necessary to clarify that health care services which require preauthorization are not subject to retrospective review.

Proposed §19.2003(35) amends the definition of "screening criteria" to provide a general definition of "screening criteria" and for more consistency with the definition of "screening criteria" in §19.1703(42). Proposed new §19.2003(36) adds a definition of "specialty utilization review agent." This definition is consistent with the Insurance Code §4201.451.

The proposed amendments to the definition of the term "utilization review" in §19.2003(40) add the term "retrospective review" and the phrase "a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services" to the definition. The additions are necessary to implement HB 4290. The change from "preauthorization" to "prospective" is necessary for consistency of terminology in Subchapters R and U.

The amendments to proposed §19.2003(40) defining "utilization review agent," are necessary for consistency with the definition in §19.1703(46). These amendments are also consistent with the Insurance Code §4201.002(14).

Proposed new §19.2003(43) adds a definition of "workers' compensation health care network." This definition is consistent with the Insurance Code §1305.004(16).

Proposed §19.2003(44) amends the definition of "workers' compensation insurance coverage" to be the same as defined in the Labor Code §401.011.

Proposed new §19.2003(45) adds a definition for "workers' compensation network coverage." Proposed new §19.2003(46) adds a definition for "workers' compensation non-network coverage."

The proposed amendments to the definition of "working day" in §19.2003(47) are necessary to update the definition to clarify "legal" holidays are as defined by the Government Code §662.003(a) and to provide consistency with 28 TAC §102.3, relating to computation of time under the general provisions of TDI-DWC. Under 28 TAC §102.3(b), use of the term "day," rather than "working day," means a calendar day.

Section 19.2004 addresses Certification or Registration of Utilization Review Agents. Proposed new §19.2004(a), which is added to implement the Insurance Code §4201.101, provides that a person acting as or holding itself out as a URA must be certified or registered under the Insurance Code Chapter 4201 and 28 TAC Chapter 19, Subchapter U and must comply with all requirements in §19.2004. Section 4201.101 provides that a URA may not conduct utilization review unless the Commissioner issues a certificate of registration to the agent in accordance with Subchapter C of Chapter 4201.

Proposed new §19.2004(a)(1) and (2) add new provisions and are necessary to address certification and registration requirements for insurance carriers. Proposed new §19.2004(a)(1) provides that, pursuant to §19.2019(b), if an insurance carrier performs utilization review for an individual or entity subject to 28 TAC Chapter 19, Subchapter U, such insurance carrier must have a valid certificate pursuant to the Insurance Code §4201.101 and §19.2004. This provision is consistent with the Insurance Code §4201.058(c).

Proposed new §19.2004(a)(2) provides that, pursuant to §19.2019(c), if an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must have a valid registration pursuant to §19.2004.

Proposed new §19.2004(b) is entitled "Application Filing Requirements." Proposed new paragraph (1) in §19.2004(b) addresses requirements relating to the application for certification. Paragraph (1)(A) provides that an application for certification of a URA must include Form No. LHL005. Paragraph (1)(B) provides that an application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19).

Proposed new paragraph (2) in §19.2004(b) addresses requirements relating to the application for registration. Paragraph (2)(A) provides that an application for registration of a URA must include Form No. LHL005, which is adopted by reference in §19.1704(b). Paragraph (2)(B) provides that the fee requirement specified by §19.802(b)(19) does not apply to an applicant for registration. These provisions are consistent with proposed §19.2019(c).

Proposed new paragraph (3) in §19.2004(b) provides information on where to obtain and file the application form.

The proposed amendments to §19.2004(c) reorganize the provisions relating to the information that is required in Form No. LHL005 and impose additional requirements in proposed new §19.2004(c)(2) - (6) pursuant to the Commissioner's authority to promulgate forms under the Insurance Code §4201.104. Additionally, the proposed amendment to §19.2004(c)(1)(A) adds "or

appropriate, or experimental or investigational in nature" to the requirement that the completed application include an adequate summary description of screening criteria and review procedures to be used to determine medical necessity of health care. The addition of "or appropriate" is necessary for consistency with the definition of "adverse determination" in §19.2003(2). The addition of "or experimental or investigational in nature" is necessary to implement HB 4290.

Proposed new §19.2004(c)(2)(A) - (O) require the written policies of the utilization review plan to evidence compliance with the specified list of Subchapter U rules.

Proposed new §19.2004(c)(2)(A) requires Form No. LHL005 to include utilization review plan written policies that evidence compliance with §19.2005. Proposed new §19.2004(c)(2)(L) requires Form No. LHL005 to include utilization review plan written policies that evidence compliance with §19.2016.

Proposed new §19.2004(c)(3) requires utilization review plan written policies which attest that peer reviews will comply with the Texas Workers' Compensation Act and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to 28 TAC Chapter 133, Subchapter D; 28 TAC Chapter 134, Subchapter G; 28 TAC Chapter 137; and 28 TAC Chapter 180, Subchapter B. These requirements reference other statutes and rules with which compliance is also necessary.

Proposed new §19.2004(c)(4) adds a new requirement that the application form must include copies of template letters for notification of determinations made in utilization review that comply with §19.2010 and §19.2012. This new requirement is necessary to enable the Department to monitor each URA's compliance with the §19.2010 and §19.2012 requirements and to assist the URA in coming into compliance with the requirements or to take enforcement action as deemed necessary.

Proposed new §19.2004(c)(5) specifies three items of organizational information that must be included with the Form No. LHL005. Proposed new §19.2004(c)(5)(A) adds a new requirement that the application form must include written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state.

Proposed new §19.2004(c)(5)(B) is proposed to require a chart showing the organizational structure of the applicant's executives, officers, and directors, replacing the existing requirement in §19.2004(c)(11)(C) that the applicant provide a chart showing the internal organization structure of the applicant's management and administrative staff. This change is necessary to require the URA to provide organizational structure information that is consistent with the proposed new §19.2004(c)(6) requirement that the URA provide fingerprints for its executives, officers, and directors.

Proposed new §19.2004(c)(5)(C) adds a new requirement that the URA application form include a letter of good standing from the Texas Comptroller of Public Accounts. This change is necessary for the Department to verify that the applicant is not delinquent in its state taxes.

Proposed new §19.2004(c)(6) adds a new requirement that the application form include the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement). This change is necessary because, in accordance with 28 TAC §1.502(c) and (e), the Department has developed guidelines relating to the matters which the Department will consider in determining whether to grant, deny, suspend, or revoke any license or authorization under its jurisdiction, which include criminal background checks for each director, officer, and executive of the applicant.

Existing §19.2004(c)(9) is proposed for deletion because TDI-DWC has determined that in lieu of that requirement, the §19.2004(c)(2)(B) requirement that the written policies in the utilization review plan to evidence compliance with §19.2006 is sufficient. The requirements of §19.2006 are discussed later in this Introduction.

Existing subsection (c)(10) is proposed for deletion because the requirement is no longer needed. The TDI-DWC has determined that in lieu of that requirement, the prohibitions in §19.2006(b) and the requirement in §19.2004(c)(7) that the URA certify in the application Form No. LHL005 that it is compliant with TDI-DWC rules are sufficient.

Existing §19.2004(c)(11)(A) - (D), relating to URA organizational information, documents, and amendments, are proposed for deletion. These requirements are proposed for deletion because the URA would already have filed the appropriate paperwork to conduct business in Texas with the Secretary of State, and is required to provide evidence of the filings to the Department in accordance with proposed new §19.2004(c)(5)(a). The Department has determined that the new requirement relating to the filing of biographical affidavits and complete sets of fingerprints of the executives, officers, and directors of the URA under these rules is sufficient and that similar requirements are proposed in new §19.2004(c)(5).

Existing §19.2004(c)(11)(D), is proposed for deletion because proposed new §19.2004(c)(2)(B) requires the application to include utilization review plan written policies that evidence compliance with §19.2006 and the Department has determined that the information required by proposed §19.2006 is sufficient to determine the URA's contractual arrangements.

Both substantive and nonsubstantive amendments are proposed to §19.2004(d)(1) - (4). The amendments to §19.2004(d)(1) - (4) propose changes to the application process pursuant to the Commissioner's general rulemaking authority under the Insurance Code §4201.003(a).

A proposed amendment to §19.2004(d)(1) adds the phrase "a complete" to modify "application" to clarify that the 60 day time period does not begin until after the application is complete. Another proposed amendment to subsection (d)(1) clarifies that the Department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered.

An amendment is proposed to §19.2004(d)(2) to change the number of days that an applicant has to correct any omissions or deficiencies in the application from 30 days to 15 working days of the date of the Department's latest notice of the omissions or deficiencies. This proposed reduction in time to correct the omissions or deficiencies is necessary to streamline the application process and to provide the Department with information more quickly. This shorter time period will allow a more efficient application process, thereby making more URAs more quickly available to the Texas consumer.

Amendments are proposed to §19.2004(d)(3) to provide that before the end of the 15 working days specified in paragraph (d)(2), the applicant may request in writing additional time to correct the omissions or deficiencies in the application. Under the proposed amendments, the request for the additional time must be approved by the Department in writing for the requested extension to be effective.

Amendments are proposed to §19.2004(d)(4) to rename what is now called an "application file" a "charter file." This file must be maintained by the Department. Under the proposed amendments, the file must contain approved application documents and requests for additional time and responses from the applicant. These documents are in addition to the documents relating to notices of omissions or deficiencies that are required to be maintained under the existing rule. Also, under the proposed amendments, the requirement that the charter file contain documents relating to "any written materials generated by any person that was considered by the Department in evaluating the application" is proposed to be deleted. This proposed deletion is necessary because it is overly broad, requiring retention of documents that will not be useful for future reference.

Proposed new §19.2004(e) states that paragraphs (1) - (4) of the subsection specify the requirements for entities that are renewing a certification or registration.

Proposed amendments to §19.2004(e)(1), relating to two-year renewal, clarify the requirements for the renewal process. The Insurance Code §4201.103 provides that certification may be renewed biennially by filing, not later than March 1, a renewal form with the Commissioner accompanied by a fee in an amount set by the Commissioner. The Insurance Code §4201.104(a) authorizes the Commissioner to promulgate forms to be filed for a renewal certificate of registration. Proposed amendments to §19.2004(e)(2), relating to continued operation of the URA during Department review, provides that if a URA has filed the required information specified in subsection (e) and submitted the fee required only for certification renewal with the Department on or before the expiration of the certification or registration, the URA may continue to operate under its certification or registration until the renewal certification or registration is finally denied or issued by the Department. Proposed new §19.2004(e)(3) specifies the requirements for renewal if the certification or registration has been expired for 90 days or less. Under proposed new §19.2004(e)(3), the URA may renew the certification or registration by filing a completed renewal application, submitting the fee as applicable for certification renewal, and providing the required information described in subsection (e). Proposed §19.2004(e)(3) prohibits the URA from operating from the time the certification or registration has expired until the time the Department has issued a renewal certification or registration. Proposed new §19.2004(e)(4) specifies the requirements if the certification or registration has been expired for longer than 90 days. Under proposed §19.2004(e)(4), the URA may not renew the certification or registration, but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accordance with §19.2004. Under proposed §19.2004(e)(4), §19.2004(d), relating to original application requirements and process, applies to applications made under paragraph (4).

The proposed deletion of existing §19.2004(i), relating to requirements for filing of changes in original applications of URAs that received their certificates prior to the 1998 effective date of Subchapter U, is necessary because the requirement is obsolete.

The proposed deletion of existing §19.2004(j), relating to the requirement for a single application and fee payment for one certification to cover all lines of utilization review business, is necessary because the requirement is obsolete.

Section 19.2005 addresses General Standards of Utilization Review. The proposed amendments to §19.2005(a) require that the utilization review plan be approved by the physician, periodically updated, and include input from both primary and specialty physicians, doctors, or other health care providers, in accordance with the Insurance Code §4201.151. The proposed deletion of the components listed in existing §19.2005(1) - (3) that must be included in the utilization review plan is necessary because the Department proposes updated required components in subsections (b) - (g) of §19.2005 or the components are otherwise incorporated into other sections of Subchapter U, and the retention of the provisions would therefore be repetitive.

Proposed new §19.2005(b) adds a statutorily required general standard of utilization review relating to special circumstances. It requires the utilization review determination to take into account special circumstances of each case that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. This requirement is consistent with the Insurance Code §4201.153, which requires that utilization review determinations be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria. Proposed new §19.2005(b) also provides that for purposes of §19.2005, disability must not be construed to mean an injured employee who is off work or receiving income benefits. This provision is included to further clarify the scope of special circumstances.

Proposed new §19.2005(c) adds a statutorily required prohibition related to performance tracking data. This provision is consistent with the Insurance Code §4201.556(a), which prohibits a URA from publishing data that identifies a particular physician or other health care provider, including data in a quality review study or performance tracking data, without providing prior written notice to the physician or other provider.

Proposed new §19.2005(d) adds statutorily required screening criteria provisions. It describes the requirements for screening criteria, requiring that they be evidence-based, scientifically valid, outcome focused, and that they comply with the Insurance Code §4201.153. The Insurance Code §4201.153(a) - (c) require: (a) that a URA use written medically acceptable screening criteria and review procedures that are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, dentists, and other health care providers; (b) that a utilization review determination be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of the case that may require deviation from the norm stated in the screening criteria; and (c) that screening criteria be: (1) objective; (2) clinically valid; (3) compatible with established principles of health care; and (4) flexible enough to allow a deviation from the norm when justified on a case-by-case basis.

Additionally, proposed new §19.2005(d) requires that screening criteria recognize that if evidence-based medicine is not avail-

able for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. This provision recognizes that evidence-based medicine will not always be available. This provision is necessary to incorporate requirements of §401.011(22-a) of the Labor Code. The Insurance Code §4201.054(c) states that Title 5 of the Labor Code prevails in the event of a conflict between Chapter 4201 of the Insurance Code and Title 5 of the Labor Code.

Proposed new §19.2005(e) adds a provision related to referral and determination of adverse determinations. It requires that adverse determinations be referred to an appropriate physician or doctor.

Proposed new §19.2005(e) also requires that physicians and doctors performing utilization review be in compliance with the Labor Code §§408.0043, 408.0044, and 408.0045. References to these Labor Code provisions are necessary to ensure that physicians and doctors meet these professional certification requirements for conducting utilization review.

Proposed new §19.2005(g) adds statutorily required provisions related to the URA's complaint system. It requires the URA to develop and implement procedures for the resolution of oral or written complaints concerning utilization review. These requirements are consistent with the Insurance Code §4201.204. Additionally, proposed §19.2005(g) adds a new requirement that the written response include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. This information is necessary to inform the consumer that he or she has the right to file a complaint with the Department after the issuance of an adverse determination by the URA, and the process by which the consumer may speak to a Department representative regarding his or her complaint to the URA.

Proposed new §19.2005(h) provides that §19.2005 applies to a specialty URA except for subsection (a), relating to utilization review plan requirements. While a specialty URA is required to have a utilization review plan pursuant to §19.2020(c) the specialty URA is exempt from the requirements that the utilization review plan be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other health care providers, including practicing health care providers. The reason that the specialty URAs are not subject to these requirements is that these requirements are based on the Insurance Code §4201.151, and pursuant to the Insurance Code §4201.452, specialty URAs are not subject to §4201.151. Specialty URAs are required, pursuant to §19.2020(c), to use only a health care provider of the appropriate specialty. Under the Insurance Code §4201.453 and §19.2020, a specialty URA must have the utilization review plan reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Section 19.2006 addresses Requirements and Prohibitions Relating to Personnel. A proposed amendment to §19.2006(a)(1) replaces the term "Personnel" with "Physicians, doctors, and other health care providers" to clarify to whom this section applies. A new requirement is added in proposed new §19.2006(a)(2) to require personnel conducting utilization review to hold an unrestricted license or administrative license in Texas or be otherwise authorized to provide health care by a licensing agency in Texas. This new requirement in §19.2006(a)(2) was unanimously recommended by the Advisory Committee and is consistent with the provisions of the Insurance Code §1305.351 and the Labor Code §408.023(h).

A new prohibition is proposed in new §19.2006(c), relating to disqualifying associations. Proposed new §19.2006(c) prohibits a physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal. The subsection also clarifies that being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. However, just because two physicians or doctors employed by or under contract with the same URA are not disqualified for that reason does not mean there may not be another disqualifying relationship between them. Proposed new §19.2003(11) defines "disqualifying association." Both §19.2003(11) and §19.2006(c) are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of the proposed new prohibition is to prevent the physician who reviews the appeal from being improperly influenced based on a relationship that he or she has with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal.

Proposed amendments to §19.2006(d) clarify that the personnel information is to be provided to the Department upon filing an original application or renewal application or upon providing updated information and add a requirement that the URA file with the Department the Texas license number of the personnel either employed by or under contract to perform the utilization review, in addition to the information that is currently required. The second sentence in existing §19.2006(c) requires URAs to adopt written procedures to determine if doctors or other health care providers utilized by the URA are licensed, qualified, and appropriately trained or experienced, and to maintain records on such.

Proposed amendments to §19.2006(e) delete the existing requirement that a URA that uses doctors to perform reviews of health care services provided under a workers' compensation policy may use doctors licensed by another state. This amendment is necessary to implement the Insurance Code §1305.351 and the Labor Code §408.023(h), which were amended by HB 1006, 80th Legislature, Regular Session, effective September 1, 2007, to provide that only doctors licensed to practice in this state may be used for utilization review.

Existing §19.2006(e), which requires utilization review dental plans to be reviewed by a dentist currently licensed by a state licensing agency in the United States, is proposed to be deleted to avoid redundancy. Review of dental plans are governed by §19.2020(c), relating to specialty URAs.

Proposed new §19.2006(g) provides that §19.2006 applies to specialty URAs, except subsections (a), (d), (e) and (f). Specialty URA requirements relating to employed or contracted physicians, doctors, other health care providers, and personnel; information required to be filed with the Department; the URA's written procedures and maintenance of records; and the conducting of a utilization review under the direction of a physician, do not apply to specialty URAs because these specialty URA requirements are in proposed new §19.2020.

Section 19.2007 addresses Prohibition of Certain Activities and Procedures Related to Health Care Providers and Injured Employees. Amendments are proposed to §19.2007(a) to require

the URA to alternatively base the frequency of contacts or reviews on "the need for medical documentation to support the necessity of the treatment requested or rendered" in lieu of the existing alternative basis of "necessary treatment and return to work planning activity." This proposed amendment was recommended by the Advisory Committee and is necessary to facilitate communication between the URA and the health care provider and avoid undue influences.

Proposed new §19.2007(c) is necessary to provide that §19.2007 applies to a specialty URA.

Section 19.2008 addresses Utilization Review Agent Contact with and Receipt of Information from Health Care Providers. The proposed amendments to §19.2008(a) are nonsubstantive. The first proposed amendment to existing §19.2008(c) require the URA, when conducting utilization review, to request "all relevant and updated medical records" in order to complete the review. This proposed amendment is necessary to ensure that the URA utilizes the most recent and complete information possible to review the injured employee's treatment. While the treatment may vary on a case-by-case basis, the Department has determined that this proposed amendment will enable the most effective review to be conducted.

Proposed amendments to §19.2008(c) also provides that the information required may include identifying information about the claim and about the treating physician, doctor, or other health care provider. This information is necessary to clarify the scope of medical records that the URA may request to ensure that the URA has all relevant and updated medical records in order to complete the review. Proposed amendments add "diagnostic testing" to the type of information that the URA may request under §19.2008(c). This additional information is necessary to assist the URA in making an informed determination.

The proposed amendments to §19.2008(f) add the modifying phrase "that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder" to clarify that the mental health therapist's process or progress notes are the subject of the prohibition. The proposed amendments also add a new provision to provide that the prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes.

Amendments are proposed to subsection (f)(1), to provide that this prohibition does not preclude the URA from requiring submission of an injured employee's mental health medical record summary. Proposed new subsection (f)(2) provides that the prohibition does not preclude the URA from requiring submission of medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder. These amendments are necessary for purposes of clarification, ease of compliance, and consistency with §19.1708(f) in Subchapter R and were recommended by the Advisory Committee. The consistency between the Subchapter R and Subchapter U rule amendments is necessary because the rules are based on the same underlying statute. The Insurance Code §4201.203 provides that (i) a URA may not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes; and (ii) notwithstanding the Insurance Code §4201.203, a URA may require submission of a patient's medical record summary.

Proposed new §19.2008(g) is necessary to provide that §19.2008 applies to a specialty URA.

Section 19.2009 addresses On-Site Review by the Utilization Review Agent. In addition to the proposed amendments for purposes of internal consistency of terminology and clarification, an amendment is proposed to §19.2009(c)(1)(A) and (B) and (2), relating to on-site review at a health care facility, change the references from hospital to a "health care facility." The broader term "health care facility," which includes a hospital, emergency clinic, outpatient clinic, or other facility providing health care, is necessary for purposes of clarification and accuracy.

Proposed new §19.2009(d) provides that §19.2009 applies to a specialty URA.

Section 19.2010 addresses Notice of Determinations Made in Prospective and Concurrent Utilization Review. An amendment is proposed to the title of existing §19.2010, "Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review," to clarify that the section regulates the notice of determinations in prospective and concurrent utilization review. Clarifying amendments are proposed to existing §19.2010(a), relating to notification of a determination made in a utilization review, including the addition of new subsection (a)(1) - (2).

Proposed new §19.2010(a)(1) sets forth time frames required for sending written notification of a favorable or adverse determination to individuals with workers' compensation non-network coverage, and proposed new §19.2010(a)(2) specifies the time frames for individuals with workers' compensation network coverage. The proposed time frames are the same as those in 28 TAC §134.600 for workers' compensation non-network coverage and the Insurance Code §1305.353 and 28 TAC §10.102, for workers' compensation network coverage.

Proposed new §19.2010(b) addresses notification requirements that pertain only to favorable determinations. Proposed new §19.2010(b)(1) provides that the written notification for favorable determinations must be mailed or electronically transmitted within certain time frames. Proposed new §19.2010(b)(1)(A) specifies that the notification of favorable determinations for workers' compensation non-network coverage must be provided within the time frames in 28 TAC §134.600. Proposed new §19.2010(b)(1)(B) specifies that such notifications for workers' compensation network coverage must be provided within the time frames in the Insurance Code §1305.353 and 28 TAC §10.102.

Proposed new §19.2010(b)(2) adds a new requirement that the URA must ensure that preauthorization numbers assigned by the URA comply with the data and format requirements contained in the standards adopted by the Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction, based on the type of service in the preauthorization request. These standards currently apply under federal law to health insurers and therefore already apply to health insurers conducting utilization review. For consistency among all URAs, the Department has determined that it is necessary to require preauthorization numbers issued by all URAs to comply with the federal data and format requirements. This requirement is necessary to ensure the use of the same preauthorization numbering systems for ease of use by URAs and providers. The requirement was also added for consistency with newly adopted TDI-DWC rules in Chapter 133 Subchap-

ter G, relating to Electronic Medical Billing, Reimbursement, and Documentation.

Some of the notice elements required in §19.2010(c)(1) are required by the Insurance Code §4201.303(a). These requirements, which are listed in §19.2010(c)(1)(A)(i), (ii), (vi), (vii), and (ix); (B); and (C) include: (i) the principal reasons for the adverse determination; (ii) the clinical basis for the adverse determination; (iii) a description of or the source of the screening criteria used as guidelines in making the adverse determination; and (iv) a description of the procedure for the complaint and appeal process, including notice to the injured employee of the injured employee's right to appeal an adverse determination to an IRO and of the procedures to obtain that review.

The proposed amendments to add new notice requirements in §19.2010(c)(1)(A)(iii), (v), and (viii), include: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and Texas licensure of the physician or doctor who made the adverse determination; and (iii) the date and time the URA offered the opportunity to discuss the adverse determination. The Department has determined that these additional notice elements are necessary for the injured employee and the provider of record in the event that the adverse determination is appealed.

The new required notice element in §19.2010(c)(1)(A)(iii), relating to documentation or evidence that can be submitted upon appeal of the adverse determination that might lead to a different utilization review decision, is important for the injured employee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and Texas license number of the physician or doctor who made the adverse determination required in proposed new §19.2010(c)(1)(A)(v), is necessary for the injured employee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the injured employee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal of the adverse determination is filed.

Consistent with the Insurance Code §4201.303(a), the requirements in proposed new §19.2010(c)(1)(A)(vii) and (ix), regarding the provision of information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the injured employee of his or her additional options following an adverse determination. The information is necessary to inform the provider of record of the procedures involved in appealing the adverse determination and the kind of information that is needed for submission to the URA on behalf of the injured employee for the appeal of an adverse determination.

Also necessary for ensuring that an injured employee who is appealing an adverse determination is well informed is the information required in proposed new §19.2010(c)(1)(A)(viii) regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination. This information is useful to inform the injured employee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to be aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Proposed new §19.2010(c)(1)(B), relating to the written notification of the adverse determination by the URA, specifies that for workers' compensation network coverage, in addition to the requirements in paragraph (A), the written notification of the adverse determination by the URA must also include a description of or the source of the screening criteria that were utilized in making the determination.

Proposed new §19.2010(c)(1)(C), relating to the written notification of the adverse determination by the URA, specifies that for workers' compensation non-network coverage, in addition to the requirements in paragraph (A), the written notification of the adverse determination by the URA must also include a description of guidelines utilized in accordance with 28 TAC Chapter 137 in making the determination.

Proposed new §19.2010(c)(2) adds a new requirement that mandates that the description of the URA's appeal process include a statement that explains the URA's process for circumstances involving an injured employee's life-threatening condition, and under the process, the injured employee must be provided an immediate independent review by an IRO and is not required to comply with procedures for an internal review of the adverse determination by a URA. This provision is based on the requirement in the Insurance Code §4201.303(b).

Proposed new §19.2010(c)(3) specifies required time frames for notification of an adverse determination and proposes time frame requirements to be consistent with 28 TAC §134.600 for workers' compensation non-network coverage; and the Insurance Code §1305.353 and 28 TAC §10.102 for workers' compensation network coverage.

Proposed new §19.2010(c)(4) requires that the notice of adverse determination for non-network workers' compensation coverage comply with the requirements of 28 TAC §134.600 in addition to the requirements in §19.2010(c)(1).

Proposed new §19.2010(c)(5) clarifies that the notice of adverse determination may constitute a peer review report required by 28 TAC §180.28 (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section. This clarification allows the URA to consolidate the notice of an adverse determination and the peer review report into one document if the document contains all the required notice elements under both §19.2010(c) and 28 TAC §180.28.

Proposed new §19.2010(d) specifies that §19.2010 applies to specialty URAs.

Section 19.2011 addresses Requirements Prior to Issuing Adverse Determination. An amendment is proposed to the title of existing §19.2011, "Requirements Prior to Adverse Determinations," to clarify that the section regulates the requirements prior to the issuance of adverse determinations. Proposed new §19.2011(a) defines the term "reasonable opportunity" for purposes of §19.2011 as at least one documented good faith attempt to contact the provider of record requesting the services (i) no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or (ii) no less than five working days prior to issuing a retrospective utilization review adverse determination. This definition is necessary to provide guidance regarding what constitutes a

"reasonable opportunity" to ensure uniform implementation of the §19.2011(b)(1) requirements relating to prospective or concurrent utilization review adverse determination and subsection (c)(1) requirements relating to retrospective utilization review adverse determination. The proposed definition is also used in proposed new §19.2012(a)(2)(D) and (b)(1)(B) and §19.2020(h)(1)(A) and (2)(A), and it is necessary that all of these requirements are implemented on the basis of a uniform definition.

Proposed newly designated §19.2011(b)(1) addresses requirements regarding any instance in which the URA is questioning the medical necessity or appropriateness of the health care services prior to issuing a prospective or concurrent utilization review adverse determination. An amendment is proposed to §19.2011(b)(1) to require the URA, prior to issuance of an adverse determination, to afford "the provider of record" a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician or doctor. The amendment changes the existing rule which addresses such discussion opportunities with "the appropriate doctor or health care provider performing the review." An amendment is proposed to §19.2011(b)(1) to clarify that the discussion must include, "at a minimum, the clinical basis" for the URA's decision in addition to the discussion of the plan of treatment for the injured employee. This amendment is needed to clarify that the required discussion may also include other matters as deemed necessary by the URA and/or provider of record.

Proposed new §19.2011(b)(2) adds a new requirement that when the URA provides the reasonable opportunity required under §19.2011(b)(1), the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination. This requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the URA.

Proposed amendments to newly designated §19.2011(b)(3) provide more detailed requirements regarding these written procedures. The proposed amendments require the URA to maintain documentation detailing the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.2011(b)(4) adds a new requirement that the URA submit this required documentation to the Department or TDI-DWC upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

Proposed new §19.2011(c) sets forth requirements prior to issuing retrospective review adverse determinations. The proposed new subsection imposes the same requirements for the peer-to-peer discussion regarding any instance in which a URA is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of a retrospective review adverse determination as those requirements prior to the issuance of an adverse determination for prospective or concurrent utilization review specified in proposed §19.2011(b)(1), (3), and (4). Additional requirements are proposed in §19.2011(c)(2) for retrospective review adverse determinations to (i) require that when the URA provides the reasonable opportunity required under subsection (c)(1), the URA must include the URA's phone number so that the provider of record may contact the URA to discuss the pending adverse determination; and (ii) require the URA to allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.2011, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record who provided the services no less than five working days prior to issuing a retrospective utilization review.

These proposed requirements to offer an opportunity to discuss the treatment prior to issuance of a retrospective review adverse determination implement statutory requirements that result from the enactment of HB 4290. As previously discussed, HB 4290 amends the definition of the term "utilization review" in §4201.002(13) of the Insurance Code to specifically include "retrospective review" as a type of "utilization review." The Insurance Code §4201.206 provides that subject to the notice requirements of Subchapter G of Chapter 4201, before an adverse determination is issued by a URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination. Because a "utilization review agent," as defined in the Insurance Code §4201.002, means "an entity that conducts utilization review...," and "utilization review" includes "retrospective review," as provided in §4201.002(13) of the Insurance Code, the §4201.206 provision requiring a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination prior to issuance of an adverse determination now applies to URAs conducting retrospective review.

Proposed new §19.2011(d) provides that the §19.2011 requirements except subsections (b) and (c) apply to a specialty URA. The requirements under subsections (b) and (c) are not applicable because the underlying peer-to-peer requirement from which the other requirements are derived is based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Proposed new §19.2012 replaces existing §19.2012; both sections address requirements and procedures for the appeal of adverse determinations of URAs. In conjunction with this proposal, existing §19.2012 is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Proposed new §19.2012 addresses Appeal of Adverse Determination.

Proposed new §19.2012(a) governs appeal of prospective or concurrent adverse determinations. A new requirement is added in proposed new §19.2012(a)(1), providing that the URA must maintain and make available a written description of the appeal procedures involving an adverse determination that are used by the URA. This requirement is consistent with the Insurance Code §4201.352.

A new requirement is added in proposed new §19.2012(a)(2), providing that each URA must comply with its written procedures for appeals. Proposed new §19.2012(a)(2) also sets forth the information that is required to be contained in the written procedures for appeals and requires the procedures to be reasonable.

Proposed new §19.2012(a)(2)(A)(i) addresses the time frames for filing the appeal for workers' compensation network coverage. It requires the URA's written procedures for appeals to include a statement specifying the time frames for filing the oral or written appeal in accordance with the Insurance Code §1305.354, which may not be less than 30 days after the issuance of written notification of an adverse determination. This 30-day provision allows the injured employee adequate time to appeal the adverse determination and is consistent with 28 TAC §10.103 (relating to Reconsideration of Adverse Determination). Under this provision, all injured employees will have at least 30 days to appeal an adverse determination, regardless of which URA handled the utilization review. This provision is also consistent with the Insurance Code §4201.353, which provides that the procedures for appealing an adverse determination must be reasonable.

Proposed new §19.2012(a)(2)(A)(ii) addresses the time frames for filing the appeal for workers' compensation non-network coverage. It requires the URA's written procedures for appeals to include a statement specifying that the time frames for filing the oral or written appeal must comply with 28 TAC §134.600 (relating to preauthorization, concurrent review, and voluntary certification of health care) and 28 TAC Chapter 133, Subchapter D (relating to dispute of medical bills). Proposed new §19.2012(a)(2)(B) requires the URA's written procedures for appeals to include a provision that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination by making an oral or written request. This is consistent with the Insurance Code §4201.354. Proposed new §19.2012(a)(2)(B) also provides that if the health care provider sets forth in the request good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review. This provision allows the injured employee an opportunity for a health care provider in the same or similar specialty to review the injured employee's case under certain circumstances.

Proposed new §19.2012(a)(2)(C) requires the URA's written procedures for appeals to include a provision that appeal decisions must be made by a physician who has not previously reviewed the case. This provision is consistent with the Insurance Code §4201.356(a), the Insurance Code §1305.354, and 28 TAC §10.103. This requirement provides consistency of utilization reviews for all injured employees.

Proposed new §19.2012(a)(2)(D) requires that in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity, as defined in proposed §19.2011(a), to discuss the plan of treatment for the injured employee with a physician. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.2012(a)(2)(E) requires the URA's written procedures for appeals to include a provision that, after the URA has sought review of the appeal of the adverse determination, the URA must issue a response letter explaining the resolution to the appeal to certain specified individuals for workers' compensation non-network coverage as provided in §19.2012(a)(2)(E)(i) and to other specified individuals for workers' compensation network coverage as provided in §19.2012(a)(2)(E)(ii).

The requirements in proposed §19.2012(a)(2)(F)(i)(I) - (IV) are consistent with the Insurance Code §4201.359. The requirement in proposed new §19.2012(a)(2)(F)(i)(V), relating to procedures for filing a complaint, is consistent with the Insurance Code §4201.204. The requirements in proposed §19.2012(a)(2)(F)(i)(I) and (III) are proposed under the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201. The requirement under §19.2012(a)(2)(F)(i)(I) is similar to the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(1), proposed §19.2010(c)(1), and proposed §19.2015(b)(2). These provisions require the URA to include the principal reasons for the adverse determination in the notice of an adverse determination.

Proposed new §19.2012(a)(2)(F)(ii) requires that for workers' compensation network coverage, a description of or the source of the screening criteria that were utilized in making the determination, including a description of the network adopted treatment guidelines, if any, be included in the response letter. The requirement under proposed new §19.2012(a)(2)(F)(ii) is consistent with the required notice element for the notice of an adverse determination under the Insurance Code §4201.303(a)(3), proposed §19.2010(c)(1)(B), and proposed §19.2015(b)(2)(D). These provisions require the URA conducting utilization review for workers' compensation network coverage to include a description of or the source of the screening criteria that were utilized as guidelines in making the determination in the notice of an adverse determination.

Proposed §19.2012(a)(2)(F)(iii) requires that for workers' compensation non-network coverage, a description of guidelines utilized in accordance with 28 TAC Chapter 137 in making a determination be included in the response letter. These requirements are necessary to provide the injured employee with important information concerning the basis for the determination. The requirement under proposed new §19.2012(a)(2)(F)(iii) is consistent with the required notice element for the notice of an adverse determination under proposed §19.2010(c)(1)(C) and proposed §19.2015(b)(2)(E). These provisions require the URA conducting utilization review for workers' compensation non-network coverage to include a description of guidelines utilized in accordance with 28 TAC Chapter 137 (relating to Disability Management) in making a determination.

Proposed new §19.2012(a)(2)(G)(i) and (ii) specify the time frames for written notifications to the appealing party of the determination of the appeal. These appeals must be resolved in accordance with 28 TAC §10.103 for workers' compensation network coverage, and 28 TAC §134.600 for workers' compensation non-network coverage.

Proposed new §19.2012(a)(3) provides for an immediate review by an IRO of an adverse determination in a circumstance involving an injured employee's life-threatening condition. This provision is consistent with the Insurance Code §4201.360.

Proposed new §19.2012(a)(4) provides that §19.2012 applies to a specialty URA except subsection (a)(2)(C) and (D), relating to the requirement that appeal decisions of prospective or concurrent adverse determinations must be made by a physician who has not previously reviewed the case. The requirement under subsection (a)(2)(C) is not applicable because §19.2020(i) governs appeal procedures specifically for specialty URAs. The requirements under subsection (a)(2)(D) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs.

Proposed new §19.2012(b)(1) - (4) govern appeals of retrospective review adverse determinations. Subsection (b)(1) applies to both workers' compensation network and non-network coverage. Subsection (b)(1) requires the URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. Appeal procedures must comply with the requirements in subparagraphs (A) and (B) of paragraph (1). Proposed subsection (b)(1)(A) requires that an appeal of an adverse determination relating to retrospective utilization review must comply with §19.2015. Proposed subsection (b)(1)(B) requires that in any instance in which the URA is questioning the medical necessity or appropriateness, prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity, as defined in §19.2011(a), to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the URA's decision.

Proposed new §19.2012(b)(2) requires workers' compensation network coverage appeal procedures to comply with the requirements in the Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133.

Proposed new §19.2012(b)(3) requires workers' compensation non-network coverage appeal procedures to comply with the requirements of 28 TAC Chapter 133.

Proposed new §19.2012(b)(4) provides that §19.2012 applies to a specialty URA except subsection (b)(1)(B), relating to the requirement that before issuing a retrospective adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician. The requirements under subsection (b)(1)(B) are not applicable because they are based on the Insurance Code §4201.206. Under the Insurance Code §4201.452, a specialty URA is not subject to the Insurance Code §4201.206. The Insurance Code §4201.456 and proposed amended §19.2020(h) impose peer-to-peer discussion requirements for prospective, concurrent, and retrospective review that are specifically applicable to specialty URAs

Section 19.2013 addresses Utilization Review Agent's Telephone Access. Proposed new §19.2013(c) requires a URA to provide a written description to the Commissioner of the procedures that the URA will implement when responding to requests for (i) drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency; and (ii) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by a treating physician or provider of record.

The proposed requirement in §19.2013(c)(1) is necessary to complement the pharmacy closed formulary rules in 28 TAC Chapter 134, Subchapter F, relating to Pharmaceutical Benefits, for both certified network and non-network claims in workers' compensation. This URA procedural requirement is necessary for those situations that may occur after the denial of a preauthorization request and is a precursor to statutorily required closed formulary appeals process that includes the medical interlocutory order process identified in 28 TAC §134.550 (relating to Medical Interlocutory Order). Section 134.550 provides a prescribing doctor of pharmacy the ability to obtain a medical interlocutory order in certain instances in which preauthorization denials of a previously prescribed and dispensed drug excluded from the closed formulary poses an unreasonable risk of a medical emergency as defined in 28 TAC §134.500(7) and the Insurance Code §1305.004(a)(13). An equivalent requirement is not included in the proposed Subchapter R rules because the pharmacy closed formulary rules do not apply to health care provided under a health benefit plan or health insurance policy.

In addition, the post-stabilization portion in §19.2013(c)(2) will extend the preauthorization decision concerning facility-based surgeries (inpatient, outpatient, or ambulatory surgical center) to include necessary pain medication, which is often overlooked during the preauthorization approval process and results in confusion regarding the availability of necessary pain medications.

Proposed new §19.2013(c) is based on the Insurance Code §4201.004(b), which requires a URA to provide to the Commissioner a written description of the procedures to be used when responding with respect to post-stabilization care subsequent to emergency treatment as requested by a treating physician or other health care provider.

Proposed new §19.2013(d) provides that §19.2013 applies to a specialty URA.

Section 19.2014 addresses Confidentiality. Proposed §19.2014(a)(4) relating to requests for recorded personal information, requires the URA to respond to an individual's written request for access to recorded personal information about the individual within 10 *working days,* instead of 10 *business* days as provided in the existing rule. This amendment is proposed for clarity and uniformity of implementation; the term "working day" is defined in §19.2003(47), and the term "business day" is not defined.

Proposed §19.2014(a)(12) relating to period of record retention, requires the information generated and obtained by a URA in the course of utilization review to be retained for at least *four* years, instead of the existing requirement of two years. The proposed amendment also deletes the qualifier in the existing rule "from the date of the final decision in the utilization review." The deletion of this qualifier will result in the calculation of time beginning from the onset of the utilization review for a given case. The deletion was necessary to clarify that all information must be retained, not just information relating to cases for which a final decision has been rendered. These changes are necessary to broaden the type of information that is to be retained and to allow sufficient time for the Department to examine the information.

The Department generally conducts URA examinations triennially but does not always examine each URA exactly every three years, so the requirement that the URA maintain information for four years will ensure that the Department has the opportunity to review such information.

Proposed §19.2014(b), relating to a URA's written procedures on confidentiality, clarify that the confidentiality requirements pertain to both the information received by the URA from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties.

Proposed new §19.2014(c) provides that §19.2014 applies to a specialty URA.

Proposed new §19.2015 replaces existing §19.2015. In conjunction with this proposal, existing §19.2015, concerning retrospective review of medical necessity, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Proposed new §19.2015 addresses Notice of Determination Made in Retrospective Review. Proposed new §19.2015(a), relating to required notice, requires a URA to provide notice of a determination made in a retrospective review to the following: (i) for workers' compensation non-network coverage the individuals specified by 28 TAC §133.240 (relating to Medical Payment and Denials); and (ii) for workers' compensation network coverage, the individuals specified by 28 TAC §133.240 and 28 TAC §10.102 (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

Proposed new §19.2015(b), relating to required procedures, requires the URA to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination, in compliance with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) - (5) of subsection (b).

Proposed new §19.2015(b)(1) requires the notice of adverse determination to be in writing and provided within the timeframes specified by (i) department rules in 28 TAC Chapter 10 (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in 28 TAC Chapter 133 (relating to General Medical Provisions) for workers' compensation network coverage; or (ii) TDI-DWC rules in 28 TAC Chapter 133 for workers' compensation non-network coverage. This provision is consistent with the Insurance Code §4201.305.

Proposed new §19.2015(b)(2) requires the notice of adverse determination to include several notice elements of information, including some statutory requirements. These statutory requirements are included in proposed §19.2015(b)(2)(A), (B), (D), (E), (G), (H), and (J).

In addition to the notice elements required by the Insurance Code §4201.303, proposed new §19.2015(b)(2)(C), (F), and (I) also require the following information be included in the notice of adverse determination for retrospective utilization review: (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and Texas license number of the physician or doctor who made the adverse determination; and (iii) the date and time the URA offered the opportunity to discuss the adverse determination, and the date and time the discussion, if any, took place. The Department has determined that these additional notice elements are necessary to provide important consumer information to the injured employee in the event that the adverse determination is appealed. The additional notice element in proposed new §19.2015(b)(2)(C), relating to helpful documentation or evidence that can be submitted upon appeal of the adverse determination, is important for the injured employee to understand what evidence or documentation the provider of record will need to submit.

Additional information relating to the professional specialty and Texas license number of the physician or doctor who made the adverse determination, required in proposed new §19.2015(b)(2)(F), is necessary for the injured employee's understanding of the professional background and training of that physician or doctor. Such information could also assist the provider of record in assessing whether the injured employee would benefit from requesting a physician or doctor of a particular specialty, other than the specialty of the physician or doctor that made the adverse determination, if an appeal to the adverse determination is filed.

The requirement in proposed new §19.2015(b)(2)(I), regarding the information on the date and time the URA offered the opportunity to discuss the adverse determination and the date and time that the discussion, if any, occurred, is also useful, to inform the injured employee of this opportunity and whether it was utilized by the provider of record. This information will enable the provider of record to ascertain what contact attempts were made by the URA before the adverse determination was issued. This information could, in turn, enable the provider of record to become aware of the URA's contact methods and thereby increase the potential for effective communication between the provider of record and the URA.

Proposed §19.2015(b)(3) clarifies that the notice of determination required under this section may constitute a peer review report required by 28 TAC §180.28 (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

Proposed new §19.2015(c) provides that §19.2015 applies to specialty URAs.

Section 19.2016 addresses Regulatory Requirements Subsequent to Certification or Registration.

Proposed new §19.2016(a), relating to reporting of material changes in the application or latest renewal form, requires the URA to report to the Department, not later than the 30th day after the date on which the change takes effect, any material changes in such information. This provision implements the Insurance Code §4201.107.

Proposed §19.2016(b)(1) continues to require that information related to complaints be included in the summary report but the proposed amendments broaden the types of information that the URA is required to provide in the summary report. The proposed amendments require URAs to also submit information related to adverse determinations, appeals of adverse determinations, and any other related information requested by the Department in accordance with the Insurance Code §38.001. This provision is proposed under the Insurance Code §4201.204(c) and the Insurance Code §38.001.

Proposed new §19.2016(b)(2) requires the summary report to be provided in the form required by the Commissioner and requires

the URA to permit the Commissioner or the Commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the Department. This provision is also proposed under the Insurance Code §4201.204(c).

A proposed amendment to §19.2016(b)(3)(B), relating to the requirement to list adverse determinations for preauthorization, clarifies that "successor codes and modifiers" are applicable as part of that requirement.

Proposed new §19.2016(b)(3)(D) broadens the types of information that the URA is required to provide in the summary report that must be submitted to the Department annually to include the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process.

These proposed additional information requirements in §19.2016(b)(3)(D) are necessary for consistency with the information requirements for a URA for utilization review for health care provided under a health benefit plan or health insurance policy and subject to proposed §19.1716(b)(3). The need for this consistency between the Subchapter R requirements and the Subchapter U requirements is discussed in the early part of this Introduction. This information will be useful to the Department in assembling and monitoring information related to the appeals of adverse determinations. This information will assist the Department in determining the results and the frequency and volume of such appeals.

Existing §19.2016(d)(1) - (4), relating to complaints to the Department, is proposed for deletion because the Department has determined that the detailed complaint procedure requirements in existing subsection (d)(1) - (4) are not necessary. The Department has determined that the Department's established procedures for investigation and resolution of other types of complaints are the more appropriate means for handling the URA complaints to the Department.

Proposed new §19.2016(d), relating to Department inquiries, reiterates the Department's authority in the Insurance Code §38.001 to address inquiries to a URA related to any matter connected with the URA transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties. Consistent with §38.001, a URA to which such an inquiry is addressed must respond in writing not later than the 10th day after the date the inquiry is received.

Existing §19.2016(e) requires the URA to provide evidence of corrective action within the specified time frame to the Commissioner or his or her representative. Because this requirement operates in conjunction with the existing §19.2016(d)(1) - (4) requirements, existing §19.2016(e) is also proposed for deletion.

Proposed new §19.2016(e) provides that Subchapter U 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 URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. This provision is necessary to clarify that the investigative authority of the Commissioner of Workers' Compensation or TDI-DWC is not limited to the authority set forth in Subchapter U.

The requirement in existing §19.2016(g) that the Commissioner maintain and update monthly a list of URAs issued certificates and the renewal date for those certificates is proposed for deletion because the Department now maintains a list of certified URAs on its website, which is available to individuals or organizations interested in obtaining information on the certification status of a URA. This list is updated in real-time. However, this requirement is still imposed by statute under the Insurance Code §4201.108.

Proposed §19.2016(f)(1)(A) clarifies that an on-site review by the Department may be scheduled or unscheduled. Under proposed new §19.2016(f)(1)(B), an on-site review will only be conducted during working days and normal business hours. Proposed new §19.2016(f)(1)(C) retains the existing provision that the URA is required to make available all records relating to its operation during the scheduled and unscheduled on-site review without a proposed substantive change. Proposed §19.2016(f)(2) retains the existing provision that the URA will be notified of any scheduled on-site review by letter. Proposed new §19.2016(f)(3) provides that, at a minimum, notice of an unscheduled on-site review of a URA will be in writing and be presented by the Department's designated representative upon arrival. Existing §19.2016(h)(4), relating to possible periodic telephone audits of URAs to determine if they are reasonably accessible, is proposed for deletion. The Department has determined that this provision is no longer necessary because of the Insurance Code §4201.601, which authorizes the Department to take certain steps if it is believed that a person or entity conducting utilization review is in violation of Chapter 4201 or applicable rules. These steps include authority to compel the production of necessary information if it is believed that the URA is in violation of the Insurance Code or rules relating to reasonable accessibility.

Proposed new §19.2016(g) provides that §19.2016 applies to specialty URAs.

Section 19.2017 addresses Administrative Violations. Proposed §19.2017(a)(3) is proposed to be amended to include subsection (a)(3)(B) - (C) to authorize the Commissioner to issue a cease and desist order under the Insurance Code Chapter 83 or assess administrative penalties under the Insurance Code Chapter 84. Chapters 83 and 84 of the Insurance Code are referenced generally in existing rules; proposed new §19.2017(a)(3)(B) - (C) specify the possible disciplinary actions that may be imposed under these chapters. Additionally, an amendment is proposed to §19.2017(a)(4) relating to the commission of fraudulent or deceptive acts in obtaining or using a URA certification, to include the commission of fraudulent or deceptive acts in obtaining or using a URA registration.

Proposed new §19.2017(b), relating to actions by the TDI-DWC for a URA's alleged violation of the Labor Code or TDI-DWC rules, provides that proposed new §19.2017 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 URAs or personnel employed by or under contract with URAs to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. Nothing in proposed new §19.2017 prohibits the joint enforcement actions of the Department and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

Proposed new §19.2017(c) provides that §19.2017 applies to specialty URAs.

In conjunction with this proposal, existing §19.2018, concerning criminal penalties, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Section 19.2019 addresses Responsibility of Insurance Carriers Performing Utilization Review. An amendment to the title of §19.2019 changes the word "companies" to the word "carriers." This change is necessary because the term "insurance company" in existing §19.2003(19) is proposed for deletion, but the definition of "insurance carrier" in proposed redesignated §19.2003(17) incorporates the definition of "insurance company." Existing §19.2019(a) - (c) address requirements for insurance companies performing utilization review. Proposed new §19.2019(a) - (c) address requirements for insurance *carriers* performing utilization review.

Proposed new §19.2019(a) provides that an insurance carrier performing utilization review only for coverage for which it is the payor is subject to Subchapter U except for the *certification* requirements in §19.2004 of this title. This proposed provision is consistent with the Insurance Code §4201.058(a).

Proposed amendments to existing §19.2019(b) update the certification requirements for an insurer performing utilization review for an individual or entity for which it is not the payor. Such insurers will be required to have a valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.2004 of this title. This provision is consistent with the Insurance Code §4201.058(c).

Amendments are proposed to §19.2019(c) to update the registration requirements for an insurer that performs utilization review under Chapter 4201 of the Insurance Code only for coverage for which it is the payor. Such insurers will be required to have a valid registration pursuant to §19.2004 and to comply with the filing requirements under §19.2004. These proposed amendments are necessary for the Department to obtain additional information about insurers conducting utilization review for coverage for which they are the payor for purposes of monitoring and oversight. Under the proposed amendments to §19.2019(c), the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for workers' compensation coverage for which it is the payor.

Proposed new §19.2019(d) provides that §19.2019 applies to specialty URAs.

Section 19.2020 addresses Specialty Utilization Review Agent. Proposed new §19.2020(a) requires a specialty URA, in order to be certified or registered as a specialty URA, to submit to the Department the application and information required in §19.2004. Proposed §19.2020(b)(1) provides that a specialty URA is subject to the requirements of the Insurance Code Chapter 4201, except as specified in the proposed amendments. Proposed §19.2020(b)(2) provides that a specialty URA is subject to the requirements of Subchapter U, except as specified in the proposed amendments. These amendments are consistent with the Insurance Code §4201.452, which provides that a specialty URA is not subject to §§4201.151, 4201.152, 4201.206, 4201.252, or 4201.356.

Proposed §19.2020(c) specifies requirements relating to the specialty URA's utilization review plan, which provide consistency with the Insurance Code §4201.453, which provides that a specialty URA's utilization review plan, including reconsideration and appeal requirements, must be reviewed by a health care provider of the appropriate specialty and conducted in accordance with standards developed with input from a health care provider of the appropriate specialty.

Proposed new §19.2020(d) addresses requirements of employed or contracted physicians, doctors, other health care providers, and personnel. Proposed new §19.2020(d)(1) requires physicians, doctors, other health care providers, and personnel employed by or under contract with a specialty URA to perform workers' compensation utilization review to be appropriately trained, qualified, and currently licensed in accordance with 28 TAC Chapter 180 (relating to Monitoring and Enforcement).

Proposed new §19.2020(d)(2) requires personnel conducting specialty utilization review to hold an unrestricted license or an administrative license issued by the Texas Medical Board or be otherwise authorized to provide health care services in Texas. This requirement is based on an Advisory Committee recommendation and is necessary to ensure that all such personnel are appropriately trained and qualified to conduct specialty utilization review.

Proposed amendments to §19.2020(d)(3) clarify that physicians or doctors obtaining information under §19.2020 must be qualified in accordance with the Labor Code §§408.0043, 408.0044, and 408.0045, and nurses, physician assistants, or other health care providers must be qualified in accordance with 28 TAC Chapter 180. The proposed provision may not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

Proposed new §19.2020(e) requires the specialty URA to provide the name, number, type, Texas license number and qualifications of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information. This requirement is necessary to enable the Department to monitor and to ensure that appropriate personnel are conducting utilization review, which should result in a higher quality of utilization review for the injured employee. The Department has authority to require this information under the Insurance Code §4201.104, which requires the Commissioner to promulgate forms to be filed for a URA's initial certification and renewal certification. Additionally, the Insurance Code §4201.107 requires the URA to report to the Department any material changes to information disclosed in the application form.

Proposed new §19.2020(f) requires the specialty URA to: (i) develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the URA are licensed, qualified, and appropriately trained or experienced; and (ii) maintain documentation demonstrating that physicians, doctors, and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced. The requirements are necessary to create a written record that the URA can provide to the Department upon request to enable the Department to determine whether the physicians, doctors, or other health care providers are licensed, qualified, and appropriately trained or experienced. The requirements should ultimately result in a higher quality of utilization review for the injured employee. These requirements are consistent with the Insurance Code §4201.454.

Under the proposed amendments to subsection (g), the utilization review by a specialty URA must be conducted under the direction of a physician, doctor, or other health care provider of the same specialty and the physician, doctor, or other health

care provider must be currently licensed to provide the specialty health care service in Texas. This change is consistent with the Insurance Code §1305.351 and the Labor Code §408.023(h). Additionally, an amendment is proposed to §19.2020(g) to provide that the directing physician, doctor, or other health care provider may be employed by or under contract to the URA. This proposed amendment is necessary to avoid any ambiguity or misunderstanding regarding the type of business relationship that the URA may have with the directing physician, doctor, or other health care provider.

Proposed new §19.2020(h)(1)(B) requires that a discussion under subsection (h) prior to the issuance of an adverse determination in prospective or concurrent utilization review include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision required under subsection (h)(1)(A), as deemed necessary by the URA and/or provider of record. This requirement is consistent with the Insurance Code §4201.456.

Proposed new §19.2020(h)(1)(C) provides that when the specialty URA provides the reasonable opportunity required under §19.2020(h)(1)(A), the specialty URA must include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. This requirement is necessary to provide the provider of record with the necessary information in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA.

Proposed new §19.2020(h)(1)(D) requires the specialty URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome. Proposed new §19.2020(h)(1)(E) requires the specialty URA to submit the subsection (h)(1)(D) documentation to the Department or TDI-DWC upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions.

Proposed new §19.2020(h)(2)(A) requires a specialty URA, before issuing a retrospective review adverse determination, to provide the provider of record a reasonable opportunity to discuss the treatment provided to the injured employee with a health care provider of the same specialty as the URA. Proposed new §19.2020(h)(2)(B) requires a discussion to include, at a minimum, the clinical basis for the specialty URA's decision. This new provision provides guidance on the matters to be discussed in the required discussion and is necessary for uniform implementation of the rule. The new provision indicates that the required discussion may include matters in addition to the clinical basis for the specialty URA's decision as deemed necessary by the URA and/or provider of record.

Proposed §19.2020(h)(2)(C) proposes new requirements that when the specialty URA provides the reasonable opportunity required under subsection (h)(2)(A), the specialty URA must include the specialty URA's phone number so that the provider of record may contact the specialty URA to discuss the pending adverse determination. Under the proposed requirements, the specialty URA must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification. The first requirement is necessary to provide the provider of record with the necessary information to contact the URA in the event that the provider of record wishes to discuss the pending adverse determination with the specialty URA. The second requirement is necessary for consistency with the definition of "reasonable opportunity" in §19.2011, which provides that a "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than five working days prior to issuing a retrospective utilization review.

A new requirement is proposed in new §19.2020(h)(2)(D) to mandate that the specialty URA maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome. The new requirement proposed in new §19.2020(h)(2)(E) requires that the specialty URA submit the §19.2020(h)(2)(D) documentation to the Department upon request. These proposed requirements are necessary to enable the Department to monitor whether a reasonable opportunity for discussion was offered and to collect information on peer-to-peer discussion results. This information will assist the Department in ensuring compliance with the requirement that URAs provide a reasonable opportunity for discussion with the provider of record prior to issuing the adverse determination and in determining the effectiveness of the peer-to-peer discussions. Both of these requirements are necessary to ensure that the proper consumer protection is afforded to injured employees who are using specialty URAs for utilization review.

Amendments are proposed to §19.2020(i) to clarify that an appeal decision must be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty URA that made the adverse determination.

In conjunction with this proposal, existing §19.2021, concerning independent review organizations non-involvement with the URA process, is proposed for repeal. The repeal proposal is also published in this issue of the *Texas Register.*

Proposed new §19.2021 addresses Independent Review of Adverse Determinations.

Proposed new §19.2021(a) addresses notifications of an adverse determination for life-threatening conditions.

Proposed new §19.2021(a)(1)(A)(i) and (ii) specify the time frames for the notification of an adverse determination: (i) for workers' compensation non-network coverage, the adverse determination notice must be provided within the time frames specified by 28 TAC §134.600; (ii) for workers' compensation network coverage, the adverse determination notice must be provided within the time frames specified by the Insurance Code §1305.353 and 28 TAC §10.102.

Proposed §19.2021(a)(1)(B) adds a requirement that the URA must, at the time of notification of the adverse determination, provide notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent

Review Organization (IRO)). This requirement is necessary to inform the injured employee of the process for independent review of the adverse determination in the event of life-threatening conditions. The provision of the copy of Form No. LHL009, will inform the injured employee of his or her additional options following an adverse determination and enable the injured employee to more quickly and efficiently request independent review.

Proposed new §19.2021(a)(1)(C) requires that the injured employee, injured employee's representative, or the injured employee's provider of record determine the existence of a life-threatening condition on the basis of the prudent layperson standard. This standard provides that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition. This new requirement is necessary to clarify that a health care provider does not have to make the determination that the condition is life-threatening, which provides more flexibility to the injured employee as long as the prudent layperson test is met. The Texas Insurance Code §4201.002(7) defines "life-threatening" as a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted. The statute does not specify who is required to make the determination that the disease or condition is life-threatening. The Department interprets this provision broadly to allow determination of the existence of a life-threatening condition based on a prudent layperson standard, rather than more narrowly to allow only medical personnel to make the determination. Under this interpretation, an injured employee who cannot obtain a medical opinion that his or her condition is life-threatening may still be entitled to a faster notice of adverse determination and immediate access to independent review. This requirement is proposed under the Department's rulemaking authority in the Insurance Code §4201.003 to adopt rules to implement Chapter 4201.

Proposed new §19.2021(a)(2) reiterates the statutory requirement that a party who receives an adverse determination involving a life-threatening condition or whose appeal of an adverse determination is denied by the URA is entitled to review of the adverse determination by an IRO. This provision is necessary to implement the Insurance Code §4201.360.

Proposed new §19.2021(b) governs independent review involving life-threatening and non-life threatening conditions. Proposed new §19.2021(b)(1) addresses the request for independent review. Proposed new §19.2021(b)(1)(A) requires the URA to notify the Department within one working day from the date the request for an independent review is received. A "working day" is defined by §19.2003(47). The proposed requirement that the URA notify the Department within one working day from the date the request for an independent review is received is necessary because prompt action is needed to initiate the process of independent review to ensure proper and timely medical treatment for injured employees. The Department has determined that the proposed "working day" requirement will avoid impractical deadlines in situations such as when the request for independent review is received outside of normal working hours or immediately before the end of a working day.

Proposed §19.2021(b)(1)(B) requires the URA to provide the Department the completed Form No. LHL009 that is submitted to the URA by the party requesting independent review. This requirement should result in greater efficiency and less time for the URA and in quicker response time for the injured employee who is requesting the independent review. Proposed §19.2021(b)(1)(C) requires the URA to submit the completed Form No. LHL009 via the Department's Internet website.

Under proposed new §19.2021(b)(2), the Department will, within one working day of receipt of the complete request for independent review, randomly assign an IRO to conduct the independent review and notify the URA, payor, IRO, injured employee or injured employee's representative, injured employee's provider of record, and any other providers listed by the URA as having records relevant to the review of the assignment of the IRO assignment. This prompt assignment is necessary for both life-threatening and non-life threatening conditions because assigning IROs is a primary function of the Department.

Proposed new §19.2021(b)(3) references additional requirements for an independent review of an adverse determination for a workers' compensation non-network coverage review under the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to 28 TAC Chapter 133, Subchapter D.

Proposed new §19.2021(b)(4) references additional requirements for an independent review of an adverse determination for a workers' compensation network coverage review under the Insurance Code Chapter 1305, Department and TDI-DWC rules, including, but not limited to 28 TAC Chapter 10, Subchapter F, and Chapter 133, Subchapter D.

Proposed new §19.2021(c) provides that §19.2021 applies to a specialty URA.

FISCAL NOTE. Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, has determined that for each year of the first five years the proposed amendments and new sections will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Ms. Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, also has determined that for each year of the first five years the proposed amendments and new sections are in effect, there are several public benefits anticipated as a result of the enforcement and administration of the proposal, as well as potential costs for persons required to comply with the proposal. The Department, however, drafted the proposed rules to maximize public benefits consistent with the intent of the authorizing statutes while mitigating costs.

ANTICIPATED PUBLIC BENEFITS

The anticipated public benefits in general are (i) the updating of existing rules regulating URAs to comply with legislation enacted by the 81st Legislature; (ii) clarification of existing rules to facilitate compliance, implementation, and enforcement of these rules; and (iii) an improved regulatory framework for URAs.

Compliance with legislation. Specifically, the anticipated public benefits of the proposed rules and amendments related to compliance with legislation include the establishment of a regulatory framework that supports the operation of a URA in compliance with the requirements of 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; these amended rules will assist health care con-

sumers by providing for review of claims that could otherwise be denied without such recourse.

Clarification of existing rules. Additionally, the anticipated public benefits of the proposed rules and amendments related to clarification of existing rules are: (i) consistency of terminology throughout the text for readability and ease of understanding; (ii) increased clarity concerning the evidence-based or generally accepted standards upon which an URA is required to base its screening criteria which will result in valid and sound decisions because credible and scientific guidelines are used and will also result in increased confidence in the URA's decisions; (iii) updated references and citations for readability and ease of understanding; (iv) increased clarity in existing rules to assist persons applying for or renewing a certificate of registration; (v) increased clarity concerning confidentiality requirements to better protect enrollee or injured employee health care information; (vi) enhanced oversight of URAs that will result in better and more efficient compliance with requirements; and (vii) improved telephone access to URAs that will provide health care consumers with easier and more efficient access to URAs.

Other anticipated public benefits of the proposed rules and amendments related to clarification of existing rules are: (i) establishment of standards for the review of the medical necessity or appropriateness of health care services by health care providers of the appropriate specialty which will result in utilization review by the appropriate personnel; (ii) the establishment of a standardized complaint process for consumers for easier and more efficient resolution of their oral or written complaints concerning the utilization review; (iii) greater transparency concerning the documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (iv) standards for the determination of a life-threatening condition to be made by the prudent layperson standard, permitting consumers to have determinations made in a timely manner when life-threatening conditions exist; (v) expanding the preauthorization decision regarding facility-based surgeries to include necessary pain medication, which reduces the risk that an injured employee would be unable to obtain necessary pain medications after surgery through their approved preauthorization request; (vi) increased coordination and cooperation between health care providers and URAs which will result in the sharing of enrollee or injured employee information necessary for the utilization review; and (vii) improved communications and knowledge of medical benefits among all parties concerned before expenses are incurred which may result in enrollees and injured employees avoiding incurring expenses for uncovered medical treatment.

Improved regulatory framework. The anticipated public benefits of the proposed rules and amendments relating to the improved regulatory framework for URAs are: (i) additional required notice elements in the Form No. LHL005 (Utilization Review Agent (URA) Application Form) that will result in the provision of additional information to the Department necessary to certify or register a URA; (ii) disclosure of screening criteria to be filed with the Department to ensure that URAs adhere to reasonable standards for conducting utilization reviews which will provide consistent use of criteria that are evidence-based, scientifically valid, or outcome focused, or if evidence-based medicine is not available for a particular health care service provided, criteria based on generally accepted standards of medical practice recognized in the medical community, for health consumers; (iii) allowing the auditing of URAs through the mandatory filing requirements to promote the delivery of quality health care in a cost-effective manner, including protection of enrollee or injured employee safety; (iv) ensuring that URAs maintain the confidentiality of medical records in accordance with applicable law; and (v) inclusion of written procedures to be filed with the Department for greater transparency concerning preauthorization of services, appeals of adverse determinations, and the licensure, qualifications, and training of health care providers used by the URA, which will result in enhanced oversight by the Department and a more efficient utilization review process for health consumers.

ANTICIPATED COSTS TO COMPLY WITH THE PROPOSAL

Ms. Diaz-Lara anticipates that there will be probable costs to persons required to comply with several of the proposed amendments and new sections during each year of the first five years that the rule will be in effect.

The Department has identified three sections in Subchapters R and three parallel sections in Subchapter U that require peer-to-peer discussions before a URA issues a retrospective review adverse determination. These requirements are the result of the HB 4290 amendments of the statutory definitions of the terms "adverse determination" and "utilization review." These three requirements are in proposed §19.1711(c) and §19.2011(c); §19.1712(b) and §19.2012(b)(1)(B); and §19.1720(h)(2)(A) and §19.2020(h)(2)(A).

Because the costs relating to the requirements for offering peer-to-peer discussions prior to issuance of retrospective review adverse determinations is a result of the enactment of HB 4290 and existing statutory requirements, any costs of complying with the proposed requirements in §19.1711(c) and §19.2011(c); §19.1712(b) and §19.2012(b)(1)(B); and 19.1720(h)(2)(A) and §19.2020(h)(2)(A), which implement statutory provisions, are not the result of the proposed rules.

The Department has identified 21 requirements of the proposal that may result in compliance costs for entities subject to Subchapter R and/or Subchapter U including proposed (i) §19.1704(d) and §19.2004(c); (ii) §19.1704(e) and §19.2004(d); (iii) §19.1705(d) and §19.2005(d); (iv) §19.1705(g) and §19.2005(g); (v) §19.1703(12) and §19.2003(11); (vi) §19.1706(c) and §19.2006(c); (vii) §19.1706(d) and §19.2006(d); (viii) §19.1710(b)(2) and §19.2010(b)(2); (ix) §19.1710(c) and §19.2010(c); (x) §19.1715(b) and §19.2015(b); (xi) §19.1711(b)(3) - (4) and §19.2011(b)(3) - (4); (xii) §19.1711(c)(3) - (4) and §19.2011(c)(3) - (4); (xiii) §19.1712(a) and §19.2012(a); (xiv) §19.1712(b) and §19.2012(b); (xv) §19.1714(a)(12) and §19.2014(a)(12); (xvi) §19.1721(a) and §19.2021(a); (xvii) §19.1719(b) and §19.2019(c); (xviii) §19.1720(c) and §19.2020(c); (xix) §19.1720(e) and §19.2020(e); (xx) §19.1720(h)(1)(D) - (E) and §19.2020(h)(1)(D) - (E); (xxi) §19.1720(h)(2)(D) - (E) and §19.2020(h)(2)(D) - (E). The Department has identified two requirements of the proposal that may result in compliance costs for entities subject only to Subchapter R including proposed §19.1719(a) and §19.1721(b)(3). The Department has identified two proposed requirements that may result in compliance costs for entities subject only to Subchapter U including proposed §19.2013(c) and §19.2016(b)(3). Any other costs to comply with proposed §§19.1704 - 19.1724 and proposed §§19.2004 - 19.2021 result from the legislative enactment of HB 4290 or are statutory requirements under Chapter 4201 of the Insurance Code and are not a result of the adoption, enforcement, or administration of the proposal.

Repetitive Cost Note Information

There are cost components and analyses that are utilized throughout this Cost Note numerous times. The Department is interested in avoiding unnecessary repetition in lengthy Cost Notes. Therefore, for purposes of readability and brevity, the Department has included under this part of the Cost Note, the detail for these repetitive cost components and analyses. These cost components and analyses are referenced under the subheading "Repetitive Cost Note Information" in the Cost Note discussions of the individual proposed provisions that require additional compliance costs. The Cost Note has been prepared in accordance with the requirements in the Government Code §2001.024(a)(5), relating to the content of a rule notice, and Chapter 2006, relating to agency actions affecting small businesses.

Wages for a general operations manager in an insurance-related industry. The Department's analysis of the cost for a URA general operations manager to perform required compliance tasks is based on the following factors. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, according to the Texas Workforce Commission, Labor Market and Career Information Department, Occupation & Employment Statistics Estimate Delivery System (hereafter referred to as the Texas Workforce Commission OES Report), available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=11-1021&compare=2. The number of hours that will be required to comply with a particular proposed requirement will vary, and as a result, any total cost, as well as other possible relevant factors, is addressed in the Cost Note discussion for the individual proposed requirement.

Wages for an administrative assistant in an insurance-related industry. The Department's analysis of the cost for a URA administrative assistant to perform required compliance tasks is based on the following factors. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, according to the Texas Workforce Commission OES Report available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=43-6011&compare=2. The number of hours that will be required to comply with a particular proposed requirement will vary, and as a result, any total cost, as well as other possible relevant factors, is addressed in the Cost Note discussion for the individual proposed requirement.

Wages for a computer programmer in an insurance-related industry. The Department's analysis of computer programmer costs in this Cost Note is based on the following factors. Computer programmers working in an insurance related industry in Texas earn a median hourly wage of $34.93, according to the Texas Workforce Commission OES Report available at: http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5242&occcode=15-1021&compare=2. The number of hours that will be required to comply with a particular proposed requirement will vary, and as a result, any total cost, as well as other possible relevant factors, is addressed in the Cost Note discussion for the individual proposed requirement.

Printing costs. The Department's analysis of standard printing and paper costs in this Cost Note is based on the following factors. The Department estimates that the cost of printing could range from approximately $.06 to $.08 per page for printing and paper. The Department anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including number of pages that will need to be printed, and whether in-house printing costs or out-of-house printing costs will be incurred. The printing costs may vary and/or be slightly higher if in-house printing is not used.

Mailing costs. The Department's analysis of standard mailing costs in this Cost Note is based on the following factors. According to the United States Postal Service business price calculator, available at: http://dbcalc.usps.gov/, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP Code in the United States is $0.26. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the $0.26 cost; this estimate is based on six pages of standard 20 lb printing paper which weighs one ounce. The Department has determined that the cost of a standard business envelope is $0.016. Accordingly, for each additional mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28. The Department anticipates that the individual or entity required to comply with a proposed provision will have the information necessary to determine its individual cost, including number of mailings and the number of pages to be mailed.

I. Estimated Costs for Entities Subject to Subchapter R and/or Subchapter U.

The following proposed provisions may result in compliance costs for URAs, including HMO and insurer URAs and specialty URAs, to comply with either Subchapter R or Subchapter U:

A. Estimated Costs to URAs, Including HMO and Insurer URAs; and Specialty

URAs when Applicable.

Proposed §19.1704(d) and §19.2004(c): Form No. LHL005 Required Information. Proposed §19.1704(d) and §19.2004(c) set forth the information required in proposed Form No. LHL005 (Utilization Review Agent (URA) Application Form). Although some of the information is required by the Insurance Code §§4201.004, 4201.102, and 4201.104, and 28 TAC §1.503 (relating to Application of Fingerprint Requirement) and 28 TAC §1.504 (relating to Fingerprint Requirement), the following information is required as a result of both proposed §19.1704(d) and §19.2004(c): (i) policies relating to availability of personnel and telephone messaging systems; (ii) utilization review plan written policies that evidence compliance with various enumerated sections of Subchapter R or Subchapter U, as applicable; (iii) copies of template letters for notification of determinations made in utilization review that comply with §19.1710 or §19.1712, or with §19.2010 or §19.2012, as applicable; (iv) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code; and (v) a letter of good standing from the Texas Comptroller of Public Accounts. Additionally, the following information is required from URAs conducting utilization review for health care provided under workers' compensation coverage and subject to §19.2004(c): utilization review plan written policies which attest that peer reviews comply with the Texas Workers' Compensation Act and rules adopted pursuant to the Texas Workers' Compensation Act.

The Department anticipates that URAs may incur costs associated with drafting new policies and procedures, obtaining additional documentation, and submitting additional information. These estimated costs will likely be initial costs upon

initial application and initial drafting of requisite policies and procedures and subsequent costs every two years on renewal and policy and procedure updating. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1704(d) or §19.2004(c), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; (ii) cost of administrative assistant wages; (iii) cost to print new policies, procedures, and additional paperwork; and (iv) cost to mail new documentation.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1704(d) or §19.2004(c), as applicable.

(i) Cost of general operations manager wages. The Department anticipates that, because the proposed required provisions will likely require development of new policies and procedures, a URA's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures. Drafting of the new policies and procedures will likely require, on average, approximately four hours of a general operations manager's time. Therefore, the Department estimates, based on the median hourly wage for general operations managers detailed under the subheading "Repetitive Cost Note Information," that the total initial cost will be approximately $269.60. Additionally, the procedures and policies required under proposed §19.1704(d) or §19.2004(c), as applicable, are also required to be submitted upon renewal of the URA's certification or registration every two years, and therefore the URA's policies and procedures may require review and/or amendments biennially. The Department anticipates that the review and/or amendments will also require a general operations manager's time.

(ii) Cost of administrative assistant wages. The Department anticipates that a URA's administrative assistant will make copies of template letters for notification of determinations made in utilization review, obtaining written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, and obtaining a letter of good standing from the Texas Comptroller of Public Accounts. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these required tasks will take approximately two hours. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of approximately $37.20. This documentation is also required to be submitted upon renewal of the URA's certification or registration every two years and therefore the URA may incur similar costs biennially.

(iii) Cost to print new policies, procedures, and additional paperwork. The Department anticipates that a URA could incur a cost for printing new policies and procedures, copies of template letters for notification of determinations made in utilization review, and written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code as specified in §19.1704(d) or §19.2004(c), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This documentation has to be submitted upon renewal of the URA's certification or registration every two years and therefore the URA may incur similar costs biennially.

(iv) Cost to mail new documentation. The Department anticipates that a URA could incur a cost if the URA opts to transmit additional documentation by mail. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information."

Proposed §19.1704(e) and §19.2004(d): Correction of omissions or deficiencies and submission of a request for a waiver. Proposed §19.1704(e) and §19.2004(d) require an applicant to correct omissions or deficiencies in the URA application within 15 working days of the date of the Department's latest notice of such omissions or deficiencies. Under existing rules, an applicant has 30 days to correct omissions or deficiencies. Proposed §19.1704(e) and §19.2004(d) also allow the applicant to request in writing additional time to correct the omissions or deficiencies. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1704(e) or §19.2004(d), as applicable, could vary based upon cost of administrative assistant wages.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1704(e) or §19.2004(d), as applicable.

Cost of administrative assistant wages. The Department anticipates that a URA's administrative assistant will correct omissions or deficiencies in the URA application. The shorter time period of 15 days for correction may require some reassignment of job responsibilities and that one-time cost will vary based on the salaries of staff. However, the Department does not anticipate that the shorter time period will require any new staff. Alternatively, if an extension of time is requested in writing, the Department anticipates that a URA's administrative assistant will write and submit the request. The Department anticipates that writing and submitting the request could take approximately an hour. The Department therefore estimates, based on the median administrative assistant wage described under the subheading "Repetitive Cost Note Information," that a URA could incur an average one-time cost of administrative staff wages of $18.60 for submitting a written request for additional time. The Department does not anticipate that there will be any additional compliance costs for actually making or submitting the corrections as a result of proposed §19.1704(e) or §19.2004(d), as applicable, because such costs are required under existing rules.

Proposed §19.1705(d) and §19.2005(d): Development of screening criteria. Proposed §19.1705(d) and §19.2005(d) require URAs to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the URA must utilize generally accepted standards of medical practice recognized in the medical community. Currently, certified URAs conducting utilization review for health coverage under workers' compensation coverage and subject to §19.2005(d) may already have acceptable screening criteria in place because of existing statutory requirements. TDI-DWC's adopted treatment guidelines under 28 TAC §137.100 are evidence-based and presumed to prescribe medically reasonable care under the Texas Workers' Compensation Act. These statutory requirements and adopted treatment guidelines should, in some cases, mitigate the costs required to comply with proposed §19.2005(d).

Although the proposed rules do not prescribe the specific review criteria and procedures to be used by the URA, the Department has determined that the total estimated cost for a URA

to comply with proposed §19.1705(d) or §19.2005(d), as applicable, could vary based upon the following cost components: (i) cost to acquire some additional review criteria in order to comply with the requirement to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the Insurance Code §4201.153; and (ii) cost to utilize generally accepted standards of medical practice recognized in the medical community if evidence-based medicine is not available. The Department cannot, however, realistically estimate costs imposed by these variables and can only state that the cost will likely be determined by the types and number of criteria and standards already used by a particular URA.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1705(d) or §19.2005(d), as applicable.

Proposed §19.1705(g) and §19.2005(g): Complaint System. Proposed §19.1705(g) requires a URA to develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, their representatives, or health care providers concerning the utilization review. Proposed §19.2005(g) requires a URA to develop and implement procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers concerning the utilization review. Under the Insurance Code §4201.204, the complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. Additionally, as a result of proposed §19.1705(g) and §19.2005(g), the written response must include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department. The Department anticipates that URAs may incur nominal costs associated with including the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department in the written response. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1705(g) or §19.2005(g) could vary based upon the cost of administrative assistant wages.

Though the Department has identified one factor attributable to the costs of compliance with proposed §19.1705(g) or §19.2005(g), as applicable, it is not possible for the Department to estimate the total amount of cost attributable to compliance with these provisions because there are numerous factors affecting such a total that are not suitable to reliable quantification by the Department, including factors such as the number of complainant responses that will be required for each URA, or are minimal.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1705(d) or §19.2005(d), as applicable.

Cost of administrative assistant wages. The Department anticipates that inclusion of the additional required information in each written response to complainants as specified in proposed §19.1705(g) and §19.2005(g) will likely require a one-time cost of approximately two hours of administrative staff time. The Department anticipates that the additional required information will be drafted, on a one-time basis, for inclusion in existing templates of the written responses to complainants. The Department anticipates that an administrative assistant will include this additional information, i.e., the Department's address; the Department's toll-free telephone number; and a statement explaining that a complainant is entitled to file a complaint with the Department. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that a URA could incur a one-time cost of approximately $37.20 for administrative staff wages.

Proposed §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c).

Proposed §19.1706(c) and §19.2006(c) prohibit the physician who reviews the appeal from having any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee or injured employee, as applicable, who is requesting the appeal. Being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not constitute a disqualifying association. Proposed §19.1703(12) and §19.2003(11) define "disqualifying association" as any association that may reasonably be perceived as having potential to influence the conduct or decision of a reviewing physician or doctor, and the sections also contain a non-exhaustive list of examples of these associations.

Any URA subject to proposed §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), as applicable, may incur some cost to comply with the proposed requirements. For purposes of determining which physician to use for reviewing the appeal of a specific case, the URA will need to determine whether a disqualifying association exists. Additionally, if all of the URA's existing employed or contracted physicians have a disqualifying association, the URA may incur costs to employ or contract with a qualified physician.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages to determine whether a disqualifying association exists; and (ii) cost of finding a physician.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed 19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c), as applicable.

Cost of general operations manager wages. The Department anticipates that a URA's general operations manager will determine whether a disqualifying association exists. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this determination will likely require on average less than an hour.

Cost of finding a physician. Because being employed by or under contract with the same URA as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association, it is not anticipated that the URA will need to contract with any additional physicians or doctors. However, in the event that all of the URA's existing employed or contracted physicians have disqualifying associations, the URA may incur costs to obtain a physician. These costs will vary depending on the URA's method of locating such a physician and the number of physicians available.

Proposed §19.1706(d) and §19.2006(d): Documentation of information on physicians, doctors, and other health care providers. Proposed §19.1706(d) and §19.2006(d) require the URA to provide the name, number, type, license number and state of licensure, and qualifications of the personnel either employed by or under contract to perform the utilization review to the Department upon filing an original application or renewal application or upon providing updated information. While some of this information is required under existing rules, the following information is required as a result of both proposed §19.1706(d) and §19.2006(d): (i) name of personnel; and (ii) license number and state of licensure of personnel.

The Department anticipates that URAs may incur minimal costs associated with submitting to the Department the name, license number, and state of licensure of its personnel either employed by or under contract to perform utilization review in accordance with proposed §19.1706(d) or §19.2006(d), as applicable. These estimated costs will vary depending on how often the URA employs or contracts with personnel to perform utilization review, which will be a primary factor in determining the total cost for a particular URA. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1706(d) or §19.2006(d), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

Specialty URAs. Proposed §19.1706(d) or §19.2006(d) are not applicable to specialty URAs.

(i) Cost of administrative assistant wages. The Department anticipates that a URA will utilize an administrative assistant on a recurring basis for submitting the requisite information to the Department. The Department anticipates that a URA's administrative assistant will take approximately one hour to obtain the information, prepare it for mailing, and transmit it in accordance with the URA's mailing processes. Therefore, the Department estimates that a URA could incur an average cost of administrative staff wages of $18.60 per submission of an individual's information.

(ii) Cost to print the information. The Department anticipates that a URA could incur a cost for printing the name, license number, and state of licensure for submission in accordance with §19.1706(d) or §19.2006(d), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department estimates that the additional information will require less than one additional page to print.

(iii) Cost to mail new documentation. The Department anticipates that a URA could incur a cost to submit the name, license number, and state of licensure to the Department in accordance with §19.1706(d) and §19.2006(d). The Department estimates that the requisite documentation will not exceed one page and will therefore result in a mailing cost of $0.28 per submission.

Proposed §19.1710(b)(2) and §19.2010(b)(2): Preauthorization numbers.

Proposed §19.1710(b)(2) and §19.2010(b)(2) require URAs to ensure that preauthorization numbers assigned by URAs, based on the type of service in the preauthorization request, comply with the data and format requirements contained in the standards adopted by the federal Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction.

Any URA subject to proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable, that has not already modified its automated system to align with the formats required under the standards adopted by the Department of Health and Human Services in 45 CFR §162.1102, will incur some cost to modify its system to comply with the proposed requirements. While the format for the preauthorization number in professional, institutional, and dental electronic transactions is alphanumeric, the format for pharmacy transactions is numeric. Accordingly, URAs that currently assign only alphanumeric preauthorization numbers will need to modify their automated systems to assign numeric preauthorization numbers for drugs. With the adoption of the Federal electronic transaction standards, it is likely that the majority of URAs have already addressed this data issue. It is estimated, however, that approximately 35 percent of URAs will need to implement the associated format change. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable, could vary based on the cost of programming to modify the URA's automated system.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1710(b)(2) or §19.2010(b)(2), as applicable.

Cost of programming to modify the automated system. The URAs that will have to modify their automated systems to comply with these proposed requirements will need to initiate an automation project to design the changes, evaluate their automation systems for other corollary impacts, modify the assignment logic for preauthorization numbers, and test the changes prior to implementation. The Department anticipates that a URA could incur a one-time cost for programming necessary for this type of automation project. The Department estimates that an in-house programmer could require approximately 90 hours to complete this automation project. Therefore, the Department estimates that a URA could incur a one-time cost of approximately $3,143.70 for programming costs based on the median hourly wage for a computer programmer detailed under the subheading "Repetitive Cost Note Information."

Proposed §19.1710(c) and §19.2010(c): Notice of adverse determinations made in prospective and concurrent utilization review; Proposed §19.1715(b) and §19.2015(b): Notice of adverse determination for retrospective review. Proposed §19.1710(c) and §19.2010(c) set forth the notice elements that a URA is required to include in the written notification of a prospective or concurrent utilization review adverse determination. Proposed §19.1715(b) and §19.2015(b) set forth the notice elements that a URA is required to include in the written notification of a retrospective utilization review adverse determination. Although some of the information in proposed §19.1710(c) and §19.2010(c) and in proposed §19.1715(b) and §19.2015(b) is required as a result of existing rules and §4201.303 of the Insurance Code, the following information is required as a result of both proposed §19.1710(c) and §19.2010(c) and proposed §19.1715(b) and §19.2015(b): (i) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision; (ii) the professional specialty and state(s) of licensure of the physician or doctor that made the determination; (iii) a description of the URA's appeal process; (iv) the date and time the URA offered the opportunity to discuss the adverse

determination; and (v) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)).

Additionally, the following information is required in a written notification of a prospective or concurrent utilization review adverse determination issued by a URA conducting utilization review for health care provided under workers' compensation insurance coverage and subject to proposed §19.2010(c) and in the written notification of a retrospective review adverse determination that a URA conducting utilization review for health care provided under workers' compensation coverage and subject to proposed §19.2015(b): for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 (relating to Disability Management).

Although the Department does not expect an increase in the number of requests for an IRO based on the required inclusion of a copy of Form No. LHL009 with the written notification of adverse determination, it is possible that the inclusion of the form could increase the number of requests. An increased number of requests could result in an increased number of independent reviews for which a URA must pay under the Insurance Code §4201.403. However, it is not possible for the Department to estimate the amount of costs that a URA would incur because there are numerous factors involved that are not suitable to reliable quantification by the Department, including factors such as the number of written notifications of adverse determinations that are sent and whether the inclusion of the copy of the Form No. LHL009 would actually result in a request for independent review that would not have otherwise been made.

The Department anticipates that under proposed §19.1710(c) or §19.2010(c), as applicable, and proposed §19.1715(b) or §19.2015(b), as applicable, a URA may incur costs associated with drafting new templates for written notification of adverse determination and sending the additional information with each written notification of adverse determination.

The Department has determined that the total estimated cost for a URA to comply with the proposed requirements in §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable, could vary based upon the following cost components for each of the set of requirements: (i) cost of general operations manager wages; (ii) cost of programming automated fields in the notice; (iii) cost of administrative assistant wages; (iv) cost to print additional paperwork and the Form No. LHL009; and (v) cost to mail additional paperwork.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable.

(i) Cost of general operations manager wages. Because the proposed requirements will likely require development of a new template for the written notification required in proposed §19.1710(c) and §19.2010(c) and for the written notification required in proposed §19.1715(b) and §19.2015(b), the Department anticipates that a URA's general operations manager will do most if not all of the drafting and basic review of each of the new templates. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require, on average, approximately one to two hours of a general operations manager's time for the initial drafting to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and will likely require, on average, approximately another one to two hours of a general operations manager's time for the initial drafting to comply with proposed §19.1715(b) or §19.2015(b), as applicable. Therefore, a URA could incur a total initial cost of $67.40 to $134.80 to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and a separate initial cost of $67.40 to $134.80 to comply with proposed §19.1715(b) or §19.2015(b), as applicable. The Department does not anticipate that a general operation manager's time will be otherwise required for the URA to comply with proposed §19.1710(c) or §19.2010(c), as applicable, or with proposed §19.1715(b) or §19.2015(b), as applicable.

(ii) Cost of programming automated fields in the notice. Each notice of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable, and under proposed §19.1715(b) or §19.2015(b), as applicable, will not be identical, but there are certain automated fields that may be created in order to comply more efficiently with the notice requirements. The Department anticipates that a URA could incur a one-time cost for programming necessary to populate certain fields that are required in the notice of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable.

The Department also anticipates that a URA could incur a one-time cost for programming necessary to populate certain fields that are required in the notice of adverse determination under proposed §19.1715(b) or §19.2015(b), as applicable. The Department estimates that an in-house programmer could require approximately five to 10 hours to format the notice required under proposed §19.1710(c) or §19.2010(c), as applicable, and another five to 10 hours to format the notice required under proposed §19.1715(b) or §19.2015(b), as applicable. A computer programmer working in an insurance-related industry in Texas earns a median hourly wage of $34.93, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Therefore, the estimated average cost for a URA's in-house programmer time could range from $174.65 to $349.30 per year for compliance with proposed §19.1710(c) or §19.2010(c), as applicable, and an additional $174.65 to $349.30 per year for compliance with proposed §19.1715(b) or §19.2015(b), as applicable. The total annual amount will depend upon the number of hours that a particular URA needs the programmer based upon its unique preferences and existing information technology resources.

A URA's total cost for programming necessary to generate notices as necessary for compliance with proposed §19.1710(c) or §19.2010(c), as applicable, and with proposed §19.1715(b) or §19.2015(b), as applicable, will vary depending on the URA's computer systems and whether the URA uses an in-house or contract programmer. The actual number of hours, types, and cost of personnel will depend on each URA's existing information systems and staffing.

(iii) Cost of administrative assistant wages. Because each written notification of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable, and under proposed §19.1715(b) or §19.2015(b), as applicable, requires some additional information that is specific to the individual case, the Department anticipates that a URA will incur a recurring cost of administrative assistant wages to tailor each notification of adverse determination. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note

under the subheading "Repetitive Cost Note Information." The Department anticipates that approximately one to two hours will be required for an administrative assistant to tailor each written notification of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable. The Department also anticipates that another approximately one to two hours will be required for an administrative assistant to tailor each written notification of adverse determination under proposed §19.1715(b) or §19.2015(b), as applicable. Therefore, a URA could have recurring administrative assistant cost of $18.60 to §37.20 per written notification of adverse determination under proposed §19.1710(c) or §19.2010(c), as applicable, and the same amount per written notification of adverse determination under proposed §19.1715(b) or §19.2015(b), as applicable. However, the total cost to the URA for administrative assistant wages will vary depending on the number of written notifications of adverse determination issued.

(iv) Cost to print additional paperwork and the Form No. LHL009. The Department anticipates that as a result of proposed §19.1710(c) or §19.2010(c), as applicable, and proposed §19.1715(b) or §19.2015(b), as applicable, a URA could incur a recurring cost for printing the additional required notice elements and a copy of the Form No. LHL009. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 contains four pages, but the additional pages necessary for the required notice elements may vary. Therefore, the Department is not able to estimate the required number of pages. In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of written notifications of adverse determination issued by each URA.

(v) Cost to mail additional paperwork. The Department anticipates that a URA could incur a recurring cost to mail the additional required notice elements and the copy of Form No. LHL009 to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and with proposed §19.1715(b) or §19.2015(b), as applicable. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 contains four pages, but the additional pages necessary for the required notice elements may vary. Therefore, the Department is not able to estimate the required number of pages per notice. In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of written notifications of adverse determination issued by each URA.

Proposed §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4): Documentation of Peer to Peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations.

Proposed §19.1711(b)(3) and §19.2011(b)(3) require the URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome. Further, proposed §19.1711(b)(4) and §19.2011(b)(4) require the URA to submit the documentation to the Department or TDI-DWC upon request, as applicable. The Department anticipates that a URA may incur ongoing weekly costs associated with recording the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome and submitting such documentation to the Department upon request, as required under proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4). The Department has determined that the total estimated cost for a URA to comply with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

Specialty URAs. Proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) are not applicable to specialty URAs.

(i) Cost of administrative assistant wages. The Department anticipates that a URA could incur a weekly cost for an administrative assistant of approximately four hours to maintain documentation of peer-to-peer communication and submit records of those communications to the Department upon request in accordance with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular URA's number of adverse determinations and communications with providers of record. The Department anticipates that each URA has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors of which the URA is aware that will impact the URA's total cost to comply with the requirements of proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. The Department also anticipates that a URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable. The Department anticipates that approximately five hours annually will be required of a URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the URA could incur an estimated annual cost of $93.00. The total annual cost to the URA will vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) Cost to print the required documentation. The Department anticipates that a URA could incur a cost for printing the required documentation of the date and time the URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome, to submit to the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) Cost to mail the documentation to the Department upon request. The Department anticipates that a URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," the total cost to the URA to transmit by mail the requisite documentation in accordance with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4), as applicable, will vary depending on the business practices of the URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

Proposed §19.1711(c)(3) - (4) and §19.2011(c)(3) - (4): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Retrospective Review Adverse Determinations.

Proposed §19.1711(c)(3) and §19.2011(c)(3) require the URA, prior to issuing a retrospective review adverse determination, to maintain certain specified documentation relating to the discussion opportunity provided to the provider of record. The requisite documentation must detail the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the date and time the discussion, if any, took place; and the discussion outcome. Proposed §19.1711(c)(4) and §19.2011(c)(4) require the URA to submit the documentation required by proposed §19.1711(c)(3) and §19.2011(c)(3) to the Department, upon request, and, for URAs subject to §19.2011(c)(4), to TDI-DWC, upon request.

The Department anticipates that URAs may incur costs associated with maintaining the required documentation and submitting it upon request to the Department or TDI-DWC, as applicable. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1711(c)(3) - (4) or §19.2011(c)(3) - (4), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation upon request.

Specialty URAs. Proposed §19.1711(c)(3) and (4) or §19.2011(c)(3) and (4) are not applicable to specialty URAs.

(i) Cost of administrative assistant wages. The Department anticipates that a URA will incur a weekly recurring cost of administrative assistant wages to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination; the date and time the discussion, if any, took place; and the discussion outcome, as required under proposed §19.1711(c)(3) or §19.2011(c)(3), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that approximately four hours per week will be required of a URA's administrative assistant to maintain the required documentation, for a recurring weekly fee of $74.40. This estimate, however, could vary depending on how much time is required based upon the particular URA's number of adverse determinations and communications with providers of record. The Department anticipates that each URA has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors of which the URA is aware that will impact the URA's total cost to comply with the requirements of proposed §19.1711(c)(3) or §19.2011(c)(3), as applicable. The Department also anticipates that a URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with §19.1711(c)(4) or §19.2011(c)(4), as applicable. The Department anticipates that approximately five hours annually will be required of a URA's administrative assistant to submit such documentation, for an annual cost of $93.00. The total annual cost to the URA will vary, however, based on the number of peer-to-peer opportunities that are offered by the URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) Cost to print required documentation. The Department anticipates that a URA could incur a recurring cost for printing the required documentation. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of times the Department or TDI-DWC requests the required documentation.

(iii) Cost to mail required documentation upon request. The Department anticipates that a URA could incur a recurring cost to mail the required documentation. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will also vary based on the number of peer-to-peer opportunities that are offered by the URA and the number of Department or TDI-DWC requests for the required documentation.

Proposed §19.1712(a) and §19.2012(a): Written procedures for appeals of prospective or concurrent review adverse determinations. Proposed §19.1712(a) and §19.2012(a) require a URA to maintain and make available a written description of appeal procedures involving an adverse determination that are used by the agent and prescribe the information that the written procedures must include. Although some of the information in §19.1712(a) is required under existing rules or is required by statute, the following new information is required as a result of proposed amendments to §19.1712(a): (i) a statement specifying the time frames for filing the written or oral appeal; (ii) a provision that appeal decisions must be made by a physician who has not previously reviewed the case; (iii) a provision that states that prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician; (iv) a provision that states that an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed by a letter within three working day of the initial telephonic or electronic notification.

Further, the following new information is also required as a result of proposed §19.1712(a): (i) a provision that after a URA has sought review of the appeal of the adverse determination,

the URA must issue a response letter, and such letter must include all of the requirements of proposed §19.1712(a)(2)(H); and (ii) a provision that the appeal must be resolved as soon as practical, but, in accordance with the Insurance Code §4201.359, in no case later than 30 days after the date the URA receives the written appeal, as required in existing rules; or, as provided in the proposed amendment, the one-page appeal form from the appealing party.

Proposed §19.2012(a) requires a URA to maintain and make available a written description of appeal procedures involving an adverse determination that are used by the agent and prescribe the information that the written procedures must include. Although some of the information is required under existing rules or is required by statute, the following new information is required for URAs conducting utilization review for health care provided under workers' compensation insurance coverage and subject to §19.2012(a): (i) a statement specifying the time frames for filing the appeal; for workers' compensation network coverage, the time frames may not be less than 30 days after the date of issuance of written notification of an adverse determination; (ii) a provision that if the health care provider sets forth in the written request for appeal good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review; (iii) a provision that appeal decisions must be made by a physician who has not previously reviewed the case in accordance with 28 TAC Chapter 180 (relating to Monitoring and Enforcement), the Insurance Code §1305.354 and 28 TAC §10.103; (iv) a provision that states that prior to issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician; and (v) a provision that states that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that complies with §19.2012(a)(2)(e) - (f).

The Department anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with drafting written procedures for appeals and implementing those procedures. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1712(a) or §19.2012(a), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; and (ii) cost of implementation of written procedures, including printing and mailing costs. For URAs subject to §19.2012, the cost of implementation will include the cost of determining whether there is good cause for a specialty reviewer and obtaining review by a specialty health care provider under §19.2012(a)(2)(B) if the URA does not have the applicable specialty reviewer on staff or under contract.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1712(a) or §19.2012(a), as applicable, with the following exceptions: (i) proposed §19.1712(a)(2)(D) or §19.2012(a)(2)(C) requiring that appeal decisions of prospective or concurrent adverse determinations be made by a physician who has not previously reviewed the case; and (ii) proposed §19.1712(a)(2)(E) requiring in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services or §19.2012(a)(2)(D) requiring in any instance in which the URA is questioning the medical necessity or appropriateness of the health care services, prior to issuance of a prospective or concurrent adverse determination, the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee or injured employee with a physician.

(i) Cost of general operations manager wages. The Department anticipates that, because the proposed requirements will likely involve drafting of new procedures, a URA's general operations manager will do most if not all of the drafting and basic review of the new written procedures. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately four to 10 hours of a general operations manager's time for the initial drafting, for a total initial fee of $269.60 to $674.00.

(ii) Cost of implementation of written procedures, including printing and mailing costs.

(a) Implementation. The Department anticipates that a URA's implementation of the proposed new procedures and requirements will also result in additional costs to the URA. Under proposed §19.1712(a), implementation of the following new procedures may require additional costs: (i) the 30-day time frame for filing the written or oral appeal; (ii) the requirement that appeal decisions must be made by a physician, doctor, or other health care provider who has not previously reviewed the case; (iii) the requirement that, for an expedited appeal determination, a letter must be provided within three working day of the initial telephonic or electronic notification; (iv) the requirement that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that must contain certain specified elements of information, including a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) and procedures for filing a complaint; and (v) the requirement that the appeal be resolved as soon as practical, but in no case later than 30 days after the date the URA receives the written appeal or one-page appeal form from the appealing party.

Under proposed §19.2012(a), implementation of the following procedures may require additional costs (i) the time frame for filing the appeal; for workers' compensation network coverage, the time frame may not be less than 30 days after the date of issuance of written notification of an adverse determination; (ii) the requirement that if the health care provider sets forth in the written request for appeal good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review; (iii) the requirement that appeal decisions be made by a physician who has not previously reviewed the case; and (iv) the requirement that after a URA has sought review of the appeal of the adverse determination, the URA must issue a response letter that must contain certain specified elements of information, including a copy of the Form No. LHL009 request for independent review and procedures for filing a complaint;

(b) Printing costs. Implementation of these written procedures may require printing costs for the additional letters or information required under proposed §19.1712(a) or §19.2012(a), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information."

In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will vary based on the number of letters the URA is required to send under proposed §19.1712(a) or §19.2012(a), as applicable.

(c) Mailing costs. Implementation of these written procedures may also include a recurring cost to mail the required letters. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total annual cost will vary based on the number of letters the URA is required to send under proposed §19.1712(a) or §19.2012(a), as applicable.

(d) Costs of implementing §19.2012(a)(2)(B). Implementation of §19.2012(a)(2)(B) may include recurring costs for (i) the URA to review the request to determine whether good cause exists for a specialty reviewer; and (ii) obtaining the specialty reviewer. The Department anticipates that a general operations manager would review the written request for appeal by a specialty reviewer and would make the decision as to whether good cause exists for a specialty reviewer. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this review will likely require on average approximately 15 minutes of a general operations manager's time, for a total recurring fee of $16.85 per request. Additionally, if the URA determines that good cause exists for a specialty reviewer, the URA may need to obtain a specialty reviewer if the URA does not have the applicable specialty reviewer on staff or under contract. The Department estimates that the cost for the specialty reviewer to conduct the review will be comparable to the cost for a physician or doctor, but obtaining such a specialty reviewer may incur costs, which will vary depending on the URA's method of obtaining a specialty reviewer and the number of specialty reviewers available.

(e) Cost factors not quantifiable. It is not possible for the Department to estimate the costs that a URA could incur to implement all of the written procedures because there are numerous factors involved that are not suitable to reliable quantification by the Department. These factors include the extent to which the URA is already implementing the new required procedures and the number of appeals of prospective or concurrent adverse determinations that the URA receives.

Proposed §19.1712(b) and §19.2012(b): Written procedures for appeals of retrospective review adverse determinations. Proposed §19.1712(b) or §19.2012(b), as applicable, require a URA to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The Department anticipates that URAs may incur costs associated with drafting this written description. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1712(b) or §19.2012(b), as applicable, could vary based upon the cost of general operations manager wages necessary for drafting the written description.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1712(b) or §19.2012(b), as applicable, with the following exception: proposed §19.1712(b)(3) or §19.2012(b)(1)(B), as applicable, requiring in any instance in which the URA is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to issuance of a retrospective review adverse determination, the URA to afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee or injured employee with a physician or, in cases of a dental plan or chiropractic services, with a dentist or chiropractor respectively.

Cost of general operations manager wages necessary for drafting the written description. The Department anticipates that, because the proposed requirements will likely require development of a written description of the appeal procedures involving an adverse determination in a retrospective review, a URA's general operations manager will do most if not all of the drafting of this written description. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately 10 hours of a general operations manager's time for the drafting, for a total one-time cost of approximately $674.00.

Proposed §19.1714(a)(12) and §19.2014(a)(12): Retention of records. Proposed §19.1714(a)(12) and §19.2014(a)(12) require a URA to retain information generated and obtained by the URA in the course of utilization review for at least four years, instead of the existing requirement of two years.

The Department anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with storing information generated and obtained by a URA in the course of utilization review for the additional two years. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable, could vary based upon the following cost component: cost of storing the required information for an additional two years.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable.

Cost of storing the required information for an additional two years. Although the Department estimates that the cost of storing the required information for an additional two years is nominal, the Department has considered the following factors: One thousand pieces of paper will not fill a standard-size file cabinet drawer or a standard-size file box. Electronically, at approximately 26 kilobytes per single page PDF file, 1,000 single-page proof files would amount to approximately 26 megabytes of storage, which is less than one-tenth of one percent of a 40-gigabyte hard drive. Thus, while storing a large number of records may increase a URA's current storage cost, it is unlikely that even the potential maximum volume that could result from compliance with proposed §19.1714(a)(12) or §19.2014(a)(12), as applicable, will result in significant additional costs or in an alteration of a URA's current record storage system. Each URA, however, that is required to comply with proposed §19.1714(a)(12) or §19.2014(a)(12) has the cost and other available information necessary to determine the URA's individual storage costs to comply. Therefore, each URA has the flexibility to determine the most economical means of complying with the §19.1714(a)(12) or §19.2014(a)(12) requirements.

Proposed §19.1721(a) and §19.2021(a): Notification of independent review of adverse determinations concerning

life-threatening conditions. Proposed §19.1721(a)(1)(B) and §19.2021(a)(1)(B) require a URA, at the time of notification of an adverse determination concerning life-threatening conditions, to include a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) for requesting independent review with the notice of the independent review process.

Although some of the information is required under existing rules, each URA will incur a cost to comply with the new requirement to include a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) with the notice of the independent review process. The inclusion of a copy of Form No. LHL009 may facilitate the submission of a request for review by an IRO, thereby increasing the overall number of requests for review by an IRO. A URA is required to pay for an independent review under the Insurance Code §4201.403, if such review is conducted under Chapter 4201, Subchapter I, of the Insurance Code. Although the Department does not expect an increase in the number of requests for an IRO based on the required inclusion of a copy of Form No. LHL009 with the written notification of adverse determination, it is possible that the inclusion of the form could increase the number of requests. An increased number of requests could result in an increased number of independent reviews for which a URA must pay under the Insurance Code §4201.403.

It is not possible for the Department to estimate the costs that a URA would incur as a result of any increase in the number of requests because the relevant factors are not suitable to reliable quantification by the Department. These factors include the number of written notifications of adverse determinations that are sent and whether the copy of the Form No. LHL009 would actually cause a request for independent review that would not have otherwise been made.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1721(a) or §19.2021(a), as applicable, could vary based upon the following cost components: (i) cost to print the independent review request form; (ii) cost to mail the independent review request form; and (iii) for URAs subject to §19.2021, cost of the potential increase in life-threatening cases based on the "prudent layperson" standard.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1721(a) or §19.2021(a), as applicable.

(i) Cost to print independent review request form. The Department anticipates that a URA could incur a cost for printing Form No. LHL009 to include with the notice of adverse determination, as required by §19.1721(a) or §19.2021(a), as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Form No. LHL009 is four pages in length; therefore, the printing cost of the form could range from approximately $.24 to $.32 per form that is included with the notice of adverse determination. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's potential printing costs will also vary depending on the number of notifications of adverse determination that the URA is required to send.

(ii) Cost to mail independent review request form. The Department anticipates that URAs may incur costs associated with sending Form No. LHL009. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Because the URA is required to send a notice of adverse determination under existing rules and Form No. LHL009 is only four pages, the Department estimates that any additional mailing cost resulting from this rule proposal would be nominal. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's potential mailing costs will also vary depending on the number of notifications of adverse determination that the URA is required to send.

(iii) For URAs subject to §19.2021, potential cost of the increase in life-threatening cases based on the "prudent layperson" standard. Under proposed §19.2021(a)(1)(C), the injured employee, injured employee's representative, or the injured employee's provider of record is required to determine the existence of a life-threatening condition on the basis that a "prudent layperson" possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition.

Existing rules do not specify who has to make the determination on whether a case is life-threatening. However, the addition of the "prudent layperson" standard to determine the existence of a life-threatening condition by the injured employee, injured employee's representative, or the injured employee's provider could increase the number of life-threatening cases, and thereby increase the number of requests for independent review for such cases. However, it is not possible for the Department to estimate the amount of costs that a URA would incur as a result of such increases because the factors involved are not reliably quantifiable by the Department. These factors include whether a life-threatening case would not otherwise be considered "life-threatening" but for the "prudent layperson" standard and the overall number of life-threatening cases.

B. Estimated Costs to Insurers Only

Proposed §19.1719(b) and §19.2019(c): Responsibility of Insurers to Comply with Registration Filing Requirements. Proposed §19.1719(b) specifies that when an insurer performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the insurer must have a valid registration pursuant to §19.1704 (relating to Certification or Registration of Utilization Review Agents) and must comply with all filing requirements under §19.1704. Proposed §19.2019(c) requires an insurance carrier performing utilization review under Chapter 4201 of the Insurance Code only for coverage for which it is the payor, to have a valid registration pursuant to §19.2004, and comply with all filing requirements under §19.2004. However, an insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health or workers' compensation coverage for which it is the payor.

The Department anticipates that proposed §19.1719(b) or §19.2019(c) could result in costs to comply for insurers that are performing utilization review for health coverage for which it is the payor. The Department anticipates that insurers may incur costs associated with preparing the application for registration and renewal of registration required under §19.1704 or §19.2004, as applicable, printing the application, and submitting it to the Department. These estimated costs will likely be one-time costs upon initial application for registration and

initial drafting of requisite policies and subsequent costs every two years on renewal of registration. The Department has determined that the total estimated cost for an insurer to comply with proposed §19.1719(b) or §19.2019(c), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages necessary for drafting policies and procedures; (ii) cost of administrative assistant wages for submitting the application for registration or renewal of registration; (iii) cost to print the application required under proposed §19.1704 or §19.2004, as applicable; and (iv) cost to mail the application required under proposed §19.1704 or §19.2004, as applicable.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1719(b) or §19.2019(c), as applicable.

(i) Cost of general operations manager wages necessary for drafting policies and procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the application requirements under §19.1704 or §19.2004, as applicable, an insurer's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures for completion of Form No. LHL005 (Utilization Review Agent (URA) Application Form). A general operations manager working for an insurer in Texas earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately eight to ten hours of a general operations manager's time for the initial drafting. Therefore, the URA's total initial cost would range from $539.20 to $674.00. Additionally, Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer's policies and procedures may require review and/or amendments biennially. The Department anticipates that the review and/or amendments could also require a general operations manager's time.

(ii) Cost of administrative assistant wages for submitting the insurer's application for registration or renewal of registration. The Department anticipates that an insurer's administrative assistant will complete and submit the application Form No. LHL005 for original registration or renewal of registration. An administrative assistant working for an insurer in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these activities will take approximately two hours. The Department therefore estimates that an insurer could incur an average cost of administrative staff wages of $37.20. Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

(iii) Cost to print the application required under §19.1704 or §19.2004. The Department anticipates that an insurer could incur a cost for printing the application Form No. LHL005 as required under §19.1704 or §19.2004, as applicable. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This application must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

(iv) Cost to mail the application required under §19.1704 or §19.2004. The Department anticipates that an insurer will incur a cost when the insurer mails the application Form No. LHL005 for registration or renewal of registration by mail. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," an insurer's total cost to mail the application will vary depending on the number of pages and the business practices of the insurer. Form No. LHL005 must be submitted upon renewal of the insurer's registration every two years, and therefore the insurer may incur similar costs biennially.

C. Estimated Costs to Specialty URAs Only

Proposed §19.1720(c) and §19.2020(c): Utilization Review Plan. Proposed §19.1720(c) and §19.2020(c) require a specialty URA to develop written procedures to ensure that existing §19.1720(c) and §19.2020(c) requirements are implemented. Existing §19.1720(c), relating to utilization review plan for specialty URAs for health care provided under a health benefit plan or health insurance policy, requires a specialty URA to have its utilization review plan, including appeal requirements, reviewed by a physician, doctor, or other health care provider of the appropriate specialty. Additionally, the plan must be implemented in accordance with standards developed with input from a physician, doctor, or other health care provider of the appropriate specialty. Existing 19.2020(c), relating to utilization review plan for specialty URAs for health care provided under workers' compensation insurance coverage, mandates the same requirements imposed under existing §19.1720(c).

The Department anticipates that proposed §19.1720(c) or §19.2020(c), as applicable, could result in costs to comply for specialty URAs. The Department estimates that the total cost for a specialty URA to comply with §19.1720(c) or §19.2020(c), as applicable, could vary based upon the following cost component: cost of general operations manager to develop written procedures.

Cost of general operations manager wages to develop written procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the requirements under §19.1720(c) or §19.2020(c), as applicable, an insurer's general operations manager will do most, if not all, of the drafting and basic review of these new policies and procedures. A general operations manager working for an insurer in Texas earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this development of written procedures will likely require on average approximately eight to ten hours of a general operations manager's time for the initial drafting. Therefore, the URA's total initial cost would range from $539.20 to $674.00.

Proposed §19.1720(e) and §19.2020(e): Documentation of physicians, doctors and other health care providers. Proposed §19.1720(e) and §19.2020(e) require the specialty URA to provide to the Department the name, number, type, license number and state of licensure, and qualifications of the personnel either employed by or under contract to perform the utilization review.

The Department anticipates that specialty URAs may incur costs associated with submitting the name, number, type, license number and state of licensure, and qualifications of its personnel either employed by or under contract to perform utilization review in accordance with proposed §19.1720(e) or §19.2020(e),

as applicable. These estimated costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review. The Department has determined that the total estimated cost for a URA to comply with proposed §19.1720(e) or §19.2020(e), as applicable, could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

(i) Cost of administrative assistant wages. The Department anticipates that a specialty URA's administrative assistant will likely submit to the Department on a recurring basis the name, number, type, license number and state of licensure, and qualifications of its personnel. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The administrative assistant will need to obtain the information, prepare it for mailing, and transmit it in accordance with the URA's mailing processes. The Department anticipates that these tasks will take approximately one hour. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of $18.60 per submission. The annual costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

(ii) Cost to print the information. The Department anticipates that a specialty URA could incur a cost for printing the name, number, type, license number and state of licensure, and qualifications for submission in accordance with §19.1720(e) or §19.2020(e). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's annual costs will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

(iii) Cost to mail new documentation. The Department anticipates that a specialty URA could incur a cost to submit the name, number, type, license number and state of licensure, and qualifications to the Department in accordance with §19.1720(e) and §19.2020(e). For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a specialty URA's total cost to transmit documentation by mail will vary depending on the number of pages and the business practices of the specialty URA. The annual costs for submission of documentation will vary depending on how often the specialty URA employs or contracts with personnel to perform utilization review.

Proposed §19.1720(h)(1)(D) - (E) and §19.2020(h)(1)(D) - (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations.

Proposed new §19.1720(h)(1)(D) and §19.2020(h)(1)(D) require the specialty URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome. Further, proposed new §19.1720(h)(1)(E) and §19.2020(h)(1)(E) require the specialty URA to submit the documentation to the Department or TDI-DWC upon request, as applicable. Under the Insurance Code §4201.456, before a specialty URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service issues an adverse determination, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the specialty URA's determination with a health care provider who is of the same specialty as the agent.

The Department anticipates that a specialty URA may incur ongoing weekly costs associated with recording the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome and submitting such documentation to the Department upon request as required under proposed new §19.1720(h)(1)(D) - (E) or proposed new §19.2020(h)(1)(D) - (E), as applicable. The Department has determined that the total estimated cost for a specialty URA to comply with proposed new §19.1720(h)(1)(D) - (E) or proposed new §19.2020(h)(1)(D) - (E), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

(i) Cost of administrative assistant wages. The Department anticipates that a specialty URA could incur a weekly cost for an administrative assistant of approximately four hours to maintain documentation of peer-to-peer communication and submit records of those communications to the Department upon request in accordance with proposed new §19.1720(h)(1)(D) - (E) or proposed new §19.2020(h)(1)(D) - (E), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the specialty URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular specialty URA's number of adverse determinations and communications with providers of record. The Department anticipates that each specialty URA has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors of which the specialty URA is aware that will impact the specialty URA's total cost to comply with the requirements of proposed new §19.1720(h)(1)(D) - (E) or proposed new §19.2020(h)(1)(D) - (E), as applicable. The Department also anticipates that a specialty URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with proposed new §19.1720(h)(1)(E) or proposed new §19.2020(h)(1)(E), as applicable. The Department anticipates that approximately five hours annually will be required of a specialty URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the specialty URA could incur an estimated annual cost of $93.00. The total annual cost to the specialty URA will vary based on the number of peer-to-peer opportunities that are offered by the specialty URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) Cost to print the required documentation. The Department anticipates that a specialty URA could incur a cost for printing the required documentation of the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion

outcome, to submit to the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a specialty URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) Cost to mail the documentation to the Department upon request. The Department anticipates that a specialty URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," the total cost to the specialty URA to transmit by mail the requisite documentation in accordance with proposed new §19.1720(h)(1)(E) or proposed new §19.2020(h)(1)(E), as applicable, will vary depending on the business practices of the specialty URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

Proposed §19.1720(h)(2)(D) - (E) and §19.2020(h)(2)(D) - (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Retrospective Review Adverse Determinations.

Proposed new §19.1720(h)(2)(D) and §19.2020(h)(2)(D) require the specialty URA to maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome. Proposed new §19.1720(h)(2)(E) and §19.2020(h)(2)(E) require the specialty URA to submit the documentation to the Department or TDI-DWC upon request, as applicable.

The Department anticipates that a specialty URA may incur ongoing weekly costs associated with recording the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome and submitting such documentation to the Department upon request as required under proposed new §19.1720(h)(2)(D) - (E) or proposed new §19.2020(h)(2)(D) - (E), as applicable. The Department has determined that the total estimated cost for a specialty URA to comply with proposed new §19.1720(h)(2)(D) - (E) or proposed new §19.2020(h)(2)(D) - (E), as applicable, could vary based upon the following components: (i) cost of administrative assistant wages; (ii) cost to print the required documentation; and (iii) cost to mail the documentation to the Department upon request.

(i) Cost of administrative assistant wages. The Department anticipates that a specialty URA could incur a weekly cost for an administrative assistant of approximately four hours to maintain documentation of peer-to-peer communication and submit records of those communications to the Department upon request in accordance with proposed new §19.1720(h)(2)(D) - (E) or proposed new §19.2020(h)(1)(D) - (E), as applicable. An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department therefore estimates that the specialty URA could incur an estimated total cost of $74.40 per week. This estimate, however, could vary depending on how much time is required based upon the particular specialty URA's number of adverse determinations and communications with providers of record. The Department anticipates that each specialty URA has the information necessary to determine its estimated total monthly and annual costs based on these factors and any other factors of which the specialty URA is aware that will impact the specialty URA's total cost to comply with the requirements of proposed new §19.1720(h)(2)(D) - (E) or proposed new §19.2020(h)(2)(D) - (E), as applicable. The Department also anticipates that a specialty URA will incur a recurring cost of administrative assistant wages to submit the required documentation upon request, in compliance with proposed new §19.1720(h)(2)(E) or proposed new §19.2020(h)(2)(E), as applicable. The Department anticipates that approximately five hours annually will be required of a specialty URA's administrative assistant to submit such documentation. The Department, therefore, estimates that the specialty URA could incur an estimated annual cost of $93.00. The total annual cost to the specialty URA will vary based on the number of peer-to-peer opportunities that are offered by the specialty URA and the number of Department or TDI-DWC requests for the required documentation.

(ii) Cost to print the required documentation. The Department anticipates that a specialty URA could incur a cost for printing the required documentation of the date and time the specialty URA offered the opportunity to discuss the adverse determination; the time that the discussion, if any, took place; and the discussion outcome, to submit to the Department upon request. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the possible cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a specialty URA's potential printing costs could vary based upon the number of adverse determinations issued and, consequently, the number of peer-to-peer communications that are required.

(iii) Cost to mail the documentation to the Department upon request. The Department anticipates that a specialty URA could incur costs to mail the documented communications to the Department upon request. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each submission to the Department of documented discussions with providers of record that does not exceed 18 pages, it is estimated that the mailing cost would be no more than $0.28 per submission. In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," the total cost to the specialty URA to transmit by mail the requisite documentation in accordance with proposed new §19.1720(h)(2)(E) or proposed new §19.2020(h)(2)(E), as applicable, will vary depending on the business practices of the specialty URA, the number of adverse determinations and, consequently, the amount of documentation that is required.

II. Estimated Costs for Entities Subject to Additional Subchapter R Requirements that have not been Previously Discussed.

The following provisions may result in compliance costs for URAs and HMO URAs, to comply with Subchapter R:

A. Estimated Costs to URAs, including HMO and insurer URAs, and specialty URAs

Proposed §19.1721(b)(3): Information required to be provided to the assigned independent review organization. Proposed §19.1721(b)(3) requires the URA, after receiving a request for independent review, to provide the assigned IRO copies of documentation. Although some of the documentation is required under existing rules, the following information is required as a result of proposed §19.1721(b)(3): (i) any documents used by the URA in making the determinations to be reviewed by the IRO; (ii) the written notification described by §19.1710 (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review), and §19.1715 (relating to Notice of Determination Made in Retrospective Review); and (iii) any documentation and written information submitted to the health benefit plan in support of the appeal.

The Department has determined that the total estimated cost for a URA to comply with proposed §19.1721(b)(3) could vary based upon the following cost components: (i) cost of administrative assistant wages; (ii) cost to print the information; and (iii) cost to mail new documentation.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1721(b)(3).

(i) Cost of administrative assistant wages. The Department anticipates that a URA's administrative assistant will need to assemble, print and submit to the Department on a recurring basis the additional documentation required by proposed §19.1721(b)(3). An administrative assistant working in an insurance-related industry in Texas earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that the requisite tasks will take approximately one to 10 hours, depending on the amount of documentation required. The Department therefore estimates that a URA could incur an average cost of administrative staff wages of $18.60 to §186.00 per assigned independent review. The annual costs will vary depending on how many independent reviews are assigned.

(ii) Cost to print the information. The Department anticipates that a URA could incur a cost for printing the additional documentation required by proposed §19.1721(b)(3). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's annual costs will vary depending on how many independent reviews are assigned.

(iii) Cost to mail new documentation. The Department anticipates that a URA could incur a cost to submit the additional documentation required by proposed §19.1721(b)(3). For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total cost to mail the documentation will vary depending on the number of pages and the business practices of the URA. The annual costs for submission of documentation will vary depending on how many independent reviews are assigned.

B. Estimated Costs to HMOs Only

Proposed §19.1719(a): Responsibility of HMOs to Comply with Registration Filing Requirements. Proposed §19.1719(a)(3) specifies that when an HMO performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the HMO must have a valid registration pursuant to §19.1704 (relating to Certification or Registration of Utilization Review Agents) of Chapter 4201, Subchapter C of the Insurance Code and must comply with all filing requirements under §19.1704. However, an HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor.

The Department anticipates that proposed §19.1719(a) could result in costs to comply for HMOs that are performing utilization review for health coverage for which it is the payor. The Department anticipates that HMOs may incur costs associated with preparing the application for registration required under §19.1704, printing the application, and submitting it to the Department. These estimated costs will likely be one-time costs upon initial application for registration and initial drafting of requisite policies and similar subsequent costs every two years on renewal of registration. The Department has determined that the total estimated cost for an HMO to comply with proposed §19.1719(a) could vary based upon the following cost components: (i) cost of general operations manager wages necessary for drafting and updating policies and procedures; (ii) cost of administrative assistant wages for submitting the application for registration or renewal of registration; (iii) cost to print the HMO application for registration or renewal of registration; and (iv) cost to mail the application.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.1719(a).

(i) Cost of general operations manager wages necessary for drafting and updating policies and procedures. The Department anticipates that, because the proposed provisions will likely require development of new policies and procedures to meet the application requirements under proposed §19.1719(a), an HMO's general operations manager will do most if not all of the drafting and basic review of these new policies and procedures for completion of Form No. LHL005 (Utilization Review Agent (URA) Application Form). A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately eight to 10 hours of a general operations manager's time for the initial drafting, for a total initial cost ranging from $539.20 to $674.00. Additionally, Form No. LHL005 must be submitted upon renewal of the HMO's registration every two years, and therefore the HMO's policies and procedures may require review and/or amendments biennially. The Department anticipates that the review and/or amendments could also require a general operations manager's time; the amount of time will vary based on how many changes, if any, are needed to the policies and procedures.

(ii) Cost of administrative assistant wages for submitting the HMO application for registration or renewal of registration. The Department anticipates that an HMO's administrative assistant will complete and submit the application Form No. LHL005 for original registration or renewal of registration. An administrative assistant working in an insurance-related industry in Texas

earns a median hourly wage of $18.60, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that these form completion and submission tasks will take approximately two hours. The Department therefore estimates that an HMO could incur an average cost of administrative staff wages of $37.20. Form No. LHL005 must also be submitted upon renewal of the HMO's registration every two years and therefore the HMO may incur similar costs biennially.

(iii) Cost to print the HMO application for registration or renewal of registration. The Department anticipates that an HMO could incur a cost for printing the application Form No. LHL005 to comply with proposed §19.1719(a). The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." This application must be submitted upon renewal of the HMO's registration every two years and therefore the HMO may incur similar costs biennially.

(iv) Cost to mail the HMO application. The Department anticipates that an HMO will incur a cost when the HMO submits the application Form No. LHL005 for registration or renewal of registration by mail. For each individual mailing that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Accordingly, for each page of the application that does not exceed 18 pages, it is estimated that the total mailing cost would be no more than $0.28. However, the total cost to the HMO to mail the application will vary depending on the number of pages and the business practices of the HMO. Form No. LHL005 must be submitted upon renewal of the HMO's registration every two years, and therefore the HMO may incur similar costs biennially.

III. Estimated Costs for Entities Subject to Additional Subchapter U Requirements that have not been Previously Discussed.

The following proposed provision may result in compliance costs for URAs to comply with Subchapter U:

Costs to URAs, including insurer URAs and specialty URAs

Proposed §19.2013(c): Requirement for a written description of procedures for responding to requests for drugs, post-stabilization care and pain management medication under certain circumstances. Proposed §19.2013(c) requires a URA for health care provided under workers' compensation insurance coverage to provide a written description to the Commissioner setting forth the procedures that the URA will follow when responding to requests for: (i) drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency; and (ii) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record.

The Department has determined that the total estimated one-time cost for a URA to comply with proposed §19.2013(c) could vary based upon the following cost components: (i) cost of general operations manager wages; (ii) cost to print the written description of procedures; (iii) cost to mail the written description of procedures; and (iv) cost to implement the written description of procedures.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.2013(c).

(i) Cost of general operations manager wages. The Department anticipates that, because the proposed provision will likely require development of new procedures, a URA's general operations manager will do most if not all of the drafting and basic review of these new procedures. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that this drafting will likely require on average approximately 10 hours of a general operations manager's time for a total one-time cost of $674.00.

(ii) Cost to print the written description of procedures. The Department anticipates that a URA could incur a cost for printing the new written description of procedures. The cost of printing could range from approximately $.06 to $.08 per page for printing and paper, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information."

(iii) Cost to mail the written description of procedures. The Department anticipates that a URA could incur a cost to transmit the written description of procedures by mail, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." In addition to the cost variables identified in the Cost Note discussion under the subheading "Repetitive Cost Note Information," a URA's total cost to mail the written description of procedures will vary depending on the number of pages and the business practices of the URA.

(iv) Cost to implement the written description of procedures. A URA may incur costs to implement the written procedures. However, it is not possible for the Department to estimate the amount of such costs because the relevant factors are not suitable to reliable quantification by the Department. These factors include (a) the number of requests for drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency; (b) the number of requests for post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record; and (c) the URA's existing practices.

Proposed §19.2016(b)(3): Summary report. Amendments to proposed §19.2016(b)(3) require additional information to be included in the summary report that the URA must submit to the Department annually. The following additional information that is required in the summary report is not required by statute and is a result of the proposed amendments: (i) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process; and (ii) the subject matter of any complaint filed with the URA with required categorization as: (a) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider); (b) qualifications of URA's personnel; or (c) appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

The Department anticipates that, for those new requirements under the proposed rules, URAs may incur costs associated with submitting the summary report information. The Department has determined that the total estimated cost for a URA to comply with proposed §19.2016(b)(3), as applicable, could vary based upon the following cost components: (i) cost of general operations manager wages; and (ii) costs for programming necessary to collect the additional required information.

Specialty URAs. The Department anticipates that specialty URAs are likely to incur these same costs to comply with proposed §19.2016(b)(3).

(i) Cost of general operations manager wages. The Department anticipates that, because the proposed requirements will involve submission of additional information, a URA's general operations manager will do most, if not all, of these submissions. A general operations manager working in an insurance-related industry earns a median hourly wage of $67.40, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." The Department anticipates that submitting the additional information will likely require on average approximately one to two hours of a general operations manager's time per annual summary report, for a total annual fee of $67.40 to $134.80.

(ii) Costs for programming necessary to collect the additional required information. The Department also anticipates that a URA could incur a one-time cost for programming necessary to collect the additional required information. The Department estimates that an in-house programmer could require approximately five to 10 hours to set up a process to automatically collect the information required under proposed §19.2016(b)(3). A computer programmer working in an insurance-related industry in Texas earns a median hourly wage of $34.93, as detailed in this Cost Note under the subheading "Repetitive Cost Note Information." Therefore, the estimated average one-time cost for a URA's in-house programmer time could range from $174.65 to $349.30 for compliance with proposed §19.2016(b)(3).

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES.

Analysis of Economic Impact

In accordance with the Government Code §2006.002(c), the Department has determined that there are several proposed amendments and new sections that may have an adverse economic impact on URAs, including HMO URAs, insurer URAs, and specialty URAs, that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

Economic Impact on URAs, including HMO and insurer URAs; and specialty URAs when applicable.

The Department was unable to obtain information relating to the number of URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 181 certified and 16 registered URAs in the state, including HMO URAs, insurer URAs, and specialty URAs. Of those 181 certified URAs, currently 72 URAs are certified for workers' compensation. Of those 16 registered URAs, currently 4 are registered for workers' compensation.

Economic Impact on HMO URAs and Specialty URAs

The Department has determined that §19.1719(a) may have an adverse economic impact on HMO and specialty URAs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

The Department was unable to obtain information relating to the number of HMO URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 19 certified or registered HMO URAs in the state. The Department estimates 1 - 2 of these HMO URAs qualify as a small or micro business.

Economic Impact on Insurer URAs and Specialty URAs

The Department has determined that proposed §19.1719(b) and §19.2019(c) may have an adverse economic impact on insurer URAs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules.

The Department was unable to obtain information relating to the number of insurer URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has identified 17 certified or registered insurer URAs in the state. The Department estimates 1 - 2 of these insurer URAs qualify as a small or micro business.

Economic Impact on Specialty URAs only

The Department has determined that the following sections may have an adverse economic impact on specialty URAs only that qualify as small or micro businesses under the Government Code §2006.001(1) and (2) and that are required to comply with the proposed rules: (i) proposed §19.1720(c) and §19.2020(c); (ii) proposed §19.1720(e) and (f) and §19.2020(e) and (f); and (iii) proposed §19.1720(h)(1)(C) - (E) and (2)(C) - (E) and proposed §19.2020(h)(1)(C) - (E) and (2)(C) - (E).

The Department was unable to obtain information relating to the number of specialty URAs that qualify as a small or micro business under the Government Code §2006.001(1) and (2). However, the Department currently has 20 specialty URAs in the state, all of which are certified.

Regulatory Flexibility Analysis

As previously indicated, the Department has identified 21 provisions of the proposal that may result in compliance costs for entities subject to Subchapter R and/or Subchapter U, including proposed (i) §19.1704(d) and §19.2004(c); (ii) §19.1704(e) and §19.2004(d); (iii) §19.1705(d) and §19.2005(d); (iv) §19.1705(g) and §19.2005(g); (v) §19.1703(12) and §19.2003(11); (vi) §19.1706(c) and §19.2006(c); (vii) §19.1706(d) and §19.2006(d); (viii) §19.1710(b)(2) and §19.2010(b)(2); (ix) §19.1710(c) and §19.2010(c); (x) §19.1715(b) and §19.2015(b); (xi) §19.1711(b)(3) - (4) and §19.2011(b)(3) - (4); (xii) §19.1711(c)(3) - (4) and §19.2011(c)(3) - (4); (xiii) §19.1712(a) and §19.2012(a); (xiv) §19.1712(b) and §19.2012(b); (xv) §19.1714(a)(12) and §19.2014(a)(12); (xvi) §19.1721(a) and §19.2021(a); (xvii) §19.1719(b) and §19.2019(c); (xviii) §19.1720(c) and §19.2020(c); (xix) §19.1720(e) and §19.2020(e); (xx) §19.1720(h)(1)(D) - (E) and §19.2020(h)(1)(D) - (E); (xxi) §19.1720(h)(2)(D) - (E) and §19.2020(h)(2)(D) - (E); two provisions of the proposal that may result in compliance costs for entities subject only to Subchapter R, including proposed §19.1719(a) and §19.1721(b)(3) and two provisions of the proposal that may result in compliance costs for entities subject only to Subchapter U, including proposed §19.2013(c) and §19.2016(b)(3).

The cost of compliance with these proposed requirements will not vary between large businesses and small or micro-businesses; therefore, the Department's cost analysis of these requirements, which can be found in the Public Benefit/Cost Note section of this proposal, applies equally to small or micro business URAs, including HMO URAs, insurer URAs, and specialty URAs.

Pursuant to the Government Code §2006.002(c), for each of these proposed requirements, the Department has considered other regulatory methods that accomplish the objectives of the proposal, minimize any adverse economic impact on URAs that qualify as small or micro businesses under the Government Code §2006.001(1) and (2), but still protect the health, safety, and environmental and economic welfare of the state.

I. Estimated Costs for Entities Subject to Subchapter R and/or Subchapter U

A. Estimated Costs to URAs, Including HMO and Insurer URAs; and Specialty URAs when Applicable

Proposed §19.1704(d) and §19.2004(c): Form No. LHL005 Required Information.

The Department considered, as a regulatory alternative, exempting small and micro business URAs from the non-statutory requirements under proposed §19.1704(d) and §19.2004(c).

The Department has determined, however, this exemption would not accomplish the objectives of proposed §19.1704(d) and §19.2004(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state, for the following reasons: (a) the exemption is inconsistent with legislative intent; (b) the exemption could result in some consumers receiving fewer health care services; and (c) the requirement will have a minimal economic impact. Additionally, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(d) and §19.2004(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements.

(a) Exemption is inconsistent with legislative intent.

The Senate Committee on State Affairs Bill Analysis for HB 4290 specifies the legislative intent of HB 4290. According to this analysis, the legislative intent of HB 4290 is to ensure that carriers have consistent standards for what is considered experimental and investigational. TEXAS SENATE STATE AFFAIRS COMMITTEE, BILL ANALYSIS (Committee Report, Substituted), C.S.H.B. 4290, 81st Leg., R.S. (May 12, 2009). Exempting small or micro business URAs from the non-statutory requirements of proposed §19.1704(b) and §19.2004(c), however, would not allow the Department to review the URAs' screening criteria and review procedures, which would not assist in the legislative goal of establishing consistent standards for what is considered experimental and investigational.

(b) Exemption could result in some consumers receiving less health care services.

Requiring all URAs to follow the submission of information requirements under proposed §19.1704(d) and §19.2004(c) for a certification or registration and for renewal of a certification or registration as a URA is important and necessary to protect the health and economic welfare of consumers. Absent these requirements, the Department's ability to oversee URAs would be diminished, and this diminished oversight could potentially lead to inconsistent standards for approval or denial of health care services or inconsistent procedures available for consumers to appeal those standards of review. For example, in proposed §19.1704(d)(1)(A), an applicant is required to submit an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care. An applicant is also required in proposed §19.1704(d)(1)(A) to submit the availability of personnel to handle consumer complaints. Proposed §19.1704(d)(2)(H) requires applicants and URAs to submit copies of procedures established for appeal of an adverse determination with an applicant's request for certification or registration as a URA. Exempting small and micro business URAs from these requirements could result in consumers of these small and micro business URAs failing to receive the same health care services because of in differing standards for approval or denial of health care services. Additionally, exempting small and micro business from these requirements could result in consumers of these small and micro business URAs not having available remedies after receiving an adverse determination or in not having the requisite information to pursue remedies after receiving an adverse determination.

Additionally, the uniform submission of policies and procedures to the Department for a certification or registration or for renewal of a certification or registration under proposed §19.1704(d) or §19.2004(c) as a URA promotes confidence in the URA's decisions. For example, under proposed §19.1704(d)(1)(B), a URA must certify that its screening criteria and review procedures are established with input from appropriate health care providers and approved by physicians. Those consumers who are involved with URAs that are not required to submit their screening criteria to the Department pursuant to proposed §19.1704(d) and §19.2004(c) could be subject to a lesser quality of review. Further, under proposed §19.1704(d)(2), a URA must submit written policies to the Department relating to the availability of personnel and telephone messaging systems for preauthorization and verification for HMO and preferred provider benefit plans. Adopting these types of requirements to apply to all URAs, regardless of size, will result in consistent application of screening criteria and review procedures. This consistent application, will, in turn, ensure that all consumers, including those that utilize small and micro business URAs, have the requisite information to obtain necessary services.

Requiring all URAs, regardless of size, to follow the application requirements under proposed §19.1704(d) or §19.2004(c) eliminates the possibility that the Department would have to create a dual tracking system for certifications, registrations, and renewals based on URA business size. Therefore, the Department determined that requiring uniform applicant information and qualifications for certification or registration and renewal of certification or registration under proposed §19.1704(d) and §19.2004(c) is necessary to protect the health and economic welfare of Texas consumers.

(c) The requirement will have a minimal economic impact. While compliance with the proposed application requirements in §19.1704(d) and §19.2004(c) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact for the following reasons. The Department anticipates that only a minimal amount of additional time and work will be required for completing the new application

because the application documents, even with the additional new requirements, will be substantially similar to the existing application that small and micro business URAs are currently required to submit. This similarity will reduce the amount of time and effort needed to prepare and submit the new application, especially for renewal applications.

Additionally, it is anticipated that any additional costs will be minimal because the URA will already have some of the information available that the Department requires under proposed §19.1704(d). For example, under proposed §19.1704(d)(6)(A) and proposed §19.2004(c)(5)(A), applicants must submit written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code. This evidence may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state. The applicant URA should already have this required evidence because they would be subject at the time of formation to existing Texas statutory business formation requirements and fees.

Department's determination. Therefore, based on the prior discussion of the potential substantial adverse impact on Texas consumers, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(d) and §19.2004(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative methods can accomplish the objectives of proposed §19.1704(d) or §19.2004(c) and protect the health and economic welfare of Texas consumers.

Proposed §19.1704(e) and §19.2004(d): Correction of omissions or deficiencies and submission of a request for a waiver. The Department considered the following regulatory alternatives for those proposed amendments to §19.1704(e) and §19.2004(d) that are not statutory requirements: (i) permitting small and micro business URAs to correct omissions or deficiencies in the URA application within 30 days; (ii) reducing the information small and micro business URAs are required to submit to the Department for a waiver under proposed §19.1704(e) and §19.2004(d); and (iii) permitting small and micro business URAs to apply for a waiver electronically. However, the Department has determined that such options would not accomplish the objectives of proposed §19.1704(e) and §19.2004(d) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

(i) Permitting small and micro business URAs to correct omissions or deficiencies in the URA application within 30 days.

The Department considered permitting small and micro business URAs to have 30 days, as existing rules permit, to correct omissions or deficiencies in the URA application. However, the proposed change from 30 days to 15 working days is necessary to streamline the application process, providing the Department with information more quickly. This shorter time period will allow a more efficient application process, thereby making more URAs more quickly available to the Texas consumer.

Additionally, there is a cost saving mechanism proposed as part of §19.1704(e) and §19.2004(d) that is available to small and micro business URAs. If a small or micro-business URA is unable to comply with the time limits prescribed in §19.1704(e) and §19.2004(d) for correction of errors or deficiencies in the application, the proposed rule enables such a URA to apply for a waiver of the time limits. The Department has determined that this waiver is a sufficient remedy for those small and micro business URAs that are unable to meet the 15 working day deadline to correct errors or deficiencies in the application.

(ii) Reducing the information small and micro business URAs are required to submit to the Department for a waiver under proposed §19.1704(e) and §19.2004(d).

The Department considered reducing the information that a URA is required to submit to the Department to obtain a waiver from the 15 working day limit for correction of errors or deficiencies in the application. The waiver only requires that a URA submit a request in writing for additional time to correct the omissions or deficiencies in the application. These waiver request requirements are minimal, and, therefore, the Department is unable to reduce the content requirements for small and micro-business URAs applying for a certification or registration for the first time. Further, the cost of submitting a waiver by mail to the Department is nominal.

(iii) Permitting small and micro business URAs to apply for a waiver electronically.

The Department considered alternatives that could assist small or micro-business URAs in obtaining waivers, such as allowing small or micro-business URAs to seek waivers through electronic applications. However, the Department concluded that such modifications would not adequately achieve the purpose of the proposed section. The purpose of requiring the mailing of waiver requests, rather than electronic filing, is to be consistent with current Chief Clerk procedures and not to add additional expense to the state in creating new electronic processes. Permitting small and micro-business URAs to make electronic filings of waiver requests, while declining to permit large URAs to do so, would impose additional cost on the Department for minimal savings to small or micro-business URAs.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1704(e) and §19.2004(d) are nominal, and the adverse impact that would result for Texas consumers of small and micro business URAs far outweighs any economic impact on small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §19.1704(e) or §19.2004(d) protect the health and economic welfare of Texas consumers.

Proposed §19.1705(d) and §19.2005(d): Development of screening criteria. The Department considered the following regulatory alternatives for those proposed amendments to §19.1705(d) and §19.2005(d) that are not statutory requirements: exempting small and micro business URAs from the requirements under proposed §19.1705(d) and §19.2005(d).

The Department has determined that this option would not accomplish the objectives of proposed §19.1705(d) and §19.2005(d) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

The purpose of these requirements is for URAs to utilize screening criteria that are evidence-based, scientifically valid, or outcome focused, or if evidence-based medicine is not available for a particular health care service provided, to utilize generally accepted standards of medical practice recognized in the medical community. These screening criteria requirements are

important for the following reasons: (a) set the parameters for screening criteria, which will provide for more uniform and evidence-based utilization review for enrollees and injured employees; (b) promote valid and sound decisions when credible and scientific guidelines are utilized; (c) promote confidence in the URA's decisions because the URA can support and substantiate its decisions; and (d) promote and ensure consistent decisions among all URAs regarding specific health care treatments and services.

Proposing the amendments to apply to all URAs, regardless of size, will result in consistent application of review criteria for all consumers involved in the URA process, regardless of the size of the URA utilized by the consumer. If the Department exempted small or micro business URAs from these requirements, those consumers who utilize URAs that are not required to acquire the additional screening criteria would be subject to a lesser quality of review, and therefore would receive potentially lower quality health care than those utilizing the larger URAs that are required to comply with the screening criteria requirements.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1705(d) and §19.2005(d) are nominal, and the adverse impact that would result for Texas consumers of small and micro business URAs far outweighs any economic impact on small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods of accomplishing the objectives of proposed §19.1705(d) or §19.2005(d) that would protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1705(g) and §19.2005(g): Complaint System.

The Department considered the following regulatory alternative to the proposed amendments to §19.1705(g) and §19.2005(g): exempting small and micro business URAs from the requirement to include the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department in the written response.

The Department, however, determined that such an exemption would not accomplish the objectives of proposed §19.1705(g) and §19.2005(g) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (a) the information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review; and (b) any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(a) The information is useful and should be available to all enrollees or injured employees whose health care has been subject to utilization review. Providing the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department in the written response will be useful to the enrollee or injured employee. This information will inform them that they can file a complaint with the Department and provide the necessary contact information to do so. Exempting small and micro business URAs from this requirement could result in the enrollees and injured employees of these URAs not receiving this information. Awareness of the complaint process for all consumers who utilize URAs, not just those that utilize large URAs, is important. Complaints will assist the Department in monitoring URAs and ensuring utilization review decisions are being made in accordance with the Insurance Code Chapter 4201 and Department rules.

(b) Any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers. While compliance with the proposed additional information requirements in §19.1705(g) and §19.2005(g) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact for the following reasons. The Department anticipates that only a minimal amount of additional time and work will be required to include the minimal additional information, i.e., the Department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the Department, because under the Insurance Code §4201.204, the complaints procedure must already include a written response to the complainant by the URA within 30 calendar days.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed §19.1705(g) and §19.2005(g) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the objectives of proposed §19.1705(g) or §19.2005(g) that would also protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1703(12) and §19.1706(c) and §19.2003(11) and

§19.2006(c): Disqualifying associations.

The Department considered the following regulatory alternative to proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c): exempting small and micro business URAs from the requirements under proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c).

The Department has determined, however, that this exemption would not accomplish the objectives of proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

These requirements are necessary to prohibit potential conflicts of interest that could undermine the appeals process for adverse determinations. The purpose of the proposed new prohibition is to prevent the physician who reviews the appeal from being improperly influenced by a relationship that he or she has with the physician or doctor who issued the initial adverse determination or the enrollee or injured employee, as applicable, who is requesting the appeal. Requiring all URAs, regardless of size, to comply with these requirements will result in a consistent prohibition on potential conflicts of interest that could undermine the utilization review appeals process. If the Department exempted small or micro business URAs from these requirements, enrollees or injured employees subject to small or micro business URA's utilization review could be subject to an appeal with a physician that is unduly influenced by the initial reviewer. This conflict of interest could result in denial of necessary medical care based on that undue influence, rather than independent medical judgment.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed new §19.1703(12) and §19.1706(c) or §19.2003(11) and §19.2006(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined based on the preceding analysis that no alternative methods can accomplish the objectives of proposed new §19.1703(12) and §19.1706(c) and §19.2003(11) and §19.2006(c) that would also protect the health and economic welfare of Texas consumers, as required under the Government Code §2006.002(c-1).

Proposed §19.1706(d) and §19.2006(d): Documentation of information on physicians, doctors, and other health care providers. The Department considered the following regulatory alternative for those proposed amendments to §19.1706(d) and §19.2006(d) that are not statutory requirements: exempting small and micro business URAs from the requirement to provide the name, license number, and state of licensure of personnel to the Department under proposed §19.1706(d) and §19.2006(d).

Exempting small and micro business URAs from the proposed requirement to provide the name, license number, and state of licensure of personnel.

The Department, however, has determined that such an exemption would not accomplish the objectives of proposed §19.1706(d) and §19.2006(d) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption could result in some consumers receiving a lesser quality of utilization review; and (b) the requirement will have a minimal economic impact.

(a) The exemption could result in some consumers receiving a lesser quality of utilization review. The requirement to provide the name, license number, and state of licensure of personnel under proposed §19.1706(d) and §19.2006(d) provides the Department with information to ensure that the URA is utilizing proper personnel to perform utilization review. Exempting small or micro business URAs from this requirement would impede the Department's ability to monitor whether proper personnel are performing utilization review, and therefore could foster a situation in which a URA could more easily utilize unqualified personnel. The use of unqualified personnel for utilization review could, in turn, result in a lesser quality of utilization review for those consumers who utilize the small or micro business URAs. All consumers are entitled to utilization review by qualified personnel, including those enrollees and injured employees using small and micro business URAs. The performance of utilization review by lesser qualified personnel could result in consumers of small and micro business URAs failing to receive appropriate or necessary medical care.

(b) The requirement will have a minimal economic impact. While compliance with the proposed requirements in §19.1706(d) and §19.2006(d) may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact since URAs are already required to collect such information when credentialing their personnel.

Department's determination. The Department has determined that the costs for small and micro businesses to comply with proposed §19.1706(d) and §19.2006(d) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the objectives of proposed §19.1706(d) or §19.2006(d) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1710(b)(2) and §19.2010(b)(2): Preauthorization numbers.

The Department considered the following regulatory alternative to the proposed amendments to §19.1710(b)(2) and §19.2010(b)(2): exempting small and micro business URAs from the requirements under proposed §19.1710(b)(2) and §19.2010(b)(2).

However, the Department has determined that such exemption would not accomplish the objectives of proposed §19.1710(b)(2) and §19.2010(b)(2) and would not be consistent with the health, safety, and environmental and economic welfare of the state.

The purpose of these requirements is to establish a uniform system for preauthorization numbers among all URAs. Requiring all URAs, regardless of size, to comply with these requirements will result in a consistent format for preauthorization numbers for all consumers involved in the URA process, regardless of the size of the URA utilized by the consumer. If the Department exempted small or micro business URAs from these requirements, the formatting for preauthorization numbers could differ substantially, potentially leading to confusion regarding whether health care is preauthorized and causing delay in the consumer's health care. Allowing or requiring different standards would increase the complexity of the system and the costs associated with supporting different formats and protocols. This approach would require all insurance carriers to support duplicate and redundant systems, increasing the administrative costs associated with the receipt and processing of medical bills.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1710(b)(2) and §19.2010(b)(2) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative methods can accomplish the objectives of proposed §19.1710(b)(2) and §19.2010(b)(2) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1710(c) and §19.2010(c): Notice of adverse determinations made in prospective and concurrent utilization review; Proposed §19.1715(b) and §19.2015(b): Notice of adverse determination for retrospective review.

The Department considered the following regulatory alternative for those proposed amendments to §§19.1710(c), 19.2010(c), 19.1715(b), and 19.2015(b) that are not statutory requirements: exempting small and micro business URAs from the requirement to provide the additional requisite information under proposed §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §§19.1710(c), 19.2010(c), 19.1715(b), and 19.2015(b), and would not be consistent with the health, safety, and environ-

mental and economic welfare of the state because: (a) the exemption could result in some consumers receiving less information in their notice of adverse determination, which may have a detrimental effect on their appeal; and (b) any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers.

(a) The exemption could result in some consumers receiving less information in their notice of adverse determination, which may have a detrimental effect on their appeal. The Department has determined that these additional notice elements are necessary for the enrollee or injured employee when receiving notice of the adverse determination. The first additional notice element is important for the enrollee or injured employee to understand what evidence or documentation can be submitted to possibly obtain a different determination. Additional information on the physician or doctor who made the adverse determination is for the enrollee's or injured employee's reference. Information on the date and time the URA offered the opportunity to discuss the adverse determination is also useful, because the enrollee or injured employee may not have been aware of when this opportunity was offered to the provider of record. Information on the URA's appeal process and notice of the independent review process, along with a copy of Form No. LHL009, will inform the enrollee or injured employee of his or her additional options following an adverse determination. For injured employees receiving notice of an adverse determination under §19.2010(c) or §19.2015(c), a description of the source of the screening criteria or guidelines will also inform the injured employee of the criteria or guidelines on which the URA relied.

Collectively, this information will potentially assist enrollees or injured employees in submitting the appropriate documentation if they choose to appeal an adverse determination. Exempting small and micro business from providing the additional requisite information may have a detrimental effect on enrollees and injured employees who utilize these URAs, in some cases even preventing them from receiving necessary medical care.

(b) Any adverse impact on small and micro business URAs does not outweigh the potential substantial adverse impact on Texas consumers. The Department anticipates that the required compliance will have a minimal adverse economic impact since URAs are already required under existing rules and under §4201.303 of the Insurance Code to mail a notice of adverse determination, and §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable only require additional notice elements.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1710(c) or §19.2010(c), as applicable, and §19.1715(b) or §19.2015(b), as applicable, are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1710(c) or §19.2010(c) and §19.1715(b) or §19.2015(b), that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4), and §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4): Documentation of Peer-to-Peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations and Prior to Issuing Retrospective Review Adverse Determinations.

Because of the similarity in the requirements in the potential compliance costs for small and micro business URAs, and in the potential impact on the health and economic welfare of enrollees and injured employees, the Department, considered for the proposed amendments to §19.1711(b)(3) and (4) and §19.2011(b)(3) and (4) and for the proposed amendments to §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), the following regulatory alternative: exempting small and micro business URAs from some or all of the proposed documentation, maintenance, and response requirements.

The Department has determined, however, that such an exemption would not accomplish the objectives of the proposed requirements and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement; and (b) the costs to comply with the proposed requirements are nominal.

(a) The total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement. The Insurance Code §4201.206 requires a URA to provide a peer-to-peer discussion opportunity prior to issuing an adverse determination. Under the Insurance Code §4201.206, before a URA who questions the medical necessity or appropriateness of a health care service issues an adverse determination, the URA must provide the health care provider who ordered the service a reasonable opportunity to discuss with a physician the patient's treatment plan and the clinical basis for the URA's determination. This peer-to-peer opportunity is important for the enrollee or injured employee, because it gives the provider of record a chance to discuss the individual's case and possibly influence the determination for a favorable outcome which would not otherwise have been possible. Requiring a URA, regardless of size, to maintain documentation that details the discussion opportunity provided to the provider of record, enables the Department or TDI-DWC to monitor each URA's compliance with the §4201.206 statutory requirement. If the Department is unable to monitor a small or micro business URA's compliance with this statutory requirement, it could be detrimental to the economic welfare and/or health of enrollees or injured employees utilizing the small or micro business URA. Such enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(b) The cost to comply with the proposed requirements are nominal. While compliance with the proposed requirements in §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and in proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), may have an adverse economic impact on small or micro business URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the URA is required to put in writing the actions that are required under the Insurance Code §4201.206 concerning the peer-to-peer discussion before issuance of an adverse determination, to maintain this written documentation, and to provide it upon request. The Department anticipates that the costs to comply with these proposed requirements will be nominal, as detailed in the Public Benefit/Cost Note part of this proposal, for all URAs, including small or micro business URAs.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply

with proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and with proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods to accomplish the objectives of proposed §19.1711(b)(3) and (4) or §19.2011(b)(3) and (4) and proposed §19.1711(c)(3) and (4) and §19.2011(c)(3) and (4), that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1712(a) and §19.2012(a): Written procedures for appeals of prospective or concurrent review adverse determinations.

The Department considered exempting small and micro business URAs from the requirements to develop and implement additional written procedures under proposed §19.1712(a) and §19.2012(a).

The Department, however, has determined that such an exemption would not accomplish the objectives of proposed §19.1712(a) and §19.2012(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: the exemption would result in inconsistent URA written appeal procedures.

The additional written procedures are important for the health and economic welfare of Texas consumers. The requirements to set time frames for filing an appeal and that appeal decisions must be made by a physician who has not previously reviewed the case are necessary to provide a fair appeal process for enrollees and injured employees. The written requirement to ensure peer-to-peer discussions are necessary to implement the Insurance Code §4201.206. The follow-up letter to an expedited appeal determination provides written documentation for the enrollee or injured employee. The required response letter is necessary to provide the enrollee or injured employee information on the screening criteria on which the decision was made, information on the physician who made the determination, a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), and procedures for filing a complaint in accordance with the Insurance Code §4201.204. All of these required procedures and information are essential to fully inform consumers and ensure that consumers are able to receiving necessary health care. If small or micro business URAs were exempt from proposed §19.1712(a) or §19.2012(a), the enrollees and injured employees who utilize small and micro business URAs would be deprived of several consumer protections that would be afforded to enrollees and injured employees of large URAs.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that no alternative method can accomplish the objectives of proposed §19.1712(a) or §19.2012(a) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1712(b) and §19.2012(b): Written procedures for appeals of retrospective review adverse determinations.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the proposed §19.1712(b) and §19.2012(b) requirements.

The Department has determined, however, that such an exemption would not accomplish the objectives of the proposed requirements and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (a) the exemption would result in inconsistent URA written appeal procedures; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in inconsistent URA written appeal procedures. The written procedures are important for the health and economic welfare of Texas consumers. The requirement under §19.1712(b)(1) that appeal procedures be in accordance with the requirements in 28 TAC Chapter 21, Subchapter T (relating to Submission of Clean Claims) is important for conformity with that chapter and to ensure that URAs are in compliance with relevant statutory requirements. The requirement under §19.1712(b)(2) and §19.2012(b) that the appeal must comply with §19.1715 and §19.2015, respectively, is important in order to incorporate the consumer protections afforded in the notice of determination for a retrospective review. These consumer protections include several required elements of information that are necessary for an enrollee or injured employee who receives an adverse determination and desires to appeal the adverse determination. The written requirement to ensure peer-to-peer discussions under §19.1712(b)(3) and §19.2012(b)(1)(B) implements the Insurance Code §4201.206. Under §19.2015(b)(2) and (3), additional references to the Insurance Code Chapter 1305 and 28 TAC Chapters 10 and 133 are necessary to incorporate other statutes and rules that govern the appeal process.

The Department intends for these written procedures to ensure that appeal of retrospective review adverse determinations are subject to a consistent process that provides the enrollee or injured employee, regardless of the size of the URA utilized by the enrollee or injured employee, with a fair procedure. Exempting small or micro businesses from this requirement could subject enrollees or injured employees who utilize small or micro business URAs to a substandard appeal process. A substandard appeal process without adequate consumer protections could adversely affect the outcome of the adverse determination appeal of these enrollees and injured employees and their access to necessary health care.

(b) The requirement will have a minimal adverse economic impact. The Department anticipates that the required compliance will have a minimal adverse economic impact, because the required written procedures essentially incorporate other statutory or regulatory consumer protection provisions. Additionally, the Department has determined that any additional cost to incorporate into the written procedures the requirement in proposed §19.1712(b)(3) or §19.2012(b)(1)(B), as applicable, will be minimal. The only costs incurred will be to draft the written procedures; the underlying requirements should already be implemented pursuant to the Insurance Code Chapter 1305 and §4201.206, 28 TAC Chapter 10; Chapter 21, Subchapter T; and Chapter 133; and §19.1715 and §19.2015.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1712(b) or §19.2012(b) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to com-

ply with these requirements. Thus, the Department has determined based on the preceding reasons that there are no alternative methods that can accomplish the objectives of proposed §19.1712(b) or §19.2012(b) that would also protect the health and economic welfare of Texas consumers.

Proposed §19.1714(a)(12) and §19.2014(a)(12): Retention of records.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirement to store the required information for four years under proposed §19.1714(a)(12) and §19.2014(a)(12).

The Department has determined, however, that this exemption would not accomplish the objectives of proposed §19.1714(a)(12) and §19.2014(a)(12) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: the exemption would result in less effective examinations based on more limited information.

As previously discussed in the Introduction, the proposed amendment to change the storage period from two years to four years allows sufficient time for the Department to examine the information. The Department generally conducts URA examinations triennially but does not always examine each URA exactly every three years, so the requirement that the URA maintain information for four years will ensure that the Department has the opportunity to review such information. Because this information is generated and obtained by a URA in the course of utilization review, it is valuable for the Department's monitoring purposes to ensure that enrollees or injured employees are afforded utilization review that is conducted in accordance with the Texas Insurance Code and applicable rules. If the URA is not required to store records for a long enough time period to ensure the Department's access to the information, it renders the Department's examinations less effective, possibly resulting in a lesser quality of utilization review for enrollees or injured employees.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1714(a)(12) or §19.2014(a)(12) and would also protect the health and economic welfare of Texas consumers.

Proposed §19.1721(a) and §19.2021(a): Notification of independent review of adverse determinations concerning life-threatening conditions.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements to include a copy of Form No. LHL009 under proposed §19.1721(a) and §19.2021(a) and to use the "prudent layperson" standard under proposed §19.2021(a).

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.1721(a) and §19.2021(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state, because: (a) the exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009; (b) the exemption could result in inconsistent standards between §19.1721 and §19.2021 regarding the "prudent layperson" standard; and (c) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in some enrollees and injured employees not receiving a copy of Form No. LHL009. Including a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) is important for enrollees or injured employees, who utilize URAs regardless of the size of the URA, because they are entitled to an immediate appeal to an IRO in the event of an adverse determination and if they have a life-threatening condition, pursuant to the Insurance Code §4201.360. In the event of such a life threatening condition, it is important that all enrollees and injured employees, including those who utilize small and micro business URAs, receive a copy of the request-for-IRO-review form as provided in proposed §19.1721(a) and §19.2021(a). The receipt of the form could significantly facilitate the request for independent review by enabling the request to be made more efficiently and quickly than if the enrollees or injured employees had to find the form on their own. Exempting small or micro business URAs from this requirement could cause unnecessary and avoidable delays for enrollees and injured employees who utilize small or micro business URAs.

(b) The exemption could result in inconsistent standards for enrollees under §19.1721 and injured employees under §19.2021 regarding the "prudent layperson" standard. Existing §19.1721 allows the determination of the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the disease or condition is a life-threatening condition. Proposed §19.2021(a) incorporates this same "prudent layperson" standard. Exempting small or micro business URAs from the "prudent layperson" standard would result in a different standard regarding who determines a life-threatening condition, based on whether the URA is subject to §19.1721 or §19.2021 and whether the patient is an enrollee or an injured employee. In the interest of equal consumer protection for both enrollees and injured employees, it is important that both of these categories of patients be entitled to an immediate appeal to an IRO in the event of a life threatening condition, and that the same standard apply to both categories of patients for determining whether there is a life threatening condition. Exempting small or micro business URAs from the proposed §19.2021 "prudent layperson" standard for injured employees would result in significant disparate consumer protections for these injured employees compared to those injured employees who utilize large URAs.

(c) The requirement will have a minimal adverse economic impact. The Department anticipates that the required compliance will have a minimal adverse economic impact. The URA is already required under the Insurance Code §4201.301 to send a notice of adverse determination, so the addition of a copy of the IRO form will incur nominal additional costs, as detailed in the Public Benefit/Cost Note part of this proposal. Although it is not possible to determine the total cost for the "prudent layperson" standard under proposed §19.2021(a), it is possible that in many cases this standard was already being used. However, for those small and micro business URAs that are not currently utilizing the "prudent layperson" standard, the Department is of the opinion that not requiring these small and micro businesses to use the standard will not result in cost savings so significant that the benefit of these potential cost savings outweigh the need for patients utilizing these URAs to be deprived of immediate appeal to an IRO in the event of a life threatening condition on the basis of this standard.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1721(a) or §19.2021(a) are likely to be nominal, but in the event that the "prudent layperson" standard, does result in additional costs, the potential adverse health and economic welfare impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods can accomplish the objectives of proposed §19.1721(a) or §19.2021(a) and protect the health and economic welfare of Texas consumers.

B. Estimated Costs to Insurers Only.

Proposed §19.1719(b) and §19.2019(c): Responsibility of Insurers to Comply with Registration Filing Requirements. The Department considered the following regulatory alternative: exempting small and micro business insurer URAs from the requirements under proposed §19.1719(b) or §19.2019(c) to have a valid registration and to comply with all the filing requirements under §19.1704 or §19.2004, respectively.

The Department has determined, however, that this exemption would not accomplish the objectives of proposed §19.1719(b) or §19.2019(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption would result in the Department's inability to monitor certain insurer URAs; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the Department's inability to monitor certain insurer URAs. The registration and filing requirements under proposed §19.1719(b) or §19.2019(c) provide the Department with information on insurer URAs that are conducting utilization review only for coverage for which they are the payors. This information allows the Department to monitor such insurer URAs. Exempting small or micro business insurer URAs from the requirements under proposed §19.1719(b) or §19.2019(c) would prevent the Department from even knowing whether these insurer URAs are conducting utilization review. Enrollees and injured employees could then be subject to utilization review that is not monitored by the Department.

(b) The requirement will have a minimal adverse economic impact. While compliance with the proposed application requirements in §19.1719(b) or §19.2019(c) may have an adverse economic impact on small or micro business insurer URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Although the insurer URA will incur costs to register and comply with filing requirements, an insurer URA is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health or workers' compensation coverage for which it is the payor.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1719(b) or §19.2019(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1719(b) or §19.2019(c) and would also protect the health and economic welfare of Texas consumers.

C. Estimated Costs to Specialty URAs Only.

Proposed §19.1720(c) and §19.2020(c): Utilization Review Plan.

The Department considered the following regulatory alternative: exempting small and micro business specialty URAs from the requirements under proposed §19.1720(c) and §19.2020(c) to develop written procedures.

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1720(c) and §19.2020(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because the potential adverse impact that could result for Texas consumers of these small and micro business specialty URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements.

The requirement for written procedures under proposed §19.1720(c) and §19.2020(c) is intended to ensure that the existing §19.1720(c) and §19.2020(c) requirements are implemented. Without the requirement that the procedures be in writing, it is impossible for the procedures to be made available to consumers for informational purposes or to the Department for regulatory purposes. Therefore, it is important for the enrollees and injured employees of small and micro business URAs to have the same consumer protections that will accrue to the enrollees and injured employees of large URAs as a result of these proposed requirements. Exempting small or micro business specialty URAs from the requirement could result in utilization review plans that are not properly developed, reviewed and implemented. As a result, enrollees and injured employees utilizing small or micro business specialty URAs could be provided a lesser quality of review that could result in inadequate health care or deprivation of necessary health care. Enrollees and injured employees utilizing small or micro business specialty URAs are entitled to the same quality of utilization review as enrollees and injured employees of large URAs.

Additionally, because the underlying requirements are already set forth in existing rules and specialty URAs regardless of size are already required to comply with these requirements, the cost to small and micro business specialty URAs to develop the written procedures are minimal.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1720(c) and §19.2020(c) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1720(c) and §19.2020(c) and would also protect the health and economic welfare of Texas consumers

Proposed §19.1720(e) and §19.2020(e): Documentation of physicians, doctors and other health care providers.

The Department considered the following regulatory alternative for those proposed amendments to §19.1720(e) and §19.2020(e) that are not statutory requirements: exempting small and micro business specialty URAs from the proposed requirement to provide the name, number, type, license number,

and state of licensure of personnel to the Department under proposed §19.1720(e) and §19.2020(e).

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1720(e) and §19.2020(e) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption could result in some consumers receiving a lesser quality of utilization review; and (b) the requirement will have a minimal economic impact.

(a) The exemption could result in some consumers receiving a lesser quality of utilization review. The requirement to provide the name, number, type, license number, and state of licensure of personnel under proposed §19.1720(e) and §19.2020(e) provides the Department with information to ensure that the URA is utilizing proper personnel to perform utilization review. Exempting small or micro business URAs from this requirement would prevent the Department from monitoring whether proper personnel are performing utilization review and use of unqualified personnel for utilization review could, in turn, result in a lesser quality of utilization review for those consumers who utilize the small or micro business URAs. But all consumers are entitled to utilization review by qualified personnel, including those enrollees and injured employees using small and micro business URAs.

(b) The requirement will have a minimal economic impact. While compliance with the proposed requirements in §19.1720(e) and §19.2020(e) may have an adverse economic impact on small or micro business specialty URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact since specialty URAs are already required to collect such information when credentialing their personnel.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1720(e) and §19.2020(e) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1720(e) and §19.2020(e) and protect the health and economic welfare of Texas consumers.

Proposed §19.1720(h)(1)(D) - (E) and §19.2020(h)(1)(D) - (E), and §19.1720(h)(2)(D) - (E) and §19.2020(h)(2)(D) - (E): Documentation of Peer-to-peer Discussion Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations and Prior to Issuing Retrospective Review Adverse Determinations. Because of the similarity in the requirements in the potential compliance costs for small and micro business specialty URAs, and in the potential impact on the health and economic welfare of enrollees and injured employees, the Department, pursuant to the Government Code §2006.002(c), considered for the proposed amendments to §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and for the proposed amendments to §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), the following regulatory alternative: exempting small and micro business specialty URAs from some or all of the proposed documentation, maintenance, and response requirements.

The Department has determined that such a total or partial exemption would not accomplish the objectives of the proposed requirements and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement; and (b) the costs to comply with the proposed requirements are nominal.

(a) The total or partial exemption could result in the Department's inability to monitor compliance with a significant statutory requirement. Under the Insurance Code §4201.456, before a specialty URA who questions the medical necessity or appropriateness, or the experimental or investigational nature, of a health care service issues an adverse determination, the specialty URA must provide the health care provider who ordered the service a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the specialty URA's determination with a health care provider who is of the same specialty as the agent.

This peer-to-peer opportunity is important for the enrollee or injured employee, because it gives the provider of record a chance to discuss the individual's case and possibly influence the determination for a favorable outcome which would not otherwise have been possible. Requiring a specialty URA, regardless of size, to maintain documentation that details the discussion opportunity provided to the provider of record, enables the Department or TDI-DWC to monitor each specialty URA's compliance with the §4201.456 statutory requirement. If the Department is unable to monitor a small or micro business specialty URA's compliance with this statutory requirement, it could be detrimental to the economic welfare and/or health of enrollees or injured employees utilizing the small or micro business specialty URA. Such enrollees or injured employees could be potentially deprived of a favorable determination for needed health care.

(b) The cost to comply with the proposed requirements are nominal. While compliance with the proposed requirements in §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), may have an adverse economic impact on small or micro business specialty URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Under the proposed requirements, the specialty URA is required to put in writing the actions that are required under the Insurance Code §4201.456 to maintain this written documentation, and to provide it upon request. The Department anticipates that the costs to comply with these proposed requirements will be nominal, as detailed in the Public Benefit/Cost Note part of this proposal, for all specialty URAs, including small or micro business specialty URAs.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed new §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and with proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), are nominal, and the adverse impact that would result for Texas consumers of these small and micro business specialty URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed new §19.1720(h)(1)(D) and (E) and §19.2020(h)(1)(D) and (E) and proposed new §19.1720(h)(2)(D) and (E) and §19.2020(h)(2)(D) and (E), and protect the health and economic welfare of Texas consumers.

II. Estimated Costs for Entities Subject to Additional Subchapter R Requirements that have not been Previously Discussed.

A. Estimated Costs to URAs, including HMO and insurer URAs and specialty URAs.

Proposed §19.1721(b)(3): Information required to be provided to the assigned independent review organization.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements under proposed §19.1721(b)(3) to provide the assigned IRO copies of the additional requisite documentation.

The Department has determined that this exemption would not accomplish the objectives of proposed §19.1721(b)(3) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption would result in the IRO not receiving as much information; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the IRO not receiving as much information. The Department has determined that the additional documentation requirements are necessary to ensure that the IRO has sufficient information to conduct a thorough and accurate independent review. The purpose of the IRO independent review is to review a URA adverse determination relating to health care requested by the enrollee who received the adverse determination. The independent review process provides the enrollee an opportunity for the request to be reviewed by an IRO, which could possibly overturn the adverse determination at issue. Exempting small or micro business URAs from providing any copies of the documents required in proposed §19.1721(b)(3) may result in the IRO making an incorrect determination or, at least, a different determination than it would have made with complete information. This additional required information is intended to provide the IRO with important information needed for a thorough and accurate independent review. Therefore, an enrollee using a URA that is not subject to these requirements will be more likely to receive an IRO determination that is based on insufficient information. Potentially, this lack of sufficient information could adversely affect the independent review decision, potentially resulting in lack of access to medically necessary and appropriate health care for an enrollee using a small or micro business URA. Enrollees are entitled to medically necessary and appropriate health care regardless of the size of the URA being used by the enrollee.

(b) The requirement will have a minimal adverse economic impact. The cost that will be incurred by the small and micro business URAs as a result of these requirements are primarily administrative assistant wages, copying and mailing costs. As detailed in the Public Benefit/Cost Note part of this proposal, the Department anticipates that these costs will be nominal. The URA is already required under existing §19.1721 to provide documentation to the IRO. Proposed §19.1721(b)(3) adds only a few additional required documents, which the URA can submit along with the existing required documentation. However, if in some instances, the cost is higher than the Department anticipates, the Department is of the opinion that the consumer protection afforded to the enrollees of these small or micro business URAs is of greater importance than any potential adverse economic impact on the small or micro business URA.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1721(b)(3) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1721(b)(3) and protect the health and economic welfare of Texas consumers.

B. Estimated Costs to HMOs Only.

Proposed §19.1719(a): Responsibility of HMOs to Comply with

Registration Filing Requirements.

The Department considered the following regulatory alternative: exempting small and micro business HMO URAs from the requirements under proposed §19.1719(a) to have a valid registration and to comply with all the filing requirements under §19.1704.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.1719(a) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) the exemption would result in the Department's inability to monitor certain HMO URAs; and (b) the requirement will have a minimal adverse economic impact.

(a) The exemption would result in the Department's inability to monitor certain HMO URAs. The registration and filing requirements under proposed §19.1719(a) provide the Department with information on HMO URAs that are conducting utilization review only for coverage for which they are the payors. This information allows the Department to monitor such HMO URAs. Exempting small or micro business HMO URAs from the requirements under proposed §19.1719(a) would prevent the Department from even knowing whether these HMO URAs are conducting utilization review. Enrollees could then be subject to utilization review that is not monitored by the Department.

(b) The requirement will have a minimal adverse economic impact. While compliance with the proposed application requirements in §19.1719(a) may have an adverse economic impact on small or micro business HMO URAs, the Department anticipates that the required compliance will have a minimal adverse economic impact. Although the HMO URA will incur costs to register and comply with filing requirements, an HMO URA is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health compensation coverage for which it is the payor.

Department's determination. Therefore, the Department has determined that the costs for small and micro businesses to comply with proposed §19.1719(a) are nominal, and the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.1719(a) and protect the health and economic welfare of Texas consumers.

III. Estimated Costs for Entities Subject to Additional Subchapter U Requirements

That Have Not Been Previously Discussed.

Costs to URAs, including insurer URAs and specialty URAs.

Proposed §19.2013(c): Requirement for a written description of procedures for responding to requests for drugs, post-stabiliza-

tion care and pain management medication under certain circumstances.

The Department considered the following regulatory alternative: exempting small and micro business URAs from the requirements under proposed §19.2013(c) to provide a written description setting forth the requisite procedures.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.2013(c) and would not be consistent with the health, safety, and environmental and economic welfare of the state because: (a) these procedures are important to ensure access to injured employees to certain drugs and post-stabilization care and pain management medication; and (b) these procedures complement existing rules.

(a) These procedures are important to ensure access to injured employees to certain drugs and post-stabilization care and pain management medication.

The requirement under proposed §19.2013(c) to provide a written description setting forth the procedures that the URA will follow when responding to requests for drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could pose an unreasonable risk of a medical emergency is important to ensure that injured employees receive responses to requests for these drugs. Post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record, is important to ensure that injured employees receive responses to requests for these drugs, post-stabilization care, or pain management medication. Exempting small or micro business URAs from these requirements could result in injured employees utilizing these small or micro business URAs receiving delayed responses to their requests for (i) drugs that require preauthorization in certain high risk situations; and (ii) post-stabilization care and pain management medication in certain high risk situations. These delayed responses could adversely impact the health and welfare of the requesting injured employee and there is no justifiable reason for subjecting injured employees using small or micro business URAs to these unnecessary, and potentially harmful, delayed responses.

(b) These procedures complement existing rules. This proposed requirement is necessary to complement the pharmacy closed formulary rules for both certified network and non-network claims in workers' compensation in 28 TAC Chapter 134, Subchapter F. This URA procedural requirement is necessary for those situations that may occur after the denial of a preauthorization request and is a precursor to statutorily required closed formulary appeals process that includes the medical interlocutory order process identified in 28 TAC §134.550. An equivalent requirement is not included in the proposed Subchapter R rules.

The post-stabilization portion is intended to extend the preauthorization decision concerning facility-based surgeries (inpatient, outpatient, or ambulatory surgical center) to include necessary pain medication, which is often overlooked during the preauthorization approval process and leads to confusion regarding the availability of necessary pain medications. The Department has determined that injured employees who use small or micro business URAs are entitled to the same consumer protective health and economic welfare benefits that are provided in these requirements to injured employees who utilize large URAs. The Department has therefore determined that these requirements which are necessary to complement the existing pharmacy closed formulary rules for both certified network and non-network claims in workers' compensation and to extend the preauthorization decision are just as necessary for injured employees who use small or micro business URAs as for those injured employees who utilize large URAs.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that can accomplish the objectives of proposed §19.2013(c) and protect the health and economic welfare of Texas consumers.

Proposed §19.2016(b)(3): Summary report.

The Department considered the following regulatory alternative to the proposed amendments to §19.2016(b)(3): exempting small and micro business URAs from the requirements to provide the additional information in the summary report.

The Department has determined, however, that such an exemption would not accomplish the objectives of proposed §19.2016(b)(3) and would not be consistent with the health, safety, and environmental and economic welfare of the state because the exemption would result in inconsistent URA summary report information.

The exemption would result in inconsistent URA summary report information. The additional summary report information is important for the health and economic welfare of Texas consumers. Information on the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process will allow the Department to monitor how many appeals result in a favorable outcome to the injured employee. If these statistics indicate an unusually high number of appeals resulting in favor of the original utilization review determination, the Department may follow-up with the URA to determine whether the appeals procedures are compliant with the Insurance Code and applicable rules. This targeted auditing may prevent future denials of appeals in situations in which the injured employee is entitled to health care. Information and the required categorization on the subject matter of any complaint filed with the URA could also assist the Department in identifying areas in which the URA requires additional monitoring to ensure statutorily mandated and quality utilization review for consumers. If small or micro business URAs are exempted from the proposed amendments to §19.2016(b)(3), small and micro business URAs would not be subject to the same level of monitoring by the Department. This lack of information from small and micro business URAs could result in the Department's inability to properly monitor and enforce the provisions of the Insurance Code and applicable rules, possibly resulting in a lesser quality of utilization review and ultimately lack of coverage for necessary health care for the injured employee who uses a small or micro business URA.

Department's determination. Therefore, the Department has determined that the adverse impact that would result for Texas consumers of these small and micro business URAs far outweighs any economic impact on these small and micro businesses that will have to comply with these requirements. Thus, the Department has determined that there are no alternative methods that

can accomplish the objectives of proposed §19.2016(b)(3) and protect the health and economic welfare of Texas consumers.

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 September 6, 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 Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

The Commissioner will consider the adoption of the proposed amendments and new sections in a public hearing under Docket No. 2727 scheduled for September 13, 2011, at 9:30 a.m. in Room 100 of the William P. Hobby, Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. Written and oral comments presented at the hearing will be considered.

SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY

28 TAC §§19.1701 - 19.1717, 19.1719 - 19.1721, 19.1723, 19.1724

STATUTORY AUTHORITY. The amendments to Subchapters R are proposed pursuant to the Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages-Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and the Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to: (i) promote the delivery of quality health care in a cost-effective manner; (ii) ensure that a URA adheres to reasonable standards for conducting utilization review; (iii) foster greater coordination and cooperation between a health care provider and URA; (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and (v) ensure that a URA maintains the confidentiality of medical records in accordance with applicable law.

The Insurance Code §4201.002 defines the various terms used in the chapter, among them "adverse determination" in §4201.002(1) and "utilization review" in §4201.002(13), which are incorporated into the proposed rules. Section 4201.003 provides that the Commissioner of Insurance may adopt rules to implement the Insurance Code Chapter 4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review; requirements for certification; certificate renewal; certification and renewal forms; fees; non-transferability of certificate; reporting material changes; and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner [of insurance] issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner [of insurance] may issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all the applicable rules adopted by the commissioner [of insurance]."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151, the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States, and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care and flexible enough to allow a deviation from the norm when justified on a case-by-case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 addresses utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252 and 4201.253 address personnel matters, including delegation of utilization review, appropriate training and qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation or performance standards.

Subchapter G (Notice of Determinations) governs the notice of determinations specifying the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the time frames for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for the appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures must be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354; acknowledgement of appeal in §4201.355; specialty review procedures in §4201.356; expedited appeal for denial of emergency care or continued hospitalization in §4201.357; response letter to interested persons in §4201.358; written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359; and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review of an adverse determination, addressing the review by the IRO and the URA's compliance with the independent determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009. Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements; consent requirements; providing information to affiliated entities; providing information to the Commissioner of Insurance; access to recorded personal information; publishing information identifiable to a health care provider; requirement to maintain data in a confidential manner; and destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the Commissioner of Insurance to initiate a proceeding under Subchapter M which is a contested case for purposes of Chapter 2001, Government Code. Under §4201.603, the Commissioner of Insurance may impose remedies and penalties for violations of Chapter 4201 which include a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83 or an assessment of an administrative penalty under Chapter 84.

The Insurance Code §38.001 provides, in relevant part, that the Department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties.

The Insurance Code §843.151 provides, in relevant part, that the Commissioner of Insurance may adopt reasonable rules as necessary and proper to implement the Insurance Code Chapter 843.

The Insurance Code §1301.007 requires, in relevant part, the Commissioner of Insurance to adopt rules as necessary to implement the Insurance Code Chapter 1301.

The Insurance Code §1305.007 provides that the Commissioner of Insurance may adopt rules as necessary to implement the Insurance Code Chapter 1305.

The Insurance Code §1352.003(g) requires the Commissioner of Insurance to adopt rules as necessary to implement the Insurance Code Chapter 1352.

The Insurance Code §1352.004(b) requires the Commissioner of Insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

The Insurance Code §1369.057 provides that the Commissioner of Insurance may adopt rules to implement the Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

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.

The Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

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 delegation must be made in writing.

The Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner of Workers' Compensation and the authority to administer and enforce the Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the TDI-DWC or the Commissioner of Workers' Compensation.

The Labor Code §402.00128 vests general operational powers in the Commissioner of Workers' Compensation to conduct daily operations of TDI-DWC and implement policy, including the au-

thority to delegate and to assess and enforce penalties and enter appropriate orders as authorized by the Labor Code Title 5.

The Labor Code §402.061 grants the Commissioner of Workers' Compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

The Labor Code §402.072(a) provides that the TDI-DWC may impose sanctions against any person regulated by the TDI-DWC.

The Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who perform health care services under the Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. The Labor Code §408.0043(b) requires that a person described by the Labor Code §408.0043(a), who reviews a specific workers' compensation case hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

The Labor Code §408.0044 pertains to dentists who perform dental services under the Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. The Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

The Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under the Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. The Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic.

The Labor Code §408.0046 authorizes the Commissioner of Workers' Compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and such rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records.

The Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

The Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the Commissioner of Workers' Compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

The Labor Code §408.0231(g) requires the Commissioner of Workers' Compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers, including standards for peer review and imposition of sanctions against doctors performing peer review functions including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues important to the quality of peer review, as determined by the Commissioner of Workers' Compensation.

The Labor Code §413.011 requires the Commissioner of Workers' Compensation 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.

The Labor Code §413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

The Labor Code §413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

The Labor Code §413.017 provides a presumption of reasonableness for medical services that are consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

The Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or Commissioner of Workers' Compensation rules promulgated under §413.014 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 Labor Code §413.0511(b) provides that the TDI-DWC Medical Advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the Commissioner of Workers' Compensation.

The Labor Code §413.0512(a) requires the TDI-DWC Medical Advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

The Labor Code §413.0513(a) provides that information collected, assembled or maintained by or on behalf of TDI-DWC under §413.0511 or §413.0512 constitutes an investigation file for purposes of and may not be disclosed.

The Labor Code §413.052 provides that the Commissioner of Workers' Compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under the Occupations Code, Title 3, Subtitle B.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §§38.001, 843.002(14), 843.308, 843.347, 1301.133, 1301.135, 1305.002 - 1305.004, 1305.351, 1305.353, 1305.354, 1352.004, 1352.006, 1369.056, 4201.002, 4201.004, 4201.051, 4201.053, 4201.054, 4201.057, 4201.058, 4201.101, 4201.103, 4201.104, 4201.107, 4201.108, 4201.151 - 4201.153, 4201.155, 4201.201 - 4201.207, 4201.251 - 4201.253, 4201.301 - 4201.305, 4201.352 - 4201.360, 4201.401 - 4201.403, 4201.451 - 4201.457, 4201.551 - 4201.558, and 4201.601 - 4201.603; Insurance Code Chapters 257, 1305, 4151, and 4201; Labor

Code §§401.011, 402.00128, 408.0043 - 408.0045, 408.023(h), 408.0231(g), 413.014, 413.0511, 413.0512, and 413.052; Labor Code Chapters 415 and 504; Labor Code Title 5; Government Code §662.003(a) and Chapter 552.

§19.1701. General Provisions.

(a) Statutory Basis [~~basis~~]. This subchapter implements the provisions of the Insurance Code Chapter 4201 which was amended by Acts 2009, 81st Legislature, Chapter 1330, which was effective September 1, 2009, but applies only to a health benefit plan delivered, issued for delivery, or renewed on or after January 1, 2010[~~, Article 21.58A, which was added by Acts 1991, 72nd Legislature, Chapter 242, §11.03(a), which was effective September 1, 1991, but applies only to utilization reviews conducted on or after June 1, 1992~~].

(b) Severability. If [~~Where any terms or sections of this subchapter are determined by~~] a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given [~~to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining terms and provisions of this subchapter shall remain in~~] effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of subchapter [~~these rules~~] is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of enrollee [~~patient~~] safety;

(2) assure that utilization review agents adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and utilization review agents;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable law.

(d) Workers' Compensation Utilization Review. For utilization review performed under workers' compensation insurance coverage, the provisions of Subchapter U of this chapter (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage) apply in lieu of the provisions in this subchapter.

§19.1702. Limitations on Applicability.

(a) Except as provided in the Insurance Code Chapter 4201, this subchapter applies to utilization review performed under a health benefit plan or a health insurance policy. [~~noted in §19.1719 of this title (relating to Responsibility of HMOs and Insurers Performing Utilization Review under the Insurance Code Article 21.58A, §14(g) and (h)), all utilization review agents performing utilization reviews of services provided or proposed to be provided to an individual within the state on or after June 1, 1992, regardless of where the utilization review activities are physically based, must comply with this subchapter. All regulations in this subchapter shall relate to persons or entities subject to this subchapter.~~]

[~~(b) Insurers and HMOs are not required to obtain a certificate of registration, but must comply with §19.1719 of this title.~~]

(b) [~~(c)~~] This subchapter does not apply to [~~a utilization review agent or other person which conducts only the functions of categories of utilization review listed in paragraphs (1)-(3) of this subsection:~~]

[~~(1)~~] a person that [~~who~~] provides information to enrollees, their representatives, or their physicians, doctors, or other health care providers about scope of coverage or benefits [~~provided under a health insurance policy or health benefit plan~~] and that [~~who~~] does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. [~~whether particular health care services provided or to be provided to an enrollee are medically necessary or appropriate;~~]

[~~(2) a person, as defined in §19.1703 of this title (relating to Definitions), performing utilization review who is employed by, or under contract to, a certified utilization review agency;~~]

[~~(3) a utilization review agency which conducts only the categories of utilization review listed in subparagraphs (A)-(E) of this paragraph:~~]

[~~(A) reviews performed pursuant to any contract with the federal government for utilization review of patients eligible for services under Title XVIII or XIX of the Social Security Act (42 United States Code §§1395 et seq. or §§1396 et seq.);~~]

[~~(B) reviews performed for the Texas Medicaid Program, except reviews performed by a health maintenance organization that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code; the Chronically Ill and Disabled Children's Services Program created pursuant to Chapter 35, Health and Safety Code, any program administered under Title 2, the Human Resources Code, any program of the Texas Department of Mental Health and Mental Retardation, or any program of the Texas Department of Criminal Justice;~~]

[~~(C) reviews of health care services provided to patients under the authority of the Texas Workers' Compensation Act (Texas Civil Statutes, §8308-1.01 et seq.);~~]

[~~(D) reviews of health care services provided under a policy or contract of automobile insurance promulgated by the department under the Insurance Code, Subchapter A, Chapter 5 or issued pursuant to the Insurance Code, Article 1.14; or~~]

[~~(E) reviews that apply to the terms and benefits of the employee welfare benefit plans as defined in §3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).~~]

§19.1703. Definitions.

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

[~~(1) Act--Insurance Code, Article 21.58A, entitled "Health Care Utilization Review Agents."~~]

[~~(2) Administrative Procedure Act--Government Code, Chapter 2001.~~]

(1) [~~(3)~~] Administrator--A person holding a certificate of authority under the Insurance Code Chapter 4151 [~~Article 21.07-6~~].

(2) [~~(4)~~] Adverse determination--A determination by a utilization review agent made on behalf of any payor that the health care services provided [~~furnished~~] or proposed to be provided [~~furnished~~] to an enrollee [~~a patient~~] are not medically necessary or [~~not~~] appropriate, or are experimental or investigational. The term does not include a denial of health care services due to the lack of prospective or concurrent utilization review.

(3) [~~(5)~~] Appeal [~~process~~]--The utilization review agent's formal process in [~~by~~] which an enrollee, an individual acting on behalf of the enrollee, or the provider of record may request reconsideration of an [~~a utilization review agent offers a mechanism to address~~] adverse determination [~~determinations~~].

(4) [~~(6)~~] Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a utilization review agent in the State of Texas. A certificate is not issued to an insurance carrier or health maintenance organization that is registered as a utilization review agent under §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents). [~~A certificate of registration granted by the commissioner to a utilization review agent.~~]

(5) [~~(7)~~] Commissioner--The commissioner of insurance.

(6) [~~(8)~~] Complaint--An oral or written expression of dissatisfaction with a utilization review agent concerning the utilization review agent's process in conducting a utilization review. The term "complaint" does not include:[~~. A complaint is not~~]

(A) an expression of dissatisfaction with a specific adverse determination; or

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party [~~enrollee~~].

(7) Concurrent utilization review--A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

(8) [~~(9)~~] Declination--A response to a request for verification in which an HMO or preferred provider benefit plan [~~carrier~~] does not issue a verification for proposed medical care or health care services. A declination is not necessarily a determination that a claim resulting from the proposed services will not ultimately be paid.

[~~(10) Department--Texas Department of Insurance.~~]

(9) [~~(11)~~] Dental plan--An insurance policy or health benefit plan, including a policy written by a company subject to the Insurance Code Chapters 842 and 843 [~~Chapter 20~~], that provides coverage for expenses for dental services.

(10) [~~(12)~~] Dentist--A licensed doctor of dentistry, holding either a D.D.S. or a D.M.D. degree.

(11) Department--Texas Department of Insurance.

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

(A) shared investment or ownership interest;

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

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

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Insurance Code or applicable department rules, or any other association with the enrollee, the employer, or insurance carrier or HMO, that may give the appearance of preventing the reviewing physician or doctor from rendering an unbiased opinion.

(13) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(14) [~~(13)~~] Emergency care--Health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

(A) placing the enrollee's [~~patient's~~] health in serious jeopardy;

(B) serious impairment to bodily functions;

(C) serious dysfunction of any bodily organ or part;

(D) serious disfigurement; or

(E) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

(15) [~~(14)~~] Enrollee--An individual [~~A person~~] covered by a health insurance policy or health benefit plan. This term includes an individual [~~a person~~] who is covered as an eligible dependent of another individual [~~person~~].

(16) 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.

(17) [~~(15)~~] Health benefit plan--A plan of benefits, other than a health insurance policy, that:

(A) defines the coverage provisions for health care for enrollees; and

(B) is offered or provided by a public or private [~~any~~] organization[~~, public or private, other than health insurance~~].

(18) Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(19) [~~(16)~~] Health care provider--A [~~Any~~] person, corporation, facility, or institution that is:

(A) licensed by a state to provide or is otherwise lawfully providing health care services; and

(B) [~~that is~~] eligible for independent reimbursement for those health care services.

(20) Health coverage--Payment for health care services provided under a health benefit plan or a health insurance policy.

(21) [~~(17)~~] Health insurance policy--An insurance policy, including a policy written by a corporation [~~company~~] subject to the Insurance Code[~~,~~] Chapter 842 [~~20,~~] that provides coverage for medical or surgical expenses incurred as a result of accident or sickness.

[~~(18) Inquiry--A request for information or assistance from a utilization review agent.~~]

(22) Health maintenance organization or HMO--A health maintenance organization as defined in the Insurance Code §843.002.

(23) Insurance carrier or insurer--An entity authorized and admitted to do the business of insurance in Texas pursuant to a certificate of authority issued by the department.

(24) Legal Holiday--A national holiday as defined in the Government Code §662.003(a).

(25) [~~(19)~~] Life-threatening--A disease or condition from [~~for~~] which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(26) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the enrollee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(27) Medical records--The entire history of diagnosis and treatment, including but not limited to medical, mental health records as allowed by law, dental, and other health care records from all disciplines rendering care to an enrollee.

(28) [~~(20)~~] Mental health medical record summary--A summary of process or progress notes relevant to understanding the enrollee's [~~patient's~~] need for treatment of a mental or emotional condition or disorder such as:

(A) identifying information; and

(B) a treatment plan that includes:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of enrollee [~~patient~~] behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(29) [~~(21)~~] Mental health therapist--Any of the following individuals [~~persons~~] who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual [~~a person~~] licensed by the Texas Medical [~~State~~] Board [~~of Medical Examiners~~] to practice medicine in this state;

(B) an individual [~~a person~~] licensed as a psychologist by the Texas State Board of Examiners of Psychologists;

(C) an individual [~~a person~~] licensed as a psychological associate by the Texas State Board of Examiners of Psychologists;

(D) an individual [~~a person~~] licensed as a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(E) an individual [~~a person~~] licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(F) an individual [~~a person~~] licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

~~[(G) a person licensed as a chemical dependency counselor by the Texas Commission on Alcohol and Drug Abuse;]~~

(G) [~~(H)~~] an individual [~~a person~~] licensed as an advanced clinical practitioner by the Texas State Board of Social Worker Examiners;

(H) [~~(I)~~] an individual [~~a person~~] licensed as a master social worker by the Texas State Board of Social Worker Examiners;

(I) [~~(J)~~] an individual [~~a person~~] licensed as a social worker by the Texas State Board of Social Worker Examiners;

(J) [~~(K)~~] an individual [~~a person~~] licensed as a physician assistant by the Texas Medical [~~State~~] Board [~~of Physician Assistant Examiners~~];

(K) [~~(L)~~] an individual [~~a person~~] licensed as a registered professional nurse by the Texas Board of Nursing [~~Nurse Examiners~~];

(L) [~~(M)~~] an individual [~~a person~~] licensed as a vocational nurse by the Texas Board of Nursing; or [~~Vocational Nurse Examiners;~~]

(M) [~~(N)~~] any other individual [~~person~~] who is licensed or certified by a state licensing board in the State of Texas to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(30) [~~(22)~~] Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current [~~revision of the~~] Diagnostic and Statistical Manual of Mental Disorders.

(31) [~~(23)~~] Nurse--A registered or professional nurse, a licensed vocational nurse, or a licensed practical nurse.

~~[(24) Open records law--Government Code, Chapter 552.]~~

~~[(25) Patient--An enrollee or an eligible dependent of the enrollee under a health benefit plan or health insurance plan.]~~

(32) [~~(26)~~] Payor--[~~An~~]

(A) an insurer that writes [~~writing~~] health insurance policies;

(B) a [~~any~~] preferred provider organization, health maintenance organization, or self-insurance plan; or

(C) any other person or entity that [~~which~~] provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits to an individual [~~persons~~] treated by a health care provider in this state under a [~~pursuant to any~~] policy, plan, or contract.

(33) Peer Review--An administrative review performed at the insurance carrier's request. For purposes of this subchapter, the term does not include a review performed by an independent review organization under the Insurance Code Chapter 4202.

(34) [~~(27)~~] Person--An individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(35) [~~(28)~~] Physician--A licensed doctor of medicine or a licensed doctor of osteopathy.

(36) [~~(29)~~] Preauthorization--A form of prospective utilization review by a payor or its utilization review agent of [~~determination by an HMO or preferred provider carrier that medical care or~~] health care services proposed to be provided to an enrollee [~~are medically necessary and appropriate~~].

(37) [~~(30)~~] Preferred Provider--

(A) with regard to a preferred provider benefit plan [~~carrier~~], a preferred provider as defined by the Insurance Code Chapter 1301 [~~Article 3.70-3C, §1(10) (Preferred Provider Benefit Plans) or Article 3.70-3C, §1(1) (Use of Advanced Practice Nurses and Physician Assistants by Preferred Provider Plans)~~].

(B) with regard to an HMO:[~~,~~]

(i) a physician, as defined by the Insurance Code §843.002(22), who is a member of that HMO's delivery network; or

(ii) a provider, as defined by the Insurance Code §843.002(24), who is a member of that HMO's delivery network.

(38) [~~(31)~~] Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care[~~, treatment, and~~] services rendered or requested on behalf of [~~to~~] the enrollee or the physician, doctor or other health care provider that has rendered or has been requested [~~is requesting or proposing~~] to provide the health care[~~, treatment and~~] services to the enrollee. This definition [~~and~~] includes any health care facility where health care services are [~~when treatment is~~] rendered on an inpatient or outpatient basis.

(39) Registration--The process for a licensed insurance carrier or health maintenance organization to register with the department to perform utilization review solely for its own insureds or enrollees.

(40) [~~(32)~~] Retrospective utilization review--A form of utilization review for [~~system in which review of the medical necessity and appropriateness of~~] health care services that have been provided to an enrollee [~~is performed for the first time subsequent to the completion of such health care services~~]. Retrospective utilization review does not include [~~subsequent~~] review of services for which prospective or concurrent utilization reviews [~~for medical necessity and appropriateness~~] were previously conducted or should have been previously conducted.

(41) [~~(33)~~] Routine vision services--A routine annual or biennial eye examination to determine ocular health and refractive conditions that may include provision of glasses or contact lenses.

(42) [~~(34)~~] Screening criteria--The written policies, decision rules, medical protocols, or guides used by the utilization review agent as part of the utilization review process (e.g., appropriateness evaluation protocol (AEP) and intensity of service, severity of illness, discharge, and appropriateness screens (ISD-A)).

(43) [~~(35)~~] Single health care service plan--A single health care service plan as defined by the Insurance Code §843.002(26) [~~Section 843.002(26)~~].

(44) Specialty utilization review agent--A utilization review agent that conducts utilization review for a specialty health care service under the Insurance Code Chapter 4201 including, but not limited to, dental services, chiropractic services, behavioral health services, vision services, or physical therapy services.

(45) [~~(36)~~] Utilization review--A system for prospective, [~~or~~] concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services [~~being provided or proposed to be provided to an individual within the state~~]. Utilization review does [~~shall~~] not include elective requests for clarification of coverage.

(46) [~~(37)~~] Utilization review agent--An entity that conducts utilization review[~~,~~] for:

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;[~~,~~]

(B) a payor;[~~,~~] or

(C) an administrator holding a certificate of authority under the Insurance Code Chapter 4151.

(47) [~~(38)~~] Utilization review plan--The screening criteria and utilization review procedures of a utilization review agent.

(48) [~~(39)~~] Verification--A guarantee by an HMO or preferred provider benefit plan [~~carrier~~] that the HMO or preferred provider benefit plan [~~carrier~~] will pay for proposed medical care or health care services if the services are rendered within the required time frame [~~timeframe~~] to the enrollee [~~patient~~] for whom the services are proposed. The term includes pre-certification, certification, re-certification and any other term that would be a reliable representation by an HMO or preferred provider benefit plan [~~carrier~~] to a physician or provider if the request for the pre-certification, certification, re-certification, or representation includes the requirements of §19.1724(d) of this subchapter [~~title~~] (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(49) [~~(40)~~] Working day--Any day, Monday - Friday, other than a national holiday as defined by the Government Code §662.003(a) and the Friday after Thanksgiving Day, December 24 and December 26. Use in this subchapter of the term "day," rather than "working day," means a calendar day. [~~A weekday, excluding New Years Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, and Christmas Day.~~]

§19.1704. Certification or Registration of Utilization Review Agents.

(a) Applicability of Certification or Registration Requirements. A person acting as or holding itself out as a utilization review agent must be certified or registered under the Insurance Code Chapter 4201 and this subchapter and must comply with all requirements in this section.

(1) Pursuant to §19.1719(a)(2) and (b)(3) of this subchapter (relating to Responsibility of HMOs and Insurers Performing Utilization Review), if an HMO or insurer, respectively, performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such HMO or insurer must have a valid certificate pursuant to the Insurance Code §4201.101 and this section.

(2) Pursuant to §19.1719(a)(3) and (b)(4) of this subchapter, if an HMO or insurer, respectively, performs utilization review only for coverage for which it is the payor, the HMO or insurer must have a valid registration pursuant to this section.

(b) Application Form. The commissioner adopts by reference Form No. LHL005 (Utilization Review Agent (URA) Application) to be used for application for a certification or registration and for renewal of a certification or registration as a utilization review agent in this state.

(c) Application Filing Requirements.

(1) Application for certification.

(A) An application for certification of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in subsection (b) of this section.

(B) The application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19) of this chapter (relating to Amount of Fees).

(2) Application for registration.

(A) An application for registration of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in subsection (b) of this section.

(B) The original application fee requirement specified by §19.802(b)(19) of this chapter does not apply to an applicant for registration.

(3) [~~(a)~~]Where to obtain and file the application form. Form No. LHL005 may be obtained from and [~~An application for certification of a utilization review agent~~] must be filed with the department [~~Texas Department of Insurance~~] at the following address: Texas Department of Insurance, Health and Workers' Compensation

Network Certification & QA (HWCN) Division, Mail Code 103-6A, [~~108-6A,~~] P.O. Box 149104, Austin, Texas 78714-9104.

[~~(b) The application must be submitted on a form which can be obtained from the Utilization Review Section, Mail Code 108-6A, Texas Department of Insurance, 333 Guadalupe, P.O. Box 149104, Austin, Texas 78714-9104.~~]

(d) Required Information. Form No. LHL005 (Utilization Review Agent (URA) Application Form) requires the following information:

[~~(c) The attachments to the application form require the following information:~~]

(1) a summary description of the utilization review plan, which must include the matters listed in subparagraphs (A) and (B) of this paragraph and otherwise comply with [~~. The utilization review plan must meet~~] the requirements of §19.1705 of this subchapter [~~title~~] (relating to General Standards of Utilization Review):

(A) an adequate summary description of screening criteria and review procedures to be used to determine medical necessity or [~~and~~] appropriateness, or the experimental or investigational nature, of health care; and

(B) a certification, signed by an authorized representative of the applicant [~~company~~] that screening criteria and review procedures to be applied in review determination are established with input from appropriate health care providers and approved by physicians;

(2) utilization review plan written policies that evidence compliance with:

(A) §19.1705 of this subchapter;

(B) §19.1706 of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.1707 of this subchapter (relating to Prohibition of Certain Activities and Procedures Related to Health Care Providers and Enrollees);

(D) §19.1708 of this subchapter (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers);

(E) §19.1709 of this subchapter (relating to On-Site Review by the Utilization Review Agent);

(F) §19.1710 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review);

(G) §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination);

(H) §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(I) §19.1713 of this subchapter (relating to Utilization Review Agent's Telephone Access);

(J) §19.1714 of this subchapter (relating to Confidentiality);

(K) §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review);

(L) §19.1716 of this subchapter (relating to Regulatory Requirements Subsequent to Certification or Registration);

(M) §19.1720 of this subchapter (relating to Specialty Utilization Review Agent), if applicable;

(N) §19.1721 of this subchapter (relating to Independent Review of Adverse Determinations);

(O) §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans), if applicable; and

(P) §19.1724 of this subchapter (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans) if applicable;

(3) copies of template letters for notification of determinations made in utilization review that comply with §19.1710 and §19.1712 of this subchapter;

(4) organizational information:

(A) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state;

(B) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and

(C) letter of good standing from the Texas Comptroller of Public Accounts;

(5) the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under §1.503 of this title (relating to Application of Fingerprint Requirement) and §1.504 of this title (relating to Fingerprint Requirement); and

[~~(2) copies of procedures established for appeal of an adverse determination. These procedures must comply with the provisions of §19.1712 of this title (relating to Adverse Determinations of Utilization Review Agents);~~]

[~~(3) copies of procedures established for handling oral or written complaints by enrollees, patients, or health care providers. These procedures must comply with §19.1716 of this title (relating to Complaints and Information);~~]

[~~(4) copies of policies and procedures which ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with §19.1714 of this title (relating to Confidentiality);~~]

(6) [~~(5)~~] a certification signed by an authorized representative of the company that the utilization review agent will comply with the provisions of Chapter 4201 of the Insurance Code. [~~the Act;~~]

[~~(6) a description of the categories of persons and names of the personnel employed or contracted to perform utilization review;~~]

[~~(7) a description of the hours of operation within the State of Texas and how the utilization review agent may be contacted during weekends and holidays. This description must be in compliance with §19.1713 of this title (relating to Utilization Review Agent's Telephone Access);~~]

[~~(8) representative samples of all materials provided by the utilization review agent/applicant to inform its clients, enrollees or providers of the requirements of the utilization review plan. Samples shall include language for notification of an adverse determination made in a utilization review;~~]

[(9) a description of the basis by which the utilization review agent compensates its employees or agents to ensure compliance with paragraph (10) of this subsection;]

[(10) a certification signed by an authorized representative that the utilization review agent shall not permit or provide compensation or anything of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards, based on the amount or volume of adverse determinations, reductions or limitations on lengths of stay, benefits, services, or charges or on the number or frequency of telephone calls or other contacts with health care providers or patients, which are inconsistent with the provisions of this subchapter;]

[(11) 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 utilization review agent.]

[(12) the name and biographical information for each director, officer and executive of the applicant.]

[(d) The utilization review agent shall report any material changes in the information in the application or renewal form referred to in this section, not later than the 30th day after the date on which the change takes effect. Material changes include, but are not limited to, new personnel hired who are officers and directors who perform utilization review; changes in the organizational structure; changes in contractual relationships and changes in the utilization review plan.]

(e) Original Application Requirements and Process. Paragraphs [The application process is described in paragraphs] (1) - (4) [(6)] of this subsection specify the requirements and process for entities that are applying for a certification or registration.

(1) Within [The department shall have] 60 days after receipt of a complete [an] application, the department will [to] process the application and [to] certify or register the entity or deny certification or registration [it]. The department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered. The department will [shall] give the applicant written notice of any omissions or deficiencies noted as a result of the review conducted pursuant to this paragraph.

(2) The applicant must correct the omissions or deficiencies in the application within 15 working [30] days of the date of the department's latest notice of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(3) The applicant may waive any of the time limits described in this subsection, except the requirement in paragraph (2) of this subsection. However, before the end of the 15 working days specified in paragraph (2) of this subsection, the[. The] applicant may request in writing additional time to correct the noted omissions or deficiencies in the application. The request for the additional time must be approved by the department in writing for the requested extension to be effective [waive the time limit in paragraph (2) of this subsection, only with the consent of the department].

(4) The department will [shall] maintain a charter [an application] file which must [shall] contain the approved application documents, notices of omissions or deficiencies, and requests for additional time and responses from the applicant [and any written materials generated by any person that was considered by the department in evaluating the application].

(f) Renewal Requirements. Paragraphs (1) - (4) of this subsection specify the requirements for entities that are renewing a certification or registration.

(1) Two-year renewal. A utilization review agent must apply for renewal of certification or registration [the certificate of registration] every two years from the date of certification or registration by submitting Form No. LHL005 (Utilization Review Agent (URA) Application Form). For an application for renewal of a certification, a utilization review agent must also submit a renewal fee in the amount specified by §19.802(b)(19) of this chapter. [A renewal form must be used for this purpose. The renewal fee must be submitted with the renewal form. The renewal form can be obtained from the address listed in subsection (b) of this section. The completed renewal form, a summary of the current screening criteria, a statement signed by an authorized representative of the company certifying that all information previously submitted is true and correct and all changes have been previously filed to the application certified by the department, and the renewal fee must be submitted to the department at the address listed in subsection (a) of this section.]

(2) Continued operation during department review. If a utilization review agent has filed the required information specified in this subsection and the fee as applicable for certification renewal with the department on or before the expiration of the certification or registration, the [A] utilization review agent may continue to operate under its certification or registration [certificate of registration if the information and the fee have been filed for renewal and timely received by the department,] until the renewal certification or registration is finally denied or issued by the department. [If the required information and fee is not received prior to the deadline for renewal of the certificate of registration the certificate of registration will automatically expire and the utilization review agent must complete and submit a new application form and a new fee with all required information.]

(3) Expiration for 90 days or less. If the certification or registration has been expired for 90 days or less, the utilization review agent may renew the certification or registration by filing a completed renewal application, fee as applicable for certification renewal, and the required information described in this subsection. The utilization review agent may not operate from the time the certification or registration has expired until the time the department has issued a renewal certification or registration.

(4) Expiration for longer than 90 days. If a utilization review agent's certification or registration has been expired for longer than 90 days, the utilization review agent may not renew the certification or registration but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accordance with this section. Subsection (e) of this section applies to applications made under this paragraph.

(g) Contesting a Denial of an Application or Renewal.

[(1)] If an application for an original or renewal certification or registration is [initially] denied under this section, the appli-

cant [or registrant] may contest [appeal] such denial under [the terms of] the provisions of Chapter 1, Subchapter A of this title (relating to Rules of Practice and Procedure) and the Government Code[,] Chapter 2001. The contesting party is entitled to a hearing [A hearing of such appeal shall be conducted] within 45 days of the date the petition for such hearing is filed with the commissioner. A decision by the commissioner must [shall] be rendered within 60 days of the date of the hearing.

[(h) An applicant for a certificate of registration as a utilization review agent must provide evidence that the applicant:]

[(1) has available the services of physicians, nurses, physician's assistants, or other health care providers qualified to provide the service requested by the provider to carry out its utilization review activities in a timely manner;]

[(2) meets any applicable provisions of this chapter and regulations relating to the qualifications of the utilization review agents or the performance of utilization review;]

[(3) has policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;]

[(4) makes itself accessible to patients and providers 40 working hours a week during normal business hours in this state in each time zone in which it operates.]

[(i) Utilization review agents that have received their certificate of registration prior to the adoption of these rules, must file with the department all changes to their original application as set forth in subsections (c) and (d) of this section by March 1, 1998.]

§19.1705. General Standards of Utilization Review.

(a) Review of Utilization Review Plan. The utilization review plan must [, including reconsideration and appeal requirements, shall] be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other [appropriate] health care providers. [, including practicing health care providers that are both primary and specialty physicians, and approved by a physician. The utilization review plan shall include the following components:]

[(1) a description of the elements of review which the utilization review agent provides such as:]

[(A) prospective review:]

[(i) hospital admission;]

[(ii) procedures (such as surgical and non-surgical procedures);]

[(iii) courses of outpatient treatment;]

[(B) second surgical opinion;]

[(C) discharge planning;]

[(D) concurrent review;]

[(E) readmission review; and]

[(F) continued stay authorization;]

[(2) written procedures for:]

[(A) identification of individuals with special circumstances who may require flexibility in the application of screening criteria through utilization review decisions. Special circumstances includes, but is not limited to, a person who has a disability, acute condition, or life-threatening illness;]

[(B) notification of the utilization review agent's determinations provided to the enrollee, a person acting on behalf of the enrollee, or the enrollee's provider of record as addressed in §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents);]

[(C) appeal of an adverse determination and a copy of any forms used during the appeal process, as required by §19.1711 and §19.1712 of this title (relating to Requirements Prior to Adverse Determination and Appeal of Adverse Determinations of Utilization Review Agents);]

[(D) receiving or redirecting a toll-free normal business hour and after-hour calls, either in person or by recording, and assurance that a toll-free number will be maintained 40 hours per week during normal business hours as addressed in §19.1713 of this title (relating to Utilization Review Agent's Telephone Access);]

[(E) review including:]

[(i) any form used during the review process;]

[(ii) time frames that shall be met during the review;]

[(F) handling of oral or written complaints by enrollees, patients, or health care providers as addressed in §19.1716(a) of this title (relating to Complaints and Information);

[(G) determining if physicians or other health care providers utilized by the utilization review agent are licensed, qualified, and appropriately trained;]

[(H) assuring that patient-specific information obtained during the process of utilization review, as addressed in §19.1714 of this title (relating to Confidentiality), will be:]

[(i) kept confidential in accordance with applicable federal and state laws;]

[(ii) used solely for the purposes of utilization review, quality assurance, discharge planning, and catastrophic case management;]

[(iii) shared with only those agencies (such as the claims administrator) who have authority to receive such information; and]

[(iv) in the case of summary data, such data shall not be considered confidential if it does not provide sufficient information to allow identification of individual patients;]

[(I) providing prior written notice to a physician or health care provider when publishing data, including quality review studies or performance tracking data which identifies a particular physician or health care provider;]

[(3) screening criteria. Each utilization review agent shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from the physicians, including practicing physicians, dentists, and other health care providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norm when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred

~~to an appropriate physician, dentist, or other health care provider to determine medical necessity. Such written screening criteria and review procedures shall be available for review and inspection to determine appropriateness and compliance as deemed necessary by the commissioner or his or her designated representative and copying as necessary for the commissioner to carry out his or her lawful duties under the Insurance Code, provided, however, that any information obtained or acquired under the authority of this chapter and the Act, is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this chapter and the Act;]~~

(b) Special Circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.

(c) Performance Tracking Data. The utilization review plan must provide prior written notice to a physician, doctor, or other health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or other health care provider, including quality review studies or performance tracking data.

(d) Screening Criteria. Each utilization review agent is required to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the utilization review agent must utilize generally accepted standards of medical practice recognized in the medical community.

(e) Referral and Determination of Adverse Determinations. Adverse determinations must be referred to and may only be determined by an appropriate physician or doctor to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

(f) [~~(4)~~] Delegation of Review. A utilization review agent, including a specialty utilization review agent, may delegate the review to qualified personnel in [~~delegation of review. Provide circumstances, if any, under which the utilization review agent may delegate the review to~~] a hospital utilization review program or a qualified health care provider. Such delegation does [~~shall~~] not relieve the utilization review agent of full responsibility for compliance with this subchapter and Chapter 4201 of the Insurance Code [~~the Act~~] including the conduct of those to whom utilization review has been delegated.

(g) Complaint System. The utilization review agent is required to develop and implement procedures for the resolution of oral or written complaints initiated by enrollees, their representatives, or health care providers concerning the utilization review and is required to maintain records of such complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include the department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the department.

(h) Pursuant to the Insurance Code §1369.056, the refusal of a group health benefit plan issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for purposes of this subchapter if:

(1) the drug is not included in a drug formulary used by the group health benefit plan; and

(2) the enrollee's physician has determined that the drug is medically necessary.

(i) Applicability to Specialty Utilization Review Agents. This section also applies to a specialty utilization review agent, except for subsection (a) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1706. Requirements and Prohibitions Relating to Personnel.

(a) Qualification Requirements.

(1) Physicians, doctors, and other health care providers [~~Personnel~~] employed by or under contract with the utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and [~~if applicable,~~] currently licensed.

(2) Personnel conducting utilization review must hold an unrestricted license or an administrative license or be otherwise authorized to provide health care services by a licensing agency in the United States.

(3) Personnel who obtain information regarding an enrollee's [~~a patient's~~] specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, [~~dentist~~] or other health care provider, either orally or in writing, and who are not physicians or doctors [~~dentists~~], must [~~shall~~] be nurses, physician [~~physicians~~] assistants, or other health care providers qualified to provide the service requested [~~by the provider~~]. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(b) Prohibitions. A utilization review agent may not permit or provide compensation or anything [~~any thing~~] of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards, based on:

(1) the amount or volume of adverse determinations; [~~,~~]

(2) reductions or limitations on lengths of stay, benefits, services, or charges; or

(3) [~~on~~] the number or frequency of telephone calls or other contacts with health care providers or enrollees [~~patients~~], which are inconsistent with the provisions of this subchapter.

(c) Disqualifying associations. The physician who reviews the appeal must not have any disqualifying associations with the physician or doctor who issued the initial adverse determination or the enrollee who is requesting the appeal. For purposes of this subsection, being employed by or under contract with the same utilization review agent as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association.

(d) [~~(c)~~] Information Required to be Filed with the Department. The utilization review agent is required to provide the name, number, type, license number and state of licensure, and [~~minimum qualification or~~] qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information [~~commissioner~~].

(e) Written Procedures and Maintenance of Records.

(1) Utilization review agents are [~~shall be~~] required to develop and implement [~~adopt~~] written procedures [~~used~~] to determine if physicians, doctors, and [~~or~~] other health care providers used [~~utilized~~]

by the utilization review agent are licensed, qualified, and appropriately trained or experienced [~~, and must maintain records on such~~].

(2) The utilization review agent must maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced in accordance with subsection (a) of this section.

(f) Training Related to Acquired Brain Injury Treatment. A utilization review agent is required to provide adequate training to personnel responsible for pre-certification, certification, and recertification of services or treatment relating to acquired brain injury in accordance with the Insurance Code §1352.004. The purpose of the training is to prevent denial of coverage in violation of the Insurance Code §1352.003 and to avoid confusion of medical benefits with mental health benefits.

(g) [~~(d)~~] Physician Direction Requirement. Utilization review conducted by a utilization review agent must [~~shall~~] be under the direction of a physician currently licensed to practice medicine by a state licensing agency in the United States. Such physician may be employed by or under contract with [~~to~~] the utilization review agent.

(h) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a), (d), (e), and (g) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

~~[(e) Utilization review dental plans shall be reviewed by a dentist currently licensed by a state licensing agency in the United States.]~~

§19.1707. Prohibition ~~[Prohibitions]~~ of Certain Activities and Procedures Related to Health Care Providers and Enrollees ~~[of Utilization Review Agents]~~.

(a) A utilization review agent may not engage in unnecessary or unreasonably repetitive contacts with the health care provider or enrollee [~~patient~~] and must [~~shall~~] base the frequency of contacts or reviews on the severity or complexity of the enrollee's [~~patient's~~] condition or on necessary treatment and discharge planning activity.

(b) A utilization review agent may [~~shall~~] not set or impose any notice or other review procedures contrary to the requirements of the health insurance policy or health benefit plan.

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1708. Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.

(a) A health care provider may designate one or more individuals as the initial contact or contacts for utilization review agents seeking routine information or data. The [~~In no event shall the~~] designation of such an individual or individuals may not in any circumstance relieve the [~~preclude a~~] utilization review agent or medical advisor of the obligation to contact [~~from contacting~~] a health care provider or others in the health care provider's [~~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 utilization review agent.

(b) Unless precluded or modified by contract, a utilization review agent must [~~shall~~] reimburse health care providers for the reasonable costs for providing medical information in writing, including copying and transmitting any requested enrollee [~~patient~~] records or other documents relevant to the utilization review. A health care provider's charge for providing medical information to a utilization review agent must be in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation) [~~shall not exceed the cost of copying set by rules of the Texas Workers Compensation Commission for records~~] and may not include any costs that are otherwise recouped as a part of the charge for health care.

(c) When conducting routine utilization review, the utilization review agent must request all relevant and updated medical records in order to complete the review [~~shall collect only the information necessary to certify the admission, procedure, or treatment and length of stay~~]. This information may include identifying information about the [~~patient and~~] enrollee;[~~,~~] the benefit plan or claim;[~~,~~] the treating physician, doctor, or other health care provider;[~~,~~] and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the enrollee [~~patient~~] and the medical history of the enrollee [~~patient~~] relevant to the diagnoses; the enrollee's [~~patient's~~] prognosis; and the [~~treatment~~] plan of treatment prescribed by the [~~treating health care~~] provider of record, along with the provider of record's [~~provider's~~] justification for the [~~treatment~~] plan of treatment. [~~Second opinion information may also be required when applicable, sufficient to support benefit plan requirements. These items shall only be requested when relevant to the utilization review in question and be requested as appropriate from the beneficiary, plan sponsor, health care provider, or health care facility.~~] The required information should be obtained from the appropriate source, since no one source will have all of this information.

(1) Utilization review agents may request [~~shall not routinely require hospitals and physicians to supply~~] numerically codified diagnoses or procedures to be considered for certification only if[~~. Utilization review agents may ask for such coding, since if it is known,~~] its inclusion in the data collected increases the effectiveness of the communication.

(2) Utilization review agents must [~~shall~~] not routinely request copies of all medical records on enrollees [~~all patients~~] reviewed. During utilization [~~prospective and concurrent~~] review, copies of medical records should only be required when a difficulty develops in determining whether the health care is medically necessary or appropriate, or whether it is experimental or investigational [~~certifying the medical necessity or appropriateness of the admission or extension of stay~~]. In those cases, only the necessary or pertinent sections of the record should be required.

(d) Information in addition to that described in this section may be requested by the utilization review agent or voluntarily submitted by the [~~health care~~] provider of record, when there is significant lack of agreement between the utilization review agent and [~~health care~~] provider of record regarding the appropriateness of health care [~~certification~~] during the review or appeal process. "Significant lack of agreement" means that the utilization review agent:

(1) has tentatively determined[~~, through its professional staff,~~] that a service cannot be approved [~~certified~~];

(2) has referred the case to a physician or doctor for review; and

(3) has had a discussion with [~~talked to~~] or attempted to have a discussion with [~~talk to~~] the [~~health care~~] provider of record in order to obtain [~~for~~] further information.

(e) The utilization review agent should share among its various divisions all clinical and demographic information on individual enrollees [~~patients among its various divisions (e.g., certification, discharge planning, case management)~~] to avoid duplicate requests for

information from enrollees, physicians, doctors, and other health care [~~or~~] providers.

(f) Notwithstanding any other provision of this section [~~chapter~~], a utilization review agent may not require as a condition of treatment approval, or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's [~~a patient's~~] mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude the utilization review agent from:

(1) requiring submission of an enrollee's [~~a patient's~~] mental health medical record summary; or

(2) requiring submission of medical records or [~~and/or~~] process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1709. On-Site Review by the Utilization Review Agent.

(a) Observing or Participating in Patient's Care. Unless approved for an individual enrollee [~~patient~~] by the provider of record or allowed [~~modified~~] by contract, a utilization review agent is [~~shall be~~] prohibited from observing, participating in, or otherwise being present during an enrollee's [~~a patient's~~] examination, treatment, procedure, or therapy. In no event may [~~shall~~] this prohibition [~~section otherwise~~] be construed to limit or deny contact with an enrollee [~~a patient~~] for purposes of conducting utilization review unless otherwise specifically prohibited by law.

(b) Identification of Utilization Review Agents. Utilization review agents' staff must [~~shall~~] identify themselves by name and by the name of their organization and must[~~, for on-site reviews, should~~] carry picture identification and the utilization review agent [~~company~~] identification card with the certificate number assigned by the department [~~Texas Department of Insurance~~].

(c) On-site Review at a Health Care Facility. For on-site review conducted at a health care facility, utilization [~~Utilization~~] review agents:

(1) must ensure [~~should assure~~] that their on-site review staff:

(A) register with the appropriate contact individual [~~person~~], if available, prior to requesting any clinical information or assistance from health care facility [~~hospital~~] staff; and

(B) wear appropriate health care facility [~~hospital~~] supplied identification tags while on the health care facility premises; and[~~.~~]

(2) are required to [~~Utilization review agents shall~~] agree, if so requested, that the medical records remain available in the designated areas during the on-site review and that reasonable health care facility [~~hospital~~] administrative procedures will [~~shall~~] be followed by on-site review staff in order [~~so as~~] to not disrupt health care facility [~~hospital~~] operations or enrollee [~~patient~~] care. Such procedures, however, should not obstruct or limit the ability of the utilization review agent to efficiently conduct the necessary review on behalf of the enrollee's [~~patient's~~] health benefit plan.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1710. Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~].

(a) Notice of Favorable or Adverse Determinations. A utilization review agent is required to [~~shall~~] notify, in accordance with this section as applicable, the enrollee, or an individual [~~a person~~] acting on behalf of the enrollee, and [~~or~~] the enrollee's provider of record of a favorable or adverse determination made in a prospective or concurrent utilization review.

(b) Favorable Determinations.

(1) Except in the case of notification of adverse determinations which are addressed in subsection (c) [~~(d)~~] of this section, the written notification required by this subsection [~~section~~] must be mailed or electronically [~~otherwise~~] transmitted no [~~not~~] later than two working days after the date of the request for utilization review and all medical information necessary to substantiate the need for the treatment or service recommended is received by the agent.

(2) A utilization review agent must ensure that preauthorization numbers assigned by the utilization review agent comply with the data and format requirements contained in the standards adopted by the federal Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction, based on the type of service in the preauthorization request.

(c) Adverse Determinations.

(1) Required notice elements. In all instances of a prospective or concurrent utilization review adverse determination, written notification [~~Notification~~] of the adverse determination by the utilization review agent must include:

(A) [~~(1)~~] the principal reasons for the adverse determination;

(B) [~~(2)~~] the clinical basis for the adverse determination;

(C) [~~(3)~~] a description or the source of the screening criteria that were utilized as guidelines in making the determination;

(D) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(E) the professional specialty and state(s) of licensure of the physician or doctor that made the adverse determination;

(F) [~~(4)~~] a description of the procedure for the utilization review agent's complaint system as required by §19.1705 of this subchapter (relating to General Standards of Utilization Review); [~~and appeal process; and~~]

(G) a description of the utilization review agent's appeal process, as required by §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(H) the date and time the utilization review agent offered the opportunity to discuss the adverse determination and the date and time the discussion, if any, took place, as required in §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.1720 of this subchapter (relating to Specialty Utilization Review Agent); and

(I) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Re-

view Organization), which is available at www.tdi.state.tx.us/forms. Such notice must include instruction that:

(i) Form No. LHL009 (Request for a Review by an Independent Review Organization) must be completed by the enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the carrier or utilization review agent that made the adverse determination to begin the independent review process; and

(ii) the release of medical information to the independent review organization, which is included as part of the independent review request form prescribed by the commissioner, must be signed by the enrollee or the enrollee's legal guardian.

[~~(5) the independent review notification and the form prescribed by the commissioner.~~]

(2) Independent review in the event of life-threatening condition. In accordance with §19.1712(a)(3) of this subchapter, the description of the utilization review agent's appeal process required by paragraph (1)(G) of this subsection must include a statement that in a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate review of the adverse determination by an independent review organization and is not required to comply with procedures for an internal review of the adverse determination by a utilization review.

(3) Release of medical information. The release of medical information to the independent review organization included in the request for review by an independent review organization required by paragraph (1)(I) of this subsection must be signed by the enrollee or the enrollee's legal guardian.

(4) [~~(d)~~] Required time frames. Unless §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) applies, the time frames for notification of the [~~The~~] adverse determination are [~~notification must be provided~~]:

(A) [~~(1)~~] with respect to an enrollee who is hospitalized at the time of the adverse determination, within one working day by telephone or electronic transmission to the provider of record [~~in the case of a patient who is hospitalized at the time of the adverse determination, to be~~] followed by a letter within three working days notifying the enrollee [~~patient~~] and the provider of record of the [~~an~~] adverse determination [~~within three working days~~];

(B) [~~(2)~~] with respect to an enrollee who is not hospitalized at the time of the adverse determination, within three working days of the request in writing to the provider of record and the enrollee [~~patient if the patient is not hospitalized at the time of the adverse determination~~]; or

(C) [~~(3)~~] with respect to a denial of post-stabilization care subsequent to emergency treatment as requested by a provider of record, within the time appropriate to the circumstances relating to the delivery of the services to the enrollee and the enrollee's condition, [~~of the patient,~~] but not later than [~~in no case to exceed~~] one hour from the time of request by telephone or electronic transmission to the provider of record, to be followed by a written notification within three working days of the telephone or electronic transmission [~~notification when denying post-stabilization care subsequent to emergency treatment as requested by a treating physician or provider. In such circumstances, notification shall be provided to the treating physician or health care provider~~].

(d) Determination Concerning an Acquired Brain Injury. In addition to the notification required by subsections (b) and (c) of this section, a utilization review agent is required to comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a utilization review agent must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made pursuant to coverage under a small employer health benefit plan.

(e) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter.

[~~(e) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames addressed in subsection (d) of this section. At the time of notification of the adverse determination, the utilization review agent shall provide to the enrollee or person acting on behalf of the enrollee, and the enrollee's provider of record, the independent review notification and the form prescribed by the commissioner.~~]

§19.1711. Requirements Prior to Issuing Adverse Determination.

(a) Reasonable Opportunity. For purposes of this section, "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or no less than five working days prior to issuing a retrospective utilization review adverse determination.

(b) Requirements Prior to Issuing Prospective or Concurrent Utilization Review Adverse Determinations.

(1) Subject to the notice requirements of §19.1710 of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]), in any instance in which [~~where~~] the utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record [~~the health care provider who ordered the services shall be afforded~~] a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision. [~~patient and the clinical basis for the utilization review agent's decision with a physician or, in the case of a dental plan with a dentist, prior to issuance of an adverse determination. The utilization review agent shall have written procedures describing how the opportunity is afforded.~~]

(2) When the utilization review agent provides the reasonable opportunity required under subsection (b)(1) of this section, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent must submit the documentation required by paragraph (3) of this subsection to the department upon request.

(c) Requirements Prior to Issuing Retrospective Review Adverse Determinations.

(1) Subject to the notice requirements of §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of an adverse determination, the utilization review agent is required to afford the provider of record a reasonable opportunity to discuss the treatment provided to the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) When the utilization review agent provides the reasonable opportunity required under paragraph (1) of this subsection, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination. The utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent is required to submit the documentation required by paragraph (3) of this subsection to the department upon request.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (b) and (c) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1712. Appeal of Adverse Determination [~~of Utilization Review Agents~~].

(a) Appeal of Prospective or Concurrent Adverse Determinations.

(1) A utilization review agent must [~~shall~~] maintain and make available a written description of appeal procedures involving an adverse determination that are used by the agent.

(2) [~~(b)~~] Each utilization review agent is required to comply with its written procedures for appeals. In accordance with the Insurance Code Chapter 4201, Subchapter H (relating to Appeal of Adverse Determination), the written [~~The~~] procedures for appeals must [~~shall~~] be reasonable and must [~~shall~~] include the information specified in this paragraph [~~following~~]:

(A) a statement specifying the time frames for filing the written or oral appeal, which may not be less than 30 days after the date of issuance of written notification of an adverse determination;

(B) a provision that an enrollee, an individual acting on behalf of the enrollee, or the provider of record may appeal the adverse determination orally or in writing;

(C) a provision that an appeal acknowledgement letter:

(i) must be sent to the appealing party within five working days from receipt of the appeal;

(ii) must acknowledge the date the utilization review agent received the appeal;

(iii) must include a list of relevant documents that must be submitted by the appealing party to the utilization review agent; and

(iv) must include a one-page appeal form to be filled out by the appealing party when the utilization review agent receives an oral appeal of an adverse determination;

[~~(1) a provision that an enrollee, a person acting on behalf of the enrollee, or the enrollee's physician or health care provider may appeal the adverse determination orally or in writing;~~]

[~~(2) a provision that within five working days from receipt of the appeal the utilization review agent shall send to the appealing party a letter acknowledging the date of the utilization review agent's receipt of the appeal and include a reasonable list of documents needed to be submitted by the appealing party to the utilization review agent for the appeal. Such letter must also include provisions listed in subsections (b) and (c) of this section. When the utilization review agent receives an oral appeal of adverse determination, the utilization review agent shall send a one-page appeal form to the appealing party;~~]

(D) [~~(3)~~] a provision that appeal decisions must [~~shall~~] be made by a physician who has not previously reviewed the case;

(E) a provision that in any instance in which the utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination), to discuss the plan of treatment for the enrollee with a physician. The provision must require that the discussion include, at a minimum, the clinical basis for the utilization review agent's decision;

(F) a provision that [~~, or dentist, as appropriate, provided that,~~] if the appeal is denied and within 10 working days from such denial the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial must [~~shall~~] be reviewed by a health care provider in the same or similar specialty that [~~as~~] typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review of the adverse determination, and such specialty review must [~~shall~~] be completed within 15 working days of receipt of the request. The provision must state that notification of the appeal under this paragraph must be in writing;

(G) [~~(4)~~] a provision that, in addition to the written appeal, a method for expedited appeals [~~appeal procedure~~] for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays for hospitalized enrollees is available [~~patients~~]. The provision must state that such [~~Such~~] procedure must [~~shall~~] include a review by a health care provider who has not previously reviewed the case who is of the same or a similar specialty as the health care provider that typically manages the medical condition, procedure, or treatment under review. The provision must state that an expedited [~~The time in which such~~] appeal must be completed [~~shall be~~] based on the [~~medical or dental~~] immediacy of the medical or dental condition, procedure, or treatment, but may in no event exceed one working day from the date all information necessary to complete the appeal is received. The provision must also state that an expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification;

(H) [~~(5)~~] a provision that after the utilization review agent has sought review of the appeal of the adverse determination,

the utilization review agent must [shall] issue a response letter to the enrollee or an individual [patient, a person] acting on behalf of the enrollee and [patient, or] the [patient's physician or health care] provider of record explaining the resolution of the appeal. The provision must state that such [Such] letter must [shall] include:

(i) [(A)] a statement of the specific medical, dental, or contractual reasons for the resolution;

(ii) [(B)] the medical or clinical basis for such decision, including screening criteria;

(iii) a description of or the source of the screening criteria that were utilized in making the determination;

(iv) the professional specialty and state or states of licensure of the physician who made the determination;

[(C) the specialization of any physician or other provider consulted; and]

(v) [(D)] notice of the appealing party's right to seek review of the denied appeal [denial] by an independent review organization in accordance with §19.1721 of this subchapter (relating to Independent Review of Adverse Determinations), [and] the procedures for obtaining that review, and Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)); and[.]

(vi) procedures for filing a complaint in accordance with the Insurance Code §4201.204 and as described in §19.1705(g) of this subchapter (relating to General Standards of Utilization Review);

(I) [(6)] a provision that the appeal must be resolved [written notification to the appealing party of the determination of the appeal,] as soon as practical, but, in accordance with the Insurance Code §4201.359, in no case later than 30 days after the date the utilization review agent receives the written appeal or the one-page appeal form from the appealing party referenced under subparagraph (C) of this paragraph.

(3) [(c)] In a circumstance involving an enrollee's life-threatening condition, the enrollee is entitled to an immediate appeal to an independent review organization and is not required to comply with procedures for an internal review of the utilization review agent's adverse determination.

(b) Appeal of Retrospective Review Adverse Determinations. A utilization review agent is required to maintain and make available a written description of the appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the requirements in paragraphs (1) - (3) of this subsection.

(1) The appeal procedures must be in accordance with the requirements in Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims).

(2) An appeal of an adverse determination relating to retrospective utilization review must comply with §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review).

(3) In any instance in which the utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the plan of treatment for the enrollee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(c) Appeals Concerning an Acquired Brain Injury. In addition to the requirements in subsections (a) and (b) of this section, a utilization review agent is required to comply with this subsection in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a utilization review agent must provide notification of the determination through a direct telephone contact to the individual making the request. This subsection does not apply to a determination made pursuant to coverage under a small employer health benefit plan.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a)(2)(D) and (E) and (b)(3) of this section. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1713. Utilization Review Agent's Telephone Access.

(a) A utilization review agent is required to [shall] have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both time zones in Texas, [if applicable,] to discuss enrollees' [patients'] care and to respond [allow response] to telephone review requests.

(b) A utilization review agent must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours and must [shall] respond to such calls not later than two working days of the later of the date on which the call was received or the date on which the details necessary to respond were [have been] received from the caller.

(c) A utilization review agent must provide a written description to the commissioner setting forth the procedures that the utilization review agent will implement [to be used] when responding to post-stabilization care subsequent to emergency treatment as requested by a treating physician, doctor, or other health care provider of record. Such procedure must comply with the Insurance Code §4201.004.

(d) This section does not apply to an HMO or preferred provider benefit plan that is subject to §19.1723 of this subchapter (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and §19.1724 of this subchapter (relating to Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(e) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1714. Confidentiality.

(a) Confidentiality Requirements.

(1) A utilization review agent is required to [shall] preserve the confidentiality of individual medical records to the extent required by law.

(2) [(b)] A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about an enrollee [a patient] obtained in the performance of utilization review without the prior written consent of the enrollee [patient] or as otherwise required by law. Personal information includes, [shall include] at a minimum, name, address, phone number, social security number, and financial information. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:

(A) [(1)] be dated; and

(B) [~~(2)~~] contain the signature of the individual whose [~~who is the subject of the~~] personal or confidential information is being requested. The signature must have been obtained one year or less prior to the date the disclosure is sought or the authorization is invalid.

(3) [~~(c)~~] A utilization review agent may provide confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties must [~~shall~~] remain confidential.

(4) [~~(d)~~] If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent must [~~shall~~] within 10 working [~~business~~] days from the date such request is received:

(A) [~~(1)~~] inform the individual submitting the request of the nature and substance of the recorded personal information in writing; and

(B) [~~(2)~~] permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must [~~shall~~] be provided in writing.

(5) [~~(e)~~] A utilization review agent's charges for providing a copy of recorded personal information to individuals may [~~shall~~] not exceed ten cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(6) [~~(f)~~] The utilization review agent may not publish data that [~~which~~] identifies a particular physician, doctor, or other health care provider, including any quality review studies or performance tracking data without prior written notice to the subject physician, doctor, or other [~~involved~~] health care provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

(7) [~~(g)~~] When the utilization review agent determines that documents [~~Documents~~] in the custody of the utilization review agent that contain confidential enrollee [~~patient~~] information or physician, doctor, or other health care provider financial data are no longer needed, the documents must [~~shall~~] be destroyed by a method that results in the [~~which induces~~] complete destruction of the information [~~when the agent determines the information is no longer needed~~].

(8) [~~(h)~~] All enrollee [~~patient~~], physician, doctor, and other health care provider data must [~~shall~~] be maintained by the utilization review agent in a confidential manner that [~~which~~] prevents unauthorized disclosure to third parties. Nothing in this section may [~~article shall~~] be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of enrollee [~~patient~~] records.

(9) [~~(i)~~] To assure confidentiality, a utilization review agent must, when contacting a physician's, doctor's [~~office~~] or other health care provider's office [~~hospital~~], provide its certification number, the caller's name, and professional qualifications [~~to the provider's named utilization review representative in the health care provider's office~~].

(10) [~~(j)~~] Upon request by the physician, doctor, or other health care provider, the utilization review agent must [~~shall~~] present written documentation that it is acting as an agent of the payor for the relevant enrollee [~~patient~~].

[~~(k) The utilization review agent's procedures shall specify that specific information exchanged for the purpose of conducting reviews will be considered confidential, be used by the private review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information, such as the claim administrator. The utilization review agent's process shall specify that procedures are in place to assure confidentiality and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual patients or providers need not be considered confidential.~~]

(11) [~~(l)~~] Medical records and enrollee [~~patient~~] specific information must [~~shall~~] be maintained by the utilization review agent in a secure area with access limited to essential personnel only.

(12) [~~(m)~~] A utilization review agent is required to retain information [~~Information~~] generated and obtained by a [~~the~~] utilization review agent [~~agents~~] in the course of utilization review [~~shall be retained~~] for at least four [~~two~~] years [~~if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case which may be reopened~~].

(13) [~~(n)~~] Notwithstanding the provisions in paragraphs (1) - (12) of this subsection and subsection (b) [~~subsections (a)-(m)~~] of this section, the utilization review agent is required to [~~shall~~] provide to the department [~~commissioner~~] on request individual medical records or other confidential information for determination of compliance with this subchapter. The information is confidential and privileged and is not subject to the [~~open records law,~~] Government Code[~~,~~] Chapter 552 (Public Information), or to subpoena, except to the extent necessary to enable the commissioner to enforce this subchapter.

(b) Written Procedures on Confidentiality. The utilization review agent must specify in writing the procedures that the utilization review agent will implement pertaining to confidentiality of information received from the enrollee, the enrollee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the purpose of conducting utilization review. These procedures must specify that specific information received from the enrollee, the enrollee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the URA and third parties for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information, such as the claim administrator. These procedures must also specify that the utilization review agent has procedures in place to assure confidentiality and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual enrollees, physicians, doctors, or other health care providers need not be considered confidential.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1715. Notice of Determination Made in Retrospective Review [~~of Medical Necessity~~].

(a) Required Notice. A utilization review agent is required to notify the enrollee, or an individual acting on behalf of the enrollee, and the enrollee's provider of record of a determination made in a retrospective review of medical necessity or appropriateness, or the experimental or investigational nature, of care. [~~When a retrospective review of the medical necessity and appropriateness of health care service is made under a health insurance policy or plan:~~]

[(1) such retrospective review shall be based on written screening criteria established and periodically updated with appropriate involvement from physicians, including practicing physicians, and other health care providers; and]

[(2) the payor's system for such retrospective review of medical necessity and appropriateness shall be under the direction of a physician.]

(b) Required Procedures. The utilization review agent is required to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination. These procedures must comply with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) - (3) of this subsection.

(1) The notice of an adverse determination required by subsection (a) of this section must be in writing and be sent to the provider of record(s), including the health care provider who rendered service, and the enrollee or the individual acting on behalf of the enrollee.

(2) The notice of an adverse determination required by subsection (a) of this section must include:

(A) the principal reasons for the adverse determination;

(B) the clinical basis for the adverse determination;

(C) a description of or the source of the screening criteria used as guidelines in making the adverse determination;

(D) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(E) the professional specialty and state(s) of licensure of the physician or doctor that made the determination;

(F) a description of the procedure for the utilization review agent's complaint system as required by §19.1705 of this subchapter (relating to General Standards of Utilization Review);

(G) a description of the utilization review agent's appeal process, as required by §19.1712 of this subchapter (relating to Appeal of Adverse Determination);

(H) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time that the discussion, if any, occurred, as required in §19.1711 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.1720(h) of this subchapter (relating to Specialty Utilization Review Agent); and

(I) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)). Such notice must include instruction that:

(i) The independent review request Form No. LHL009 must be completed by the enrollee, individual acting on behalf of the enrollee, or the enrollee's provider of record and be returned to the utilization review agent to begin the independent review process.

(ii) The release of medical information to the independent review organization, which is included as part of the independent review request Form No. LHL009, must be signed by the enrollee or the enrollee's legal guardian.

[(b) When an adverse determination is made under a health insurance policy or plan based on a retrospective review of the medical necessity and appropriateness of the allocation of health care resources and services, the payor shall afford the health care providers the opportunity to appeal the determination in the same manner afforded the enrollee, with the enrollee's consent to act on his or her behalf, but in no event shall health care providers be precluded from appeal if the enrollee is not reasonably available or competent to consent. Such appeal shall not be construed to imply or confer on such health care providers any contract rights with respect to the enrollee's health insurance policy or plan that the health care provider does not otherwise have.]

(3) [(c)] When a retrospective review of the medical necessity or [and] appropriateness, or the experimental or investigational nature, of health care service is made in relation to health coverage, [under a health insurance policy or health benefit plan,] the utilization review agent may not require the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an enrollee's [a patient's] mental or emotional condition or disorder [may not be required]. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude:

(A) [(1)] requiring submission of an enrollee's [a patient's] mental health medical record summary; or

(B) [(2)] requiring submission of medical records and/or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

(c) Determination Concerning an Acquired Brain Injury. In addition to the notification required by subsection (a) of this section, a utilization review agent is required to comply with this paragraph in regard to a determination concerning an acquired brain injury as defined by §21.3102 of this title (relating to Definitions). Not later than three business days after the date on which an individual requests utilization review or requests an extension of coverage based on medical necessity or appropriateness, a utilization review agent must provide notification of the determination through a direct telephone contact to the individual making the request. This paragraph does not apply to a determination made pursuant to coverage under a small employer health benefit plan.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter.

§19.1716. Regulatory Requirements Subsequent to Certification or Registration [Complaints and Information].

(a) Reporting of Material Changes. The utilization review agent is required to report any material changes in the information in the application or renewal Form No. LHL005 (Utilization Review Agent (URA) Application Form) last filed with the department by the utilization review agent, not later than the 30th day after the date on which the change takes effect. [Utilization review agent's complaint system. A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by enrollees, patients, or health care providers concerning the utilization review and shall maintain records of such complaints for three years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within 30 days.]

(b) Summary Report Review Agent's Reporting to the Department [Utilization review agent's reporting requirements to the department].

(1) By March 1, of each year, the utilization review agent must [shall] submit to the department [commissioner or his or her delegated representative,] a summary report of information related to complaints, adverse determinations, appeals of adverse determinations, and

any other related information requested by the department in accordance with the Insurance Code §38.001. [all complaints at such times and in such form as the commissioner may require and shall permit the commissioner to examine the complaints and all relevant documents at any time.]

(2) The summary report must be provided in the form required by the commissioner, and the utilization review agent must permit the commissioner or the commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the department.

(3) The summary report is required to cover [covers] reviews performed by the utilization review agent during the preceding calendar year and must include [includes]:

(A) [(1)] the total number of written notices of adverse determinations;

(B) [(2)] a listing of appeals of adverse determinations, by the medical condition that is the source of the dispute using primary ICD-9 (physical diagnosis) or DSM-IV (mental health diagnosis) code, or successor codes and modifiers, and by the treatment in dispute, if any, using CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure;

(C) [(3)] the classification of appellant (i.e., health care provider, enrollee, patient, etc.);

[(4) the subject matter of the appeal of the adverse determination. Appeal of adverse determinations shall be categorized as follows:]

[(A) benefit denial or limitation (e.g., treatment not preauthorized, treatment not medically necessary, hospital stay not medically necessary, referral to specialty physician not provided);]

[(B) timely determinations (e.g., utilization review agent not responding to requests in a timely manner, appropriate personnel not available by telephone);]

[(C) screening criteria;]

(D) [(5)] the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process;

(E) [(6)] the subject matter of any [the] complaint filed with the utilization review agent. Complaints must [shall] be categorized as follows:

(i) [(A)] administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);

(ii) [(B)] qualifications of utilization review agent's personnel; or

(iii) [(C)] appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

(c) Complaints to the Department. Complaints filed with the department against a utilization review agent must be processed in accordance with the department's established procedures for investigation and resolution of complaints. [department. Within a reasonable time period, upon receipt of a written complaint alleging a violation of this subchapter or the Act, by a utilization review agent, from an enrollee's health care provider, a person acting on behalf of the enrollee, or the enrollee, the commissioner or his or her delegated representative shall investigate the complaint, notify the utilization review agent of the complaint, require response by the utilization review agent addressing the complaint within 10 days of receipt of the complaint, and furnish a written response to the complainant and the utilization review agent named. The response will not identify in any manner, the patient or patients, without written consent. This response must include the following:]

[(1) a statement of the original complaint;]

[(2) a copy of any written response by the utilization review agent. The written response should not contain privileged medical records. If it is necessary to refer to medical records, they shall be separately forwarded with the response and clearly marked as privileged medical records;]

[(3) a statement of the findings of the commissioner or his or her delegated representative and an explanation of the basis of such findings;]

[(4) corrective actions, if any, on the part of the utilization review agent which the commissioner or his or her designated representative finds appropriate and whether the utilization review agent has voluntarily agreed to take such action;]

[(5) a time frame in which any corrective actions should be completed.]

(d) Department Inquiries. Pursuant to the Insurance Code §38.001, the department may address inquiries to a utilization review agent related to any matter connected with utilization review agent transactions that the department considers necessary for the public good or for the proper discharge of the department's duties. In accordance with the Insurance Code §38.001, a utilization review agent that receives an inquiry from the department pursuant to the Insurance Code §38.001 is required to respond to the inquiry in writing not later than the 10th day after the date the inquiry is received. [Evidence of corrective action. The utilization review agent will provide evidence of corrective action within the specified time frame to the commissioner or his or her representative.]

[(e) Authority of the department to make inquiries. In addition to the authority of the commissioner to respond to complaints described in subsection (b) of this section, the department is authorized to address inquiries to any utilization review agent in relation to the agents' business condition or any matter connected with its transactions which the department may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.]

[(f) Lists of utilization review agents. The commissioner shall maintain and update monthly a list of utilization review agents issued certificates and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.]

(e) [(g)] On-site Review [review] by the [Texas] Department [of Insurance].

(1) Provisions for scheduled and unscheduled on-site reviews.

(A) The department may [commissioner or the commissioner's designated representative is authorized to] make a complete on-site review of the operations of each utilization review agent at the principal place of business for such agent, as often as is deemed necessary. Such review may be scheduled or unscheduled.

(B) An on-site review will only be conducted during working days and normal business hours.

(C) The utilization review agent must make available all records relating to its operation during such scheduled and unscheduled on-site review.

(2) Scheduled on-site reviews. Utilization review agents will be notified of any [the] scheduled on-site review [visit] by letter, which will specify, at a minimum, the identity of the department's [commissioner's] designated representative and the expected arrival date and time.

(3) Unscheduled on-site reviews. At a minimum, notice of an unscheduled on-site review of a utilization review agent will be in writing and be presented by the department's designated representative upon arrival. [The utilization review agent must make available during such on-site visits all records relating to its operation.]

[(4) The commissioner or the designated representative may perform periodic telephone audits of utilization review agents authorized to conduct business in this state, to determine if the agents are reasonably accessible.]

(f) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1717. Administrative Violations.

(a) In accordance with the Insurance Code §4201.601, if [If] the department [commissioner through the commissioner's designated representative,] believes that any individual [person] or entity conducting utilization review pursuant to this subchapter [article] is in violation of Chapter 4201 of the Insurance Code [the Act] or applicable rules or any other provision of the Insurance Code or rules [regulations], the department [commissioner's designated representative] shall notify the utilization review agent, health maintenance organization, or insurer 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 occurred [taken place].

(b) The department [commissioner's designated representative] may initiate the proceedings under this section.

(c) Proceedings under this subchapter are a contested case for the purpose of the Government Code[,] Chapter 2001.

(d) If the commissioner determines that the utilization review agent, health maintenance organization, insurer, or other [person or] entity or individual conducting utilization review pursuant to this subchapter has violated or is violating Chapter 4201 of the Insurance Code, any other provision of the Insurance Code, or department rules, [any provision of this Act], the commissioner may:

(1) impose sanctions under the Insurance Code Chapter 82 [, Article 1.10, §7];

(2) issue a cease and desist order under the Insurance Code Chapter 83 [, Article 1.10A]; or

(3) assess administrative penalties under the Insurance Code Chapter 84 [, Article 1.10E].

[(e) If the utilization review agent has violated or is violating any provisions of the Insurance Code other than the Act, or applicable rules of the department, sanctions may be imposed under the Insurance Code, Article 1.10 or 1.10A.]

(e) [(f)] The commission of fraudulent or deceptive acts or omissions in obtaining, attempting to obtain, or use of certification or registration as a utilization review agent is [shall be] a violation of Chapter 4201 of the Insurance Code [the Act].

(f) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1719. Responsibility of HMOs and Insurers Performing Utilization Review [under the Insurance Code, Article 21.58A, §14(g) and (h)].

(a) HMOs Performing Utilization Review [HMOs performing utilization review].

(1) An HMO [HMOs] performing utilization review under the Insurance Code Chapter 4201 is subject to this subchapter, except, pursuant to the Insurance Code §4201.057, an HMO performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents), if the HMO performs utilization review only for coverage for which it is the payor. [, Article 21.58A, §14(g) shall be subject to §19.1701 of this title (relating to General Provisions), §19.1702 of this title (relating to Limitations on Applicability), §19.1703 of this title (relating to Definitions), §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents), §19.1705 of this title (relating to General Standards of Utilization Review), §19.1706 of this title (relating to Personnel), §19.1707 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.1708 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.1709 of this title (relating to On-Site Review by the Utilization Review Agent), §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents), §19.1711 of this title (relating to Requirements Prior to Adverse Determination), §19.1712 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.1713 of this title (relating to Utilization Review Agent's Telephone Access), §19.1714 of this title (relating to Confidentiality), §19.1715 of this title (relating to Retrospective Review of Medical Necessity), §19.1716 of this title (relating to Complaints and Information), §19.1717 of this title (relating to Administrative Violations), §19.1720 of this title (relating to Specialty Utilization Review Agent), and §19.1721 of this title (relating to Independent Review of Adverse Determinations) with respect to their operations under the provisions of the Act, §14(g).]

(2) Notwithstanding paragraph (1) of this subsection, when an HMO [When a health maintenance organization] performs utilization review for an individual [a person] or entity subject to this subchapter [other than one] for which it is not the payor, such HMO must have [health maintenance organization shall be required to obtain] a valid certificate under Chapter 4201 of the Insurance Code and in accordance with §19.1704 of this subchapter [the Act, §3, and comply with all the provisions of the Act].

(3) Notwithstanding paragraph (1) of this subsection, when an HMO performs [Health maintenance organizations performing] utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the HMO must have a valid registration pursuant to §19.1704 of this subchapter and must comply with all filing requirements under §19.1704 of this subchapter. However, an HMO is not required to submit an original application fee or renewal fee if the HMO only performs utilization review for health coverage for which it is the payor [the Act, §14(g) must register with the department and submit written documentation demonstrating compliance with all filing requirements defined in §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the health maintenance organization].

(4) An HMO [A health maintenance organization], including an HMO [a health maintenance organization] that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under the [Chapter 32,] Human Resources Code Chapter 32, is subject to the Insurance Code Chapter 4201 and this subchapter [article].

(5) An HMO [Health maintenance organizations] must submit to assessment of maintenance taxes under the Insurance Code Chapter 258 [Article 20A.33], to cover the costs of administering compliance of HMOs [health maintenance organizations] under Chapter 4201 of the Insurance Code [the Act].

(b) Insurers Performing Utilization Review [performing utilization review].

(1) An insurer performing utilization review under the Insurance Code Chapter 4201 is subject to this subchapter, except, pursuant to the Insurance Code §4201.058, an insurer performing utilization review under the Insurance Code Chapter 4201 is not subject to the certification requirements in §19.1704 of this subchapter, if the insurer performs utilization review only for coverage for which it is the payor.

(2) [(1)] Pursuant to the Insurance Code §4201.058, an [An] insurer that delivers or issues for delivery a health insurance policy in Texas and that performs utilization review is [is subject to the Insurance Code, Article 21.58A and such insurer shall be] subject to assessment of maintenance tax under the Insurance Code Chapter 257 to cover the costs of administering compliance of insurers.

(3) Notwithstanding paragraph (1) of this subsection, when an insurer performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurer must have a valid certificate as required by the Insurance Code §4201.101 and in accordance with §19.1704 of this subchapter.

[(2) Insurers performing utilization review under the Insurance Code, Article 21.58A, §14(g) will be subject to §19.1701 of this title (relating to General Provisions), §19.1702 of this title (relating to Limitations on Applicability), §19.1703 of this title (relating to Definitions), §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents), §19.1705 of this title (relating to General Standards of Utilization Review), §19.1706 of this title (relating to Personnel), §19.1707 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.1708 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.1709 of this title (relating to On-Site Review by the Utilization Review Agent), §19.1710 of this title (relating to Notice of Determinations Made by Utilization Review Agents), §19.1711 of this title (relating to Requirements Prior to Adverse Determination), §19.1712 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.1713 of this title (relating to Utilization Review Agent's Telephone Access), §19.1714 of this title (relating to Confidentiality), §19.1715 of this title (relating to Retrospective Review of Medical Necessity), §19.1716 of this title (relating to Complaint and Information), §19.1717 of this title (relating to Administrative Violations), §19.1720 of this title (relating to Specialty Utilization Review Agent), and §19.1721 of this title (relating to Independent Review of Adverse Determinations) with respect to their operations under the provisions of the Act, §14(h).]

(4) [(3)] Notwithstanding paragraph (1) of this subsection, when [When] an insurer performs utilization review under Chapter 4201 of the Insurance Code only for health coverage for which it is the payor, the insurer must have a valid registration pursuant to §19.1704 of this subchapter and comply with all filing requirements under §19.1704 of this subchapter. However, the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for health coverage for which it is the payor. [for a person or entity subject to this subchapter other than one for which it is the payor, such insurer shall be required to obtain a certificate under the Act, §3, and comply with all the provisions of the Act.]

[(4) Insurers performing utilization review under the Act, §14(h) must register with the department and submit written documentation demonstrating compliance with all the filing requirements defined in §19.1704(c) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the insurer.]

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1720. Specialty Utilization Review Agent.

(a) Application. In order to be certified or registered as a specialty utilization review agent, an applicant must submit to the department the application and information required in §19.1704 of this subchapter (relating to Certification or Registration of Utilization Review Agents).

(b) Statutory and Rule Requirements.

(1) [(a)] In accordance with the Insurance Code §4201.452, a specialty utilization review agent [A utilization review agent that solely performs specialty review under the Insurance Code, Article 21.58A, §14(j)] is subject to the requirements of [Act, except for] the Insurance Code Chapter 4201, except that the specialty utilization review agent is not subject to the following sections: [, Article 21.58A, §4(b), (c), (h) or (k) or §6(b)(3) of the Act.]

(A) §4201.151 (Utilization Review Plan);

(B) §4201.152 (Utilization Review Under Direction of Physician);

(C) §4201.206 (Opportunity to Discuss Treatment Before Adverse Determination);

(D) §4201.252 (Personnel); and

(E) §4201.356 (Decision by Physician Required; Specialty Review).

(2) A specialty utilization review agent [that does not solely perform specialty review,] is [not] subject to the requirements of this subchapter, except for the following provisions: [of this section or the Insurance Code, Article 21.58A, §14(j).]

(A) [(b)] §19.1705(a) [A utilization review agent that performs specialty review under the Insurance Code, Article 21.58A, §14(j) is subject to this subchapter, except §19.1704(c)(1)(B); (c)(6); (j)(1)] of this subchapter [title (relating to Certification of Utilization Review Agents); §19.1705 of this title] (relating to General Standards of Utilization Review); [and]

(B) §19.1706(a), (d), (e), and (g) of this subchapter [title] (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.1711(b) and (c) [§19.1711)] of this subchapter [title] (relating to Requirements Prior to Issuing Adverse Determination); and

(D) §19.1712(a)(2)(D) and (E) and (b)(3) [§19.1712(b)(3)] of this subchapter [title] (relating to Appeal of Adverse Determination [of Utilization Review Agents]).

(c) Utilization Review Plan. A specialty utilization review agent is required to have its [~~must submit by attachment to the application assurance that the~~] utilization review plan, including [~~reconsideration and~~] appeal requirements, [~~shall be~~] reviewed by a health care provider of the appropriate specialty, and the plan must be implemented [~~conducted~~] in accordance with standards developed with input from a health care provider of the appropriate specialty. The specialty utilization review agent must have written procedures to ensure that these requirements are implemented.

[~~(d) A specialty utilization review agent must submit by attachment to the application a description of the categories of personnel who perform utilization review, such as physicians, dentists, nurses, physicians assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States, except that this provision does not require those qualifications from personnel who perform solely clerical or administrative tasks.~~]

[~~(e) An applicant for a certificate of registration as a specialty utilization review agent must provide evidence that the applicant has available the services of physicians, dentists, nurses, physician's assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States to carry out its utilization review activities in a timely manner.~~]

(d) Requirements of Employed or Contracted Physicians, Doctors, Other Health Care Providers, and Personnel.

(1) [~~(f)~~] Physicians, doctors, other health care providers, and personnel [~~Personnel~~] employed by or under contract with the specialty utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and[~~, if applicable,~~] currently licensed.

(2) Personnel conducting specialty utilization review must hold an unrestricted license or an administrative license issued by the Texas Medical Board or be otherwise authorized to provide health care services by a licensing agency in the United States.

(3) Personnel who obtain information regarding an enrollee's [~~a patient's~~] specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, [~~dentist~~] or health care provider, either orally or in writing, and who are not physicians or doctors [~~dentists~~], must [~~shall~~] be nurses, physician [~~physician's~~] assistants, or [~~other~~] health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(e) Information Required to be Filed with the Department. The specialty utilization review agent is required to provide the name, number, type, license number, and state of licensure and qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information.

(f) Written Procedures and Maintenance of Records.

(1) Specialty utilization review agents are required to develop and implement written procedures for determining if physicians, doctors or other health care providers used by the utilization review agent are licensed, qualified, and appropriately trained or experienced.

(2) The specialty utilization review agent must maintain documentation that demonstrates that physicians, doctors and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced, in accordance with subsection (d) of this section.

(g) Utilization Review by a Specialty Utilization Review Agent. Utilization review conducted by a specialty utilization review agent must [~~shall~~] be [~~conducted~~] under the direction of a physician, doctor, or health care provider of the same specialty, and the physician, doctor, or health care provider must [~~shall~~] be currently licensed or otherwise authorized to provide the specialty health care service by a state licensing agency in the United States. Such physician, doctor, or health care provider may be employed by or under contract to the specialty utilization review agent.

(h) Reasonable Opportunity for Discussion.

(1) Prospective and concurrent utilization review.

(A) Subject to the notice requirements of §19.1710 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review) and §19.1712 of this subchapter [~~title (relating to Appeal of Adverse Determination)~~], in any instance in which [~~where~~] the specialty utilization review agent questions the medical necessity or appropriateness, or the experimental or investigational nature, of health care services, the health care provider of record [~~who ordered the services~~] must [~~shall~~], prior to the issuance of an adverse determination, be afforded a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the plan of treatment for the patient and the clinical basis for the decision of the utilization review agent with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent must submit the documentation required by subparagraph (D) of this paragraph to the department upon request.

(2) Retrospective utilization review.

(A) Subject to the notice requirements of §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the specialty utilization review agent is questioning the medical necessity or appropriateness, or the experimental or investigational nature, of the health care services provided, prior to the issuance of an adverse determination, the specialty utilization review agent must provide the provider of record a reasonable opportunity, as defined in §19.1711(a) of this subchapter, to discuss the treatment provided to the enrollee with a health care provider of the same specialty as the specialty utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination. The specialty utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent is required to submit the documentation required by subparagraph (D) of this paragraph to the department upon request.

(i) Appeal. The decision in any appeal of an adverse determination by a specialty utilization review agent must [~~An appeal decision shall~~] be made by a physician or other health care provider who has not previously reviewed the case and who is of [~~in~~] the same [~~or a similar~~] specialty as the specialty utilization review agent that made the adverse determination. [~~typically manages the medical, dental or specialty condition, procedure, or treatment which is the subject of the adverse determination under review. The specialty review must be completed within 15 working days of receipt of the request.~~]

§19.1721. Independent Review of Adverse Determinations.

(a) Life-threatening Conditions.

(1) Notification for life-threatening conditions.

(A) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames specified [~~addressed~~] in §19.1710(c)(4) [~~§19.1710(d)~~] of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]).

(B) At the time of notification of the adverse determination, the utilization review agent must [~~shall~~] provide to the enrollee[~~,~~] or individual [~~person~~] acting on behalf of the enrollee, and to the enrollee's provider of record, the notice of the independent review process [~~notification~~] and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) [~~the form prescribed by the commissioner~~] for requesting [~~accessing~~] independent review. Such notice must [~~notification shall~~] describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization[~~, and include the form requesting enrollee information~~].

(C) [~~(b)~~] The enrollee, individual [~~person~~] acting on behalf of the enrollee, or the enrollee's provider of record is required to [~~shall~~] determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the enrollee's [~~his or her~~] disease or condition is a life-threatening condition.

(2) [~~(c)~~] Appeal of adverse determination involving life-threatening condition. Any [~~A utilization review agent shall permit any~~] party who receives an adverse determination involving a life-threatening condition(s) or whose [~~has completed the internal appeals process as defined in Insurance Code, Article 21.58A, §6 and such~~] appeal of an adverse determination is denied [~~resulted in a denial~~] by the utilization review agent may[~~, health maintenance organization or insurer, to~~] seek review of that determination or denial by an independent review organization assigned [~~to the appeal~~] in accordance with the Insurance Code Chapter 4202.[~~, Article 21.58C as follows:~~]

[~~(1) the utilization review agent shall provide a notification prescribed by the commissioner to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record, on how to appeal the denial of an internal appeal to an independent review organization. The notification shall describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization, and include the form requesting enrollee information;~~]

[~~(2) the utilization review agent shall provide the notification and the form prescribed by the commissioner to the enrollee or the person acting on behalf of the enrollee and the enrollee's provider of record at the time of denial of the appeal;~~]

[~~(3) the form prescribed by the commissioner shall be completed by the enrollee, person acting on behalf of the enrollee or the enrollee's provider of record and returned to the utilization review agent to begin the independent review process. The form prescribed by the commissioner authorizing release of medical information to the independent review organization must be signed by the enrollee or the enrollee's legal guardian.~~]

(b) [~~(d)~~] Independent Review Involving Life-Threatening and Non-Life Threatening Conditions.

(1) Request for independent review.

(A) The utilization review agent is required to [~~shall~~] notify the department within one working day from the date the request [~~upon receipt of the request~~] for an independent review is received.

(B) [~~(e)~~] The utilization review agent must [~~shall~~] provide to the department the completed Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) submitted to the utilization review agent by the party requesting independent review [~~information contained in the form prescribed by the commissioner to the department~~].

(C) The contained in Form No. LHL009 must [~~notification and information shall~~] be submitted to the department via the department's Internet website [~~modem or, in the event that modem is unavailable, through facsimile~~].

[~~(f) The utilization review agent may access the department on working days, between 7:00 a.m. and 6:00 p.m. Central time, Monday through Friday, to obtain assignment of an independent review organization.~~]

(2) [~~(g)~~] Assignment of independent review organization. The department will [~~shall~~], within one working day of receipt of the complete request for independent review, randomly assign an independent review organization to conduct the independent review and notify the utilization review agent, payor, [~~and~~] the independent review organization, [~~of the assignment. The department shall send notification to~~] the enrollee or individual [~~person~~] acting on behalf of the enrollee, [~~and~~] the enrollee's provider of record, and any other providers listed by the utilization review agent as having records relevant to the review of the assignment [~~no later than one working day after the assignment has been made~~].

(3) [~~(h)~~] Information required to be provided to the assigned independent review organization. Not later than the third working day after the date that the utilization review agent receives a request for independent review, the utilization review agent must [~~shall~~] provide to the assigned independent review organization a copy of:

(A) [~~(1)~~] any medical records of the enrollee in the possession of the utilization review agent or health benefit plan that are relevant to the review;

(B) [~~(2)~~] any documents used by the utilization review agent or the health benefit plan in making the determinations to be reviewed by the independent review organization;

(C) [~~(3)~~] the written notification described by §19.1710 of this subchapter, §19.1712 of this subchapter (relating to Appeal of Adverse Determination), and §19.1715 of this subchapter (relating to Notice of Determination Made in Retrospective Review) [~~§19.1712(b)(6) of this title (relating to Appeal of Adverse Determination of Utilization Review Agents)~~];

(D) [~~(4)~~] any documentation and written information submitted to the utilization review agent or health benefit plan in support of the appeal; and

(E) [~~(5)~~] a list containing the name, address, and phone number of each physician, doctor, or other health care provider who has provided care to the enrollee and who may have medical records relevant to the review [~~appeal~~].

(4) [~~(i)~~] Payor and utilization review agent compliance. The payor and utilization review agent must [~~shall~~] comply with the independent review organization's determination with respect to the medical necessity or appropriateness, or the experimental or investigational nature, of health care items and services for an enrollee.

(5) Costs of independent review.

(A) [~~(j)~~] The utilization review agent is required to [~~shall~~] pay for the independent review.

(B) [~~(k)~~] The utilization review agent may recover costs associated with the independent review from the payor.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1723. Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) An HMO or preferred provider benefit plan [~~carrier~~] that requires preauthorization as a condition of payment to a preferred provider must [~~shall~~] comply with the procedures of this section for determinations of medical necessity or appropriateness, or the experimental or investigational nature, of care for those services the HMO or preferred provider benefit plan [~~carrier~~] identifies in accordance with subsection (b) of this section.

(b) An HMO or preferred provider benefit plan [~~carrier~~] that uses a preauthorization process for medical care and health care services must [~~shall~~] provide to each contracted preferred provider, not later than the 10th working [~~business~~] day after the date a request is made, a list of medical care and health care services that allows a preferred provider to determine which services require preauthorization and information concerning the preauthorization process.

(c) If the proposed medical care or health care services involve inpatient care, the HMO or preferred provider benefit plan must [~~carrier shall~~] review the request and, if approved, issue a length of stay for the admission into a health care facility based on the recommendation of the enrollee's [~~patient's~~] preferred provider and the HMO or preferred provider benefit plan's [~~carrier's~~] written medically accepted screening criteria and review procedures.

(d) On receipt of a preauthorization request from a preferred provider for proposed services that require preauthorization, the HMO or preferred provider benefit plan must [~~carrier shall~~] issue and transmit a determination indicating whether the proposed medical or health care services are preauthorized. An HMO or preferred provider benefit plan must [~~carrier shall~~] respond to request for preauthorization within the following time periods.

(1) For services not included under paragraphs (2) and (3) of this subsection, the determination must be issued and transmitted not later than the third calendar day after the date the request is received by the HMO or preferred provider benefit plan [~~carrier~~]. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within three calendar days from the beginning of the next time period requiring such personnel.

(2) If the proposed medical or health care services are for concurrent hospitalization care, the HMO or preferred provider benefit plan must [~~carrier shall~~] issue and transmit a determination indicating whether proposed services are preauthorized within 24 hours of receipt of the request followed within three working days after the transmittal of the determination by a letter notifying the enrollee or the individual acting on behalf of the enrollee and the provider of record of an adverse determination. If the request for medical or health care services for concurrent hospitalization care is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within 24 hours from the beginning of the next time period requiring such personnel.

(3) If the proposed medical care or health care services involve post-stabilization treatment, or a life-threatening condition as defined in §19.1703 of this subchapter [~~title~~] (relating to Definitions), the HMO or preferred provider benefit plan must [~~carrier shall~~] issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the enrollee [~~patient~~], but in no case to exceed one hour from receipt of the request. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (e) and (f) of this section, the determination must be issued and transmitted within one hour from the beginning of the next time period requiring such personnel. In such circumstances, the determination must [~~shall~~] be provided to the treating physician, doctor, or other health care provider. If the HMO or preferred provider benefit plan [~~carrier~~] issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the HMO or preferred provider benefit plan must [~~carrier shall~~] provide to the enrollee or individual [~~person~~] acting on behalf of the enrollee, and the enrollee's provider of record, the notification required by §19.1721(a)(1)(A) and (B) [~~§19.1721(c)~~] of this subchapter [~~title~~] (relating to Independent Review of Adverse Determinations).

(e) A preferred provider may request a preauthorization determination [~~inquire~~] via telephone from [~~as to~~] the HMO or preferred provider benefit plan [~~carrier's preauthorization determination~~]. An HMO or preferred provider benefit plan must [~~carrier shall~~] have appropriate personnel as described in §19.1706 of this subchapter [~~title~~] (relating to Requirements and Prohibitions Relating to Personnel) reasonably available at a toll-free telephone number to provide the determination between 6:00 a.m. and 6:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan [~~carrier~~] must have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 6:00 p.m. Central Time [~~central time~~] Monday through Friday and after noon Central Time [~~central~~

~~time~~] on Saturday, Sunday, and legal holidays and must acknowledge each of those calls not later than 24 hours after the call is received. An HMO or preferred provider benefit plan [~~carrier~~] providing a preauthorization determination under subsection (d) of this section must [~~shall~~], within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(f) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (e) of this section with respect to those services. An HMO that is exempt from subsection (e) of this section, as described in this subsection, must [~~shall~~]:

(1) have appropriate personnel as described in §19.1706 of this subchapter [~~title (relating to Personnel)~~] reasonably available at a toll-free telephone number to provide the preauthorization determination between 8:00 a.m. and 5:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday;

(2) have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 5:00 p.m. Central Time [~~central time~~] Monday through Friday and all day on Saturday, Sunday, and legal holidays, and must acknowledge each of those calls not later than the next working [~~business~~] day after the call is received; and

(3) when providing a preauthorization determination under subsection (d) of this section, within three calendar days of receipt of the request, provide a written notification to the preferred provider.

(g) If an HMO or preferred provider benefit plan [~~carrier~~] has preauthorized medical care or health care services, the HMO or preferred provider benefit plan [~~carrier~~] may not deny or reduce payment to the physician or provider for those services based on medical necessity or appropriateness, or the experimental or investigational nature, of care unless the physician or provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the preauthorized medical or health care services.

(h) If an HMO or preferred provider benefit plan [~~carrier~~] issues an adverse determination in response to a request made under subsection (d) of this section, a notice consistent with the provisions of §19.1710(c)(1) [~~§19.1710(c)~~] of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents~~]) must [~~shall~~] be provided to the enrollee, an individual [~~a person~~] acting on behalf of the enrollee, or the enrollee's provider of record. An enrollee may appeal any adverse determination in accordance with §19.1712 of this subchapter [~~title~~] (relating to Appeal of Adverse Determination [~~of Utilization Review Agents~~]).

(i) This section applies to an agent or other person with whom an HMO or preferred provider benefit plan [~~carrier~~] contracts to perform utilization review, or to whom the HMO or preferred provider benefit plan [~~carrier~~] delegates the performance of preauthorization of proposed medical or health care services. Delegation of preauthorization services does not limit in any way the HMO or preferred provider benefit plan's [~~carrier's~~] responsibility to comply with all statutory and regulatory requirements.

(j) The provisions of this section may not be waived, voided, or nullified by contract.

(k) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

§19.1724. Verification for Health Maintenance Organizations and Preferred Provider Benefit Plans.

(a) The provisions of this section apply to:

(1) HMOs;

(2) preferred provider benefit plans [~~carriers~~];

(3) preferred providers; and

(4) physicians, doctors, or other health care providers that provide to an enrollee of an HMO or preferred provider benefit plan [~~carrier~~]:

(A) care related to an emergency or its attendant episode of care as required by state or federal law; or

(B) specialty or other medical care or health care services at the request of the HMO, preferred provider benefit plan [~~carrier~~], or a preferred provider because the services are not reasonably available from a preferred provider who is included in the HMO or preferred provider benefit plan's [~~carrier's~~] network.

(b) An HMO or preferred provider benefit plan [~~carrier~~] must be able to receive a request for verification of proposed medical care or health care services:

(1) by telephone call;

(2) in writing; and

(3) by other means, including the Internet [~~internet~~], as agreed to by the preferred provider and the HMO or preferred provider benefit plan [~~carrier~~], provided that such agreement may not limit the preferred provider's option to request a verification by telephone call.

(c) An HMO or preferred provider benefit plan is required to [~~carrier shall~~] have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 6:00 a.m. and 6:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday and between 9:00 a.m. and noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. An HMO or preferred provider benefit plan [~~carrier~~] must have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 6:00 p.m. Central Time [~~central time~~] Monday through Friday and after noon Central Time [~~central time~~] on Saturday, Sunday, and legal holidays. The HMO or preferred provider benefit plan [~~carrier~~] must acknowledge each of those calls not later than:

(1) for requests relating to post-stabilization care or a life-threatening condition, within one hour after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number; [~~and~~]

(2) for requests relating to concurrent hospitalization, within 24 hours after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number; and

(3) for all other requests, within two calendar days after the beginning of the next time period requiring the availability of appropriate personnel at the toll-free telephone number.

(d) An HMO providing routine vision services or dental health care services as a single health care service plan is not required to comply with subsection (c) of this section with respect to those services. Instead, such exempt HMO must [~~An HMO that is exempt from subsection (c) of this section, as described in this subsection, shall~~]:

(1) have appropriate personnel reasonably available at a toll-free telephone number to accept telephone requests for verification and to provide determinations of previously requested verifications between 8:00 a.m. and 5:00 p.m. Central Time [~~central time~~] Monday through Friday on each day that is not a legal holiday; and

(2) have a telephone system capable of accepting or recording incoming requests [~~inquiries~~] after 5:00 p.m. Central Time [~~central time~~] Monday through Friday and all day on Saturday, Sunday, and legal holidays. The HMO must acknowledge each of those calls not later than the next working [~~business~~] day after the call is received.

(e) Any request for verification must [~~shall~~] contain the following information:

(1) enrollee [~~patient~~] name;

(2) enrollee [~~patient~~] ID number, if included on an identification card issued by the HMO or preferred provider benefit plan [~~carrier~~];

(3) enrollee [~~patient~~] date of birth;

(4) name of enrollee or subscriber, if included on an identification card issued by the HMO or preferred provider benefit plan [~~carrier~~];

(5) enrollee [~~patient~~] relationship to enrollee or subscriber;

(6) presumptive diagnosis, if known; [~~,~~] otherwise presenting symptoms;

(7) description of proposed procedure(s) or procedure code(s);

(8) place of service code where services will be provided and, if place of service is other than provider's office or provider's location, name of hospital or facility where proposed service will be provided;

(9) proposed date of service;

(10) group number, if included on an identification card issued by the HMO or preferred provider benefit plan [~~carrier~~];

(11) if known to the provider, name and contact information of any other carrier, including the name, address and telephone number, name of enrollee, plan or ID number, group number (if applicable), and group name (if applicable);

(12) name of provider providing the proposed services; and

(13) provider's federal tax ID number.

(f) Receipt of a written request or a written response to a request for verification under this section is subject to the provisions of §21.2816 of this title (relating to Date of Receipt).

(g) If necessary to verify proposed medical care or health care services, an HMO or preferred provider benefit plan [~~carrier~~] may, within one day of receipt of the request for verification, request information from the preferred provider in addition to the information provided in the request for verification. An HMO or preferred provider benefit plan [~~carrier~~] may make only one request for additional information from the requesting preferred provider under this section.

(h) A request for information under subsection (g) of this section must:

(1) be specific to the verification request;

(2) describe with specificity the clinical and other information to be included in the response;

(3) be relevant and necessary for the resolution of the request; and

(4) be for information contained in or in the process of being incorporated into the enrollee's medical or billing record maintained by the preferred provider.

(i) On receipt of a request for verification from a preferred provider, the HMO or preferred provider benefit plan must [~~carrier shall~~] issue a verification or declination. An HMO or preferred provider benefit plan must [~~carrier shall~~] issue the verification or declination within the following time periods.

(1) Except as provided in paragraphs (2) and (3) of this subsection, an HMO or preferred provider benefit plan must [~~carrier shall~~] provide a verification or declination in response to a request for verification without delay, and as appropriate to the circumstances of the particular request, but not later than five days after the date of receipt of the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (c) and (d) of this section, the determination must be provided within five days from the beginning of the next time period requiring such personnel.

(2) If the request is related to a concurrent hospitalization, the response must be sent to the preferred provider without delay but not later than 24 hours after the HMO or preferred provider benefit plan [~~carrier~~] received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (c) and (d) of this section, the determination must be provided within 24 hours from the beginning of the next time period requiring such personnel.

(3) If the request is related to post-stabilization care or a life-threatening condition, the response must be sent to the preferred provider without delay but not later than one hour after the HMO or preferred provider benefit plan [~~carrier~~] received the request for verification. If the request is received outside of the period requiring the availability of appropriate personnel as required in subsections (c) and (d) of this section, the determination must be provided within one hour from the beginning of the next time period requiring such personnel.

(j) If the request involves services for which preauthorization is required, the HMO or preferred provider benefit plan is required to implement [~~carrier shall follow~~] the procedures set forth in §19.1723 of this subchapter [~~title~~] (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans) and respond regarding the preauthorization request in compliance with that section.

(k) A verification or declination may be delivered via telephone call, in writing or by other means, including the Internet, as agreed to by the preferred provider and the HMO or preferred provider benefit plan [~~carrier~~]. If the verification or declination is delivered via telephone call, the HMO or preferred provider benefit plan must [~~carrier shall~~], within three calendar days of providing a verbal response, provide a written response which must include, at a minimum:

(1) enrollee name;

(2) enrollee ID number;

(3) requesting provider's name;

(4) hospital or other facility name, if applicable;

(5) a specific description, including relevant procedure codes, of the services that are verified or declined;

(6) if the services are verified, the effective period for the verification, which must [~~shall~~] not be less than 30 days from the date of verification;

(7) if the services are verified, any applicable deductibles, copayments, or coinsurance for which the enrollee is responsible;

(8) if the verification is declined, the specific reason for the declination;

(9) a unique verification number that allows the HMO or preferred provider benefit plan [~~carrier~~] to match the verification and subsequent claims related to the proposed service; and

(10) a statement that the proposed services are being verified or declined [~~pursuant to Title 28 Texas Administrative Code §19.1724~~].

(l) An HMO or preferred provider benefit plan [~~carrier~~] that issues a verification may not deny or otherwise reduce payment to the preferred provider for those medical care or health care services if provided on or before the expiration date for the verification, which may [~~shall~~] not be less than 30 days, unless the preferred provider has materially misrepresented the proposed medical or health care services or has substantially failed to perform the medical or health care services as verified.

(m) The provisions of this section may not be waived, voided, or nullified by contract.

(n) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.1720 of this subchapter (relating to Specialty Utilization Review Agent).

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 June 23, 2011.

TRD-201102360
Gene C. Jarmon
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Texas Department Insurance
Proposed date of adoption: September 6, 2011
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SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE

28 TAC §§19.2001 - 19.2017, 19.2019 - 19.2021

STATUTORY AUTHORITY. The amendments and new sections to Subchapter U are proposed pursuant to the Insurance Code Chapter 4201 (Utilization Review Agents), §38.001 (Data Collection and Reports: Inquiries), §843.151 (Regulation of Health Maintenance Organizations: Rules), §1301.007 (Preferred Provider Benefit Plans: Rules), §1305.007 (Workers' Compensation Health Care Networks: Rules), §1352.003(g) (Brain Injury: Required Coverages-Health Benefit Plans Other than Small Employer Health Benefit Plans), §1352.004(b) (Brain Injury: Training for Certain Personnel Required), §1369.057 (Benefits Related to Prescription Drugs and Devices and Related Services: Rules), and the Insurance Code §36.001 (Department Rules and Procedures: General Rulemaking Authority). Additionally, the Subchapter U amendments and new sections are also proposed pursuant to the Labor Code §401.011 (Definitions: General Definitions); Chapter 402 (Operation and Administration of Workers' Compensation System), including §402.00111(b) (Relationship between Commissioner of Insurance and Commissioner of Workers' Compensation; Separation of Authority; Rulemaking), §402.00116 (Chief Executive), §402.00128 (General Powers and Duties of Commissioner), §402.061 (Adoption of Rules), and §402.072 (Sanctions); Chapter 408 (Workers' Compensation Benefits), including §408.0043 (Professional Specialty Certification Required for Certain Review), §408.0044 (Review of Dental Services), §408.0045 (Review of Chiropractic Services), §408.0046 (Rules), §408.021 (Entitlement to Medical Benefits), §408.023 (List of Approved Doctors; Duties of Treating Doctors), and §408.0231 (Maintenance of List of Approved Doctors; Sanctions and Privileges Relating to Health Care); Chapter 413 (Medical Review), including §413.011 (Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols), §413.014 (Preauthorization Requirements; Concurrent Review and Certification of Health Care), §413.015 (Payment by Insurance Carriers; Audit and Review), §413.017 (Presumption of Reasonableness), §413.031 (Medical Dispute Resolution), §413.0511 (Medical Advisor), §413.0512 (Medical Quality Review Panel), §413.0513 (Confidentiality Requirements), §413.052 (Production of Documents); and the Occupations Code §155.001 (License to Practice Medicine: Examination Required).

The purpose of Chapter 4201 is stated in Subchapter A §4201.001, which is to: (i) promote the delivery of quality health care in a cost-effective manner; (ii) ensure that a URA adheres to reasonable standards for conducting utilization review; (iii) foster greater coordination and cooperation between a health care provider and URA; (iv) improve communications and knowledge of benefits among all parties concerned before an expense is incurred; and (v) ensure that a URA maintains the confidentiality of medical records in accordance with applicable law.

The Insurance Code §4201.002 defines the various terms used in the chapter, among them "adverse determination" in §4201.002(1) and "utilization review" in §4201.002(13), which are incorporated into the proposed rules. Section 4201.003 provides that the Commissioner of Insurance may adopt rules to implement the Insurance Code Chapter 4201. Section 4201.004 specifies the statutory requirements concerning telephone access to a URA.

Subchapter B (Applicability of Chapter) of Chapter 4201 addresses persons providing information about scope of coverage or benefits; certain contracts with the federal government; Medicaid and certain other state health or mental health programs; workers' compensation benefits; health care service provided under automobile insurance policies; employee welfare benefit plans; HMOs; and insurers. Regarding workers' compensation benefits, §4201.054(a) provides, in relevant part, "The commissioner of workers' compensation shall regulate as provided by this chapter a person who performs utilization review of a medical benefit provided under Title 5, Labor Code." Section 4201.054(c) also states, "Title 5, Labor Code, prevails in the event of a conflict between this chapter and Title 5, Labor Code." Section 4201.054(d) further provides, "The commissioner of workers' compensation may adopt rules as necessary to implement this section."

Subchapter C (Certification) specifies that a certification of registration is required to conduct utilization review; requirements for certification; certificate renewal; certification and renewal forms; fees; non-transferability of certificate; reporting material changes; and list of URAs. Section 4201.101 provides, "A utilization review agent may not conduct utilization review unless the commissioner [of insurance] issues a certificate of registration to the agent under this subchapter." Further, §4201.102(a) provides, "The commissioner [of insurance] may

issue a certificate of registration only to an applicant who has met all the requirements of this chapter and all the applicable rules adopted by the commissioner [of insurance]."

Subchapter D (Utilization Review: General Standards) sets forth statutory standards regarding utilization review plans under §4201.151, the mandate under §4201.152 that a utilization review must be under the direction of a physician licensed to practice medicine by a state licensing agency in the United States, and the mandate under §4201.153 that screening criteria be objective, clinically valid, compatible with established principles of health care and flexible enough to allow a deviation from the norm when justified on a case-by-case basis. Section 4201.154 provides for review and inspection of screening criteria and review procedures. Section 4201.155 provides that a URA may not establish or impose a notice requirement or other review procedure that is contrary to the requirements of the health insurance policy or health benefit plan.

Subchapter E (Utilization Review: Relations with Patients and Health Care Providers) §§4201.201, 4201.202, 4201.203, 4201.204, 4201.205, 4201.206, and 4201.207 addresses utilization review relations with patients and health care providers, including repetitive contacts; frequency of reviews; observing or participating in patient's care; mental health therapy; complaint system of the URA; designated initial contact; and opportunity to discuss treatment before issuance of adverse determination.

Subchapter F (Utilization Review: Personnel) §§4201.251, 4201.252 and 4201.253 address personnel matters, including delegation of utilization review, appropriate training and qualification of employed or contracted personnel, and prohibited bases for employment, compensation, evaluation or performance standards.

Subchapter G (Notice of Determinations) governs the notice of determinations specifying the general duty to notify under §4201.301, the general time for notice under §4201.302, what the contents of the notice of an adverse determination must include under §4201.303, the time frames for notice of adverse determination under §4201.304, and what the notice of adverse determination for retrospective utilization review must include under §4201.305.

Subchapter H (Appeal of Adverse Determination) specifies the procedure for the appeal of an adverse determination, including a provision in §4201.351 that for purposes of Subchapter H, a complaint filed concerning dissatisfaction or disagreement with an adverse determination constitutes an appeal of that adverse determination. Section 4201.352 requires a URA to maintain and make available a written description of the procedures for appealing an adverse determination, and §4201.353 mandates that these procedures must be reasonable. Subchapter H further addresses requirements for persons or entities that may appeal in §4201.354; acknowledgement of appeal in §4201.355; specialty review procedures in §4201.356; expedited appeal for denial of emergency care or continued hospitalization in §4201.357; response letter to interested persons in §4201.358; written notice to the appealing party of the determination of the appeal as soon as practicable in §4201.359; and immediate appeal to an IRO in life-threatening circumstances in §4201.360.

Subchapter I (Independent Review of Adverse Determination) sets forth the statutory requirements for the independent review of an adverse determination, addressing the review by the IRO and the URA's compliance with the independent determination in §4201.401, the information a URA must provide to the appropriate IRO in §4201.402, and payment for independent review in §4201.403.

Subchapter J (Specialty Utilization Review Agents) §4201.451 specifies definitions and requirements governing URAs that conduct utilization review for a specialty health care service, including dentistry, chiropractic services, or physical therapy.

Subchapter K (Claims Review of Medical Necessity and Appropriateness) of Chapter 4201 was repealed effective September 1, 2009. Subchapter L (Confidentiality of Information; Access to Other Information) addresses general confidentiality requirements; consent requirements; providing information to affiliated entities; providing information to the Commissioner of Insurance; access to recorded personal information; publishing information identifiable to a health care provider; requirement to maintain data in a confidential manner; and destruction of certain confidential documents.

Subchapter M (Enforcement) concerns notice of suspected violation, compelling production of information, enforcement proceedings, and remedies and penalties for violation. Section 4201.602 authorizes the Commissioner of Insurance to initiate a proceeding under Subchapter M which is a contested case for purposes of Chapter 2001, Government Code. Under §4201.603, the Commissioner of Insurance may impose remedies and penalties for violations of Chapter 4201 which include a sanction under Chapter 82, an issuance of a cease and desist order under Chapter 83 or an assessment of an administrative penalty under Chapter 84.

The Insurance Code §38.001 provides, in relevant part, that the Department may address a reasonable inquiry to any insurance company, including a Lloyd's plan or reciprocal or interinsurance exchange, or an agent or other holder of an authorization relating to: (i) the person's business condition; or (ii) any matter connected with the person's transactions that the Department considers necessary for the public good or for the proper discharge of the Department's duties.

The Insurance Code §843.151 provides, in relevant part, that the Commissioner of Insurance may adopt reasonable rules as necessary and proper to implement the Insurance Code Chapter 843.

The Insurance Code §1301.007 requires, in relevant part, the Commissioner of Insurance to adopt rules as necessary to implement the Insurance Code Chapter 1301.

The Insurance Code §1305.007 provides that the Commissioner of Insurance may adopt rules as necessary to implement the Insurance Code Chapter 1305.

The Insurance Code §1352.003(g) requires the Commissioner of Insurance to adopt rules as necessary to implement the Insurance Code Chapter 1352.

The Insurance Code §1352.004(b) requires the Commissioner of Insurance by rule to require a health benefit plan issuer to provide adequate training to personnel responsible for preauthorization of coverage or utilization review under the plan.

The Insurance Code §1369.057 provides that the Commissioner of Insurance may adopt rules to implement the Insurance Code Chapter 1369, Subchapter B (Coverage of Prescription Drugs Specified by Drug Formulary).

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.

The Labor Code §401.011 specifies definitions used in the Texas Workers' Compensation Act. In particular, §401.011(17) defines the term "doctor"; §401.011(19) defines the term "health care," which includes a prescription drug, medicine or other remedy under §401.011(19)(E); §401.011(20) defines "health care facility"; and §401.011(22-a) defines the terminology "health care reasonably required." Section 401.011(27) defines the term "insurance carrier"; §401.011(28) defines "insurance company"; and §401.011(44) defines "workers' compensation insurance coverage."

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 delegation must be made in writing.

The Labor Code §402.00116 grants the powers and duties of chief executive and administrative officer to the Commissioner of Workers' Compensation and the authority to administer and enforce the Labor Code Title 5, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to the TDI-DWC or the Commissioner of Workers' Compensation.

The Labor Code §402.00128 vests general operational powers in the Commissioner of Workers' Compensation to conduct daily operations of TDI-DWC and implement policy, including the authority to delegate and to assess and enforce penalties and enter appropriate orders as authorized by the Labor Code Title 5.

The Labor Code §402.061 grants the Commissioner of Workers' Compensation the authority to adopt rules as necessary for the implementation and enforcement of the Texas Workers' Compensation Act.

The Labor Code §402.072(a) provides that the TDI-DWC may impose sanctions against any person regulated by the TDI-DWC.

The Labor Code §408.0043(a) applies to a person, other than a chiropractor or dentist, who perform health care services under the Labor Code Title 5, as a doctor performing peer reviews, utilization reviews, independent reviews, required medical examinations, or who serves on the medical quality review panel or as a designated doctor for TDI-DWC. The Labor Code §408.0043(b) requires that a person described by the Labor Code §408.0043(a), who reviews a specific workers' compensation case hold a professional certification in a health care specialty appropriate to the type of health care that the injured employee is receiving.

The Labor Code §408.0044 pertains to dentists who perform dental services under the Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, or required dental examinations. The Labor Code §408.0044(b) requires that a dentist who reviews a dental service in conjunction with a specific workers' compensation case be licensed to practice dentistry.

The Labor Code §408.0045 pertains to chiropractors who perform chiropractic services under the Labor Code Title 5 for peer reviews, utilization reviews, independent reviews, required medical examinations, or who serve on the medical quality review panel or as designated doctors providing chiropractic services for TDI-DWC. The Labor Code §408.0045(b) requires that a chiropractor who reviews a chiropractic service in conjunction with a specific workers' compensation case be licensed to engage in the practice of chiropractic.

The Labor Code §408.0046 authorizes the Commissioner of Workers' Compensation to adopt rules as necessary to determine which professional health practitioner specialties are appropriate for treatment of certain compensable injuries, and such rules must require an entity requesting a peer review to obtain and provide to the doctor providing the peer review services all relevant and updated medical records.

The Labor Code §408.021(a) specifies that an employee who sustains a compensable injury is entitled to all health care reasonably required by the nature of the injury as and when needed.

The Labor Code §408.023(h) requires that a URA or an insurance carrier that uses doctors to perform reviews of health care services provided under Labor Code Title 5, Subtitle A, including utilization review, only use doctors licensed to practice in this state. Section 408.023(n) requires the Commissioner of Workers' Compensation to adopt rules to establish reasonable requirements for doctors and health care providers financially related to those doctors, including training, impairment rating testing, financial disclosure, and monitoring.

The Labor Code §408.0231(g) requires the Commissioner of Workers' Compensation to adopt rules regarding doctors who perform peer review functions for insurance carriers, including standards for peer review and imposition of sanctions against doctors performing peer review functions including restriction, suspension, or removal of the doctor's ability to perform peer review on behalf of insurance carriers in the workers' compensation system, and other issues important to the quality of peer review, as determined by the Commissioner of Workers' Compensation.

The Labor Code §413.011 requires the Commissioner of Workers' Compensation 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.

The Labor Code §413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.014(a) defines the terminology "investigational or experimental service or device."

The Labor Code §413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the TDI-DWC ensure compliance with the medical policies and fee guidelines through audit and review.

The Labor Code §413.017 provides a presumption of reasonableness for medical services that are consistent with TDI-DWC medical policies and fee guidelines and medical services that are provided subject to prospective, concurrent or retrospective review as required by TDI-DWC policies and authorized by the insurance carrier.

The Labor Code §413.031(d) provides that a review of the medical necessity of a health care service requiring preauthorization under §413.014 or Commissioner of Workers' Compensation rules promulgated under §413.014 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 Labor Code §413.0511(b) provides that the TDI-DWC Medical Advisor shall make recommendations regarding the adoption of rules and policies relating to medical benefits as required by the Commissioner of Workers' Compensation.

The Labor Code §413.0512(a) requires the TDI-DWC Medical Advisor to establish a medical quality review panel of health care providers to assist the medical advisor in performing the required duties under §413.0511.

The Labor Code §413.0513(a) provides that information collected, assembled or maintained by or on behalf of TDI-DWC under §413.0511 or §413.0512 constitutes an investigation file for purposes of and may not be disclosed.

The Labor Code §413.052 provides that the Commissioner of Workers' Compensation by rule shall establish procedures to enable TDI-DWC to compel the production of documents.

The Occupations Code §155.001 provides that a person may not practice medicine in this state unless the person holds a license issued under the Occupations Code, Title 3, Subtitle B.

CROSS REFERENCE TO STATUTE. The following statutes are affected by this proposal: Insurance Code §§38.001, 843.002(14), 843.308, 843.347, 1301.133, 1301.135, 1305.002 - 1305.004, 1305.351, 1305.353, 1305.354, 1352.004, 1352.006, 1369.056, 4201.002, 4201.004, 4201.051, 4201.053, 4201.054, 4201.057, 4201.058, 4201.101, 4201.103, 4201.104, 4201.107, 4201.108, 4201.151 - 4201.153, 4201.155, 4201.201 - 4201.207, 4201.251 - 4201.253, 4201.301 - 4201.305, 4201.352 - 4201.360, 4201.401 - 4201.403, 4201.451 - 4201.457, 4201.551 - 4201.558, and 4201.601 - 4201.603; Insurance Code Chapters 257, 1305, 4151, and 4201; Labor Code §§401.011, 402.00128, 408.0043 - 408.0045, 408.023(h), 408.0231(g), 413.014, 413.0511, 413.0512, and 413.052; Labor Code Chapters 415 and 504; Labor Code Title 5; Government Code §662.003(a) and Chapter 552

§19.2001. General Provisions.

(a) Statutory basis. This subchapter implements the provisions of the Insurance Code Chapter 4201, which was amended by Acts 2009, 81st Legislature, Chapter 1330, which was effective September 1, 2009; the Insurance Code Chapter 1305 as of the effective date of the rule, and the Labor Code Title 5 as of the effective date of the rule [~~, Article 21.58A~~].

(b) Severability. If [~~Where any terms or sections of this subchapter are determined by~~] a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given [~~to be inconsistent with any statutes of this state, or to be unconstitutional, the remaining terms and provisions of this subchapter shall remain in~~] effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(c) Purpose. The purpose of subchapter [~~these rules~~] is to:

(1) promote the delivery of quality health care in a cost-effective manner, including protection of injured employee safety;

(2) assure that utilization review agents adhere to reasonable standards for conducting utilization reviews;

(3) foster greater coordination and cooperation between health care providers and utilization review agents;

(4) improve communications and knowledge of medical benefits among all parties concerned before expenses are incurred; and

(5) ensure that utilization review agents maintain the confidentiality of medical records in accordance with applicable law.

(d) Health Care Utilization Review. For utilization review performed under a health benefit plan or health insurance policy, the provisions of Subchapter R of this chapter (relating to Utilization Reviews for Health Care Provided under a Health Benefit Plan or Health Insurance Policy) apply in lieu of the provisions in this subchapter.

§19.2002. Limitations on Applicability.

(a) Except as provided in the Insurance Code Chapter 4201, this subchapter applies to utilization review performed under workers' compensation insurance coverage. This subchapter does not affect the authority of the TDI-DWC [~~Texas Workers' Compensation Commission~~] to exercise the powers granted to it [~~that commission~~] under the [~~Title 5,~~] Labor Code Title 5 and the Insurance Code Chapter 4201. This subchapter applies to utilization review as set forth in the Insurance Code Chapters 1305 and 4201 and the Labor Code Title 5.

(b) Health care providers performing peer reviews regarding the prospective, concurrent, or retrospective review of the medical necessity or appropriateness of health care are performing utilization review and must comply with this subchapter, the Labor Code Title 5, and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to, Chapter 180 of this title (relating to Monitoring and Enforcement). If there is a conflict between this chapter and rules adopted by the Commissioner of Workers' Compensation, the rules adopted by the Commissioner of Workers' Compensation prevail.

(c) This subchapter does not apply to [~~a utilization review agent or other person which conducts only the functions of categories of utilization review listed in paragraphs (1)-(3) of this section:~~]

[~~(1)~~] a person that only [~~who~~] provides information to injured employees, their representatives, or their physicians, doctors, or other [~~and/or~~] health care providers about scope of coverage or benefits provided for under workers' compensation insurance coverage but that [~~and who~~] does not determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services. [~~whether particular health care provided or to be provided to an injured employee is medically reasonable and necessary;~~]

[~~(2) a doctor, as defined in §19.2003 of this title (relating to Definitions), or any other individual licensed to provide health care, performing utilization review who is an employee of, or a contractor to, a certified utilization review agent;~~]

[~~(3) a utilization review agency which conducts only the categories of utilization review listed in subparagraphs (A)-(D) of this paragraph:~~]

[~~(A) reviews performed pursuant to any contract with the federal government for utilization review of patients eligible for services under Title XVIII or XIX of the Social Security Act (42 United States Code §§1395 et seq. or §§1396 et seq.);~~]

[~~(B) reviews performed for the Texas Medicaid Program, except reviews performed by a health maintenance organization that contracts with the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program to provide health care services to recipients of medical assistance under Chapter 32, Human Resources Code, the Chronically Ill and Disabled Children's Services Program created pursuant to Chapter 35, Health and Safety Code, any program administered under Title 2, the Human Resources Code, any program of the Texas Department of~~

Mental Health and Mental Retardation, or any program of the Texas Department of Criminal Justice;]

[(C) reviews of health care services provided under a policy or contract of automobile insurance promulgated by the department under the Insurance Code, Subchapter A, Chapter 5 or issued pursuant to the Insurance Code Article 1.14; or]

[(D) reviews that apply to the terms and benefits of the employee welfare benefit plans as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1)).]

§19.2003. Definitions.

The following words and terms, when used in this subchapter, [shall] have the following meanings, unless the context clearly indicates otherwise.

[(1) Act--Insurance Code Article 21.58A, entitled "Health Care Utilization Review Agents."]

[(2) Active practice--A minimum of 20 hours per week in the examination, diagnosis and/or treatment of patients.]

[(3) Administrative Procedure Act--Government Code Chapter 2001.]

(1) Administrator--A person holding a certificate of authority under the Insurance Code Chapter 4151.

(2) [(4)] Adverse determination--A determination by a utilization review agent made on behalf of any payor that the health care services provided [furnished] or proposed to be provided [furnished] to an injured employee are [is] not medically [reasonable and] necessary or appropriate. The term does not include a denial of health care services due to the lack of prospective or concurrent utilization review. For the purposes of this subchapter, an adverse determination does not include a determination that health care services are experimental or investigational.

(3) [(5)] Appeal [process]--The utilization review agent's formal process in which an injured employee, an injured employee's representative, or the injured employee's provider of record may request reconsideration of an adverse determination. For the purposes of this subchapter the term also applies to reconsideration processes prescribed by the Labor Code Title 5 and applicable rules for workers' compensation. [The processes outlined in the Texas Workers' Compensation Act, including but not limited to Texas Labor Code §413.031, Chapter 134, Subchapter G of this title (relating Prospective and Concurrent Review of Health Care), and Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).]

(4) [(6)] Certificate--A certificate issued by the commissioner to an entity authorizing the entity to operate as a utilization review agent in the State of Texas. A certificate is not issued to an insurance carrier that is registered as a utilization review agent under §19.2004 of this subchapter (relating to Certification or Registration of Utilization Review Agents). [A certificate of registration granted by the commissioner to a utilization review agent.]

(5) [(7)] Commissioner--The commissioner of insurance [Commissioner of Insurance].

(6) [(8)] Compensable injury--An injury that arises out of and in the course and scope of employment for which compensation is payable under the Texas Workers' Compensation Act.

(7) [(9)] Complaint--An oral or written expression of dissatisfaction with a utilization review agent concerning the utilization review agent's process in conducting a utilization review. The term "complaint" does not include:[. A complaint is not]

(A) an expression of dissatisfaction with a specific adverse determination; or [,]

(B) a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or by clearing up the misunderstanding to the satisfaction of the complaining party.

(8) Concurrent utilization review-- A form of utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

[(10) Department--Texas Department of Insurance.]

(9) [(11)] Dentist--A licensed doctor of dentistry, holding either a D.D.S. or a D.M.D. degree.

(10) Department--Texas Department of Insurance.

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

(A) shared investment or ownership interest;

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

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

(D) personal or family relationships; or

(E) any other financial arrangement that would require disclosure under the Labor Code or applicable TDI-DWC rules, the Insurance Code, or applicable department rules, or any other association with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the reviewing physician or doctor from rendering an unbiased opinion.

(12) Doctor--A doctor of medicine, osteopathic medicine, optometry, dentistry, podiatry, or chiropractic who is licensed and authorized to practice.

(13) 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.

(14) [(13)] Health care--Includes all reasonable and necessary medical aid, medical examinations, medical treatments, medical diagnoses, medical evaluations, and medical services. The term does not include vocational rehabilitation. The term includes:

(A) medical, surgical, chiropractic, podiatric, optometric, dental, nursing, and physical therapy services provided by or at the direction of a doctor;

(B) physical rehabilitation services performed by a licensed occupational therapist provided by or at the direction of a doctor;

(C) psychological services prescribed by a doctor;

(D) the services of a hospital or other health care facility;

(E) a prescription drug, medicine, or other remedy; and

(F) a medical or surgical supply, appliance, brace, artificial member, or prosthetic or orthotic device [prosthesis], including

the fitting of, change or repair to, or training in the use of the appliance, brace, member, or device [~~prosthesis~~].

(15) [~~(14)~~] Health care facility--A hospital, emergency clinic, outpatient clinic, or other facility providing health care.

(16) [~~(15)~~] Health care provider--A [~~Any~~] person, corporation, facility, or institution that is:

(A) licensed by a state to provide or is otherwise lawfully providing health care services; and

(B) [~~that is~~] eligible for independent reimbursement for those health care services.

[~~(16) Injured employee--An employee with a compensable injury under the Texas Workers' Compensation Act.~~]

[~~(17) Inquiry--A request for information or assistance from a utilization review agent.~~]

(17) [~~(18)~~] Insurance carrier or insurer--[~~.~~]

(A) a person authorized and admitted by the Texas Department of Insurance to do the business of insurance in this state under a certificate of authority that includes authorization to write workers' compensation insurance [~~an insurance company~~];

(B) a certified self-insurer for workers' compensation insurance; [~~or~~]

(C) a certified self-insurance group under the Labor Code Chapter 407A; or

(D) [~~(C)~~] a governmental entity that self-insures, either individually or collectively.

[~~(19) Insurance company--A person authorized and admitted by the Texas Department of Insurance to do insurance business in this state under a certificate of authority that includes authorization to write workers' compensation insurance.~~]

(18) Legal holiday--A national holiday as defined in the Government Code §662.003(a).

(19) [~~(20)~~] Life-threatening--A disease or condition resulting from a compensable injury, from [~~for~~] which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(20) [~~(21)~~] Medical benefit--Payment for health care reasonably required by the nature of a compensable injury and intended to:

(A) cure or relieve the effects naturally resulting from the compensable injury, including reasonable expenses incurred by the injured employee for necessary treatment to cure and relieve the injured employee from the effects of an occupational disease before and after the injured employee knew or should have known the nature of the disability and its relationship to the employment;

(B) promote recovery; or

(C) enhance the ability of the injured employee to return to or retain employment.

(21) Medical emergency--The sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the injured employee's health or bodily functions in serious jeopardy; or

(B) serious dysfunction of any body organ or part.

(22) Medical records--The entire history of diagnosis and treatment for a compensable injury, including but not limited to medical, mental health records as allowed by law, dental, and other health care records from all disciplines rendering care to an injured employee.

(23) Mental health medical record summary--A summary of process or progress notes relevant to understanding the injured employee's need for treatment of a mental or emotional condition or disorder such as:

(A) identifying information; and

(B) a treatment plan that includes:

(i) diagnosis;

(ii) treatment intervention;

(iii) general characterization of injured employee behaviors or thought processes that affect level of care needs; and

(iv) discharge plan.

(24) Mental health therapist--Any of the following individuals who, in the ordinary course of business or professional practice, as appropriate, diagnose, evaluate, or treat any mental or emotional condition or disorder:

(A) an individual licensed by the Texas Medical Board to practice medicine in this state;

(B) an individual licensed as a psychologist by the Texas State Board of Examiners of Psychologists;

(C) an individual licensed as a psychological associate by the Texas State Board of Examiners of Psychologists;

(D) an individual licensed as a specialist in school psychology by the Texas State Board of Examiners of Psychologists;

(E) an individual licensed as a marriage and family therapist by the Texas State Board of Examiners of Marriage and Family Therapists;

(F) an individual licensed as a professional counselor by the Texas State Board of Examiners of Professional Counselors;

(G) an individual licensed as an advanced clinical practitioner by the Texas State Board of Social Worker Examiners;

(H) an individual licensed as a master social worker by the Texas State Board of Social Worker Examiners;

(I) an individual licensed as a social worker by the Texas State Board of Social Worker Examiners;

(J) an individual licensed as a physician assistant by the Texas Medical Board;

(K) an individual licensed as a registered professional nurse by the Texas Board of Nursing;

(L) an individual licensed as a vocational nurse by the Texas Board of Nursing; or

(M) any other individual who is licensed or certified by a state licensing board in the State of Texas to diagnose, evaluate, or treat any mental or emotional condition or disorder.

(25) Mental or emotional condition or disorder--A mental or emotional illness as detailed in the most current Diagnostic and Statistical Manual of Mental Disorders.

(26) [~~(23)~~] Nurse--A professional or registered nurse, a licensed vocational nurse, or a licensed practical nurse.

(27) Payor--Any person or entity that provides, offers to provide, or administers hospital, outpatient, medical, or other health benefits including workers' compensation benefits to an individual treated by a health care provider in this state under a policy, plan, or contract.

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

[(24) Open records law--Government Code Chapter 552.]

(29) [(25)] Person--An individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing acting in concert.

(30) [(26)] Physician--A licensed doctor of medicine or a licensed doctor of osteopathy.

(31) [(27)] Preauthorization--A form of prospective utilization review by a payor or its utilization review agent of health care services proposed to be provided to an injured employee. [The process requesting approval to provide a specific treatment or service prior to rendering the treatment or service as defined and delineated in Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care).]

(32) Provider of record--The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the injured employee, or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the injured employee. This definition includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

(33) Registration--The process for an insurance carrier to register with the department to perform utilization review solely for its own insureds or injured employees.

(34) [(28)] Retrospective utilization review--A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted. [The process of reviewing health care which has been provided to injured employees under the Texas Workers' Compensation Act to determine if the health care was medically reasonable and necessary.]

(35) [(29)] Screening criteria--The written policies, decision rules, medical protocols, or guidelines [TWCC fee and treatment guidelines, and TWCC rules and advisories] used by the utilization review agent as part of the utilization review process (e.g., appropriateness evaluation protocol (AEP)[,] and intensity of service, severity of illness, discharge, and appropriateness screens (ISD-A)). [The TWCC Treatment Guidelines are tools that identify recommended treatment parameters and typical courses of intervention, whose purpose is to clarify those services that are reasonable and medically necessary. The guidelines are not to be used as fixed treatment protocols by either the health care provider or insurance carrier and shall not be viewed as prescriptive or the sole basis for approval or denial of proposed services. There may be injured employees who will require more or less treatment than is recommended in the guidelines. Treatment falling outside the parameters of the guidelines will be subject to more careful scrutiny and may require additional documentation of special circumstances to justify the need for treatment. Each guideline includes specific ground rules which establish the use of the guideline.]

(36) Specialty utilization review agent--A utilization review agent that conducts utilization review for a specialty health care service under the Insurance Code Chapter 4201 including, but not limited to, dental services, chiropractic services, behavioral health services, vision services, or physical therapy services.

(37) TDI-DWC--The Texas Department of Insurance, Division of Workers' Compensation.

(38) [(30)] Texas Workers' Compensation Act--The [Texas] Labor Code Title 5, Subtitle A.

(39) [(31)] Treating doctor--The doctor primarily responsible for treating the injured employee's compensable injury as defined in the [Texas] Labor Code, §401.011(42).

[(32) TWCC--Texas Workers' Compensation Commission.]

(40) [(33)] Utilization review--A system for prospective, [preauthorization and] concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. [, or both preauthorization and retrospective review or both concurrent and retrospective review, to determine if health care proposed to be provided, being provided, or which has been provided to an injured employee is medically reasonable and necessary.] Utilization review does [shall] not include elective requests for clarification of coverage [or prepayment guarantee].

(41) [(34)] Utilization review agent--An entity that conducts utilization review for: [insurance carrier, the carriers' agent(s), and/or any entity contracted or subcontracted to provide utilization review.]

(A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy;

(B) a payor; or

(C) an administrator holding a certificate of authority under the Insurance Code Chapter 4151.

(42) [(35)] Utilization review plan--The screening criteria and utilization review procedures of a utilization review agent.

(43) Workers' compensation health care network--An organization that is:

(A) formed as a health care provider network to provide or arrange to provide health care services to injured employees;

(B) required to be certified in accordance with the Insurance Code Chapter 1305, this chapter, and other rules of the commissioner as applicable; and

(C) established by, or operating under contract with, an insurance carrier.

(44) Workers' compensation insurance coverage--As defined in the Labor Code §401.011.

(45) Workers' compensation network coverage--Healthcare provided pursuant to a workers' compensation health care network.

(46) Workers' compensation non-network coverage--Health care delivered pursuant to the Labor Code Title 5, excluding health care provided pursuant to the Insurance Code Chapter 1305.

(47) [~~(36)~~] Working day--Any day, Monday - Friday, other than a national holiday as defined by the Government Code §662.003(a) and the Friday after Thanksgiving Day, December 24, and December 26. Use in this subchapter of the term "day," rather than "working day," means a calendar day. [~~A weekday, excluding a legal holiday.~~]

[~~(37) Workers' compensation insurance coverage:~~]

[~~(A) an approved insurance policy, pursuant to Article 5.56 of the Insurance Code, to secure the payment of compensation under the Texas Workers' Compensation Act;~~]

[~~(B) coverage to secure the payment of compensation through self-insurance as provided by the Texas Workers' Compensation Act; or~~]

[~~(C) coverage provided by a governmental entity to secure the payment of compensation under the Texas Workers' Compensation Act.~~]

[~~(38) Concurrent review--A review of on-going health care for an extension of treatment beyond previously approved health care in accordance with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).~~]

§19.2004. Certification or Registration of Utilization Review Agents.

(a) Applicability of Certification or Registration Requirements. A person acting as or holding itself out as a utilization review agent must be certified or registered under the Insurance Code Chapter 4201 and this subchapter and must comply with all requirements in this section.

(1) Pursuant to §19.2019(b) of this subchapter (relating to Responsibility of Insurance Carriers Performing Utilization Review), if an insurance carrier performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurance carrier must have a valid certificate pursuant to the Insurance Code §4201.101 and this section.

(2) Pursuant to §19.2019(c) of this subchapter, if an insurance carrier performs utilization review only for coverage for which it is the payor, the insurance carrier must have a valid registration pursuant to this section.

(b) Application Filing Requirements.

(1) Application for certification.

(A) An application for certification of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in §19.1704(b) of this chapter (relating to Certification or Registration of Utilization Review Agents).

(B) The application for certification must be accompanied by the original application fee in the amount specified by §19.802(b)(19) of this chapter (relating to Amount of Fees).

(2) Application for registration.

(A) An application for registration of a utilization review agent must include Form No. LHL005 (Utilization Review Agent (URA) Application Form), which is adopted by reference in §19.1704(b) of this chapter.

(B) The original application fee requirement specified by §19.802(b)(19) of this chapter does not apply to an applicant for registration.

(3) Where to obtain and file the application form. Form No. LHL005 may be obtained from and must be filed with the department at the following address: Texas Department of Insurance, Health and Workers' Compensation Network Certification & QA (HWCN) Division, Mail Code 103-6A, P.O. Box 149104, Austin, Texas 78714-9104.

[~~(a) An application for certification of a utilization review agent must be filed with the Texas Department of Insurance at the following address: HMO Compliance/URA/IRO Section, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.~~]

[~~(b) The application must be submitted on a form which can be obtained from the HMO Compliance/URA/IRO Section, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104.~~]

(c) Required Information. Form No. LHL005 (Utilization Review Agent (URA) Application Form) requires [~~The attachments to the application form require~~] the following information:

(1) a summary description of the utilization review plan, which must include the matters listed in subparagraphs (A) and (B) of this paragraph and otherwise comply with [~~. The utilization review plan must meet~~] the requirements of §19.2005 of this subchapter [~~title~~] (relating to General Standards of Utilization Review):[~~;~~]

(A) an adequate summary description of screening criteria and review procedures to be used to determine health care is medically [~~reasonable and~~] necessary or appropriate, or experimental or investigational in nature; and

(B) a certification, signed by an authorized representative of the applicant [~~company~~], that screening criteria and review procedures to be applied in review determination are established with input from appropriate health care providers and approved by physicians;

(2) utilization review plan written policies that evidence compliance with:

(A) §19.2005 of this subchapter;

(B) §19.2006 of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.2007 of this subchapter (relating to Prohibition of Certain Activities and Procedures Related to Health Care Providers and Injured Employees);

(D) §19.2008 of this subchapter (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers);

(E) §19.2009 of this subchapter (relating to On-Site Review by the Utilization Review Agent);

(F) §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review);

(G) §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination);

(H) §19.2012 of this subchapter (relating to Appeal of Adverse Determination);

(I) §19.2013 of this subchapter (relating to Utilization Review Agent's Telephone Access);

(J) §19.2014 of this subchapter (relating to Confidentiality);

(K) §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review);

(L) §19.2016 of this subchapter (relating to Regulatory Requirements Subsequent to Certification or Registration);

(M) §19.2020 of this subchapter (relating to Specialty Utilization Review Agent), if applicable;

(N) §19.2021 of this subchapter (relating to Independent Review of Adverse Determinations); and

(O) the Labor Code §504.055, regarding expedited provision of medical benefits for first responders employed by political subdivisions who sustain a serious bodily injury in the course and scope of employment;

(3) utilization review plan written policies which attest that peer reviews will comply with the Texas Workers' Compensation Act and rules adopted pursuant to the Texas Workers' Compensation Act including, but not limited to, Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills); Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care); Chapter 137 of this title (relating to Disability Management); and Chapter 180, Subchapter B of this title (relating to Medical Benefit Regulation);

(4) copies of template letters for notification of determinations made in utilization review that comply with §19.2010 and §19.2012 of this subchapter;

(5) organizational information:

(A) written evidence that the applicant is doing business in Texas in accordance with the Texas Business Organizations Code, which may include a letter from the Texas Secretary of State indicating that the entity has filed the appropriate paperwork to conduct business in this state;

(B) a chart showing the internal organizational structure of the applicant's executives, officers, and directors and title of position held by each; and

(C) a letter of good standing from the Texas Comptroller of Public Accounts;

(6) the name and biographical affidavit and a complete set of fingerprints for each director, officer, and executive of the applicant, as required under §1.503 of this title (relating to Application of Fingerprint Requirement) and §1.504 of this title (relating to Fingerprint Requirement); and

[(2) copies of procedures established for informing appropriate parties of the process for appeal of an adverse determination to TWCC. These procedures must comply with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers);]

[(3) copies of procedures established for handling oral or written complaints by injured employees, their representatives or health care providers. These procedures must comply with §19.2016 of this title (relating to Complaints and Information);]

[(4) copies of policies and procedures which ensure that all applicable state and federal laws to protect the confidentiality of medical records are followed. These procedures must comply with §19.2014 of this title (relating to Confidentiality);]

(7) [(5)] a certification signed by an authorized representative of the company that the utilization review agent will comply with the provisions of the Insurance Code Chapter 1305, the Insurance Code Chapter 4201 [Act], the Texas Workers' Compensation Act and department and TDI-DWC rules. [TWCC Rules;]

[(6) a description of the categories of persons and names of the personnel employed or under contract to perform utilization review;]

[(7) a description of the hours of operation within the State of Texas and how the utilization review agent may be contacted during weekends and holidays. This description must be in compliance with §19.2013 of this title (relating to Utilization Review Agent's Telephone Access);]

[(8) representative samples of all materials provided by the utilization review agent/applicant to inform its clients, injured employees, their representatives or providers of the requirements of the utilization review plan. Samples shall include language for notification of an adverse determination made in a utilization review;]

[(9) a description of the basis by which the utilization review agent compensates its employees or agents to ensure compliance with paragraph (10) of this subsection;]

[(10) a certification signed by an authorized representative of the company that the utilization review agent shall not permit or provide compensation or anything of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards based on: the amount or volume of adverse determinations; reductions or limitations on lengths of stay, duration of treatment, medical benefits, services, or charges; or on the number or frequency of telephone calls or other contacts with health care providers or injured employees, which are inconsistent with the provisions of this subchapter;]

[(11) the organizational information, documents and all amendments, including:]

[(A) the bylaws, rules, 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 utilization review agent related to utilization review.]

[(12) the name and biographical information for each director, officer and executive of the applicant.]

[(d) The utilization review agent shall report any material changes in the information in the application or renewal form referred to in this section, not later than the 30th day after the date on which the change takes effect. Material changes include but are not limited to new personnel hired as directors, officers, or executives, changes in the organizational structure, changes in contractual relationships, changes in the utilization review plan and changes in methods of compensation to utilization review agents or their employees.]

(d) [(e)] Original Application Requirements and Process. Paragraphs [The application process is described in paragraphs] (1) - (4) of this subsection specify the requirements and process for entities that are applying for a certification or registration.

(1) Within [The department shall have] 60 days after receipt of a complete [an] application, the department will [to] process the application and [to] certify or register the entity or deny certification or registration [it]. The department will issue a certificate to an entity that is certified and a letter of registration to an entity that is registered. The department will [shall] give the applicant written notice of

any omissions or deficiencies noted as a result of the review conducted pursuant to this paragraph.

(2) The applicant must correct the omissions or deficiencies in the application within 15 working [~~30~~] days of the date of the department's latest notice of such omissions or deficiencies. If the applicant fails to do so, the application file will be closed as an incomplete application. The application fee will not be refundable.

(3) The applicant may waive any of the time limits described in this subsection, except the requirement in paragraph (2) of this subsection. However, before the end of the 15 working days specified in paragraph (2) of this subsection, the [~~The~~] applicant may request in writing additional time to correct the noted omissions or deficiencies in the application. The request for the additional time must be approved by the department in writing for the requested extension to be effective. [~~waive the time limit in paragraph (2) of this subsection only with the consent of the department.~~]

(4) The department will [~~shall~~] maintain a charter [~~an application~~] file which must [~~shall~~] contain the approved application documents, notices of omissions or deficiencies, and requests for additional time and responses from the applicant [~~and any written materials generated by any person that was considered by the department in evaluating the application~~].

(e) Renewal Requirements. Paragraphs (1) - (4) of this subsection specify the requirements for entities that are renewing a certification or registration.

[~~(f) An applicant for a certificate of registration as a utilization review agent must provide evidence that the applicant:~~]

[~~(1) has available the services of doctors, nurses, physician's assistants, or other health care providers qualified to provide the service requested by the provider to carry out its utilization review activities in a timely manner;~~]

[~~(2) meets any applicable provisions of this subchapter and regulations relating to the qualifications of the utilization review agents or the performance of utilization review;~~]

[~~(3) has policies and procedures which protect the confidentiality of medical records in accordance with applicable state and federal laws;~~]

[~~(4) makes itself accessible to injured employees, their representatives and health care providers 40 working hours a week during normal business hours in this state in each time zone in which it operates.~~]

(1) [~~(g)~~] Two-year renewal. A utilization review agent must apply for renewal of certification or registration [~~the certificate of registration~~] every two years from the date of certification or registration by submitting Form No. LHL005 (Utilization Review Agent (URA) Application Form). For an application for renewal of a certification, a utilization review agent must also submit a renewal fee in the amount specified by §19.802(b)(19) of this chapter. [~~A renewal form must be used for this purpose. The renewal fee must be submitted with the renewal form. The renewal form can be obtained from the address listed in subsection (b) of this section. The completed renewal form, a summary of the current screening criteria, a statement signed by an authorized representative of the company certifying that all information previously submitted is true and correct and all changes have been previously filed to the application certified by the department, and the renewal fee must be submitted to the department at the address listed in subsection (a) of this section.~~]

(2) Continued operation during department review. If a utilization review agent has filed the required information specified in this subsection and submitted the fee as applicable for certification renewal with the department on or before the expiration of the certification or registration, the [~~A~~] utilization review agent may continue to operate under its certification or registration [~~certificate of registration, if the information and the fee have been filed for renewal and timely received by the department,~~] until the renewal certification or registration is finally denied or issued by the department. [~~If the required information and fee are not received prior to the deadline for renewal of the certificate of registration, the certificate of registration will automatically expire and the utilization review agent must complete and submit a new application form and a new fee with all required information.~~]

(3) Expiration for 90 days or less. If the certification or registration has been expired for 90 days or less, the utilization review agent may renew the certification or registration by filing a completed renewal application, submitting the fee as applicable for certification renewal, and providing the required information described in this subsection. The utilization review agent may not operate from the time the certification or registration has expired until the time the department has issued a renewal certification or registration.

(4) Expiration for longer than 90 days. If a utilization review agent's certification or registration has been expired for longer than 90 days, the utilization review agent may not renew the certification or registration but must obtain a new certification or registration by submitting an application for original issuance of the certification or registration and an original application fee as applicable for certification in accordance with this section. Subsection (d) of this section applies to applications made under this paragraph.

(f) [~~(h)~~] Contesting a Denial of an Application or Renewal. If an application for an original or renewal certification or registration is [~~initially~~] denied under this section, the applicant [~~or registrant~~] may contest [~~appeal~~] such denial under [~~the terms of~~] the provisions of Chapter 1, Subchapter A of this title (relating to Rules of Practice and Procedure) and the Government Code Chapter 2001. The contesting party is entitled to a hearing [~~A hearing of such appeal shall be conducted~~] within 45 days of the date the petition for such hearing is filed with the commissioner. A decision by the commissioner must [~~shall~~] be rendered within 60 days of the date of the hearing.

[~~(i) A utilization review agent providing utilization review on the effective date of this subchapter must abide by the provisions of this subchapter effective upon its adoption, and must file with the department its original application within 180 days of the effective date of this subchapter. Utilization review agents that have received their certificate of registration prior to the adoption of these rules, and are performing workers' compensation utilization review as defined in §19.2003 of this title (relating to Definitions), must file with the department all changes to their original application as set forth in subsections (c) and (d) of this section within 180 days of the effective date of this subchapter.~~]

[~~(j) A utilization review agent will be required to make a single application and fee payment for one certification to cover all lines of utilization review business.~~]

§19.2005. General Standards of Utilization Review.

(a) Review of Utilization Review Plan. The utilization review plan must [~~shall~~] be reviewed and approved by a physician and conducted in accordance with standards developed, and periodically updated, with input from both primary and specialty physicians, doctors, or other [~~appropriate~~] health care providers, including practicing health care providers. [~~doctors engaged in an active practice that are both primary and specialty doctors, and approved by a physician. The utilization review plan shall include the following components:~~]

[(1) a description of the elements of review which the utilization review agent provides, including:]

[(A) prospective and concurrent review in accordance with Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care);]

[(B) the elements of review in the TWCC guidelines contained in Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care);]

[(C) The elements of review contained in Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).]

[(2) written procedures for:]

[(A) identification of individuals with special circumstances who may require flexibility in the application of screening criteria through utilization review decisions. Special circumstances include, but are not limited to, a person who has a disability, an acute condition, or life-threatening illness. Disability shall not be construed to mean an injured employee who is off work or receiving income benefits;]

[(B) notification of the utilization review agent's determinations provided in accordance with Chapter 134, Subchapter G of this title and as addressed in §19.2010(b) of this title (relating to Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review);]

[(C) informing appropriate parties of the process for appeal of an adverse determination to TWCC, as required by §19.2011 and §19.2012 of this title (relating to Requirements Prior to Adverse Determination and Appeal of Adverse Determinations of Utilization Review Agents);]

[(D) receiving or redirecting a toll-free normal business hour and after-hour calls, either in person or by recording, and assurance that a toll-free number will be maintained 40 hours per week during normal business hours as addressed in §19.2013 of this title (relating to Utilization Review Agent's Telephone Access);]

[(E) review including:]

[(i) any form used during the review process;]

[(ii) time frames that shall be met during the review;]

[(F) handling of oral or written complaints by injured employees, their representatives or health care providers as addressed in §19.2016(a) of this title (relating to Complaints and Reporting Requirements);]

[(G) determining if doctors or other health care providers utilized by the utilization review agent are licensed, qualified and appropriately trained, including written procedures for ensuring that doctors that perform utilization review for the utilization review agent are either on TWCC's list of approved doctors or, if licensed in another state, will perform utilization review under the direction of a doctor licensed in Texas who is on TWCC's list of approved doctors, in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement);]

[(H) assuring that injured employee-specific information obtained during the process of utilization review, as addressed in §19.2014 of this title (relating to Confidentiality), will be:]

[(i) kept confidential in accordance with applicable federal and state laws;]

[(ii) used solely for the purposes of utilization review, quality assurance and case management;]

[(iii) shared with only those agencies who have authority to receive such information; and]

[(iv) in the case of summary data, not considered confidential if it does not provide sufficient information to allow identification of individual injured employees;]

[(I) providing prior written notice to a doctor or health care provider when publishing data, including quality review studies or performance tracking data which identifies a particular doctor, or health care provider;]

[(3) screening criteria. Each utilization review agent shall utilize written medically acceptable screening criteria as defined in §19.2003 of this title (relating to Definitions) and review procedures which are established and periodically evaluated and updated, at a minimum, upon certification renewal with appropriate involvement from the doctors, including doctors engaged in an active practice, and other health care providers. Utilization review decisions shall be made in accordance with currently accepted medical or health care practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Screening criteria must be objective, clinically valid, compatible with established principles of health care, and flexible enough to allow deviations from the norm when justified on a case-by-case basis. Screening criteria must be used to determine only whether to approve the requested treatment. Denials must be referred to an appropriate doctor or other health care provider to determine whether health care is medically reasonable and necessary. Such written screening criteria and review procedures shall be available for review and inspection to determine appropriateness and compliance as deemed necessary by the commissioner, his or her designated representative, or TWCC and copying as necessary for the commissioner and/or TWCC to carry out the lawful duties under the Insurance Code, and the Texas Labor Code, provided, however, that any information obtained or acquired under the authority of this subchapter and the Act, is confidential and privileged and not subject to the open records law or subpoena except to the extent necessary for the commissioner to enforce this subchapter and the Act, and for TWCC to enforce the Texas Workers' Compensation Act.]

(b) Special Circumstances. A utilization review determination must be made in a manner that takes special circumstances of the case into account that may require deviation from the norm stated in the screening criteria or relevant guidelines. Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness. For the purposes of this section, disability must not be construed to mean an injured employee who is off work or receiving income benefits.

(c) Performance Tracking Data. The utilization review plan must provide prior written notice to a physician, doctor or health care provider and an opportunity to correct reports prior to publishing data that identifies the particular physician, doctor, or health care provider, including quality review studies or performance tracking data.

(d) Screening Criteria. Each utilization review agent is required to utilize written screening criteria that are evidence-based, scientifically valid, outcome focused and that comply with the requirements in the Insurance Code §4201.153. The screening criteria must also recognize that if evidence-based medicine is not available for a particular health care service provided, the utilization review agent must utilize generally accepted standards of medical practice recognized in the medical community. For workers' compensation network coverage, screening criteria must comply with the Insurance Code Chapter 1305 and §10.101 of this title (relating to General

Standards for Utilization Review and Retrospective Review); and, for workers' compensation non-network coverage, screening criteria must comply with the Labor Code §413.011 and §413.014, and Chapters 133, 134, and 137 of this title (relating to General Medical Provisions; Benefits--Guidelines for Medical Services, Charges, and Payments; and Disability Management, respectively).

(e) Referral and Determination of Adverse Determinations. Adverse determinations must be referred to and may only be determined by a physician or doctor with appropriate credentials in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement). Physicians and doctors performing utilization review must also be in compliance with the Labor Code §§408.0043, 408.0044, and 408.0045.

(f) [~~(4)~~] Delegation of Review. A utilization review agent, including a specialty utilization review agent, [~~delegation of review. Provide circumstances, if any, under which the utilization review agent~~] may delegate the review to qualified personnel in a [~~the~~] hospital utilization review program or a qualified health care provider. [~~or health care facility where the health care is to be provided.~~] Such delegation does [~~shall~~] not relieve the utilization review agent of full responsibility for compliance with this subchapter, Chapter 4201 of the Insurance Code [~~the Act~~], and the Texas Workers' Compensation Act, including the conduct of those to whom utilization review has been delegated.

(g) Complaint System. The utilization review agent is required to develop and implement procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers concerning the utilization review and is required to maintain records of such complaints for three years from the date the complaints are filed. The complaints procedure must include a requirement for a written response to the complainant by the agent within 30 calendar days. The written response must include the department's address and toll-free telephone number and a statement explaining that a complainant is entitled to file a complaint with the department.

(h) Applicability to Specialty Utilization Review Agents. This section also applies to a specialty utilization review agent except for subsection (a) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2006. Requirements and Prohibitions Relating to Personnel.

(a) Qualification Requirements.

(1) Physicians, doctors, and other health care providers [~~Personnel~~] employed by or under contract with the utilization review agent to perform utilization review must [~~shall~~] be appropriately trained, [~~and~~] qualified, and[~~, if applicable,~~] currently licensed.

(2) Personnel conducting utilization review must hold an unrestricted license or an administrative license in Texas or be otherwise authorized to provide health care services in Texas. Doctors conducting utilization review must hold a professional certification in a health care specialty appropriate to the type of health care the injured employee is receiving in accordance with the Labor Code §§408.0043, 408.0044, and 408.0045. Physicians, doctors and other health care providers conducting utilization review must have the appropriate credentials in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement). [~~Doctors that perform utilization review for the utilization review agent must be on TWCC's list of approved doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement), or comply with subsection (d) of this section.~~]

(3) Personnel who obtain information regarding an injured employee's specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, or other health care provider, either orally or in writing, and who are not physicians or doctors, must [~~shall~~] be nurses, physician [~~physicians~~] assistants, or other health care providers qualified to provide the service requested by the provider. This provision may [~~shall~~] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(b) Prohibitions. A utilization review agent may not permit or provide compensation or anything [~~any thing~~] of value to its employees or agents, condition employment or its employee or agent evaluations, or set its employee or agent performance standards, based on:

(1) the amount or volume of adverse determinations;

(2) reductions or limitations on lengths of stay, [~~duration of treatment, medical~~] benefits, services, or charges; or

(3) the number or frequency of telephone calls or other contacts with health care providers or injured employees, which are inconsistent with the provisions of this subchapter or the Insurance Code Chapter 4201.

(c) Disqualifying Associations. The physician who reviews the appeal must not have any disqualifying associations with the physician or doctor who issued the initial adverse determination or the injured employee who is requesting the appeal. For purposes of this subsection, being employed by or under contract with the same utilization review agent as the physician or doctor who issued the initial adverse determination does not in itself constitute a disqualifying association.

(d) [~~(c)~~] Information Required to be Filed with the Department. The utilization review agent is required to provide the name, number, type, Texas license number, and [~~minimum qualification or~~] qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information [~~commissioner~~].

(e) Written Procedures and Maintenance of Records.

(1) Utilization review agents are [~~shall be~~] required to develop and implement [~~adopt~~] written procedures [~~used~~] to determine if physicians, doctors, and [~~or~~] other health care providers used [~~utilized~~] by the utilization review agent are licensed, qualified, and appropriately trained or experienced [~~, and must maintain records on such~~].

(2) The utilization review agent must maintain documentation that demonstrates that physicians, doctors, and other health care providers that are utilized to perform utilization review, are licensed, qualified, and appropriately trained or experienced in accordance with subsection (a) of this section.

(f) [~~(d)~~] Physician Direction Requirement. Utilization [~~A utilization~~] review conducted by a utilization review agent [~~agent that uses doctors to perform reviews of health care services provided under a workers' compensation policy may use doctors licensed by another state to perform the reviews, but the reviews~~] must be [~~performed~~] under the direction of a physician currently [~~doctor~~] licensed to practice medicine in Texas [~~in this state who is on TWCC's approved doctor list, in accordance with Chapter 180 of this title~~]. Such physician [~~doctor~~] may be employed by or under contract to the utilization review agent.

(g) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (a), (d), (e) and (f) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

[(e) Utilization review of dental health care shall be reviewed by a dentist currently licensed by a state licensing agency in the United States prior to issuance of an adverse determination.]

§19.2007. Prohibition [Prohibitions] of Certain Activities and Procedures Related to Health Care Providers and Injured Employees [of Utilization Review Agents].

(a) A utilization review agent may not engage in unnecessary or unreasonably repetitive contacts with the health care provider or injured employee and must [shall] base the frequency of contacts or reviews on the severity or complexity of the injured employee's condition or on the need for medical documentation to support the necessity of the [necessary] treatment requested or rendered [and return to work planning activity].

(b) A utilization review agent may [shall] not set or impose any notice or other review procedures contrary to the requirements of the Insurance Code, Labor Code Title 5, department rules, and TDI-DWC rules [this subchapter, the Texas Workers' Compensation Act, and the TWCC rules].

(c) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2008. Utilization Review Agent Contact with and Receipt of Information from Health Care Providers.

(a) A health care provider may designate one or more individuals as the initial contact or contacts for utilization review agents seeking routine information or data. The [In no event shall the] designation of such an individual or individuals may not in any circumstance relieve the [preclude a] utilization review agent or medical advisor of the obligation to contact [from contacting] a health care provider or others in the health care provider's [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 utilization review agent.

(b) Unless precluded or modified by contract, a utilization review agent must [the workers' compensation insurance carrier shall] reimburse health care providers for the reasonable costs for [of] providing [written] medical information in writing, including copying and transmitting any requested injured employee records or other documents relevant to the utilization review [pursuant to Chapter 133, Subchapter B of this title (relating to Required Reports)]. A health care provider's charge for providing medical information to a utilization review agent must be in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation) [shall not exceed the cost of copying records set by rules of the Texas Workers' Compensation Commission] and may not include any costs that [are otherwise specified in TWCC rules and/or guidelines as not reimbursed separately or] are recouped as a part of the charge for health care.

(c) When conducting utilization review, the utilization review agent must request all relevant and updated medical records in order [shall require only the information necessary] to complete the review. This information may include identifying information about the injured employee; the claim;[,] the treating physician, doctor, or other health care provider;[,] and the facilities rendering care. It may also include clinical and diagnostic testing information regarding the diagnoses of the injured employee and the medical history of the injured employee relevant to the diagnoses and the compensable injury, the injured employee's prognosis, and the plan of treatment [plan] prescribed by the [treating health care] provider of record, along with the provider of record's [provider's] justification for the plan of treatment [plan. It must include the medical information to substantiate the medical necessity for the specific treatment in review. These items shall only be requested when relevant to the utilization review in question, and be requested as appropriate from the health care provider or health care facility]. The required information should be obtained from the appropriate source, since no one source will have all of this information.

(1) Utilization review agents may request [shall not routinely require hospitals and doctors to supply] numerically codified diagnoses or procedures to be considered for certification only if[. Utilization review agents may ask for such coding, since if it is known,] its inclusion in the data collected increases the effectiveness of the communication.

(2) Utilization review agents must [shall] not routinely request copies of all medical records on [all] injured employees reviewed. During utilization review, copies of medical records should only be required when a difficulty develops in determining whether the health care is medically [reasonable and] necessary or appropriate, or experimental or investigational in nature. In those cases, only the necessary or pertinent sections of the record should be required.

(d) Information in addition to that described in this section may be requested by the utilization review agent or voluntarily submitted by the [health care] provider of record when there is significant lack of agreement between the utilization review agent and [health care] provider of record regarding the appropriateness of health care during the review or appeal process. "Significant lack of agreement" means that the utilization review agent:

(1) has tentatively determined[, through its professional staff,] that a service cannot be approved [authorized to be provided or reimbursed];

(2) has referred the case to a physician, [an appropriate] doctor, or other health care provider for review; and

(3) has had a discussion with [talked to] or attempted to have a discussion with [talk to] the [health care] provider of record in order to obtain [for] further information.

(e) The utilization review agent must [shall] share among its various divisions all [pertinent] clinical and demographic information on individual injured employees [among its various divisions (e.g., preauthorization, return to work planning, case management)] to avoid duplicate requests for information from injured employees, physicians, doctors, and other [or] health care providers.

(f) Notwithstanding any other provision of this section [subchapter], a utilization review agent may not require as a condition of treatment approval, or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes that relate to the mental health therapist's treatment of an injured employee's mental or emotional condition or disorder. This prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes. This prohibition does not preclude the utilization review agent from:

(1) requiring submission of an injured employee's mental health medical record summary; or[.]

(2) requiring submission of medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder.

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2009. On-Site Review by the Utilization Review Agent.

(a) Observing or Participating in Patient's Care. Unless approved by an injured employee and the treating doctor or allowed [~~modified~~] by contract, a utilization review agent is [~~shall be~~] prohibited from observing, participating in, recording, or otherwise being present during an injured employee's examination, treatment, procedure, or therapy. In no event may [~~shall~~] this prohibition [~~section otherwise~~] be construed to limit or deny contact with an injured employee or the health care provider for purposes of conducting utilization review unless otherwise specifically prohibited by law.

(b) Identification of Utilization Review Agents. Utilization review agents' staff must [~~shall~~] identify themselves by name and by the name of their organization and must [~~, for on-site reviews, should~~] carry picture identification and the utilization review agent [~~company~~] identification card with the certification or registration number assigned by the department [~~Texas Department of Insurance~~].

(c) On-site Review at a Health Care Facility. For on-site review conducted at a health care facility, utilization [~~Utilization~~] review agents:

(1) must ensure [~~should assure~~] that their on-site review staff:

(A) register with the appropriate contact individual [~~person~~], if available, prior to requesting any clinical information or assistance from health care facility [~~hospital~~] staff;[~~,~~] and

(B) wear appropriate health care facility [~~hospital~~] supplied identification tags while on the health care facility premises; and[~~.~~]

(2) are required to [~~Utilization review agents shall~~] agree, if so requested, that the medical records remain available in the designated areas during the on-site review, and that reasonable health care facility [~~hospital~~] administrative procedures will [~~shall~~] be followed by on-site review staff in order [~~so as~~] to not disrupt health care facility [~~hospital~~] operations or injured employee [~~patient~~] care. Such procedures, however, should not obstruct or limit the ability of the utilization review agent to efficiently conduct the necessary review.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2010. Notice of Determinations Made in Prospective and Concurrent Utilization Review [~~by Utilization Review Agents, Excluding Retrospective Review~~].

(a) Notice of Favorable or Adverse Determinations. A utilization review agent is required to provide notice, in accordance with this section as applicable, of a determination made in a prospective or concurrent utilization review to the following individuals: [~~shall notify the injured employee, their representative and the treating doctor or the treating doctor's designated representative (e.g., referred health care providers or health care facilities) of a determination made in a utilization review.~~]

(1) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

(2) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by the Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(b) Favorable Determinations.

(1) Except in the case of adverse determinations which are addressed in subsection (c) of this section, the written notification required by this subsection must be mailed or electronically transmitted within the following time frames:

(A) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title.

(B) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title.

(2) A utilization review agent must ensure that preauthorization numbers assigned by the utilization review agent comply with the data and format requirements contained in the standards adopted by the federal Department of Health and Human Services in 45 Code of Federal Regulations §162.1102, relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction, based on the type of service in the preauthorization request.

[~~(b) The notification and time frames for notification required by this section must be made in accordance with TWCC rules contained in Chapter 134, Subchapter G of this title (relating Prospective and Concurrent Review of Health Care).~~]

(c) Adverse Determinations.

(1) Required Notice Elements.

(A) [~~(c)~~] In all instances of a prospective or concurrent utilization review adverse determination, written notification [~~Notification~~] of the adverse determination by the utilization review agent must include:

(i) [~~(1)~~] the principal reasons for the adverse determination;

(ii) [~~(2)~~] the clinical basis for the adverse determination;

(iii) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(iv) a description of the procedure for filing a complaint with the department;

(v) the professional specialty and Texas license number of the physician or doctor that made the adverse determination. Decisions must be made by physicians or doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement);

(vi) a description of the procedure for the utilization review agent's complaint system as required by §19.2005 of this subchapter (relating to General Standards of Utilization Review);

(vii) a description of the utilization review agent's appeal process, as required by §19.2012 of this subchapter (relating to Appeal of Adverse Determination) or §19.2020(h) of this subchapter (relating to Specialty Utilization Review Agent);

(viii) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time that the discussion, if any, took place, as required in §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination); and

(ix) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)), which is available at www.tdi.state.tx.us/forms. Such notice must include statements that:

(I) Form No. LHL009 must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to the insurance carrier or utilization review agent that made the adverse determination to begin the independent review process;

(II) a request of independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor consistent with §133.308 of this title (relating to MDR by Independent Review Organizations); and

(III) a request of independent review of an adverse determination made under workers' compensation network coverage must be timely filed by the requestor consistent with §10.104 of this title (relating to Independent Review of Adverse Determination).

(B) Workers' compensation network coverage. In addition to the requirements in subparagraph (A) of this paragraph, the written notification of the adverse determination by the utilization review agent must also include, for workers' compensation network coverage, a description of or the source of the screening criteria that were utilized in making the determination.

(C) Workers' compensation non-network coverage. In addition to the requirements in subparagraph (A) of this paragraph, the written notification of the adverse determination by the utilization review agent must also include, for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making the determination.

(2) Independent review in the event of life-threatening condition. In accordance with §19.2012(a)(3) of this subchapter, the description of the utilization review agent's appeal process required by paragraph (1)(A)(vii) of this subsection must include a statement that in a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review of the adverse determination to an independent review organization and is not required to comply with procedures for an internal review of the adverse determination by the utilization review agent.

(3) Required time frames. The time frames for notification of the adverse determination are:

(A) Workers' compensation non-network coverage. The adverse determination notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title.

(B) Workers' compensation network coverage. The adverse determination notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title.

(4) Other requirements for non-network workers' compensation coverage. In addition to the requirements of paragraph (1) of this subsection, the notice of adverse determination for non-network workers' compensation coverage must also comply with the requirements of §134.600 of this title.

(5) Peer review reports. This notice may constitute a peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

~~[(3) a description or the source of the screening criteria that were utilized as guidelines in making the determination;]~~

~~[(4) a description of the procedure for the complaint process to the Department and appeal process to TWCC, and]~~

~~[(5) plain language notifying the employee of the right to timely request reconsideration of the health care denied in accordance with Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care).]~~

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2011. Requirements Prior to Issuing Adverse Determination.

(a) Reasonable Opportunity. For purposes of this section, "reasonable opportunity" means at least one documented good faith attempt to contact the provider of record requesting the services no less than one working day prior to issuing a prospective or concurrent utilization review adverse determination or no less than five working days prior to issuing a retrospective utilization review adverse determination.

(b) Requirements Prior to Issuing Prospective and Concurrent Utilization Review Adverse Determinations.

(1) Subject to the notice requirements of §19.2010 of this subchapter [~~title~~] (relating to Notice of Determinations Made in Prospective and Concurrent [~~by~~] Utilization Review [~~Agents, Excluding Retrospective Review~~]), in any instance in which [~~where~~] the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision. [~~whether the health care is medically reasonable and necessary, the health care provider who ordered the services shall be afforded a reasonable opportunity to discuss the plan of treatment for the injured employee and the clinical basis for the utilization review agent's decision with the appropriate doctor or health care provider performing the review, prior to issuance of an adverse determination. The utilization review agent shall have written procedures describing how the opportunity is afforded.~~]

(2) When the utilization review agent provides the reasonable opportunity required under paragraph (1) of this subsection, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent must submit the documentation required by paragraph (3) of this subsection to the department or TDI-DWC upon request.

(c) Requirements Prior to Issuing Retrospective Review Adverse Determinations.

(1) Subject to the notice requirements of §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of an adverse determination, the

utilization review agent is required to afford the provider of record a reasonable opportunity to discuss the treatment provided to the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) When the utilization review agent provides the reasonable opportunity required under paragraph (1) of this subsection, the utilization review agent must include the utilization review agent's phone number so that the provider of record may contact the utilization review agent to discuss the pending adverse determination. The utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(3) The utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(4) The utilization review agent is required to submit the documentation required by paragraph (3) of this subsection to the department or TDI-DWC upon request.

(d) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent except subsections (b) and (c) of this section. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2012. Appeal of Adverse Determination.

(a) Appeal of Prospective or Concurrent Adverse Determinations.

(1) A utilization review agent must maintain and make available a written description of the appeal procedures involving an adverse determination that are used by the agent.

(2) Each utilization review agent is required to comply with its written procedures for appeals. In accordance with the Insurance Code Chapter 4201, Subchapter H (relating to Appeal of Adverse Determination), the written procedures for appeals must be reasonable and must include the information specified in this paragraph:

(A) time frames for filing the appeal:

(i) Workers' compensation network coverage. A statement specifying the time frames for filing the oral or written appeal in accordance with the Insurance Code §1305.354, which may not be less than 30 days after the date of issuance of written notification of an adverse determination; and

(ii) Workers' compensation non-network coverage. A statement specifying that the time frames for filing the oral or written appeal of the adverse determination must comply with §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care) and Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills);

(B) a provision that an injured employee, the injured employee's representative, or the provider of record may appeal the adverse determination by making an oral or written request; if the health care provider sets forth in the request good cause for having a particular type of specialty provider review the case, the adverse determination must be reviewed by a health care provider in the same or similar specialty as the health care provider that typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion for review;

(C) a provision that appeal decisions must be made by a physician who has not previously reviewed the case in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement), Insurance Code §1305.354 and §10.103 of this title (relating to Reconsideration of Adverse Determination);

(D) a provision that subject to the notice requirements of §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review), in any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination), to discuss the plan of treatment for the injured employee with a physician. The provision must state that the discussion must include, at a minimum, the clinical basis for the utilization review agent's decision;

(E) a provision that after the utilization review agent has sought review of the appeal of the adverse determination, the utilization review agent must issue a response letter explaining the resolution to the appeal to the following individuals:

(i) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §134.600 of this title.

(ii) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by the Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements);

(F) the provision required in subparagraph (E) of this paragraph must also require that such letter include:

(i) for both workers' compensation network coverage and for workers' compensation non-network coverage:

(I) a statement of the specific medical or dental reasons for the resolution;

(II) the medical or clinical basis for such decision, including screening criteria;

(III) the professional specialty and Texas license number of the physician who made the determination;

(IV) notice of the appealing party's right to seek review of the denied appeal by an independent review organization in accordance with §19.2021 of this subchapter (relating to Independent Review of Adverse Determinations), the procedures for obtaining that review, and Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)); and

(V) procedures for filing a complaint in accordance with the Insurance Code §4201.204 as described in §19.2005(g) of this subchapter (relating to General Standards of Utilization Review);

(ii) for workers' compensation network coverage, a description of or the source of the screening criteria that were utilized in making the determination, including a description of the network adopted treatment guidelines, if any; and

(iii) for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making a determination;

(G) time frames required for written notifications to the appealing party of the determination of the appeal:

(i) Workers' Compensation Network Coverage. A provision that the appeal must be resolved in accordance with §10.103 of this title;

(ii) Workers' Compensation Non-Network Coverage. A provision that the appeal must be resolved in accordance with §134.600 of this title.

(3) In a circumstance involving an injured employee's life-threatening condition, the injured employee is entitled to an immediate review by an independent review organization of the adverse determination and is not required to comply with procedures for an internal review of the adverse determination by the utilization review agent.

(4) This subsection applies to a specialty utilization review agent except for paragraph (2)(C) and (D) of this subsection. A specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

(b) Appeal of Retrospective Review Adverse Determinations.

(1) Workers' compensation network and non-network coverage. A utilization review agent is required to maintain and make available a written description of appeal procedures involving an adverse determination in a retrospective review. The appeal procedures must comply with the requirements in subparagraphs (A) and (B) of this paragraph.

(A) An appeal of an adverse determination relating to retrospective utilization review must comply with §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review).

(B) In any instance in which the utilization review agent is questioning the medical necessity or appropriateness of the health care services, prior to issuance of an adverse determination, the utilization review agent must afford the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the plan of treatment for the injured employee with a physician or doctor. The discussion must include, at a minimum, the clinical basis for the utilization review agent's decision.

(2) Workers' compensation network coverage. For workers' compensation network coverage, appeal procedures must comply with the requirements in the Insurance Code Chapter 1305, Chapter 10 of this title (relating to Workers' Compensation Health Care Networks), and Chapter 133 of this title (relating to General Medical Provisions).

(3) Workers' compensation non-network coverage. For workers' compensation non-network coverage, the appeal procedures must comply with the requirements of Chapter 133 of this title.

(4) Applicability to specialty utilization review agents. This subsection, except for paragraph (1)(B) of this subsection, applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2013. Utilization Review Agent's Telephone Access.

(a) A utilization review agent is required to [~~shall~~] have appropriate personnel reasonably available by toll-free telephone at least 40 hours per week during normal business hours in both time zones in Texas, [~~if applicable,~~] to discuss an injured employee's care and to respond [~~allow response~~] to telephone review requests.

(b) A utilization review agent must have a telephone system capable of accepting or recording or providing instructions to incoming calls during other than normal business hours and must [~~shall~~] respond to such calls not later than two working days of the later of [~~from~~] the date on which the call was received or the date on which the details necessary to respond were [~~have been~~] received from the caller.

(c) A utilization review agent must provide a written description to the commissioner setting forth the procedures that the utilization review agent will implement when responding to requests for:

(1) drugs that require preauthorization in situations in which the injured employee has received or is currently receiving the requested drugs and an adverse determination could lead to a medical emergency; and

(2) post-stabilization care and pain management medication immediately subsequent to surgery or emergency treatment as requested by the treating physician or provider of record.

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2014. Confidentiality.

(a) Confidentiality Requirements.

(1) A utilization review agent is required to [~~shall~~] preserve the confidentiality of individual medical records to the extent required by law.

(2) [~~(b)~~] A utilization review agent may not disclose or publish individual medical records, personal information, or other confidential information about an injured employee obtained in the performance of utilization review without the prior written consent of the injured employee or as otherwise required by law. Personal information includes [~~shall include~~], at a minimum, name, address, phone number, social security number, and financial information. If such authorization is submitted by anyone other than the individual who is the subject of the personal or confidential information requested, such authorization must:

(A) [~~(1)~~] be dated; and

(B) [~~(2)~~] contain the signature of the individual whose [~~who is the subject of the~~] personal or confidential information is being requested. The signature must have been obtained one year or less prior to the date the disclosure is sought or the authorization is invalid.

(3) [~~(c)~~] A utilization review agent may provide confidential information to a third party under contract or affiliated with the utilization review agent for the sole purpose of performing or assisting with utilization review. Information provided to third parties must [~~shall~~] remain confidential.

(4) [~~(d)~~] If an individual submits a written request to the utilization review agent for access to recorded personal information about the individual, the utilization review agent must [~~shall~~] within 10 working [~~business~~] days from the date such request is received:

(A) [~~(1)~~] inform the individual submitting the request of the nature and substance of the recorded personal information in writing; and

(B) [~~(2)~~] permit the individual to see and copy, in person, the recorded personal information pertaining to the individual or to obtain a copy of the recorded personal information by mail, at the discretion of the individual, unless the recorded personal information is in coded form, in which case an accurate translation in plain language must [~~shall~~] be provided in writing.

(5) [~~(e)~~] A utilization review agent's charges for providing a copy of recorded personal information to individuals may [~~shall~~] not exceed ten cents per page and may not include any costs that are otherwise recouped as part of the charge for utilization review.

(6) [~~(f)~~] The utilization review agent may not publish data that [~~which~~] identifies a particular physician, doctor, or other health care provider, including any quality review studies or performance tracking data without prior written notice to the subject physician, doctor, or other [~~involved~~] health care provider. This prohibition does not apply to internal systems or reports used by the utilization review agent.

(7) [~~(g)~~] When the utilization review agent determines that documents [~~Documents~~] in the custody of the utilization review agent that contain confidential injured employee information or physician, doctor, or other health care provider financial data are no longer needed, the documents must [~~shall~~] be destroyed by a method that results in the [~~which induces~~] complete destruction of the information [~~when the agent determines the information is no longer needed~~].

(8) [~~(h)~~] All injured employee, physician, doctor, and other health care provider data must [~~shall~~] be maintained by the utilization review agent in a confidential manner that [~~which~~] prevents unauthorized disclosure to third parties. Nothing in this section may [~~article shall~~] be construed to allow a utilization review agent to take actions that violate a state or federal statute or regulation concerning confidentiality of injured employee records and the confidentiality provisions of [~~in~~] the Texas Workers' Compensation Act.

(9) [~~(i)~~] To assure confidentiality, a utilization review agent must, when contacting a physician's, doctor's, [~~office~~] or other health care provider's office [~~hospital~~], provide its certification number, the caller's name, and professional qualifications [~~to the provider's named utilization review representative in the health care provider's office~~].

(10) [~~(j)~~] Upon request by the physician, doctor, or other health care provider, the utilization review agent must [~~shall~~] present written documentation that it is acting as an agent of the insurance carrier for the relevant injured employee.

[~~(k) The utilization review agent's procedures shall specify that specific information exchanged for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information. The utilization review agent's process shall specify that procedures are in place to assure confidentiality and that the utilization review agent agrees to abide by the confidentiality provisions of the Texas Workers' Compensation Act and any other federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual injured employees or health care providers need not be considered confidential.~~]

(11) [~~(l)~~] Medical records and injured employee specific information must [~~shall~~] be maintained by the utilization review agent in a secure area with access limited to essential personnel only.

(12) [~~(m)~~] A utilization review agent is required to retain information [~~Information~~] generated and obtained by a [~~the~~] utilization review agent [~~agents~~] in the course of utilization review [~~shall be retained~~] for at least four [~~two~~] years [~~from the date of the final decision in the utilization review~~].

(13) [~~(n)~~] Notwithstanding the provisions in paragraphs (1) - (12) of this subsection and subsection (b) [~~subsections (a) - (m)~~] of this section, the utilization review agent is required to [~~shall~~] provide to the department or TDI-DWC [~~commissioner and/or the Texas Workers' Compensation Commission~~] on request individual medical records or other confidential information for determination of compliance with this subchapter. The information is confidential and privileged and is not subject to the [~~open records law,~~] Government Code[~~,~~] Chapter 552 (Public Information), or to subpoena, except to the extent necessary to enable the commissioner to enforce this subchapter.

(b) Written Procedures on Confidentiality. The utilization review agent must specify in writing the procedures that the utilization review agent will implement pertaining to confidentiality of information received from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the utilization review agent and third parties for the purpose of conducting utilization review. These procedures must specify that specific information received from the injured employee, the injured employee's representative, and/or the physician, doctor, or other health care provider and the information exchanged between the utilization review agent and third parties for the purpose of conducting reviews will be considered confidential, be used by the review agent solely for the purposes of utilization review, and shared by the utilization review agent with only those third parties who have authority to receive such information, such as the claim administrator. These procedures must also specify that the utilization review agent has procedures in place to assure confidentiality, and that the utilization review agent agrees to abide by any federal and state laws governing the issue of confidentiality. Summary data which does not provide sufficient information to allow identification of individual injured employees, physicians, doctors, or other health care providers need not be considered confidential.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2015. Notice of Determination Made in Retrospective Review.

(a) Required Notice. A utilization review agent is required to provide notice of a determination made in a retrospective review to the following individuals:

(1) Workers' compensation non-network coverage. The notification for workers' compensation non-network coverage must be provided to the individuals specified by §133.240 of this title (relating to Medical Payment and Denials).

(2) Workers' compensation network coverage. The notification for workers' compensation network coverage must be provided to the individuals specified by §133.240 of this title and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(b) Required Procedures. The utilization review agent is required to develop and implement written procedures for providing the notice of adverse determination for retrospective utilization review, including the time frames for the notice of adverse determination. These procedures must comply with the Insurance Code §4201.305 and the requirements specified in paragraphs (1) - (3) of this subsection.

(1) The notice of adverse determination required by subsection (a) of this section must be in writing and provided within the timeframes specified by:

(A) department rules in Chapter 10 of this title (relating to Workers' Compensation Health Care Networks) and TDI-DWC rules in Chapter 133 of this title (relating to General Medical Provisions) for workers' compensation network coverage; or

(B) TDI-DWC rules in Chapter 133 of this title for workers' compensation non-network coverage.

(2) The notice of an adverse determination required by subsection (a) of this section must include:

(A) the principal reasons for the adverse determination;

(B) the clinical basis for the adverse determination;

(C) a description of documentation or evidence, if any, that can be submitted by the provider of record that, upon appeal, might lead to a different utilization review decision;

(D) for workers' compensation network coverage, a description or the source of the screening criteria that were utilized in making the determination;

(E) for workers' compensation non-network coverage, a description of guidelines utilized in accordance with Chapter 137 of this title (relating to Disability Management) in making a determination;

(F) the professional specialty and Texas license number of the physician or doctor that made the determination;

(G) a description of the procedure for the utilization review agent's complaint system as required by §19.2005(g) of this subchapter (relating to General Standards of Utilization Review);

(H) a description of the utilization review agent's appeal process, as required by §19.2012 of this subchapter (relating to Appeal of Adverse Determination);

(I) the date and time the utilization review agent offered the opportunity to discuss the adverse determination, and the date and time the discussion, if any, took place, as required in §19.2011 of this subchapter (relating to Requirements Prior to Issuing Adverse Determination) or §19.2020(h) of this subchapter (relating to Specialty Utilization Review Agent);

(J) notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)). Such notice must include instructions that:

(i) the independent review request Form No. LHL009 must be completed by the injured employee, the injured employee's representative, or the injured employee's provider of record and be returned to the utilization review agent to begin the independent review process;

(ii) a request of independent review of an adverse determination made under workers' compensation non-network coverage must be timely filed by the requestor in accordance with §133.308 of this title (relating to MDR by Independent Review Organizations); and

(iii) a request of independent review of an adverse determination made under workers' compensation network coverage must be timely filed by the requestor in accordance with §10.104 of this title (relating to Independent Review of Adverse Determination).

(3) Peer review reports. The notice of determination required under this section may constitute a peer review report required by §180.28 of this title (relating to Peer Review Requirements, Reporting, and Sanctions) if the notice also meets the required elements of that section.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter.

§19.2016. Regulatory Requirements Subsequent to Certification or Registration [~~Complaints and Reporting Requirements~~].

(a) Reporting of Material Changes. The utilization review agent is required to report any material changes in the information in the application or renewal Form No. LHL005 (Utilization Review Agent (URA) Application Form) last filed with the department by the utilization review agent, not later than the 30th day after the date on which the change takes effect. [~~Utilization review agent's complaint system. A utilization review agent shall establish and maintain a complaint system that provides reasonable procedures for the resolution of oral or written complaints initiated by injured employees, their representatives, or health care providers, concerning the utilization review process, and shall maintain records of such complaints for three years from the time the complaints are filed. The complaint procedure shall include a written response to the complainant by the agent within 30 days of the agent's receipt of the complaint.~~]

(b) Summary Report to the Department. [~~Utilization review agent's complaint reporting requirements to the department.~~]

(1) By March 1, of each year, the utilization review agent must [~~shall~~] submit to the department [~~commissioner or his or her delegated representative~~] a summary report of information related to complaints, adverse determinations, appeals of adverse determinations, and any other related information requested by the department in accordance with the Insurance Code §38.001. [~~all complaints involving workers' compensation at such times and in such form as the commissioner may require, and shall permit the commissioner to examine the complaints and all relevant documents at any time. To be disclosed in the report is the subject matter of the complaint categorized as follows:~~]

[~~(1) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);~~]

[~~(2) qualifications of utilization review agent's personnel;~~]

[~~(3) complaint process (e.g., treating doctor has not been afforded the opportunity to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal to TWCC not provided).~~]

(2) The summary report must be provided in the form required by the commissioner, and the utilization review agent must permit the commissioner or the commissioner's designee to examine all relevant documents related to the report at any time subsequent to the filing of the summary report with the department.

(3) [~~(c)~~] [~~Utilization review agent's adverse determination reporting requirements to the department.~~] The summary report is required to cover [~~also covers~~] reviews performed by the utilization review agent during the preceding calendar year and includes:

(A) [~~(1)~~] the total number of written notices of adverse determinations;

(B) [~~(2)~~] a listing of adverse determinations for preauthorization, by the medical condition and treatment using primary ICD-9 (physical diagnosis) or DSM-IV (mental health diagnosis) code, or successor codes and modifiers, and CPT (procedure) code or other relevant procedure code if a CPT designation is not available, or any other nationally recognized numerically codified diagnosis or procedure; [~~and~~]

(C) [~~(3)~~] the classification of party requesting review (i.e., health care provider, injured employee, their representative, etc.);[~~,~~]

(D) the disposition of the appeal of adverse determination (either in favor of the appellant, or in favor of the original utilization review determination) at each level of the notification and appeal process; and

(E) the subject matter of any complaint filed with the utilization review agent. Complaints must be categorized as follows:

(i) administration (e.g., copies of medical records not paid for, too many calls or written requests for information from provider, too much information requested from provider);

(ii) qualifications of utilization review agent's personnel; or

(iii) appeal/complaint process (e.g., treating physician unable to discuss plan of treatment with utilization review physician, no notice of adverse determination, no notice of clinical basis for adverse determination, written procedures for appeal not provided).

(c) Complaints to the Department. Complaints filed with the department against a utilization review agent must be processed in accordance with the department's established procedures for investigation and resolution of complaints.

(d) Department Inquiries. Pursuant to the Insurance Code §38.001, the department may address inquiries to a utilization review agent related to any matter connected with utilization review agent transactions that the department considers necessary for the public good or for the proper discharge of the department's duties. In accordance with the Insurance Code §38.001, a utilization review agent that receives an inquiry from the department pursuant to the Insurance Code §38.001 is required to respond to the inquiry in writing not later than the 10th day after the date the inquiry is received.

(e) TDI-DWC Inquiries. This section 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 utilization review agents or personnel employed by or under contract with utilization review agents to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules.

[(d) Complaints to the department. Within a reasonable time period, upon receipt of a written complaint alleging a violation of this subchapter or the Act, by a utilization review agent, from an injured employee, their representative or health care provider, the commissioner or his or her delegated representative shall investigate the complaint, notify the utilization review agent of the complaint, require response by the utilization review agent addressing the complaint within 10 days of receipt of the complaint, and furnish a written response to the complainant and the utilization review agent named. This response must include the following:]

[(1) a statement of the original complaint;]

[(2) a statement of the findings of the commissioner or his or her delegated representative and an explanation of the basis of such findings;]

[(3) corrective actions, if any, on the part of the utilization review agent which the commissioner or his or her designated representative finds appropriate and whether the utilization review agent has voluntarily agreed to take such action; and]

[(4) a time frame in which any corrective actions should be completed.]

[(e) Evidence of corrective action. The utilization review agent will provide evidence of corrective action within the specified time frame to the commissioner or his or her representative.]

[(f) Authority of the department to make inquiries. In addition to the authority of the commissioner to respond to complaints described in subsection (b) of this section, the department is authorized to address inquiries to any utilization review agent in relation to the agents' business condition or any matter connected with its transactions which the department may deem necessary for the public good or for a proper discharge of its duties. It shall be the duty of the agent to promptly answer such inquiries in writing.]

[(g) Lists of utilization review agents. The commissioner shall maintain and update monthly a list of utilization review agents issued certificates and the renewal date for those certificates. The commissioner shall provide the list at cost to all individuals or organizations requesting the list.]

(f) [(h)] On-site Review [review] by the [Texas] Department [of Insurance].

(1) Provisions for scheduled and unscheduled on-site reviews.

(A) The department may [commissioner or the commissioner's designated representative is authorized to] make a complete on-site review of the operations of each utilization review agent at the principal place of business for such agent, as often as is deemed necessary. Such review may be scheduled or unscheduled.

(B) An on-site review will only be conducted during working days and normal business hours.

(C) The utilization review agent must make available all records relating to its operation during such scheduled and unscheduled on-site reviews.

(2) Scheduled on-site reviews. Utilization review agents will be notified of any [the] scheduled on-site review [visit] by letter, which will specify, at a minimum, the identity of the department's [commissioner's] designated representative and the expected arrival date and time.

(3) Unscheduled on-site reviews. At a minimum, notice of an on-site review of a utilization review agent will be in writing and be presented by the department's designated representative upon arrival.

[(3) The utilization review agent must make available during such on-site visits all records relating to its operation.]

[(4) The commissioner or the designated representative may perform periodic telephone audits of utilization review agents authorized to conduct business in this state to determine if the agents are reasonably accessible.]

(g) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2017. Administrative Violations.

(a) Actions by the Department. In accordance with the Insurance Code §4201.601, if [If] the department [commissioner, through the commissioner's designated representative,] believes that any individual [person] or entity conducting utilization review pursuant to this subchapter [article] is in violation of Chapter 4201 of the Insurance Code [the Act] or applicable rules or any other provision of the Insurance Code or rules [regulations], the department [commissioner's designated representative] shall notify the utilization review agent or insurance carrier 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 occurred [taken place].

(1) [(b)] The department [commissioner's designated representative] may initiate the proceedings under this section.

(2) [(c)] Proceedings under this subchapter [section] are a contested case for the purpose of the Government Code Chapter 2001.

(3) [(d)] If the commissioner determines that the utilization review agent, insurance carrier, or other [person or] entity or individual conducting utilization review pursuant to this subchapter has violated

or is violating any provision of Chapter 4201 of the Insurance Code [~~the Act~~], the Insurance Code, or department rules [~~this subchapter~~], the commissioner may:

(A) impose sanctions under the Insurance CodeChapter 82; [~~, Chapters 82, 83, and 84.~~]

(B) issue a cease and desist order under the Insurance Code Chapter 83; or

(C) assess administrative penalties under the Insurance Code Chapter 84.

(4) [~~(c)~~] The commission of fraudulent or deceptive acts or omissions in obtaining, attempting to obtain, or use of certification or registration as a utilization review agent is [~~shall be~~] a violation of Chapter 4201 of the Insurance Code and the Labor Code [~~the Act~~].

(b) Actions by TDI-DWC. This section 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 utilization review agents or personnel employed by or under contract with utilization review agents to perform utilization review to determine compliance with or violations of the Labor Code Title 5 or applicable TDI-DWC rules. Nothing in this section prohibits joint enforcement actions by the department and TDI-DWC or delegations of authority to enforce relevant statutes or rules.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2019. Responsibility of Insurance Carriers [~~Companies~~] Performing Utilization Review [~~under the Insurance Code, Article 21.58A, §14~~].

(a) An insurance carrier that performs utilization review under the Texas Workers' Compensation Act is subject to this subchapter, except, pursuant to the Insurance Code §4201.058, an insurance carrier that performs utilization review under the Texas Workers' Compensation Act is not subject to the certification requirements in §19.2004 of this subchapter (relating to Certification of Utilization Review Agents), if it performs utilization review only for coverage for which it is the payor. [~~An insurance company licensed by the department and performing utilization review under the Insurance Code, Article 21.58A, §14(h) will be subject to §19.2001 of this title (relating to General Provisions), §19.2002 of this title (relating to Limitations on Applicability), §19.2003 of this title (relating to Definitions), §19.2004(c)(1) - (10) and (d) of this title (relating to Certification of Utilization Review Agents), §19.2005 of this title (relating to General Standards of Utilization Review), §19.2006 of this title (relating to Personnel), §19.2007 of this title (relating to Prohibitions of Certain Activities of Utilization Review Agents), §19.2008 of this title (relating to Utilization Review Agent Contact with and Receipt of Information from Health Care Providers), §19.2009 of this title (relating to On-Site Review by the Utilization Review Agent), §19.2010 of this title (relating to Notice of Determinations Made by Utilization Review Agents, Excluding Retrospective Review), §19.2011 of this title (relating to Requirements Prior to Adverse Determination), §19.2012 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents), §19.2013 of this title (relating to Utilization Review Agent's Telephone Access), §19.2014 of this title (relating to Confidentiality), §19.2015 of this title (relating to Retrospective Review of Medical Necessity), §19.2016 of this title (relating to Complaint and Reporting Requirements), §19.2017 of this title (relating to Administrative Violations), and §19.2020 of this title (relating to Specialty Utilization Review Agent) with respect to their operations under the provisions of the Act, §14(h).~~]

(b) Notwithstanding subsection (a) of this section, when [~~When~~] an insurance carrier that [~~company~~] performs utilization review for an individual or entity subject to this subchapter for which it is not the payor, such insurance carrier must have a valid certificate as required by the Insurance Code §4201.101 and in accordance with §19.2004 of this subchapter. [~~under the Texas Workers' Compensation Act or TWCC rules for an insurance carrier, an employer, or a utilization review agent other than the insurance company itself, such insurance company shall be required to obtain a certificate under this subchapter and comply with all the provisions of this subchapter.~~]

(c) Notwithstanding subsection (a) of this section, an insurance carrier [~~Insurance companies~~] performing utilization review under Chapter 4201 of the Insurance Code only for coverage for which it is the payor must have a valid registration pursuant to §19.2004 of this subchapter and comply with all filing requirements under §19.2004 of this subchapter. However, the insurer is not required to submit an original application fee or renewal fee if the insurer only performs utilization review for workers' compensation coverage for which it is the payor. [~~§14(h) of the Act must register with the department and submit written documentation demonstrating compliance with all the filing requirements defined in §19.2004(c)(1) - (10) and (d) of this title (relating to Certification of Utilization Review Agents) and the name, address, contact name and phone number of the insurance company.~~]

(d) This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

§19.2020. Specialty Utilization Review Agent.

(a) Application. In order to be certified or registered as a specialty utilization review agent, an applicant must submit to the department the application and information required in §19.2004 of this subchapter (relating to Certification or Registration of Utilization Review Agents).

(b) Statutory and Rule Requirements.

(1) [~~(a)~~] In accordance with the Insurance Code §4201.452, a specialty utilization review agent [~~A utilization review agent that solely performs specialty review under the Insurance Code, Article 21.58A, §14(j)~~] is [~~not~~] subject to the requirements of the Insurance Code Chapter 4201, except that the specialty utilization review agent is not subject to the following sections: [~~, Article 21.58A, §4(b), (c), (h) or (k) or §6(b)(3) of the Act. A utilization review agent that does not solely perform specialty review, is not subject to the provisions of this section or the Insurance Code, Article 21.58A, §14(j).~~]

(A) §4201.151 (Utilization Review Plan);

(B) §4201.152 (Utilization Review Under Direction of Physician);

(C) §4201.206 (Opportunity to Discuss Treatment Before Adverse Determination);

(D) §4201.252 (Personnel); and

(E) §4201.356 (Decision by Physician Required; Specialty Review).

(2) [~~(b)~~] A specialty utilization review agent [~~that performs specialty review under the Insurance Code, Article, 21.58A, §14(j)~~] is subject to the requirements of this subchapter, except for the following provisions: [~~§19.2004(c)(1)(B) and (c)(6) of this title (relating to Certification of Utilization Review Agents); the first sentence of §19.2005 of this title (relating to General Standards of Utilization Review); §19.2006(a), (d), (e) of this title (relating to Personnel); §19.2011 of this title (relating to Requirements Prior to~~

Adverse Determination) and §19.2012 of this title (relating to Appeal of Adverse Determination of Utilization Review Agents).]

(A) §19.2005(a) of this subchapter (relating to General Standards of Utilization Review);

(B) §19.2006(a), (d), (e), and (f) of this subchapter (relating to Requirements and Prohibitions Relating to Personnel);

(C) §19.2011(b) and (c) of this subchapter (relating to Requirements Prior to Issuing Adverse Determination); and

(D) §19.2012(a)(2)(D) and (b)(1)(B) of this subchapter (relating to Appeal of Adverse Determination).

(c) Utilization Review Plan. A specialty utilization review agent is required to have its [must submit, by attachment to the application, assurance that the] utilization review plan [shall be] reviewed by a physician, doctor, or other health care provider of the appropriate specialty, and the plan must be implemented [and conducted] in accordance with standards developed with input from a physician, doctor, or other health care provider of the appropriate specialty. The specialty utilization review agent must have written procedures to ensure that these requirements are implemented.

(d) Requirements of Employed or Contracted Physicians, Doctors, Other Health Care Providers, and Personnel.

(1) Physicians, doctors, other health care providers, and personnel employed by or under contract with a specialty utilization review agent to perform workers' compensation utilization review must be appropriately trained, qualified, and currently licensed in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement).

(2) Personnel conducting utilization review must hold an unrestricted license or an administrative license issued by the Texas Medical Board in Texas or be otherwise authorized to provide health care services in Texas.

[(d) A specialty utilization review agent must submit by attachment to the application a description of the categories of personnel who perform utilization review, such as doctors, nurses, physicians assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care by a state licensing agency in the United States, except that this provision does not require those qualifications from personnel who perform solely clerical or administrative tasks.]

[(e) An applicant for a certificate of registration as a specialty utilization review agent must provide evidence that the applicant has available the services of doctors, nurses, physician's assistants, or other health care providers of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care by a state licensing agency in the United States to carry out its utilization review activities in a timely manner.]

[(f) Personnel employed by or under contract with the specialty utilization review agent to perform utilization review shall be appropriately trained and qualified and, if applicable, currently licensed. Doctors that perform utilization review for the specialty utilization review agent must be on TWCC's list of approved doctors in accordance with Chapter 180 of this title (relating to Monitoring and Enforcement).]

(3) Personnel who obtain information regarding an injured employee's specific medical condition, diagnosis, and treatment options or protocols directly from the physician, doctor, or health care provider, either orally or in writing, and who are not physicians or doctors qualified in accordance with the Labor Code §§408.0043, 408.0044, and 408.0045 to provide the requested service, must [shall] be nurses, physician [physician's] assistants, or other health care providers qualified in accordance with Chapter 180 of this title to provide the requested service [of the same specialty as the utilization review agent and who are licensed or otherwise authorized to provide the specialty health care by a state licensing agency in the United States]. This provision may [shall] not be interpreted to require such qualifications for personnel who perform clerical or administrative tasks.

(e) Information Required to be Filed with the Department. The specialty utilization review agent is required to provide the name, number, type, Texas license number and qualifications of the personnel either employed or under contract to perform the utilization review to the department upon filing an original application or renewal application or upon providing updated information.

(f) Written Procedures and Maintenance of Records.

(1) Specialty utilization review agents are required to develop and implement written procedures for determining if physicians, doctors, or other health care providers used by the specialty utilization review agent are licensed, qualified, and appropriately trained or experienced.

(2) The specialty utilization review agent must maintain documentation that demonstrates that physicians, doctors, and other health care providers that are utilized to perform utilization review are licensed, qualified, and appropriately trained or experienced, in accordance with subsection (d) of this section.

(g) Utilization Review by a Specialty Utilization Review Agent. Utilization review conducted by a specialty utilization review agent must [shall] be [conducted] under the direction of a physician, doctor, or other health care provider of the same specialty and the physician, doctor, or other health care provider must [shall] be currently licensed [or otherwise authorized] to provide the specialty health care service in Texas [by a state licensing agency in the United States]. Such physician, doctor, or other health care provider may be employed by or under contract to the utilization review agent.

(h) Reasonable Opportunity for Discussion.

(1) Prospective or concurrent utilization review.

(A) Subject to the notice requirements of §19.2010 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review) and §19.2012 of this subchapter [title], in any instance in which [where] the specialty utilization review agent questions whether the health care is medically [reasonable and] necessary or appropriate, the health care provider that [who] ordered the services must [shall], prior to the issuance of an adverse determination, be afforded a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the plan of treatment for the patient and the clinical basis for the decision of the utilization review agent with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent must submit the documentation required by subparagraph (D) of this paragraph to the department or TDI-DWC upon request.

(2) Retrospective utilization review.

(A) Subject to the notice requirements of §19.2015 of this subchapter (relating to Notice of Determination Made in Retrospective Review), in any instance in which the specialty utilization review agent is questioning the medical necessity or appropriateness of the health care services provided, prior to the issuance of an adverse determination, the specialty utilization review agent must provide the provider of record a reasonable opportunity, as defined in §19.2011(a) of this subchapter, to discuss the treatment provided to the injured employee with a health care provider of the same specialty as the utilization review agent.

(B) The discussion must include, at a minimum, the clinical basis for the specialty utilization review agent's decision.

(C) When the specialty utilization review agent provides the reasonable opportunity required under subparagraph (A) of this paragraph, the specialty utilization review agent must include the specialty utilization review agent's phone number so that the provider of record may contact the specialty utilization review agent to discuss the pending adverse determination. The specialty utilization review agent must allow the provider of record five working days from receipt of the notification to respond orally or in writing to the notification.

(D) The specialty utilization review agent must maintain documentation that details the discussion opportunity provided to the provider of record, including the date and time the specialty utilization review agent offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(E) The specialty utilization review agent is required to submit the documentation required by subparagraph (D) of this paragraph to the department or TDI-DWC upon request.

(i) Appeal. The decision in an appeal of any adverse determination by [~~Appeals from an adverse determination by~~] a specialty utilization review agent must [~~shall~~] be made by a physician or other health care provider who has not previously reviewed the case and who is of the same specialty as the specialty utilization review agent that made the adverse determination. [~~governed by the Texas Workers' Compensation Act and the applicable rules and procedures of the TWCC including but not limited to Chapter 134, Subchapter G of this title (relating to Prospective and Concurrent Review of Health Care) and Chapter 133, Subchapter D of this title (relating to Dispute and Audit of Bills by Insurance Carriers).~~]

§19.2021. Independent Review of Adverse Determinations.

(a) Life-threatening Conditions.

(1) Notification for life-threatening conditions.

(A) For life-threatening conditions, notification of adverse determination by the utilization review agent must be provided within the time frames specified in clauses (i) and (ii) of this subparagraph.

(i) Workers' compensation non-network coverage. The adverse determination notification for workers' compensation non-network coverage must be provided within the time frames specified by §134.600 of this title (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

(ii) Workers' compensation network coverage. The adverse determination notification for workers' compensation network coverage must be provided within the time frames specified by the Insurance Code §1305.353 and §10.102 of this title (relating to Notice of Certain Utilization Review Determinations; Preauthorization and Retrospective Review Requirements).

(B) At the time of notification of the adverse determination, the utilization review agent must provide the notice of the independent review process and a copy of Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) for requesting independent review as required by §19.2010 and §19.2015 of this subchapter (relating to Notice of Determinations Made in Prospective and Concurrent Utilization Review and Notice of Determination Made in Retrospective Review, respectively). Such notice must describe how to obtain independent review of such determination and how the department assigns a request for review to an independent review organization.

(C) The injured employee, injured employee's representative, or the injured employee's provider of record is required to determine the existence of a life-threatening condition on the basis that a prudent layperson possessing an average knowledge of medicine and health would believe that the injured employee's disease or condition is a life-threatening condition.

(2) Appeal of adverse determination involving life-threatening condition. Any party who receives an adverse determination involving a life-threatening condition(s) or whose appeal of an adverse determination involving a life-threatening condition(s) is denied by the utilization review agent may seek review of the adverse determination by an independent review organization assigned in accordance with the Insurance Code Chapter 4202 and Chapter 12 of this title (relating to Independent Review Organizations).

(b) Independent Review Involving Life-Threatening and Non-Life Threatening Conditions.

(1) Request for independent review.

(A) The utilization review agent is required to notify the department within one working day from the date of the request for an independent review is received.

(B) The utilization review agent must provide to the department the completed Form No. LHL009 (Request for a Review by an Independent Review Organization (IRO)) submitted to the utilization review agent by the party requesting independent review.

(C) The Form No. LHL009 must be submitted to the department via the department's Internet website.

(2) Assignment of independent review organization The department will, within one working day of receipt of the complete request for independent review, randomly assign an independent review organization to conduct the independent review and notify the utilization review agent, payor, the independent review organization, injured employee or the injured employee's representative, injured employee's provider of record and any other providers listed by the utilization review agent as having records relevant to the review of the assignment.

(3) Workers' compensation non-network coverage. Additional requirements for independent review of an adverse determination

for a workers' compensation non-network coverage review are governed by the Texas Workers' Compensation Act and TDI-DWC rules, including but not limited to Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

(4) Workers' compensation network coverage. Additional requirements for independent review of an adverse determination for a workers' compensation network coverage review are governed by the Insurance Code Chapter 1305, department rules, and TDI-DWC rules, including but not limited to Chapter 10, Subchapter F of this title (relating to Utilization Review and Retrospective Review) and Chapter 133, Subchapter D of this title.

(c) Applicability to Specialty Utilization Review Agents. This section applies to a specialty utilization review agent. The specialty utilization review agent must comply with §19.2020 of this subchapter (relating to Specialty Utilization Review Agent).

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 June 23, 2011.

TRD-201102361
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department Insurance
Proposed date of adoption: September 6, 2011
For further information, please call: (512) 463-6327

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CHAPTER 19. AGENTS' LICENSING

The Texas Department of Insurance (Department) proposes the repeal of §§19.1718, 19.1722, 19.2012, 19.2015, 19.2018, and 19.2021, concerning utilization review. The repeal of these sections is necessary because they are obsolete and no longer necessary. The repeal of §19.1718, concerning criminal penalties, is necessary because the statute on which it was based, the Insurance Code Article 21.58A §10, was repealed by Senate Bill (SB) 14, 77th Legislature, Regular Session, effective September 1, 2001. The repeal of §19.1722, concerning the utilization review advisory committee, is necessary because the utilization review agents advisory committee was abolished by House Bill (HB) 1951, 82nd Legislature, Regular Session, effective September 1, 2011. The repeal of §19.2012, concerning appeal of adverse determination of utilization review agents, is necessary because the Department is proposing a new §19.2012 relating to appeal of adverse determinations, which contains more specific guidelines. The repeal of §19.2015, concerning retrospective review of medical necessity, is necessary because the Department is proposing: (i) amendments to §19.2005 that address requirements for retrospective review; and (ii) new §19.2015, concerning notice of determination made in retrospective review, which contains more specific notice requirements. The repeal of §19.2018, concerning criminal penalties, is necessary because the statute on which it was based, the Insurance Code Article 21.58A §10, was repealed by SB 14, 77th Legislature, Regular Session, effective September 1, 2001. The repeal of §19.2021, concerning independent review organizations non-involvement, is necessary because the Department is proposing a new §19.2021, relating to independent review of adverse determinations, which contains more specific requirements relating to independent review. In conjunction with this proposal, the Department is proposing amendments to §§19.1701 - 19.1717, 19.1719 - 19.1721, 19.1723, 19.1724, 19.2001 - 19.2011, 19.2013, 19.2014, 19.2016, 19.2017, 19.2019, and 19.2020 (relating to Utilization Reviews for Health Care Provided under a Health Benefit Plan or Health Insurance Policy and Utilization Reviews for Health Care Provided under Workers' Compensation Insurance Coverage, respectively); and new §§19.2012, 19.2015, and 19.2021 (relating to Appeal of Adverse Determination, Notice of Determination Made in Retrospective Review, and Independent Review of Adverse Determinations, respectively) also published in this issue of the *Texas Register.*

FISCAL NOTE. Debra Diaz-Lara, Deputy Commissioner, Health and Workers' Compensation Network Certification and Quality Assurance Division, has determined that during each year of the first five years that the proposed repeal is in effect, there will be no fiscal impact on state or local government as a result of enforcing or administering the repeal of the sections. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Ms. Diaz-Lara also has determined that for each year of the first five years the repeal of the sections is in effect, the public benefit anticipated as a result of administration and enforcement of the repealed sections will be the elimination of obsolete regulations. There is no anticipated economic cost to persons who are required to comply with the proposed repeal. There is no anticipated difference in cost of compliance between small and large businesses.

ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS FOR SMALL AND MICRO BUSINESSES. In accordance with the Government Code §2006.002(c), the Department has determined that this proposed repeal will not have an adverse economic effect on small or micro business carriers because it is simply a repeal of unnecessary rules. Therefore, in accordance with the Government Code §2006.002(c), the Department is not required to prepare a regulatory flexibility analysis.

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 August 8, 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 Debra Diaz-Lara, Deputy Commissioner of the Health and Workers' Compensation Network Certification and Quality Assurance/HWCN for the Life, Health & Licensing Division, Mail Code 103-6A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing must be submitted separately to the Office of 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 R. UTILIZATION REVIEW AGENTS

28 TAC §19.1718, §19.1722

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

STATUTORY AUTHORITY. The repeal of §19.1718 and §19.1722 is proposed pursuant to SB 14, 77th Legislature, Regular Session, effective September 1, 2001 (SB 14), HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011 (HB 1951), the Insurance Code §4201.003, and §36.001. SB 14 repealed Article 21.58A Section 10, which was the statutory basis for repealed §19.1718. HB 1951 abolished the utilization review agents advisory committee. Section 4201.003 provides that the Commissioner of Insurance may adopt rules to implement Chapter 4201 of the Insurance Code. Section 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 Chapter 4201 and Chapter 4202, Subchapter M; Insurance Code §4201.003; Insurance Code Chapter 4201, Subchapter H; and Labor Code Title 5, Subtitle A.

§19.1718. Criminal Penalties.

§19.1722. Utilization Review Advisory Committee.

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

Filed with the Office of the Secretary of State on June 23, 2011.

TRD-201102362
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Proposed date of adoption: September 6, 2011
For further information, please call: (512) 463-6327

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SUBCHAPTER U. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER WORKERS' COMPENSATION INSURANCE COVERAGE

28 TAC §§19.2012, 19.2015, 19.2018, 19.2021

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

STATUTORY AUTHORITY. The repeal of §§19.2012, 19.2015, 19.2018, and 19.2021 is proposed pursuant to SB 14, 77th Legislature, Regular Session, effective September 1, 2001 (SB 14), HB 1951, 82nd Legislature, Regular Session, effective September 1, 2011 (HB 1951), the Insurance Code §4201.003, and §36.001. SB 14 repealed Article 21.58A Section 10, which was the statutory basis for repealed §19.2018. HB 1951 abolished the utilization review agents advisory committee. Section 4201.003 provides that the Commissioner of Insurance may adopt rules to implement Chapter 4201 of the Insurance Code. Section 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 Chapter 4201 and Chapter 4202, Subchapter M; Insurance Code §4201.003; Insurance Code Chapter 4201, Subchapter H; and Labor Code Title 5, Subtitle A.

§19.2012. Appeal of Adverse Determination of Utilization Review Agents.

§19.2015. Retrospective Review of Medical Necessity.

§19.2018. Criminal Penalties.

§19.2021. Independent Review Organizations Non-Involvement.

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 June 23, 2011.

TRD-201102363
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Proposed date of adoption: September 6, 2011
For further information, please call: (512) 463-6327

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 10. TEXAS WATER DEVELOPMENT BOARD

CHAPTER 363. FINANCIAL ASSISTANCE PROGRAMS

SUBCHAPTER L. WATER INFRASTRUCTURE FUND

31 TAC §363.1205, §363.1207

The Texas Water Development Board ("TWDB" or "Board") proposes an amendment to Chapter 363, Financial Assistance Programs, §363.1205, regarding Interest Rates for Loans, and §363.1207, regarding Prioritization System.

BACKGROUND AND SUMMARY OF THE FACTUAL BASIS FOR THE PROPOSED AMENDMENTS

The Water Infrastructure Fund (WIF) was established in Senate Bill 2, 77th Legislature, 2001, to provide affordable financing for water conservation and development projects for the implementation of recommended strategies in the State Water Plan (State Water Plan Projects).

Although the WIF contemplated a level of subsidization to encourage funding for State Water Plan Projects, there was no appropriation by the Legislature for this purpose at that time. Beginning in 2007, the Texas Legislature enabled the Texas Water Development Board (TWDB) to provide subsidized financing for the WIF in order to move State Water Plan projects forward. General revenue appropriations have enabled the TWDB to provide the 200 basis point interest rate subsidy provided in the TWDB's

rules and meet the full debt service obligations for the bonds issued.

The TWDB's rule at 31 Texas Administrative Code (TAC) §363.1205 requires the Executive Administrator to reduce the market rate by 200 basis points and thereby identify a subsidized interest rate for WIF loans. Texas Water Code §15.974 provides that the board may use the fund to make loans at or below market interest rates for projects but does not specify a specific basis point subsidy. The Board proposes to amend §363.1205 to allow the amount of WIF subsidy to be set by the Board as appropriate based WIF financing and appropriations by the Legislature.

The TWDB's rule at 31 TAC §363.1207 provides that the Board will prioritize applications based on criteria in §363.1208. The executive administrator must provide to the Board the amount of funds requested and the priority of each application, along with the total amount of WIF funds available for new applications. The Board will first consider projects that the Legislature has determined shall receive priority for financial assistance from the WIF, then make commitments in descending order of priority, and will consider the next application on the list only if there are funds available to fund all or part of the application. The Board proposes to amend §363.1207 to provide notice to potential borrowers that the Board reserves the right to limit the amount of funding available to an individual entity based on a proportionate share of total funds available for a particular round of prioritization.

SECTION BY SECTION DISCUSSION OF PROPOSED AMENDMENTS

Section 363.1205. Interest Rates for Loans

The Board proposes to amend §363.1205(a)(2)(C) to allow the amount of WIF subsidy to be set by the Board as appropriate based on WIF financing and appropriations by the Legislature. The amount of the subsidy can be determined by the Board and provided to potential applicants prior to the WIF application deadlines for project prioritization by the Board.

The proposed amendments to §363.1205(a)(2)(A) and (b) also delete references to "bond proceeds issued through the Water Development Fund" and "Water Development Fund bonds." The amendments are technical corrections to avoid any confusion, since the WIF is funded through the issuance of Water Financial Assistance Bonds, the proceeds of which are deposited in the Texas Water Development Fund II and then transferred to the WIF.

Section 363.1207. Prioritization System

Board proposes to amend §363.1207(c) to provide notice to potential borrowers that the Board reserves the right to limit the amount of funding available to an individual entity based on a proportionate share of total funds available for a particular round of prioritization.

FISCAL NOTE: COSTS TO STATE AND LOCAL GOVERNMENTS

Ms. Melanie Callahan, Chief Financial Officer, has determined that there will be no fiscal implications for state or local governments as a result of the proposed rulemaking. For the first five years these rules are in effect, there is no expected additional cost to state or local governments resulting from their administration.

These rules are not expected to result in reductions in costs to either state or local governments. There is no change in costs for local entities that apply for financial assistance because, although the rulemaking adds required information with an application, the TWDB application already requires this information, so the proposed rule documents a current procedure. These rules are not expected to have any impact on state or local revenues. The rules do not require any increase in expenditures for state or local governments as a result of administering these rules. Additionally, there are no foreseeable implications relating to state or local governments' costs or revenue resulting from these rules.

PUBLIC BENEFITS AND COSTS

Ms. Callahan also has determined that for each year of the first five years the proposed rulemaking is in effect, the public will benefit from the rulemaking as it allows financing for state water plan projects at a cost below the market rate at which the entity would be able to finance the project.

LOCAL EMPLOYMENT IMPACT STATEMENT

The Board has determined that a local employment impact statement is not required because the proposed rules do not adversely affect a local economy in a material way for the first five years that the proposed rules are in effect because it will impose no new requirements on local economies. The Board also has determined that there will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing this rulemaking. The Board also has determined that there is no anticipated economic cost to persons who are required to comply with the rulemaking as proposed. Therefore, no regulatory flexibility analysis is necessary.

REGULATORY ANALYSIS

The Board has determined that the proposed rulemaking is not subject to Government Code §2001.0225 because it is not a major environmental rule under that section.

TAKINGS IMPACT ASSESSMENT

The Board has determined that the promulgation and enforcement of these proposed rules will constitute neither a statutory nor a constitutional taking of private real property. The proposed rules do not adversely affect a landowner's rights in private real property, in whole or in part, temporarily or permanently, because the proposed rules do not burden or restrict or limit the owner's right to or use of property. Therefore, the proposed rules do not constitute a taking under Texas Government Code, Chapter 2007 or the Texas Constitution.

SUBMITTAL OF COMMENTS

Comments on the proposed rulemaking will be accepted for 30 days following publication in the *Texas Register* and may be submitted to Legal Services, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231, rulescomments@twdb.state.tx.us, or by fax at (512) 463-5580.

STATUTORY AUTHORITY

The amendments are proposed under the authority of Water Code §6.101, which authorizes the Board to adopt rules necessary to carry out the powers and duties of the Board, §6.194, which authorizes the Board to adopt rules governing its actions regarding applications, and §15.977 which authorizes the Board to adopt rules regarding the WIF.

The code affected by this proposal is Water Code Chapter 15.

§363.1205. Interest Rates for Loans.

(a) For loans from the Water Infrastructure Fund, the following procedures will be used to set fixed interest rates.

(1) The executive administrator will set fixed interest rates under this section for loans on a date that is five business days prior to the political subdivision's adoption of the ordinance or resolution authorizing its bonds and not more than 45 days before the anticipated closing of the loan from the board. After 45 days from the establishment of the interest rate of a loan, rates will be reconsidered, and may be extended only with the approval of the executive administrator.

(2) For loans from the fund, the executive administrator will set the interest rates in accordance with the following:

(A) to the extent that the source of funding is provided from bond proceeds [~~issued through the Water Development Fund~~], the lending rate scale(s) will be determined as provided under §363.33(b) of this title (relating to Interest Rates for Loans and Purchase of Board's Interest in State Participation Projects);

(B) Although the program is designed to provide borrowers with a [~~200 basis point~~] reduction from the market rate based on a level debt service schedule, in no event shall the loan interest rate as determined under this section be less than zero;

(C) The loan interest rate will be determined based on a debt service schedule that provides interest only will be paid in the first year of the debt service schedule and in which the annual debt service payments are level, as determined by the executive administrator. The executive administrator will identify the appropriate scale for the borrower and identify the market rate for the maturity due in each year. The executive administrator will reduce that market rate by a subsidy to be determined by the board [~~200 basis points~~] and thereby identify a proposed loan interest rate for each maturity. The proposed loan interest rate will be applied to the proposed principal repayment schedule.

(D) For loans made under §363.1203(a)(2) of this title (relating to Use of Fund), which receive deferred principal and interest payments, the executive administrator will identify the appropriate scale for the borrower and identify the market rate for the maturity due in each year. The executive administrator will reduce that market rate by a subsidy to be determined by the board [~~200 basis points~~] and thereby identify a proposed loan interest rate for each maturity. The proposed loan interest rate will be applied to the proposed principal repayment schedule.

(b) The board will establish separate lending rate scales for loans according to source of funds, if any funds other than [~~Water Development Fund~~] bond proceeds are used.

§363.1207. Prioritization System.

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

(c) If there are funds in the Water Infrastructure Fund available for all or part of any of the prioritized projects, the board will first consider any projects that the legislature has determined shall receive priority for financial assistance from the Water Infrastructure Fund. If, after considering projects with legislative priority, there are funds available for other eligible projects in the Water Infrastructure Fund, then the board will consider applications to make a commitment for financial assistance in descending order of priority according to §363.1208 of this title. The board will consider the next application on the list only if there are funds available in the account to fund all or, if acceptable to the applicant, a part of the application. The Board reserves the right to limit the amount of funding available to an individual entity based on a proportionate share of total funds available for a particular round of prioritization.

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 June 24, 2011.

TRD-201102378
Kenneth L. Petersen
General Counsel
Texas Water Development Board
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 463-8061

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TITLE 34. PUBLIC FINANCE

PART 3. TEACHER RETIREMENT SYSTEM OF TEXAS

CHAPTER 23. ADMINISTRATIVE PROCEDURES

34 TAC §23.5

The Teacher Retirement System of Texas (TRS or system) proposes necessary and appropriate amendments to §23.5, which concerns the nominating elections for appointment to the TRS Board of Trustees and the terms of board members. TRS proposes changes to §23.5 to implement recently enacted legislation that becomes effective September 1, 2011 and amends provisions of §825.002 of the Government Code concerning elections to nominate persons for the governor to consider in making appointments to the TRS Board of Trustees (board). TRS also proposes rule amendments updating, clarifying, or reorganizing §23.5.

Section 825.002(c) - (g) of the Government Code requires the governor to appoint four trustees nominated at elections by TRS participant groups comprised of retirees who are receiving benefits (retirees) or TRS members whose most recent credited service was performed for a public school district (public school employees) or institution of higher education (higher education employees). Trustee appointments subject to nominating elections reflect the qualifications of eligible voters for each election. One nominee must be a retiree, two nominees must be TRS members who are currently employed by a public school district (current public school employees) and one nominee must be a TRS member who is currently employed by an institution of higher education (current higher education employee). The statute requires the governor to make an appointment from a slate of three candidates nominated at an election. Subsection (f) of §825.002 requires the nominating elections to be conducted under rules adopted by the board. The board has adopted §23.5 to implement the statutory provisions on nominating elections.

The 82nd Legislature (2011) recently amended §825.002, and the statutory changes go into effect September 1, 2011. House Bill (HB) 2120 amends §825.002 by providing for a future "at-large" position on the board (the at-large position or trustee). This at-large position will replace the seat on the board reserved for a current higher education employee (the higher education-only position or trustee). To be considered for appointment to the at-large position, a person must have been nominated at an election by voters who are retirees, public school employees or

higher education employees. To be a candidate in the nominating election for the at-large position, a person must be a retiree or a current public school or higher education employee. The first nominating election for the at-large position will be held after the next appointee to the higher education-only position, for a six-year term beginning September 1, 2011, leaves office.

Senate Bill (SB) 1667 amends §825.002 by clarifying that TRS may conduct a nominating election for the retiree position by telephone or other electronic means. Before amendment by SB 1667, the statute already generally authorized TRS to conduct nominating elections using such means. But the new legislation clarifies that authority with respect to the retiree position elections by not requiring a paper ballot alone or in conjunction with voting electronically. SB 1667 also amends the statute by providing for the contingency that a nominating election may yield fewer than three nominees for consideration and allowing the governor to make an appointment under such circumstances.

TRS proposes amending §23.5 by creating a new subsection (a) to define terms used in the rule. The proposed new definitions would clarify the meaning of terms used in the rule, ensure their consistent use and avoid the repetition of long terms. Significant definitions are those providing abbreviated references to the appointments subject to a nominating election, including the future "at-large position" and the present one solely for a current higher education employee, "the higher education-only position", which the at-large seat will eventually succeed.

Proposed new subsection (e) would establish the requirements for becoming a candidate in a nominating election for the at-large position. To have their names listed on the at-large ballot, prospective candidates must get at least 250 qualified signatures, the same number required to run in the public school district or retiree elections.

TRS also proposes amending §23.5 by relettering subsections (f) as "(k)" and (g) as "(l)" and setting out the legislatively enacted succession of the first at-large appointee to the office of the last higher education-only trustee. The proposed rule amendments reflect that the last higher education-only appointee serves a six-year term beginning September 1, 2011. The first at-large trustee would be appointed to serve a term beginning September 1, 2016 or could be nominated sooner if the last higher education-only trustee vacated office before the expiration of his or her term.

As needed, the proposed rule adds references to the at-large position or trustee and deletes obsolete references to holding another nominating election for the higher education-only position. In spring 2011, TRS held the last election for the higher education-only position and certified the results to the governor.

TRS proposes relettering subsection (c) as "(g)" and adding a new subsection "(h)" to establish manners of voting other than paper ballot, as authorized by the statute and clarified by SB 1667. The proposed rule changes would allow TRS or its designated agent to conduct a nominating election by electronic means such as by telephone, e-mail or the Internet or in combination with paper balloting. Whatever manner of voting is used must be secure, effective, and verifiable. Further, when requested, TRS must provide a voter the appropriate means to vote for a candidate who is not on the ballot (in conventional terms, a "write-in" candidate).

In addition, proposed new subsection (f) would clarify the deadline for submitting nominating election petitions by requiring that they be "received" by TRS by the specified date. The proposed change would eliminate any ambiguity or misunderstanding about when TRS considered a petition to have been "filed." In establishing a firm deadline, the clarification also would accommodate prospective candidates by extending the deadline by five calendar days and providing that it would be further extended to the next business day if the deadline fell on a weekend or holiday.

Similarly, another proposed change in relettered subsection (g) (current subsection (c)) would establish a clear, hard deadline for casting votes: to be counted, votes must be "received" by--rather than "submitted to"--TRS or its designated agent by the specified date. As with similar proposed changes to the deadline for nominating petitions, the deadline for casting votes would be extended by five calendar days, with a further extension to the next business if the deadline falls on a weekend or holiday.

Finally, TRS proposes minor wording or formatting changes throughout §23.5 to conform the language of the whole rule to the proposed amendments described above.

Ken Welch, Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §23.5 will be in effect, there will be no fiscal implications to state or local governments as a result of administering the proposed amended rule.

For each year of the first five years that the proposed amended rule will be in effect, Mr. Welch and Ronnie Jung, Executive Director, have determined that the public benefit will be to provide current information on the terms of TRS board members.

Mr. Welch and Mr. Jung have determined that there is no economic cost to entities or persons required to comply with the proposed rule. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy because of the proposed rule, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the executive director at the designated TRS address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §825.102 of the Government Code, which authorizes the board of trustees to adopt rules for the transaction of the business of the board, and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendments affect the following statutes: §825.002 of the Government Code, as amended by Act of May 24, 2011, 82nd Leg., R.S., H.B. 2120, §1, eff. Sept. 1, 2011, and Act of May 20, 2011, 82nd Leg., R.S., S.B. 1667, §14, eff. Sept. 1, 2011; §825.004 of the Government Code.

§23.5. Nomination for Appointment to the Board of Trustees.

(a) Definitions. In this section:

(1) "At-large position" means the position on the board for which a person is nominated or appointed under subsection (e) of §825.002 of the Government Code or nominated under subsection (e-1) of §825.002 of the Government Code, as those subsections existed on Sept. 1, 2011.

(2) "At-large trustee" means the person appointed to the at-large position.

(3) "Board" means the Board of Trustees of TRS.

(4) "Gubernatorial position" means a position on the board for which a person is appointed under subsection (b) of §825.002 of the Government Code.

(5) "Higher education-only position" means the position on the board for which a person is nominated or appointed under subsection (e) of §825.002 of the Government Code, as that subsection existed on Aug. 31, 2011.

(6) "Member" means a member of Teacher Retirement System of Texas.

(7) "Public school district position" means a position on the board for which a person is nominated or appointed under subsection (c) of §825.002 of the Government Code.

(8) "Public school district trustee" means a person appointed to a public school district position.

(9) "Retiree" means a former TRS member who has retired and is receiving benefits from TRS.

(10) "Retiree position" means the position on the board for which a person is nominated or appointed under subsection (d) of §825.002 of the Government Code.

(11) "Retiree trustee" means the person appointed to the retiree position.

(12) "State Board of Education position" means a position on the board for which a person is nominated or appointed under §825.003 of the Government Code.

(13) "System" means the Teacher Retirement System of Texas.

(14) "TRS" means the Teacher Retirement System of Texas.

(15) "Trustee" means a member of the board.

(b) [~~(a)~~] During any calendar year in which the term of office of a public school district trustee, [~~member, institution of higher education member, or~~] retiree trustee or at-large trustee [~~member of the board of trustees of the Teacher Retirement System of Texas (TRS)~~] expires, TRS will conduct an election between March 15 and May 5 [~~April 30~~] to select the nominees to be considered by the governor for appointment to the position.

(c) [~~(b)~~] Public school district members [~~of the system~~] who are currently employed by a public school district may have their names listed on the official ballot as candidates for nomination to a public school district position by filing an official petition bearing the signature, printed or typed name, first five digits of the member's current residential zip code, and last four digits of the member's Social Security number of 250 members of the retirement system whose most recent credited service is or was performed for a public school district. [~~Institution of higher education members of the system who are currently employed by an institution of higher education may have their names listed on the official ballot as candidates for nomination to the institution of higher education position by filing an official petition bearing the signature, printed or typed name, first five digits of the member's current residential zip code, and last four digits of the member's Social Security number of 250 members whose most recent credited service is or was performed for an institution of higher education.~~]

(d) Retirees may have their names listed on the official ballot as candidates for nomination to the retiree position by filing an official petition bearing the signature, printed or typed name, first five digits of the retiree's current residential zip code, and last four digits of the retiree's Social Security number of 250 retirees [~~of the system~~]. Official petition forms shall be available from the Teacher Retirement System of Texas, 1000 Red River Street, Austin, Texas 78701-2698.

(e) Members who are currently employed by an institution of higher education or a public school district or who are retirees may have their names listed on the official ballot as candidates for nomination to the at-large position by filing an official petition bearing the signature, printed or typed name, first five digits of the signatory's current residential zip code, and last four digits of the signatory's Social Security number of 250 signatories who are members whose most recent credited service is or was performed for an institution of higher education or a public school district or who are retirees. Official petition forms shall be available from the Teacher Retirement System of Texas, 1000 Red River Street, Austin, Texas 78701-2698.

(f) Official petitions must be received by the system [~~filed~~] by January 20 [~~15~~] of the calendar year in which the election is to be held. If January 20 is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. A qualified public school district member, institution of higher education member, or retiree may sign more than one candidate's petition as long as they are eligible to vote in the election of the candidate or candidates for whom they are signing.

(g) [~~(c)~~] Upon verification of petitions by the system or its designated agent, the names of qualified candidates shall be represented on the ballot. The system may designate an agent to implement and to monitor the ballot process in a manner authorized by this section. Voting [~~Balloting~~] may be conducted by paper [~~printed~~] ballot or in another manner established by the board in this section, including by telephone or other electronic means [~~combination with electronic balloting~~]. Upon request by a qualified voter, the system or its designated agent shall provide the voter the means to vote for a candidate who is not on the ballot, and such means shall be appropriate for the manner in which the election is conducted [~~a printed ballot containing a space for write-in candidates~~]. Voting instructions shall be sent [~~mailed~~] on or before March 15 of the year in which the election is held to the last known home address of each active member or retiree or to a location designated by the active member or retiree for receiving an electronic communication. To be counted, a [~~printed~~] ballot must be completed and received by [~~returned to~~] the system or its designated agent by May 5 [~~April 30~~] of the year in which the election is held and in accordance with the instructions printed on the ballot or provided in connection with another manner of voting. If May 5 is a Saturday, Sunday, or legal holiday, the period is extended to include the next day that is not a Saturday, Sunday, or legal holiday. [~~To be counted, an electronic ballot must be completed and submitted to the system or its designated agent by April 30 of the year in which the election is held and in accordance with the instructions contained in the electronic voting format.~~] The executive director shall cause the ballots to be counted. Names of the candidates for each position receiving the three highest number of votes shall be certified by the executive director to the governor.

(h) Voting at an election under this section may be conducted in a secure, effective, and verifiable manner other than by paper ballot, including by:

(1) telephone, including an automated telephone system;

(2) electronic mail, an Internet-enabled service or application, or other means of electronic transmission; or

(3) a combination of paper balloting and one or more means provided under this subsection.

(i) [~~(d)~~] When a vacancy in a public school district position, [~~institution of higher education position, or~~] retiree position or at-large position occurs for a reason other than the expiration of a term of office, the board [~~of trustees~~] may conduct an appropriate election at any time [~~they determine appropriate~~]. The board [~~of trustees~~] shall establish deadlines for filing petitions, the date of mailing ballots, the date for returning ballots[~~,~~] and any other necessary details related to the election process.

(j) [~~(e)~~] When more than one public school district member position [~~on the board of trustees~~] is being contested at the same election, each candidate shall specify on his or her petition which position he or she is seeking by indicating expiration date of the term of office sought. Petitions that [~~which~~] fail to specify shall be returned to the candidates for completion if time permits. Failure to designate a specific position by the deadline shall disqualify the candidate. When more than one position is contested at the same election, a person may be a candidate for only one of the positions.

(k) [~~(f)~~] Terms of trustees [~~board members~~] run for six years and expire August 31. Terms expire on the following dates and every six years thereafter:

(1) Public school district position [~~appointment~~], Place One, August 31, 2013.

(2) Gubernatorial position [~~appointment~~], Place One, August 31, 2013.

(3) State Board of Education position [~~appointment~~], Place One, August 31, 2013.

(4) Public school [~~School~~] district position [~~appointment~~], Place Two, August 31, 2015.

(5) Gubernatorial position [~~appointment~~], Place Two, August 31, 2015.

(6) State Board of Education position [~~appointment~~], Place Two, August 31, 2015.

(7) At-large position [~~Higher Education appointment~~], August 31, 2023 for a term beginning on or after September 1, 2017 [~~2011~~].

(8) Retiree position [~~appointment~~], August 31, 2011.

(9) Gubernatorial position [~~appointment~~], Place Three, August 31, 2011.

(10) Higher education-only position, August 31, 2017. This paragraph expires August 31, 2017 or upon the appointment of a person to the at-large position, whichever is earlier.

(l) [~~(g)~~] A vacancy in the office of a trustee shall be filled for the unexpired term in the same manner that the office was previously filled, unless the vacancy to be filled for the unexpired term occurs in the higher education position.

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 June 22, 2011.

TRD-201102348
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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CHAPTER 25. MEMBERSHIP CREDIT
SUBCHAPTER B. COMPENSATION

34 TAC §25.30

The Teacher Retirement System of Texas (TRS) proposes amendments to §25.30, concerning conversion of noncreditable compensation. Chapter 25 concerns membership credit and Subchapter B addresses various types of compensation typically paid to public education employees and whether such compensation is creditable for TRS benefit calculation purposes. The amendments are proposed to reflect the exclusion of converted compensation (compensation converted from noncreditable compensation to creditable compensation) in benefit calculations for nongrandfathered members (those using a five-year salary average instead of a three-year salary average).

Section 25.30 concerns conversion of noncreditable compensation to salary. TRS proposes amending §25.30 to address when compensation that has been converted from noncreditable compensation to creditable compensation in the years prior to retirement will be excluded from benefit calculations for nongrandfathered members.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §25.30 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rule. Any fiscal impact is a result of the enacted legislation.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amended rule will be in effect, there is no economic cost to entities or persons required to comply with the proposed amended rule. Any economic cost results from the enacted legislation. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy or local employment because of the proposed amended rule, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §825.102 of the Government Code, which authorizes the TRS board of trustees to adopt rules for the administration of the funds of the retirement system and for the transaction of the

business of the board. Further statutory authority for adopting changes to this rule is provided in §825.110 of the Government Code which requires the TRS board of trustees to adopt rules to exclude compensation derived from a conversion of noncreditable compensation that occurred in the final years of a member's employment.

Cross-Reference to Statute: No other codes, articles, or sections are affected.

§25.30. Conversion of Noncreditable Compensation to Salary.

(a) For members who on or before August 31, 2005 had attained the age of 50, had at least 25 years of service credit, or whose combined age and service credit equaled 70 or greater, TRS excludes from creditable compensation any amount of otherwise eligible compensation that represents amounts converted into salary and wages from noncreditable compensation to be received in any of the last three school years prior to retirement. Amounts excluded under this subsection [~~section~~] are excluded in the year of conversion and each subsequent year until retirement.

(b) For members who on or before August 31, 2005 did not meet the requirements of subsection (a) of this section, TRS excludes from creditable compensation any amount of otherwise eligible compensation that represents amounts converted into salary and wages from noncreditable compensation to be received in any of the last five school years prior to retirement. Amounts excluded under this subsection are excluded in the year of conversion and each subsequent year until retirement.

(c) [~~(b)~~] For purposes of this section, conversion occurs when an employer agrees to pay a member with creditable compensation for services performed in the future that in the past were paid by that employer with noncreditable compensation. Compensation in the form of accrued paid leave or accrued compensatory time for overtime worked cannot be converted to eligible compensation and are expressly excluded from creditable compensation at any time.

(d) [~~(c)~~] The employer certifies whether compensation was converted in the last three school years prior to retirement for those members meeting the requirements of subsection (a) of this section and whether compensation was converted in the last five school years prior to retirement for those members who do not meet the requirements of subsection (a) of this section.

(e) [~~(d)~~] Only compensation converted after the 2005-2006 school or contract year will be excluded under this section.

(f) [~~(e)~~] TRS will adjust a member's annual compensation at the time of retirement to comply with the requirements of subsection (a) of this section and refund the member contributions on excluded amounts. The refund will be made after the date on which TRS makes the first annuity payment.

(g) [~~(f)~~] If compensation is excluded under subsection (a) or (b) of this section, the member may provide additional information in the form of written documentation to demonstrate that the compensation should not be excluded. TRS makes the final determination regarding the characterization of compensation as creditable or noncreditable.

(h) [~~(g)~~] Upon the request of TRS, the employer shall provide documents or records evidencing characterization of the compensation.

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 June 23, 2011.

TRD-201102367

Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER C. UNREPORTED SERVICE OR COMPENSATION

34 TAC §§25.41, 25.43, 25.45, 25.47

The Teacher Retirement System of Texas (TRS) proposes new §25.47 and amendments to §§25.41, 25.43, and 25.45 concerning unreported service or compensation of TRS members. Chapter 25 concerns membership credit, and Subchapter C establishes policies related to service or compensation a member's employer must report but did not. TRS proposes new §25.47 and amendments to §§25.41, 25.43, and 25.45, which are necessary and appropriate to implement Senate Bill 1668, 82nd Legislature, Regular Session, 2011 (SB 1668), which takes effect September 1, 2011.

Section 25.41 concerns deposits for unreported service or compensation; under the current rule, deposits must be paid before TRS will pay any benefits to a member. TRS proposes amending §25.41 by deleting subsection (b), which provides that failure to make all required deposits will result in ineligibility for benefits from TRS. Under SB 1668, establishing unreported service or compensation credit is discretionary rather than mandatory. However, a member's benefits will not be based on the credit unless required deposits are paid. The amendments also reflect that the cost of unreported service or compensation credit shall be the actuarial cost, as required under SB 1668.

Section 25.43 concerns fee on deposits for unreported service or compensation. TRS proposes amending §25.43 to reflect that the cost of the credit is actuarial cost rather than the deposits plus a fee of 5%. The amendments also reflect that SB 1668 establishes a two-year transition period during which credit may be established at the old cost for members and service or compensation that meets the stated eligibility requirements.

Section 25.45 concerns verification of unreported compensation or service. TRS proposes amending §25.45 to make conforming changes by changing the reference to the title of §25.43 and references to fees to be assessed.

Proposed new §25.47 concerns the deadline for verification of unreported compensation or service. The new rule reflects the deadline, established in SB 1668, of five years to verify unreported compensation or service to TRS. Verification must be received by the deadline in order for the service or compensation to be creditable.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §§25.41, 25.43, and 25.45 and new §25.47 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rules and new rule. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed amended rules and new rule will be in effect, Ronnie Jung, TRS Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1668 concerning

verification of unreported service or compensation and cost of the establishing credit.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amended rule will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed rules. Any economic cost results from the enacted legislation. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposed rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules or new rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments and new rule are proposed under §825.102 of the Government Code, which authorizes the board of trustees to adopt rules for the administration of the funds of the retirement system and for the transaction of the business of the board, and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendments and new rule affect §825.403 of the Government Code and Act of May 20, 2011, 82nd Leg., R.S., S.B. 1668, §§6, 9, 10, eff. Sept. 1, 2011.

§25.41. Deposits for Unreported Service or Compensation.

[~~(a)~~] Persons who have been required by law to be members of the Teacher Retirement System of Texas or who have service or compensation on which contributions were required but who have not made the required deposits shall start making deposits immediately for current service and may [~~shall~~] make payment of the actuarial cost [~~deposits as quickly as possible~~] for previous service or compensation[~~, along with the fee required~~] under §25.43 of this title (Cost [~~Fee on Deposits~~] for Unreported Service or Compensation).

[~~(b) Failure to make all required deposits will result in ineligibility for benefits from TRS.~~]

§25.43. Cost [~~Fee on Deposits~~] for Unreported Service or Compensation.

(a) Except as provided by subsections (e) and (f) of this section, the cost of establishing unreported service or compensation credit is the actuarial cost, as determined by TRS, of the additional standard annuity retirement benefits that would be attributable to the unreported service or compensation credit purchased under this subchapter.

(b) To calculate the actuarial cost of purchasing a year of unreported service credit, TRS will use the cost factors and method described in §25.302 of this title (relating to Calculation of Actuarial Cost). To calculate the actuarial cost of purchasing unreported compensation credit, TRS will use the factors and method as set forth in §25.302, modified as necessary to reflect the purchase of compensation credit instead of service credit.

(c) The purchase cost described in this section assumes a lump-sum deposit will be made. If deposits are made under an installment agreement, a non-refundable installment fee of 9% applies.

(d) No credit will be applied to the cost of a year of unreported service credit or to the cost of unreported compensation credit for any TRS contributions made in the same school year.

(e) A member may establish unreported service or compensation credit by paying the deposits and fees required in subsection (f) of this section if the member meets all applicable requirements to purchase unreported service or compensation credit and if:

(1) the person otherwise meets all eligibility requirements of §825.403, Government Code, as amended by Acts of the 82nd Legislature, R.S., S.B. 1668 (2011);

(2) the service for which credit is sought to be established was rendered, or the compensation for which credit is sought was paid, before September 1, 2011; and

(3) the person makes payment for the credit, or enters into an installment agreement for payment, not later than August 31, 2013.

(f) The cost of establishing unreported service or compensation credit under subsection (e) of this section is the amount of deposits previously required but not paid plus a fee computed [~~A fee will be charged on deposits for unreported service or compensation~~] at the rate of 5.0% per annum of the deposits due from the end of the school year in which the deposits were due or the end of the 1974-1975 school year, whichever is later, until the date of payment.

§25.45. Verification of Unreported Compensation or Service.

Members who claim unreported service or compensation after the school year in which it was received must verify the claim on a form prescribed by the Teacher Retirement System and must present such evidence as the staff of the system may require to provide clear and convincing proof of the existence and amount of such service or compensation, such as a copy of the minutes of the governing board of the employing institution, copies of any written contracts between the member and the employer, a verified statement by the employer of the reasons why such service or compensation was not reported earlier, and copies of income tax documents showing that the compensation was reported as income for the member. In no event shall verification, salary reports, or member contributions for additional compensation or service credit be accepted after a member has retired from the system and the first monthly annuity payment has been issued, after the effective date of a member's participation in the Deferred Retirement Option Plan, or after the payment of a death benefit. The cost [~~A fee for deposits~~] for unreported service or compensation shall be as provided in §25.43 of this title (relating to Cost [~~Fee on Deposits~~] for Unreported Service or Compensation) [~~will be assessed when applicable on the amount of such unreported service or compensation~~].

§25.47. Deadline for Verification.

(a) For unreported service or unreported compensation paid after August 31, 2011, TRS must receive the required verification not later than five years after the end of the school year in which the service was rendered or compensation was paid in order for it to be creditable with TRS.

(b) For unreported service rendered or unreported compensation paid before September 1, 2011, TRS must receive the required verification not later than August 31, 2016, in order for it to be creditable with TRS.

(c) The person seeking credit must obtain the required verification from the employer and submit it to TRS before the applicable deadline.

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 June 22, 2011.

TRD-201102349
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER G. PURCHASE OF CREDIT FOR OUT-OF-STATE SERVICE

34 TAC §25.82

The Teacher Retirement System of Texas (TRS) proposes amendments to §25.82, concerning the purchase of credit for out-of-state service, in Chapter 25, Subchapter G of TRS' rules. Chapter 25 concerns membership credit, and Subchapter G establishes policies for eligible members to purchase up to 15 years of out-of-state service credit in the system. TRS proposes necessary and appropriate amendments to §25.82 to implement Senate Bill 1668 (82nd Legislature, Regular Session, 2011) (SB 1668). That legislation, which takes effect September 1, 2011, amends or repeals certain provisions in §823.401 of the Government Code as well as an uncodified session law enacted in 2005, §57, Chapter 1359 (SB 1691), Acts of the 79th Legislature, Regular Session, relating to eligibility for, and computation of cost of, out-of-state service credit.

Section 25.82 concerns the cost and eligibility to purchase out-of-state service credit. SB 1668 amends §823.401(c) of the Government Code to require that a member must complete at least one year of TRS service credit after completing the necessary out-of-state service. In addition, under SB 1668, certain TRS members with certain out-of-state service will no longer be grandfathered under prior law that allowed them to continue to purchase credit for such service by paying a flat 12% rate based on their first full year of out-of-state service to establish such service. Rather, those formerly grandfathered members now must pay the actuarial cost of their out-of-state service to establish credit for it. SB 1668, however, provides a two-year transition period for those formerly grandfathered members who are eligible to establish their out-of-state service credit at the old flat rate instead of paying actuarial cost. TRS proposes amending §25.82 to reflect the statutory amendments by eliminating the grandfathered cost provisions and adding the transition period provisions.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §25.82 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rule. Any fiscal impact results from the enacted legislation.

For each year of the first five years that the proposed amended rule will be in effect, Ronnie Jung, TRS Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1668 concerning the eligibility, establishment and computation of out-of-state service credit.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amended rule will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed rule. Any economic cost results from the enacted legislation. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposed rule, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §825.102 of the Government Code, which authorizes the board to adopt rules for eligibility for membership, the administration of the funds of the system and the transaction of business of the board; §823.401(d), which authorizes the board to adopt rates and tables to establish actuarial cost; and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendments affect §823.401 of the Government Code and Act of May 20, 2011, 82nd Leg., R.S., S.B. 1668, §§3, 7, 8, eff. Sept. 1, 2011.

§25.82. Cost.

(a) Except as provided by subsections (g) and (h) of this section, the cost of establishing out-of-state service credit is the actuarial cost, as determined by TRS, of the additional standard annuity retirement benefits that would be attributable to the out-of-state service credit purchased under this section.

~~[(a) For a person who was a member of TRS on December 31, 2005, and whose out-of-state service was performed before January 1, 2006, including service in the 2005-2006 school year that began before January 1, 2006, but continued after that date, the cost of establishing out-of-state service credit is 12% per year of the full annual salary rate for the first year of service in Texas which is both after the out-of-state service and after September 1, 1956. Annual salary is limited to $8,400 for years prior to September 1, 1969, and $25,000 for years after September 1969 but before September 1, 1979. For years starting on or after September 1, 1979, TRS will apply any relevant creditable compensation limitations to determine the full salary rate. Cost will not be based on years granted for substitute service. In addition a crediting fee of 8.0% compounded annually of the amount of deposits due and paid shall be charged from the end of the school year in which the member was first eligible to purchase credit for such service until payment for the credit is received.]~~

~~[(b) For a person who does not meet the eligibility requirements of subsection (a) of this section, the cost of establishing out-of-state service credit is the actuarial cost, as determined by TRS, of the~~

~~additional standard annuity retirement benefits that would be attributable to the out-of-state service credit purchased under this section.~~]

(b) [~~(c)~~] To calculate the actuarial cost, TRS will use the cost factors and method described in §25.302 of this title (relating to Calculation of Actuarial Cost).

(c) [~~(d)~~] The purchase cost described in this section assumes a lump-sum deposit will be made. If deposits are made under an installment agreement, a non-refundable installment fee of 9% applies.

(d) [~~(e)~~] No credit will be applied to the cost of a year of out-of-state service credit for any TRS contributions made in the same school year.

(e) [~~(f)~~] The date of first eligibility to purchase credit for any year of out-of-state service shall be the latest of the following dates:

(1) the date the member received 5 years' credit for service in the public schools of Texas;

(2) the date state law made the out-of-state service available for TRS service credit;

(3) the date in which the member qualified to deposit payment for each year of out-of-state service under the one for two rule in effect until March 20, 1975;

(4) the date the member completed one year of creditable service in the public schools of Texas after relevant out-of-state service.

(f) [~~(g)~~] No deposits for out-of-state service credit may be made before the member accumulates 5 years of credit for service in the public schools of Texas.

(g) A member may establish out-of-state service credit by paying the deposits and fees required in subsection (h) of this section if the member meets all applicable requirements to purchase out-of-state service credit and if:

(1) the person was a member of TRS on December 31, 2005;

(2) the out-of-state service was performed before January 1, 2006, including service in the 2005-2006 school year that began before January 1, 2006; and

(3) the member makes payment for the out-of-state service credit, or enters into an installment agreement for payment, not later than August 31, 2013.

(h) The cost of establishing out-of-state service credit under subsection (g) of this section is 12% per year of the full annual salary rate for the first year of service in Texas which is both after the out-of-state service and after September 1, 1956. Annual salary is limited to $8,400 for years prior to September 1, 1969, and $25,000 for years after September 1969 but before September 1, 1979. For years starting on or after September 1, 1979, TRS will apply any relevant creditable compensation limitations to determine the full salary rate. Cost will not be based on years granted for substitute service. In addition a crediting fee of 8.0% compounded annually of the amount of deposits due and paid shall be charged from the end of the school year in which the member was first eligible to purchase credit for such service until payment for the credit is received.

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 June 22, 2011.

TRD-201102350

Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER J. CREDITABLE TIME AND SCHOOL YEAR

34 TAC §25.135

The Teacher Retirement System of Texas (TRS) proposes new §25.135, concerning service credit missing from a member's annual statement. Chapter 25 concerns membership credit, and Subchapter J addresses how membership service may be credited with TRS. As necessary and appropriate, TRS proposes new §25.135 to implement Senate Bill (SB) 1667, 82nd Legislature, Regular Session, 2011, which takes effect September 1, 2011.

SB 1667, §7 amends Government Code §823.002 to require a member to notify TRS in writing of membership service that has not been properly credited by TRS on the member's annual statement. The member must notify TRS of the service in writing on or before the last day of the fifth school year after the end of the school year in which the service was rendered in order for the service to be creditable. Under SB 1667, §25, a member who seeks credit for service rendered before September 1, 2011, but not credited to a member's annual statement must notify TRS not later than the last day of the fifth school year after the end of the school year in which the service was rendered or August 31, 2016, whichever is later. The §25 transition provision ensures that members will have five years to notify TRS of the need for a correction, even if the service was rendered more than five years before the new law takes effect.

New §25.135 is proposed to include the applicable deadlines in the subchapter of TRS rules addressing membership service and the requirements for such service to be creditable with TRS. Subsection (g) of proposed new §25.135 provides that a member must verify the missing service in accordance with applicable laws and rules, including proposed new §25.47, concerning the verification deadline, which is published elsewhere in this issue of the *Texas Register.*

Ken Welch, Chief Financial Officer, estimates that, for each year of the first five years that proposed new §25.135 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed new rule. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed new rule will be in effect, Ronnie Jung, Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1667 concerning the administration of and benefits payable by TRS.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed new rule will be in effect, there is no economic cost to entities or persons required to comply with the proposed new rule. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy because of the proposed new rule, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also deter-

mined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed new rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The new rule is proposed under the following statutes: §825.102 of the Government Code, which authorizes the TRS Board of Trustees to adopt rules for the administration of the funds of the system and the transaction of business of the board; §823.002 of the Government Code, which authorizes the TRS Board of Trustees to determine by rule how much service in a year is equivalent to one year of service credit; and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed new rule affects §§802.106, 823.002 and 825.501 of the Government Code and Act of May 20, 2011, 82nd Leg., R.S., SB 1667, §§7, 25, eff. Sept. 1, 2011.

§25.135. Service Credit Missing from Annual Statement.

(a) If membership service has not been credited by TRS on a member's annual statement, the member must notify TRS in writing of the service that the member requests to be credited.

(b) For service rendered after August 31, 2011, in order for service missing from an annual statement to be creditable, TRS must receive the written notification on or before the last day of the fifth school year after the end of the school year in which the service was rendered.

(c) For service rendered on or before August 31, 2011, in order for service missing from an annual statement to be creditable, TRS must receive the written notification on or before the last day of the fifth school year after the end of the school year in which the service was rendered or August 31, 2016, whichever is later.

(d) The notification deadline is applicable to any membership service that has not been properly credited on a member's annual statement, including service not reported by an employer or service reported but for which TRS did not grant credit to the member.

(e) Failure to receive an annual statement in one or more years, including years in which the person is not a member of TRS, does not extend the notification deadline.

(f) Required deposits deducted and paid to TRS are not refundable to a member if service is not creditable, unless a member terminates membership by withdrawal of all contributions in accordance with applicable law.

(g) After making timely notification to TRS, a member must provide verification and make deposits as required by TRS before service may be credited. Verification must be made in the form and within the time period specified by applicable laws and rules, including §25.47 of this title (relating to Deadline for Verification). Service shall be creditable only if TRS determines that the verified service is sufficient to establish the credit being sought.

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

Filed with the Office of the Secretary of State on June 22, 2011.

TRD-201102351
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER K. DEVELOPMENTAL LEAVE

34 TAC §25.151, §25.152

The Teacher Retirement System of Texas (TRS) proposes amendments to §25.151 and §25.152, concerning developmental leave. Chapter 25 concerns membership credit, and Subchapter K establishes processes for an eligible member to obtain up to two years of developmental leave service credit. TRS proposes necessary and appropriate amendments to §25.151 and §25.152 to implement Senate Bill 1668, 82nd Legislature, Regular Session, 2011 (SB 1668), which takes effect September 1, 2011.

Section 25.151 concerns developmental leave, its eligibility and cost. TRS proposes amending §25.151 to reflect changes to eligibility for and cost of purchasing developmental service credit enacted by SB 1668. Under SB 1668, the cost is the actuarial cost of the additional benefit resulting from the purchase of the service credit; therefore, the description of the old cost method is deleted. Additionally, the proposed amendments simplify the purchasing process by permitting the employee, rather than the employer, to transmit the employer's certification form to TRS and by no longer requiring that the employer certify that the leave was actually completed. The proposed amendments add the requirement that the developmental leave must cover at least 90 days during a school year to reflect the new standard for the amount of service required for credit, as established by recent amendments to §25.131 of TRS rules. TRS also proposes renaming the section "Application for Developmental Leave" to reflect the reorganization of the content of §25.151 and §25.152.

Section 25.152 concerns application and payment for developmental leave credit. TRS proposes amending §25.152 by revising the cost of developmental leave to actuarial cost as required by SB 1668 and by including the two-year transition period for eligible members to purchase developmental leave at the old cost. TRS also proposes renaming the section "Eligibility, Cost, and Payment for Developmental Leave Credit" to reflect the reorganization of the content of §25.151 and §25.152.

Ken Welch, Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §25.151 and §25.152 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rules. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed amended rules will be in effect, Ronnie Jung, Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1668 concerning developmental leave service credit, to simplify the process for establishing de-

velopmental leave, and to update these sections to reflect other recent rule amendments.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the rule will be in effect, there is no economic cost to entities or persons required to comply with the proposed rules. Any economic cost results from the enacted legislation. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy because of the proposed rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §825.102 of the Government Code, which authorizes the TRS board of trustees to adopt rules for the administration of the funds of the retirement system and for the transaction of the business of the board, and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendment affects §823.402 of the Government Code, as amended by Act of May 20, 2011, 82nd Leg., R.S., SB 1668, §4, eff. Sept. 1, 2011.

§25.151. Application for Developmental Leave[, ~~Eligibility, Cost~~].

(a) An eligible [~~A~~] member with five years of membership service before the developmental leave occurs may receive retirement service credit for up to two years of developmental leave if the leave was [~~has been~~] approved as developmental leave in advance by the member's employer and notice of intent to take the leave was [~~has been~~] filed with the retirement system on or before the date a member began [~~begins~~] the leave.

(b) (No change.)

(c) Application for developmental leave credit must be made on or before the leave begins on a form available from the Teacher Retirement System of Texas entitled "Notice of Intent to Take Developmental Leave." [~~Credit granted for developmental leave may not exceed two school years.~~]

(d) A member desiring developmental leave credit must submit the completed application form, including certification by the member's employer, to the Teacher Retirement System of Texas on or before the date the leave begins. The member must sign a statement on the form that he or she intends to take developmental leave for which credit is desired and must indicate the beginning and ending dates of the leave that has been granted. To be creditable, developmental leave must cover at least 90 days during a school year determined in accordance with the method set forth in §25.131 of this title (relating to Required Service) and in TRS policies implementing that section. After completing the form, the member must submit it to his or her employer for certification. [~~To obtain service credit for each year of developmental leave, the member must deposit an amount equal to the current member and state contributions based on the member's annual compensation rate during the last school year of creditable service which preceded the developmental leave. Persons making deposits for developmental leave credit must be employed in the public schools of Texas at the time of the deposit. A member must make the deposits for developmental leave credit, whether by lump sum or installment payments, by the end of the first creditable school year of service after taking developmental leave. A member who does not make deposits by the end of that year loses eligibility for purchasing credit for any preceding developmental leave.~~]

(e) The employer must certify in the space provided on the application form that the leave satisfies the statutory requirements for developmental leave.

(f) The completed and certified form must be received by the Teacher Retirement System of Texas not later than the date the member's developmental leave begins. The Teacher Retirement System of Texas will acknowledge receipt of the form.

(g) To obtain service credit for the leave after it has been completed, the member must meet the eligibility requirements and pay the required deposits.

§25.152. Eligibility, Cost, [~~Application~~] and Payment for Developmental Leave Credit.

(a) A cost statement for developmental leave may be obtained from the retirement system on request by an eligible member after completion of the leave.

(b) To be eligible to establish developmental leave credit, a member must:

(1) have at least five years of service credited in the retirement system before the developmental leave occurs;

(2) have, at the time the required deposits for credit are paid, at least one year of membership service credit in the retirement system following the developmental leave; and

(3) have at least five years of service credited in the retirement system at the time the required deposits for the credit are paid.

(c) Credit will be granted to the member upon receipt of the full amount of the required deposits.

(d) Except as provided by subsections (h) and (i) of this section, the cost of establishing developmental service credit is the actuarial cost, as determined by TRS, of the additional standard annuity retirement benefits that would be attributable to the developmental leave service credit purchased under this section.

(e) To calculate the actuarial cost, TRS will use the cost factors and method described in §25.302 of this title (relating to Calculation of Actuarial Cost).

(f) The purchase cost described in this section assumes a lump-sum deposit will be made. If deposits are made under an installment agreement, a non-refundable installment fee of 9% applies.

(g) No credit will be applied to the cost of a year of developmental leave credit for any TRS contributions made in the same school year.

(h) A member may establish developmental leave service credit by paying the deposits and fees required in subsection (i) of this section if:

(1) the member otherwise meets all eligibility requirements under Government Code, §823.402, as amended;

(2) the developmental leave for which credit is sought to be established ended before August 31, 2011; and

(3) the member makes payment for the developmental leave service credit, or enters into an installment agreement for payment, not later than August 31, 2013.

(i) The cost of establishing developmental leave credit under subsection (h) of this section is an amount equal to the current member and state contributions based on the member's annual compensation rate during the last school year of creditable service that preceded the developmental leave.

~~[(a) Application for developmental leave credit must be made on a form available from the Teacher Retirement System of Texas entitled "Notice of Intent to Take Developmental Leave."]~~

~~[(b) A member desiring developmental leave credit should obtain the form in time for it to be completed, certified by the member's employer, and submitted to the Teacher Retirement System of Texas before the leave begins. The member must sign a statement on the form that he or she intends to take developmental leave for which credit is desired and must indicate the beginning and ending dates of the leave which has been granted. After completing the form, the member must submit it to his or her employer for certification.]~~

~~[(c) The employer must certify in the space provided on the form that the leave satisfies the statutory requirements for developmental leave. The employer must submit the form directly to the Teacher Retirement System of Texas. The form will not be accepted directly from the member.]~~

~~[(d) The completed and certified form must be received by the Teacher Retirement System of Texas not later than the date the member's developmental leave begins.]~~

~~[(e) The Teacher Retirement System of Texas will acknowledge receipt of the form. A cost statement for developmental leave may be obtained on request by the member upon his or her return to employment. The cost statement will contain space for certification by the employer granting the leave that the developmental leave as approved was in fact taken.]~~

~~[(f) Credit will be granted to the member if the cost statement, including the employer's certification, and the full amount of the required deposits are submitted by the end of the first school year of creditable service after the member's return to employment.]~~

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 June 22, 2011.

TRD-201102352
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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CHAPTER 27. TERMINATION OF MEMBERSHIP AND REFUNDS

34 TAC §27.3, §27.6

The Teacher Retirement System of Texas (TRS) proposes amendments to §27.3 and §27.6, relating to termination of membership and refunds, in Chapter 27 of TRS' rules. Chapter 27 concerns termination of membership and refunds. TRS proposes necessary and appropriate amendments to §27.3 and §27.6 to implement Senate Bill 1668, 82nd Legislature, Regular Session, 2011 (SB 1668). That legislation, which takes effect September 1, 2011, amends or repeals certain provisions in §823.501 of the Government Code relating to eligibility to reinstate TRS service credit and computation of the cost of reinstatement.

Section 27.3 concerns a false affidavit regarding termination of employment and ineligible refunds. This rule addresses ineligible refunds made when a person is still employed or when a person has a contract to be employed. Prior to enactment of SB 1668, §823.501(e) of the Government Code required that service credit canceled by an unauthorized withdrawal is required to be reinstated. TRS would not pay any benefits, if a person later resumed TRS membership, unless the ineligible refund was first reinstated. SB 1668 repealed §823.501(e). TRS proposes amending §27.3 to reflect the statutory amendments by deleting provisions relating to mandatory reinstatement of ineligible refunds.

Section 27.6 concerns the reinstatement of an account. This rule addresses the eligibility requirements to reinstate service credit that was cancelled by a termination of membership and the cost of reinstatement. TRS proposes amending §27.6 to reflect the statutory amendments by requiring a reinstatement fee of 8%, instead of 6%. SB 1668 amended applicable law to require an 8% fee from the date of withdrawal to the date of deposit. Additionally, SB 1668 provides for a two-year transition period during which eligible members may pay the old cost to reinstate eligible withdrawn service credit. TRS proposes amending §27.6 to reflect the transition period and to describe when service credit may be reinstated at the old 6% cost.

Ken Welch, Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §27.3 and §27.6 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rules. Any fiscal impact results from the enacted legislation.

For each year of the first five years that the proposed amended rules will be in effect, Ronnie Jung, Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1668 concerning the eligibility, establishment and computation of withdrawn service credit.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the rule will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed rules. Any economic cost results from the enacted legislation. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposed rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at

the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §825.102 of the Government Code, which authorizes the board to adopt rules for eligibility for membership, the administration of the funds of the system and the transaction of business of the board and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendments affect §823.501 of the Government Code, as amended by Act of May 20, 2011, 82nd Leg., R.S., SB 1668, §§5, 7, eff. Sept. 1, 2011, and Chapter 822, Subchapter A of the Government Code.

§27.3. False Affidavit and Ineligible Refunds.

A member who makes affidavit that he or she has permanently terminated employment with any TRS-covered employer but who is so employed or who contracts for such employment before TRS mails the refund shall not be entitled to the refund. [~~If the refund is made because the retirement system is not aware of the continued employment, necessary steps will be taken to secure the redeposit of the withdrawn account. No benefits will be paid until this withdrawn account is returned to the retirement system. If an ineligible refund is not returned before August 31 of the plan year in which the withdrawal occurred, a reinstatement fee as described in §27.6 of this title (relating to Reinstatement of an Account) shall apply.~~]

§27.6. Reinstatement of an Account.

(a) Any member who has withdrawn an account resulting in the cancellation of service credit may reinstate this account and receive credit for the canceled service by meeting the following requirements:

(1) resume membership service in the retirement system or establish eligibility under Government Code, Chapter 803 or 805;

(2) redeposit the amount withdrawn for the years during which the membership was terminated;

(3) except as provided by subsections (b) and (c) of this section, pay a reinstatement fee of 8.0% [~~6.0%~~] compounded annually in whole year increments from August 31st of the plan year in which the withdrawal occurred to the date of redeposit;

(4) reinstate all withdrawn accounts which resulted in the cancellation of service credit. A withdrawn account representing less than a creditable year of service must be reinstated only when it is necessary to combine the canceled service in the account with all other canceled service or with other eligible membership service or equivalent membership service performed in the same year to constitute a creditable year of service.

(b) A member may establish withdrawn service credit by paying the deposits and fees required in subsection (c) of this section if:

(1) the member otherwise meets all eligibility requirements under Government Code, §823.501, as amended;

(2) all of the service for which credit is sought to be established was rendered before September 1, 2011, and TRS received an application to withdraw the credit on or before August 31, 2011; and

(3) the member makes payment for the withdrawn service credit, or enters into an installment agreement for payment, not later than August 31, 2013.

(c) To reinstate withdrawn service credit under subsection (b) of this section, the member shall redeposit the amount withdrawn for the years during which the membership was terminated and shall pay a reinstatement fee of 6% compounded annually in whole year increments from August 31 of the plan year in which the withdrawal occurred to the date of redeposit.

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 June 22, 2011.

TRD-201102353
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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CHAPTER 29. BENEFITS
SUBCHAPTER A. RETIREMENT

34 TAC §29.1

The Teacher Retirement System of Texas (TRS or system) proposes necessary and appropriate amendments to §29.1 in Chapter 29 of TRS' rules concerning service retirement eligibility. TRS proposes amending the rule to implement Senate Bill 1667, 82nd Legislature, Regular Session, 2011. Section 12 of SB 1667, which takes effect September 1, 2011, corrects references in §824.202 of the Government Code relating to the applicability of certain eligibility conditions based on when a person first became a member of TRS. Section 824.202 establishes certain conditions under which a member is eligible to retire and receive a standard service retirement annuity based on when the person became a TRS member. The statute also provides when a member may retire and receive a reduced service retirement annuity based on age at retirement and start of membership. SB 1667 amends §824.202 to clarify that certain eligibility conditions apply only to a TRS member who becomes a member on or after September 1, 2007, rather than on or after September 1, 2006. The proposed rule reflects amended §824.202.

TRS proposes deleting the last phrase in subsection (a) of §29.1 concerning references to September 1, 2006 in subsections (a-1) and (b-1) of §824.202. In 2005, §824.202 was amended to change the retirement eligibility requirements for new members joining TRS after a specific date. The bill enacting the provision--Senate Bill 1691, 79th Legislature, Regular Session (2005)--alternately stated the triggering membership date as "September 1, 2006" or as "September 1, 2007." Based on the context of the statutory provisions in the overall retirement plan terms of the system, TRS construed the legislatively intended date to be September 1, 2007. Consequently, TRS adopted §29.1 in 2008 in part to clarify that the new service retirement eligibility requirements applied to persons who became TRS members on or after September 1, 2007. The more recent statutory amendments to §824.202 affirm that interpretation. Accordingly, the "notwithstanding" language in §29.1(a) in reference to "September 1, 2006" as the trigger date is no longer needed.

Ken Welch, Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §29.1

will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of enforcing or administering the proposed rule.

For each year of the first five years that the proposed amended rule will be in effect, Ronnie Jung, Executive Director, has determined that the public benefit will be to clarify and streamline the rule by deleting an obsolete reference to superseded legislation.

Mr. Jung and Mr. Welch have determined that there will be no foreseeable economic cost to entities or persons required to comply with the proposed rule. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposed rule, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rule; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendment is proposed under the following statutes: §825.102 of the Government Code, which authorizes the TRS Board of Trustees to adopt rules for the administration of the funds of the system and the transaction of business of the board, and §2001.006 of the Government Code, which authorizes TRS, in preparation for the implementation of legislation that has become law but has not taken effect, to adopt a rule that TRS determines is necessary or appropriate and that TRS would have been authorized to adopt had the legislation been in effect at the time of the action.

Cross-Reference to Statute: The proposed amendment affects §824.202 of the Government Code, as amended by Act of May 20, 2011, 82nd Leg., R.S., SB 1667, §12, eff. Sept. 1, 2011.

§29.1. Eligibility for Service Retirement.

(a) The provisions of subsections (a-1) and (b-1) of §824.202, Texas Government Code, apply only to a person who becomes a member of the retirement system on or after September 1, 2007[~~, notwithstanding the reference to the date of September 1, 2006 stated in those subsections~~].

(b) - (d) (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 June 22, 2011.

TRD-201102354
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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CHAPTER 31. EMPLOYMENT AFTER RETIREMENT

SUBCHAPTER A. GENERAL PROVISIONS

34 TAC §31.1, §31.2

The Teacher Retirement System of Texas (TRS) proposes amendments to §31.1 and §31.2, concerning definitions applicable for certain terms used in Chapter 31 and employers' reporting of employed retirees. Chapter 31 addresses the opportunities and limitations on employment with a TRS-covered employer after retirement and the limitations on the amount of compensation a disability retiree may receive from any source after retirement without forfeiting the disability retirement benefit. In general, a retiree is not entitled to a service or disability retirement benefit for any month in which the retiree is employed by a TRS-covered employer or a third-party entity providing personnel to a TRS-covered employer unless the employment meets the requirements for one of the exceptions provided by law to this general rule. Chapter 31 provides TRS-covered employers and retirees with more detailed information and instructions on these exceptions to the general rule than provided in the law. In addition, Chapter 31 establishes the circumstances under which a TRS-covered employer must pay a surcharge to the pension plan for hiring a retiree to work in a TRS-covered position. Subchapter A of Chapter 31 addresses the general provisions governing employment after retirement. TRS proposes amendments to §31.1 to enhance administrative efficiency for TRS and changes to §31.2 to implement Senate Bill (SB) 1669, which took effect immediately on June 17, 2011.

Section 31.1 provides definitions to certain terms applicable to Chapter 31. Section 31.2 concerns the requirements of the monthly certified statement. TRS proposes amending §31.1(b) regarding the definition of a substitute by deleting the requirement that the pay for a substitute may not exceed the rate for substitute work established by the employer. Experience in administering the exception to return to work for substitutes indicates that the compensation paid to a substitute has not been a factor in properly identifying a retiree as a substitute and creates an unnecessary administrative burden for TRS. TRS proposed amending §31.2 by deleting or updating references to certain exceptions that were affected by SB 1669.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §31.1 and §31.2 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rules. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed amended rules will be in effect, Ronnie Jung, TRS Executive Director, has determined that the public benefit will be to provide guidance in administering Chapter 31 and the provisions of SB 1669 concerning employment after retirement.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amended rules will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed amended rules. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposed amended rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse

economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: Government Code, §824.601, which authorizes the board to adopt rules necessary for administering laws in Government Code, Chapter 824, Subchapter G, concerning loss of benefits on resumption of service, including §824.601 and §824.6022; and Government Code, §825.102, which authorizes the board to adopt rules for the administration of the funds of the retirement system.

Cross-reference to Statute: Government Code, §825.4092, which provides for a pension surcharge for re-employed retirees; Government Code, §824.601, which provides for loss of annuity by any service or disability retiree who works for a TRS-covered employer unless such employment is exempted by law from forfeiture of annuity; Government Code, §824.602, which sets forth the exceptions to the loss of monthly annuities of retirees employed in Texas public educational institutions; Government Code, §824.6022, which requires employers to file a monthly certified statement of employment of retirees and makes it an offense for an administrator who is responsible for filing such a statement to knowingly fail to do so; and Insurance Code, §1575.204, which provides for a retiree health benefit (TRS-Care) surcharge for re-employed retirees.

§31.1. Definitions.

(a) (No change.)

(b) Substitute--For purposes of employment after retirement, a person who serves on a temporary basis in the place of a current employee [~~and the pay does not exceed the rate of pay for substitute work established by the employer~~]. Service as a substitute that does not meet this definition is not eligible substitute service for purposes of an exception to forfeiture of annuity payments under §31.13 of this chapter (relating to Substitute Service) [~~title~~].

(c) (No change.)

§31.2. Monthly Certified Statement.

(a) For purposes of administering Government Code, §824.601, a reporting entity shall furnish Teacher Retirement System of Texas (TRS) a monthly certified statement of all employment of TRS service or disability retirees. Effective June 20, 2003, the certified statement must include information regarding employees of third party entities if the employees are service or disability retirees who were first employed by the third party entity on or after May 24, 2003 and are performing duties or providing services on behalf of or for the benefit of the reporting entity. The statement shall contain information required by TRS to administer applicable limitations and necessary for the executive director or his designee to classify employment as one of the following:

(1) substitute service;

(2) employment that is not more than one-half time;

[~~(3) employment under the six month exception;~~]

[~~(4) employment under the acute shortage area exception;~~]

[~~(5) employment under the principal or assistant principal exception;~~]

[~~(6) employment under the bus driver exception;~~]

[~~(7) employment under the faculty member of a professional nursing program exception;~~]

(3) [~~(8)~~] full-time employment;

(4) [~~(9)~~] trial employment of disability retiree for three months; or

(5) [~~(10)~~] employment of a service retiree who retired before January 1, 2011 [~~2001~~].

(b) (No change.)

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

Filed with the Office of the Secretary of State on June 23, 2011.

TRD-201102364
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER B. EMPLOYMENT AFTER SERVICE RETIREMENT

The Teacher Retirement System of Texas (TRS) proposes amendments to §§31.11 - 31.15; and repeal of §§31.16 - 31.19, concerning employment after service retirement. Chapter 31 addresses the opportunities and limitations on employment with a TRS-covered employer after retirement and the limitations on the amount of compensation a disability retiree may receive from any source after retirement without forfeiting the disability retirement benefit. In general, a retiree is not entitled to a service or disability retirement benefit for any month in which the retiree is employed by a TRS-covered employer or a third party entity providing personnel to a TRS-covered employer unless the employment meets the requirements for one of the exceptions provided by law to this general rule. Chapter 31 provides TRS-covered employers and retirees with more detailed information and instructions on these exceptions to the general rule than provided in the law. In addition, Chapter 31 establishes the circumstances under which a TRS-covered employer must pay a surcharge to the pension plan for hiring a retiree to work in a TRS-covered position. Subchapter B of Chapter 31 addresses employment after service retirement. TRS proposes amendments to §§31.11 - 31.15; and repeal of §§31.16 - 31.19 to implement Senate Bill (SB) 1669, which took effect immediately on June 17, 2011 and changes to the definition of a substitute to promote administrative efficiency. Additionally, TRS proposes amendments to §31.14 to establish a new standard for half-time employment after retirement.

Section 31.11 concerns employment resulting in forfeiture of service retirement annuity. TRS proposes amending §31.11 by making a revision enacted in SB 1669. Under SB 1669, a person who retired before January 1, 2011 and who is receiving a service retirement annuity may be employed in any capacity in Texas public education without forfeiture of benefits for the

months of employment. Under previous law, this opportunity was available to service retirees who retired before January 1, 2001. The proposed revisions update the rule to reflect the new date.

Section 31.12 concerns exceptions to the general rule of forfeiture of service retirement annuity for employment after retirement. The proposed amendments describe the general rule of forfeiture for retirees who retire after January 1, 2011, and list the exceptions to the general rule available for these retirees. TRS proposes amending §31.12 to reflect the repeal of certain exceptions under SB 1669 and to reflect the January 1, 2011 date set forth in SB 1669 (replacing the date of January 1, 2001).

Section 31.13 concerns the substitute service exception to the general rule of forfeiture of service retirement annuity for employment after retirement. The rule describes the exception for retirees serving as substitutes. TRS proposes amending §31.13 by deleting the requirement regarding the amount of pay allowed for a substitute and by deleting a reference to the "six month" exception, which was repealed by SB 1669, and replacing it with a reference to the new full-time exception established by SB 1669. The proposed amendments also delete references to other exceptions repealed by SB 1669, specifically the acute shortage exception, the principal and assistant principal exception, and the nurse faculty exception.

Section 31.14 concerns the exception for one-half time employment. TRS proposes amending §31.14 by deleting references to other exceptions repealed by SB 1669. Also, TRS proposes to amend this section by establishing a new standard for one-half time employment for service retirees. The proposed amendments define one-half time as working the equivalent of 4 clock hours for each work day in that calendar month. This would replace the existing half-time standard that is based on the full-time load for that job and establishes a uniform standard for all retirees in order to simplify the administration of this exception for employees, employers, and TRS.

Section 31.15 concerns the six-month exception. TRS proposes amending §31.15 by deleting references to the "six month" exception, which was repealed by SB 1669. The title of the section is proposed to be amended to reflect the repeal of the six month exception. Under SB 1669, a new full-time exception was established. It permits a service retiree to work without forfeiture of annuities on up to a full-time basis after the retiree has had a break in service of 12 full consecutive months after the date of retirement. The proposed amendments implement the new full-time exception.

Section 31.16 concerns the acute shortage area exception. TRS proposes repealing §31.16 because SB 1669 repealed this exception.

Section 31.17 concerns the principal or assistant principal exception. TRS proposes repealing §31.17 because SB 1669 repealed this exception.

Section 31.18 concerns the bus driver exception. TRS proposes repealing §31.18 because SB 1669 repealed this exception.

Section 31.19 concerns the exception for faculty members of professional nursing programs. TRS proposes repealing §31.19 because SB 1669 repealed this exception.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §§31.11 - 31.15 and repeal of §§31.16 - 31.19 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposal. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed amendments and repeal will be in effect, Ronnie Jung, TRS Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1669 concerning employment after retirement for service retirees and to simplify the administration of the substitute and half-time exceptions for service retirees, their employers, and TRS.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amendments and repeal will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposal. Any economic cost results from the enacted legislation. Mr. Jung and Mr. Welch have determined that there will be no effect on a local economy because of the proposal, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amendments and repeal; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

34 TAC §§31.11 - 31.15

Statutory Authority: The amendments are proposed under §824.601(f) of the Government Code, which authorizes TRS to adopt rules necessary for administering Chapter 824, Subchapter G, of the Government Code concerning loss of benefits on resumption of service, and §825.102 of the Government Code, which authorizes the board to adopt rules for eligibility for membership, the administration of the funds of the system, and the transaction of business of the board.

Cross-Reference to Statute: The proposed amendments affect Chapter 824, Subchapter G, of the Government Code, concerning loss of benefits on resumption of service.

§31.11. Employment Resulting in Forfeiture of Service Retirement Annuity.

(a) A person who retired prior to January 1, 2011 [~~2001~~], and who is receiving a service retirement annuity may be employed in any capacity in Texas public education without forfeiture of benefits for the months of employment.

(b) A person who retired after January 1, 2011 [~~2001~~], and who is receiving a service retirement annuity, is not entitled to an annuity payment for any month in which the retiree is employed by a Texas public educational institution, unless the employment meets the requirements for an exception to forfeiture of payments under this chapter. Effective June 20, 2003 and for purposes of this chapter, employment by a third party entity is considered employment by a Texas public educational institution unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

(c) - (d) (No change.)

§31.12. Exceptions to Forfeiture of Service Retirement Annuity.

A person who is receiving a service retirement annuity who retired after January 1, 2011 [2001], forfeits the annuity for any month in which the retiree is employed by a public educational institution covered by TRS, except in the cases set forth in §31.13 of this chapter (relating to Substitute Service [Employment]), §31.14 of this chapter (relating to One-half Time Employment), and §31.15 of this chapter (relating to Full-time Employment after 12-Consecutive-Month Break in Service) [Six Month Exception), §31.16 of this chapter (relating to the Acute Shortage Area Exception), §31.17 of this chapter (relating to the Principal/Assistant Principal Exception), §31.18 of this chapter (relating to the Bus Driver Exception), and §31.19 of this chapter (relating to the Faculty Member of a Professional Nursing Program Exception)]. Effective June 20, 2003, employment by a third party entity is considered employment by a Texas public educational institution unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

§31.13. Substitute Service.

(a) Any person receiving a service retirement annuity who retired after January 1, 2011 [2001], may work in a month as a substitute in a public educational institution without forfeiting the annuity payment for that month[, provided the pay for work as a substitute does not exceed the daily rate of substitute pay established by the employer].

(b) (No change.)

(c) A person working under the [The] exception described in this section is not separated from service with all Texas public educational institutions for the purpose of the required 12 full consecutive month break [is not available to retirees who have elected the exception] described in §31.15 of this chapter (relating to Full-time Employment after 12-Consecutive-Month Break in Service [Six-Month Exception]).

(d) The exception described in this section and the exception for one-half time employment described in §31.14 of this chapter (relating to One-half Time Employment) may be used during the same school year. If the substitute service and the one-half time employment occur in the same calendar month, the total amount of time that the retiree works in both positions may not exceed the amount of time available that month for work on a one-half time basis. Beginning September 1, 2011 and thereafter, the exception for substitute service under this section and the exception for one-half time employment under §31.14 of this chapter may be used during the same calendar month without forfeiting the annuity only if the total number of days that the retiree works in those positions in that month does not exceed one-half the number of days available for that month for work [on a one-half time basis].

[(e) In addition to the service described in subsection (d) of this section, substitute service under this exception may be combined in the same school year with work under the following exceptions without loss of annuity provided the requirements for work under each exception are met:]

[(1) acute shortage area as described in §31.16 of this chapter (relating to Acute Shortage Area Exception);]

[(2) principal or assistant principal as described in §31.17 of this chapter (relating to Principal or Assistant Principal Exception); and]

[(3) faculty member of a professional nursing program as described in §31.19 of this chapter (relating to Faculty Member of Professional Nursing Program Exception).]

(e) [(f)] The exception described in this section does not apply for the first month after the person's effective date of retirement (or the first two months if the person's retirement date has been set on May 31 under §29.14 of this title (relating to Eligibility for Retirement at the End of May).

(f) [(g)] A retiree who reports for duty as a daily substitute during any day and works any portion of that day shall be considered to have worked one day.

§31.14. One-half Time Employment.

(a) A person who is receiving a service retirement annuity may be employed on a one-half time basis without forfeiting annuity payments for the months of employment. In this section, one-half time basis means the equivalent of 4 clock hours for each work day in that calendar month. The total number of hours allowed for that month may be worked in any arrangement or schedule.

(b) Employment by a third party entity is considered employment by a Texas public educational institution unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

(c) [(b)] [Except as provided in subsection (e) of this section, one-half time employment measured in clock hours shall not in any month exceed one-half of the time required for a similar full time position in a calendar month or 92 clock hours, whichever is less.] Paid time-off, including sick leave, vacation leave, administrative leave, and compensatory time for overtime worked, is employment for purposes of this section and must be included in the determining the total amount of time worked in a calendar month and reported to TRS as employment for the calendar month in which it is taken. [reduces the number of hours available to work in the calendar month in which it is taken. Because the time required for a full time position may vary from month to month, determination of one-half time will be made on a calendar month basis. If an employer is scheduled to be closed for business during all or part of a calendar month, the amount of time available for one-half time employment is reduced by the number of business days the employer is closed.]

(d) For the purpose of this section, actual [Actual] course instruction in state-supported colleges (including junior colleges), and universities that is measured in course or semester hours[, and public schools] shall be counted as a minimum of two clock hours per one course or semester hour in order to reflect instructional time as well as preparation and other time typically associated with one course hour of instruction. If the employer has established a greater amount of preparation time for each course or semester hour, the employer's established standard will be used to determine the number of course or semester hours a retiree may teach under the exception to loss of annuity provided by this section. [not exceed during any calendar month one-half the normal load for full-time employment at the same teaching level.]

[(c) For bus drivers, "one-half time" employment shall in no case exceed 12 days in any calendar month, unless the retiree qualifies for the bus driver exception in §31.18 of this chapter (relating to Bus Driver Exception). Work by a bus driver for any part of a day shall count as a full day for purposes of this section.]

(e) [(d)] This [exception and the exception for substitute service may be used during the same school year provided the substitute service and one-half time employment do not occur in the same month. Effective September 1, 2003, this] exception and the exception for substitute service may be used during the same calendar month without forfeiting the annuity only if the total amount of time that the retiree works in those positions in that month does not exceed the amount of time per month for work on a one-half time basis. Beginning September 1, 2011 and thereafter, the exception for one-half time employment under this section and the exception for substitute service under §31.13

of this chapter (relating to Substitute Service) may be used during the same calendar month without forfeiting the annuity only if the total number of days that the retiree works in those positions in that month does not exceed one-half the number of days available for that month for work [~~on a one-half time basis~~].

(f) A person working under the exception described in this section is not separated from service with all Texas public educational institutions for the purpose of the required 12 full consecutive month break described in §31.15 of this chapter (relating to Full-time Employment after 12-Consecutive-Month Break in Service).

~~[(e) Paid time off, including sick leave, vacation leave, and compensatory time for overtime worked, is employment for purposes of this section and must be included in determining the total amount of time available to work in a calendar month and reported to TRS as employment for the calendar month in which it is taken.]~~

§31.15. Full-time Employment after 12 Consecutive Month Break in Service [~~Six-Month Exception~~].

(a) If a person who retired after January 1, 2011, and who is receiving a service retirement annuity complies with subsection (b) of this section, the [~~Any~~] person [~~receiving a service retirement annuity, who retired after January 1, 2001,~~] may, without forfeiting payment of the annuity for the months of employment, be employed in any capacity in Texas public education, including [~~on~~] as much as full time [~~for no more than six months in a school year if the work meets the requirements in subsection (b) of this section and the person complies with the requirements of subsection (c) of this section. Employment by a third party entity is considered employment by a Texas public educational institution unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003~~].

(b) To be eligible to be employed without forfeiting payment of the annuity under subsection (a) of this section, the service retiree must have been separated from service with all Texas public educational institutions for at least 12 full consecutive calendar months after the effective date of retirement. The 12 month separation period required under Government Code, §824.602(a)(3) for the full-time exception may be any 12 consecutive calendar months following the month of retirement. During the separation period, the retiree may not be employed in any position or capacity by a public educational institution covered by TRS.

(1) Employment as a substitute or on a half-time basis under the exceptions provided for in this chapter is considered employment for the purpose of this subsection.

(2) Paid time off, including sick leave, vacation leave, administrative leave, and compensatory time for overtime worked, is considered employment for purposes of this subsection.

(3) Employment by a third party entity is considered employment by a Texas public educational institution for purposes of this subsection unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

(c) If a person who retired after January 1, 2011, and who is receiving a service retirement annuity does not meet the separation from service period required in subsection (b) of this section, the person will forfeit payment of the annuity for any month of full-time employment in Texas public education. In this section full-time employment means any employment that does not meet the substitute service exception as described in §31.13 of this chapter (relating to Substitute Service) or the one-half time exception in §31.14 of this chapter (relating to One-half Time Employment).

(1) Paid time off, including sick leave, vacation leave, administrative leave, and compensatory time for overtime worked, is considered employment for purposes of this section and must be reported to TRS as employment for the calendar month in which it is taken.

(2) Employment by a third party entity is considered employment by a Texas public educational institution for purposes of this section and must be reported to TRS as employment for the calendar month in which it occurs unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

~~[(b) The work must occur:]~~

~~[(1) in no more than six months in a school year; and]~~

~~[(2) in a school year that begins after the retiree's effective date of retirement or no earlier than October 1 if the effective date of retirement is August 31. Except in cases set forth in §31.18 of this title (relating to Bus Driver Exception), employment in a full-time position during any month in the school year in which the retiree retired results in the forfeiture of annuity for that month without regard to the number of days worked.]~~

~~[(c) A person who retired after January 1, 2001, and who, during a school year, has already used the exception described in §31.13 of this title (relating to Substitute Service) or §31.14 of this title (relating to One-half Time Employment) is eligible for the exception described in this section during the same school year. However, the permissible substitute service, the employment for work at no more than half time during the same school year, and any combination in the same calendar month of substitute service and one-half time employment must be included in the six months of employment allowed under this section. The six-month exception will be allowed so long as the retiree is eligible and is reported under that exception by the employer. A retiree using the six-month exception must use the first six months of a school year in which any work occurs. In the event the retiree wants to use the six-month exception and has not been reported in that manner, the reporting entity must notify TRS in writing by amending the previous TRS 118, Employment of Retired Member(s), report(s).]~~

~~[(d) Except as provided in subsections (h) and (i) of this section, a person who retired after January 1, 2001, and is using the six-month exception, will forfeit an annuity payment for any month in the school year for work in excess of the six-month period. This applies even if the work would otherwise qualify for an exception under §31.13 of this title for substitute work or for exceptions applicable to one-half time or less employment, employment as a bus driver, employment in an acute shortage area, or employment as a principal or assistant principal.]~~

~~[(e) A retiree may elect to revoke the six-month exception by submitting the election in writing and returning any ineligible payments.]~~

~~[(f) A retiree employed under the six-month exception who, during the same school year, also works as a substitute or one-half time or less may not be employed in or reported under the substitute or one-half time category during the remaining months of the school year.]~~

~~[(g) Paid time off, including sick leave, vacation leave, and compensatory time for overtime worked, is employment for purposes of this section and must be reported to TRS as employment for the calendar month in which it is taken.]~~

~~[(h) A retiree working under the six-month exception does not forfeit the annuity for June for work performed in June if the work the retiree agreed to complete under the contract or work agreement cannot~~

~~be completed by May 31 and the retiree does not work beyond June 15 of that year.]~~

~~[(i) For a retiree working under the six-month exception, time spent attending professional development classes or activities is not considered work for purposes of this section provided the professional or staff development classes or activities are not included in the employee's total number of required days of work under a contract or work agreement.]~~

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 June 23, 2011.

TRD-201102365
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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34 TAC §§31.16 - 31.19

(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 Teacher Retirement System of Texas or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

Statutory Authority: The repeal is proposed under §824.601(f) of the Government Code, which authorizes TRS to adopt rules necessary for administering Chapter 824, Subchapter G, of the Government Code concerning loss of benefits on resumption of service, and §825.102 of the Government Code, which authorizes the board to adopt rules for eligibility for membership, the administration of the funds of the system, and the transaction of business of the board.

Cross-Reference to Statute: The proposed repeal affects Chapter 824, Subchapter G, of the Government Code, concerning loss of benefits on resumption of service.

§31.16. Acute Shortage Area Exception.

§31.17. Principal or Assistant Principal Exception.

§31.18. Bus Driver Exception.

§31.19. Faculty Member of Professional Nursing Program Exception.

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 June 27, 2011.

TRD-201102398
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER C. EMPLOYMENT AFTER DISABILITY RETIREMENT

34 TAC §31.31, §31.32

The Teacher Retirement System of Texas (TRS) proposes amendments to §31.31 and §31.32, concerning employment after disability retirement. Chapter 31 addresses the opportunities and limitations on employment with a TRS-covered employer after retirement and the limitations on the amount of compensation a disability retiree may receive from any source after retirement without forfeiting the disability retirement benefit. In general, a retiree is not entitled to a service or disability retirement benefit for any month in which the retiree is employed by a TRS-covered employer or a third-party entity providing personnel to a TRS-covered employer unless the employment meets the requirements for one of the exceptions provided by law to this general rule. Chapter 31 provides TRS-covered employers and retirees with more detailed information and instructions on these exceptions to the general rule than provided in the law. In addition, Chapter 31 establishes the circumstances under which a TRS-covered employer must pay a surcharge to the pension plan for hiring a retiree to work in a TRS-covered position. Subchapter C of Chapter 31 addresses employment after disability retirement. TRS proposes amendments to §31.31 to implement Senate Bill (SB) 1669, which took effect immediately on June 17, 2011. Additionally, TRS proposes to amend §31.32 by establishing a new standard for one-half time employment for disability retirees. The proposed amendments define one-half time as working the equivalent of 4 clock hours for each work day in that calendar month. This would replace the existing half-time standard that is based on the full-time load for that job and establishes a uniform standard for all retirees in order to simplify the administration of the employment after retirement exceptions for disability retirees, employers, and TRS.

Section 31.31 concerns employment resulting in forfeiture of disability retirement annuity. TRS proposes amending §31.31 by deleting references to service retiree exceptions that were repealed by SB 1669.

Section 31.32 concerns the exception for one-half time employment for up to 90 days. TRS proposes amending §31.32 by defining employment on a one-half time basis as employment that is the equivalent of 4 clock hours for each work day in that calendar month. Employment in excess of this amount of time in the month will result in forfeiture of the disability retirement annuity for that month.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §31.31 and §31.32 will be in effect, there will be no foreseeable fiscal implications to state or local governments as a result of administering the proposed amended rules. Any fiscal impact is a result of the enacted legislation.

For each year of the first five years that the proposed amended rules will be in effect, Ronnie Jung, TRS Executive Director, has determined that the public benefit will be to provide guidance in administering the provisions of SB 1669 concerning employment after disability retirement and to simplify the administration of the one-half time exception for disability retirees, their employers, and TRS.

Mr. Jung and Mr. Welch have determined that, for each year of the first five years that the proposed amended rules will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed amended rules. Any economic cost results from the enacted legislation. Mr. Jung and Mr. Welch have determined that there will be no effect on

a local economy because of the proposed amended rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Jung and Mr. Welch have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the Executive Director at the designated address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §824.601(f) of the Government Code, which authorizes TRS to adopt rules necessary for administering Chapter 824, Subchapter G, of the Government Code concerning loss of benefits on resumption of service, and §825.102 of the Government Code, which authorizes the board to adopt rules for eligibility for membership, the administration of the funds of the system, and the transaction of business of the board.

Cross-Reference to Statute: The proposed amendments affect Chapter 824, Subchapter G, of the Government Code.

§31.31. Employment Resulting in Forfeiture of Disability Retirement Annuity.

(a) (No change.)

(b) A person receiving a disability retirement annuity may not exercise the exception [~~exceptions~~] applicable to service retirees in §31.15 of this chapter (relating to Full-time Employment after 12-Consecutive-Month Break in Service). [~~Six-Month Exception); §31.16 of this chapter (relating to Acute Shortage Area Exception); §31.17 of this chapter (relating to Principal or Assistant Principal Exception); §31.18 of this chapter (relating to Bus Driver Exception); and §31.19 of this chapter (relating to Faculty Member of Professional Nursing Program Exception).~~]

§31.32. Half-time Employment Up to 90 Days.

(a) Any person receiving a disability retirement annuity may, without affecting payment of the annuity, be employed for a period not to exceed 90 days during any school year by a public educational institution covered by TRS on as much as a one-half time basis. In this section, one-half time basis means the equivalent of 4 clock hours for each work day in that calendar month. The total number of hours allowed for that month may be worked in any arrangement or schedule; working any part of a day counts as one day towards the 90 day annual limit established in this section. This exception does not apply for the first month after the retiree's effective date of retirement (or the first two months if the person's retirement date has been set on May 31 under §29.14 of this title (relating to Eligibility for Retirement at the End of May)). [~~one-half the full time load for the particular position according to the personnel policies of the employer.~~]

(b) Employment by a third party entity is considered employment by a Texas public educational institution unless the retiree does not perform duties or provide services on behalf of or for the benefit of the institution or the retiree was first employed by the third party entity before May 24, 2003.

(c) Total substitute service under §31.33 of this chapter (relating to Substitute Service Up to 90 Days) and half-time employment may not exceed 90 days during any school year. Substitute service under §31.33 of this chapter and half-time employment may be combined in the same calendar month only if the total number of days that the disability retiree works in those positions in that month do not exceed one-half the number of days available that month for work [~~on a one-half time basis~~]. Working any part of a day as a substitute or half-time counts as working one day. [~~This exception does not apply for the first month after the retiree's effective date of retirement (or the first two months if the person's retirement date has been set on May 31 under §29.14 of this title (relating to Eligibility for Retirement at the End of May).~~]

(d) Paid time off, including sick leave, vacation leave, administrative leave, and compensatory time for overtime worked, is employment for purposes of this section and must be included in determining the total amount of time worked in a calendar month and reported to TRS as employment for the calendar month in which it is taken.

(e) For the purpose of this section, actual course instruction in state-supported colleges (including junior colleges), and universities that is measured in course or semester hours shall be counted as a minimum of two clock hours per one course or semester hour in order to reflect instructional time as well as preparation and other time typically associated with one course hour of instruction. If the employer has established a greater amount of preparation time for each course or semester hour, the employer's established standard will be used to determine the number of course or semester hours a retiree may teach under the exception to loss of annuity provided by this section.

[~~(b) "One-half time" employment measured in clock hours must never exceed one-half of the time required for the full time position in a calendar month or 92 clock hours, whichever is less, and may not exceed a total of 90 days in a school year. Determination of one-half time will be made on a calendar month basis as the full time load may vary from month to month. Actual course instruction in state-supported colleges (including junior colleges), universities, and public schools shall not exceed during any month one-half the normal load for full-time employment at the same teaching level.~~]

[~~(c) "One-half time" employment for bus drivers shall in no case exceed 12 days in any calendar month. Work by a bus driver for any part of a day shall count as full day for purposes of this section.~~]

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 June 23, 2011.

TRD-201102366
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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CHAPTER 41. HEALTH CARE AND INSURANCE PROGRAMS

SUBCHAPTER A. RETIREE HEALTH CARE BENEFITS (TRS-CARE)

34 TAC §41.2, §41.7

The Teacher Retirement System of Texas (TRS) proposes amendments to §41.2, which concerns additional enrollment

opportunities in TRS-Care, and §41.7, which concerns the effective date of coverage under TRS-Care. TRS proposes changes to §41.2 and to §41.7 to implement changes mandated by the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119 (2010)), which became law on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029 (2010)), which became law on March 30, 2010 (hereinafter referred to jointly as the "PPACA"). TRS-Care will become subject to the PPACA on September 1, 2011. More specifically, under the PPACA, TRS-Care may no longer "opt out" of the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)) ("HIPAA"). The proposed changes to §41.2 and §41.7 reflect that the special enrollment rights under TRS-Care will, beginning on September 1, 2011, be defined by HIPAA, not by TRS-Care itself. The result of these changes is to broaden the rights of individuals who are eligible to enroll in TRS-Care due to a special enrollment event.

Finally, TRS proposes minor wording or formatting changes throughout §41.2 to conform the language of the whole rule to the proposed amendments.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §41.2 and to §41.7 will be in effect, there will be no significant fiscal implications to state or local governments as a result of administering the proposed amended rules.

For each year of the first five years that the proposed amended rules will be in effect, Mr. Welch and Ronnie Jung, TRS Executive Director, have determined that the public benefit will be to increase the special enrollment opportunities available to individuals enrolled or eligible to enroll in TRS-Care.

Mr. Welch and Mr. Jung have determined that, for each year of the first five years that the proposed amended rules will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed amended rules. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy because of the proposed amended rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the executive director at the designated TRS address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §1575.052 of the Insurance Code, which authorizes the TRS Board of Trustees to adopt rules it considers necessary to implement and administer the TRS-Care health benefits program.

Cross-reference to Statute: The proposed amendments affect Chapter 1575, Insurance Code, the PPACA, and HIPAA.

§41.2. Additional Enrollment Opportunities.

(a) (No change.)

(b) Special Enrollment [~~Event~~] Opportunity.

(1) For a special enrollment event that occurs on or after September 1, 2011, an individual who becomes eligible for coverage under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), including a dependent whose coverage under TRS-Care was waived due to the existence of other coverage for the dependent during the Age 65 Additional Enrollment Opportunity described in subsection (a) of this section, may elect to enroll in TRS-Care.

(2) [~~(1)~~] For a special enrollment event that occurs on or before August 31, 2011, except [~~Except~~] as provided in the exceptions found in subparagraphs (A) - (C) of this paragraph, an individual who becomes eligible for coverage under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)), including a dependent whose coverage under TRS-Care was waived due to the existence of other coverage for the dependent during the Age 65 Additional Enrollment Opportunity described in subsection (a) of this section, may elect to enroll in TRS-Care.

(A) In no event may an individual who is already enrolled in TRS-Care elect a different plan, for himself or any eligible dependents, but may only add eligible dependents for coverage under the individual's existing plan selection upon the occurrence of a special enrollment event.

(B) In no event may a TRS retiree enroll in TRS-Care as a result of a special enrollment event applicable to his dependent.

(C) In no event, as a result of a special enrollment event applicable to the dependent, may the dependent of a TRS retiree enroll in TRS-Care if the TRS retiree is not enrolled in TRS-Care.

(3) [~~(2)~~] The enrollment period for an individual who becomes eligible for coverage due to a special enrollment event shall be the 31 calendar days immediately after the date of the special enrollment event. To make an effective election, a completed TRS-Care application must be received by TRS within this 31-day period.

(c) - (d) (No change.)

§41.7. Effective Date of Coverage.

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

(g) The effective date of coverage for a special enrollment event is determined as follows:

(1) For a special enrollment event that occurs on or after September 1, 2011, the effective date of coverage for an eligible individual who is enrolled in TRS-Care as a result of a special enrollment event, as described in §41.2(b) of this chapter (relating to Additional Enrollment Opportunities), is the date specified under the provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)).

(2) [~~(g)~~] For a special enrollment event that occurs on or before August 31, 2011, the [~~The~~] effective date of coverage for an eligible individual [~~dependent~~] who is enrolled under a retiree's or surviving spouse's TRS-Care coverage as a result of a special enrollment event, as described in and limited by §41.2(b) of this chapter [~~title (relating to Additional Enrollment Opportunities)~~], is the date specified under the provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)).

(h) - (n) (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 June 23, 2011.

TRD-201102368
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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SUBCHAPTER C. TEXAS SCHOOL EMPLOYEES GROUP HEALTH (TRS-ACTIVECARE)

34 TAC §§41.34, 41.36, 41.39, 41.50

The Teacher Retirement System of Texas (TRS) proposes amendments to §41.34, which concerns eligibility for coverage under TRS-ActiveCare; §41.36, which concerns the enrollment periods for TRS-ActiveCare; §41.39, which concerns coverage under TRS-ActiveCare for individuals changing employers; and §41.50, which concerns appeals under TRS-ActiveCare relating to claims or other benefits. TRS proposes changes to §§41.34, 41.36, 41.39, and 41.50 to implement changes mandated by the Patient Protection and Affordable Care Act (Pub. L. No. 111-148, 124 Stat. 119 (2010)), which became law on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act of 2010 (Pub. L. No. 111-152, 124 Stat. 1029 (2010)), which became law on March 30, 2010 (hereinafter referred to jointly as the "PPACA"). TRS-ActiveCare will become subject to the PPACA on September 1, 2011. More specifically, with regard to §§41.34, 41.36, and 41.39, under the PPACA, TRS-ActiveCare may no longer "opt out" of the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)) ("HIPAA"). The proposed changes to §§41.34, 41.36, and 41.39 reflect that the special enrollment rights under TRS-ActiveCare will, beginning on September 1, 2011, be defined by HIPAA, not by TRS-ActiveCare itself. The result of these changes is to broaden the rights of individuals who are eligible to enroll in TRS-ActiveCare due to a special enrollment event. In addition, the proposed changes to §41.50 reflect new appeal requirements that are to go into effect for TRS-ActiveCare beginning on September 1, 2011, as mandated by the PPACA. For the first time, TRS-ActiveCare will be required to provide external review for benefit denials and will be required to comply with existing Department of Labor claims rules that heretofore have not applied to non-ERISA plans such as TRS-ActiveCare.

Finally, TRS proposes minor wording or formatting changes in §§41.34, 41.36, 41.39, and 41.50 to conform all of the language of each rule to the proposed amendments.

Ken Welch, TRS Chief Financial Officer, estimates that, for each year of the first five years that the proposed amendments to §§41.34, 41.36, 41.39, and 41.50 will be in effect, there will be no significant fiscal implications to state or local governments as a result of administering the proposed amended rules.

For each year of the first five years that the proposed amended rules will be in effect, Mr. Welch and Ronnie Jung, TRS Executive Director, have determined that the public benefit will be to increase the special enrollment opportunities and appeal rights available to individuals enrolled or eligible to enroll in TRS-ActiveCare.

Mr. Welch and Mr. Jung have determined that, for each year of the first five years that the proposed amended rules will be in effect, there will be no foreseeable economic cost to entities or persons required to comply with the proposed amended rules. Mr. Welch and Mr. Jung have determined that there will be no effect on a local economy because of the proposed amended rules, and therefore no local employment impact statement is required under §2001.022 of the Government Code. Mr. Welch and Mr. Jung have also determined that there will be no direct adverse economic effect on small businesses or micro-businesses within TRS' regulatory authority as a result of the proposed amended rules; therefore, neither an economic impact statement nor a regulatory flexibility analysis is required under §2006.002 of the Government Code.

Comments may be submitted in writing to Ronnie Jung, Executive Director, 1000 Red River Street, Austin, Texas 78701-2698. Written comments must be received by the executive director at the designated TRS address no later than 30 days after publication of this notice in the *Texas Register.*

Statutory Authority: The amendments are proposed under §1579.052 of the Insurance Code, which authorizes the TRS Board of Trustees to adopt rules it considers necessary to implement and administer the TRS-ActiveCare health benefits program.

Cross-reference to Statute: The proposed amendments affect Chapter 1579, Insurance Code, the PPACA, and HIPAA.

§41.34. Eligibility for Coverage under the Texas School Employees Uniform Group Health Coverage Program.

The following persons are eligible to be enrolled in TRS-ActiveCare under terms, conditions and limitations established by the trustee unless expelled from the program under provisions of Chapter 1579, Insurance Code:

(1) A full-time employee as defined in §41.33 of this chapter [~~title~~] (relating to Definitions Applicable to the Texas School Employees Uniform Group Health Coverage Program).

(2) A part-time employee as defined in §41.33 of this chapter [~~title (relating to Definitions Applicable to the Texas School Employees Uniform Group Health Coverage Program)~~].

(3) Dependents, as defined in §41.33 of this chapter [~~title~~] pursuant to §1579.004, Insurance Code. A child defined in §1579.004(3), Insurance Code, who is 25 years of age or older, is eligible for coverage only if, and only for so long as, such child's mental disability or physical incapacity is a medically determinable condition that prevents the child from engaging in self-sustaining employment as determined by TRS.

(4) Individuals employed or formerly employed by a participating entity, and their dependents, who are eligible for, or participating in, continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272), through a group health benefit plan sponsored by the individual's employer on the first day that employer becomes a participating entity if such individuals or their dependents would have met the requirements for eligibility in paragraph [~~paragraphs~~] (1), (2), or (3) of this section on the individual's last day of employment with the participating entity. Notwithstanding the foregoing, the individual is eligible to participate in TRS-ActiveCare only for the duration of the individual's eligibility for COBRA continuation coverage.

(5) An individual who qualifies for coverage pursuant to §41.38(b) of this chapter [~~title~~] (relating to Termination Date of Coverage), and their dependents.

(6) Full-time or part-time employees as defined in §41.33 of this chapter [~~title (relating to Definitions Applicable to the Texas School Employees Uniform Group Health Coverage Program)~~] and their eligible dependents may participate in an approved HMO if they reside, live, or work in the approved service area of the HMO and are otherwise eligible to participate in the HMO under the terms of the TRS contract with the HMO.

(7) Individuals who become eligible as determined by TRS for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. No. 99-272), through their participation in TRS-ActiveCare.

(8) As a result of a special enrollment event that occurs on or after September 1, 2011, individuals who become eligible for coverage under the special enrollment provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996)).

(9) [~~(8)~~] As a result of a special enrollment event that occurs on or before August 31, 2011, individuals [~~Individuals~~] who become eligible for coverage under the special enrollment provisions of TRS-ActiveCare.

(10) [~~(9)~~] Any other individuals who are required to be covered under applicable law.

§41.36. Enrollment Periods for TRS-ActiveCare.

(a) - (c) (No change.)

(d) On or after September 1, 2011, the enrollment period for an individual who becomes eligible for coverage due to a special enrollment event, as described in §41.34(8) of this chapter (relating to Eligibility for Coverage under the Texas School Employees Uniform Group Health Coverage Program), shall be the 31 calendar days immediately after the date of the special enrollment event. To make an effective election, a completed enrollment form must be received by a participating entity or the health plan administrator of TRS-ActiveCare within this 31-day period.

(e) [~~(d)~~] On or before August 31, 2011, the [~~The~~] enrollment period for an individual who becomes eligible for coverage due to a special enrollment provision of TRS-ActiveCare, as described in §41.34(9)[~~(8)~~] of this chapter [~~title (relating to Eligibility for Coverage under the Texas School Employees Uniform Group Health Coverage Program)~~], shall be the 31 calendar days immediately after the date of the special enrollment event. To make an effective election, a completed enrollment form must be received by a participating entity or the health plan administrator of TRS-ActiveCare within this 31-day period.

(f) [~~(e)~~] Eligible full-time and part-time employees and their eligible dependents who are enrolled in an HMO with a TRS contract that is not renewed for the next plan year may make one of the elections provided under this subsection. To make an effective election, a completed enrollment form must be received by a participating entity or the health plan administrator of TRS-ActiveCare during the plan enrollment period. Coverage under the elected option becomes effective on September 1 of the next plan year. One of the following elections may be made under this subsection:

(1) change to another approved HMO for which the full-time or part-time employee is eligible; or

(2) enroll in the TRS-ActiveCare preferred provider organization coverage plan, without preexisting condition exclusions.

(g) [~~(f)~~] Eligible full-time or part-time employees and their eligible dependents who are enrolled in an HMO with a TRS contract that is terminated during the plan year may make one of the elections provided under this subsection. To make an effective election, a completed enrollment form must be received by a participating entity or the health plan administrator of TRS-ActiveCare within 31 calendar days after notice of the contract termination is sent to the eligible full-time or part-time employee by TRS or its designee. Coverage under the elected option becomes effective on a date determined by TRS. One of the following elections may be made under this subsection:

(1) change to another approved HMO for which the full-time or part-time employees and their eligible dependents are eligible; or

(2) enroll in the TRS-ActiveCare preferred provider organization coverage plan, without preexisting condition exclusions.

(h) [~~(g)~~] Eligible full-time or part-time employees and their eligible dependents enrolled in an approved HMO whose eligibility status changes because the eligible full-time or part-time employee no longer resides, lives, or works in the HMO service area may make one of the elections provided under this subsection. To make an effective election, a completed enrollment form must be received by a participating entity or the health plan administrator of TRS-ActiveCare within 31 calendar days after the employee's change in eligibility status. Coverage under the elected option becomes effective on the first day of the month following the date the employee's eligibility status changed. One of the following elections may be made under this subsection:

(1) enroll in another approved HMO for which the full-time or part-time employee is eligible; or

(2) enroll in the TRS-ActiveCare preferred provider organization coverage plan, subject to applicable preexisting condition limitations.

(i) [~~(h)~~] The trustee by resolution may prescribe open-enrollment periods and the conditions under which an eligible full-time or part-time employee and his eligible dependents may enroll during an open enrollment.

§41.39. Coverage for Individuals Changing Employers.

(a) A full-time or part-time employee enrolled in TRS-ActiveCare who, on or after September 1, 2011, changes employment from one participating entity to another participating entity within the same plan year may not change coverage plans or add dependents unless:

(1) changes to add dependents are authorized due to a special enrollment event under provisions of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191, 110 Stat. 1936 (1996));

(2) an open-enrollment period exists on the first day of the new employment and the full-time or part-time employee makes such changes in compliance with open-enrollment conditions prescribed by the trustee; or

(3) the new employment is with a participating entity that does not make available the option under which the individual was covered on the last date of previous employment, provided that options are offered under TRS-ActiveCare that are not applicable to all participating entities.

(b) [~~(a)~~] A full-time or part-time employee enrolled in TRS-ActiveCare who, on or before August 31, 2011, changes employment from one participating entity to another participating entity within the same plan year may not change coverage plans or add dependents unless:

(1) changes to add dependents are authorized due to a special enrollment event under special enrollment provisions of TRS-ActiveCare;

(2) an open-enrollment period exists on the first day of the new employment and the full-time or part-time employee makes such changes in compliance with open-enrollment conditions prescribed by the trustee; or

(3) the new employment is with a participating entity that does not make available the option under which the individual was covered on the last date of previous employment, provided that options are offered under TRS-ActiveCare that are not applicable to all participating entities.

(c) [~~(b)~~] No break in coverage will occur for a full-time or part-time employee enrolled in TRS-ActiveCare who changes employment from one participating entity to another participating entity within the same plan year if all the criteria set forth in paragraphs (1) - (3) of this subsection are met. The former employer participating entity shall determine the last date of employment for purposes of this subsection.

(1) The new employer makes available the same coverage option under which the full-time or part-time employee was enrolled on the last day of employment with the former employer;

(2) The individual is employed by the new participating entity no later than the last day of the next calendar month after the last date of employment with the former participating entity employer; and

(3) The individual promptly files an election to continue coverage with the new participating entity employer with coverage to be effective in the calendar month in which the individual is first employed with the new participating entity.

(d) [~~(c)~~] Full-time or part-time employees who initially waive coverage under TRS-ActiveCare may enroll during any open enrollment as prescribed by resolution of the trustee; however, they may not enroll due to a change in employment from one participating entity to another during the same plan year unless the change occurs during a concurrent open enrollment.

§41.50. Appeals Relating to Claims or Other Benefits.

(a) For appeals relating to claims or other benefits received on or after September 1, 2011, the following procedures apply:

(1) [~~(a)~~] A person enrolled in TRS-ActiveCare, other than a person enrolled in a health maintenance organization (HMO) participating in TRS-ActiveCare, who is denied payment of a claim or other benefit ("Claimant") may appeal the denial through a written request filed with the administering firm in accordance with [~~according to~~] procedures established by the administering firm. [~~All such procedures must be exhausted before the administering firm will issue a final decision. All relevant medical information should be submitted to the administering firm prior to the issuance of a final decision. Persons enrolled in a TRS-ActiveCare HMO shall follow the appeal procedures set out by the HMO.~~]

(2) The final decision by the administering firm or by any external review organization, whichever occurs later, shall be the final decision on the appeal.

(b) For appeals relating to claims or other benefits received before September 1, 2011, the following procedures apply:

(1) A Claimant may appeal the denial through a written request filed with the administering firm in accordance with procedures established by the administering firm. All such procedures must be exhausted before the administering firm will issue a final decision.

(2) [~~(b)~~] A [~~For a claim or other benefit with any date of service or denial for service that occurs before September 1, 2011, a~~] Claimant may appeal the final denial of the claim or other benefit by the administering firm to the Teacher Retirement System of Texas (TRS), acting in its capacity as trustee of TRS-ActiveCare.

(3) [~~(c)~~] An appeal made pursuant to paragraph (2) of this subsection [~~subsection (b) of this section~~] must be submitted by the Claimant in writing and received by TRS before September 1, 2011 and no later than 60 days after the date of the letter from the administering firm finally denying the claim. The appeal shall be directed to the attention of the TRS-ActiveCare Grievance Administrator.

(4) [~~(d)~~] An appeal made pursuant to paragraph (2) of this subsection [~~subsection (b) of this section~~] shall state the nature of the claim and shall include copies of all relevant documents that were considered by the administering firm, including copies of the correspondence to and from the administering firm.

(5) [~~(e)~~] The TRS Appeal Committee ("Committee") is responsible for review and determination of appeals made pursuant to paragraph (2) of this subsection [~~subsection (b) of this section~~]. The Committee shall be appointed by the TRS Deputy Director or, if the position of the Deputy Director is vacant, the TRS Chief Financial Officer and shall serve at the discretion of the Deputy Director or, if the position of the Deputy Director is vacant, the Chief Financial Officer.

(6) [~~(f)~~] The Committee shall apply the TRS-ActiveCare plan design and rules in effect on the date the first of the following events occurs:

(A) [~~(1)~~] the date the claim was incurred; or

(B) [~~(2)~~] the date the benefit was denied by the administering firm.

(7) [~~(g)~~] If the Committee determines that the claim should be paid or a benefit allowed, it shall so inform the administering firm and the Claimant.

(8) [~~(h)~~] If the Committee determines that the information submitted with the appeal supports the denial by the administering firm, the Committee shall provide a written decision, which shall include an explanation of the reasons for the decision, to the Claimant and to the administering firm. The written decision shall include information on how the Claimant may request an appeal conference or an appeal to the Executive Director.

(9) [~~(i)~~] The initial written decision of the Committee may be appealed by the Claimant to the Committee for an appeal conference. A request for an appeal conference must be submitted by the Claimant in writing and must be received by TRS no later than 45 days after the date of the initial written decision by the Committee. The request for an appeal conference shall be directed to the attention of the TRS-ActiveCare Grievance Administrator.

(10) [~~(j)~~] Upon receipt of a timely request for an appeal conference, the TRS-ActiveCare Grievance Administrator shall schedule an appeal conference with the Committee. The Grievance Administrator shall notify the Claimant and the administering firm of the time, date, and manner of the conference, as well as the procedures applicable to the conference.

(11) [~~(k)~~] At any time prior to the appeal conference, the Committee may decide to grant the appeal and will notify the Claimant of this determination without the necessity of an appeal conference. The Committee cannot deny a claim after an appeal conference has been requested without holding the conference, but the initial denial by the Committee shall stand until the conference is held.

(12) [~~(l)~~] At the conference, the Committee shall consider the medical information previously submitted to the administering firm in support of the payment of the claim or benefit, as well as the administering firm's determination regarding medical issues. The Committee may request additional review by the administering firm on medical issues before the Committee issues a decision.

(13) [~~(m)~~] The Committee shall decide the appeal and shall notify the Claimant and the administering firm of the decision in writing. The decision will include an explanation of the basis for the decision.

(14) [~~(n)~~] The initial written decision of the Committee or the written decision by the Committee made pursuant to an appeal conference may be appealed by the Claimant to the TRS Executive Director. A request for an appeal to the Executive Director must be submitted by the Claimant in writing and must be received by TRS no later than 45 days after the date of the initial written decision by the Committee or no later than 30 days after the date of the written decision by the Committee made pursuant to an appeal conference. The request for an appeal to the Executive Director shall be directed to the attention of the TRS-ActiveCare Grievance Administrator. The appeal shall specifically describe why the Claimant alleges that the Committee's decision is erroneous. The Executive Director shall make a decision based on the written appeal and based on the written decision of the Committee, as well as any written documents reviewed by the Committee. Subject to paragraph (15) of this subsection [~~subsection (o) of this section~~] and pursuant to the delegation of authority through this section, the decision of the Executive Director is the final decision of TRS.

(15) [~~(o)~~] The Committee shall review an appeal made pursuant to paragraph (2), (9), or (14) of this subsection [~~(b), (i), or (n) of this section~~] for timeliness and may deny an appeal that is not timely received by TRS. An appeal made pursuant to paragraph (2), (9), or (14) of this subsection [~~(b), (i), or (n) of this section~~] that is denied because TRS did not timely receive the appeal is a final decision by TRS.

(c) Persons enrolled in an HMO under contract with TRS-ActiveCare shall follow the appeal procedures set out by the HMO.

[~~(p) For a claim or other benefit with all dates of service or all denials for services that occur on or after September 1, 2011, the final decision by the administering firm or by an external review organization, whichever occurs later, shall be the final decision on the appeal.~~]

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 June 23, 2011.

TRD-201102369
Ronnie Jung
Executive Director
Teacher Retirement System of Texas
Earliest possible date of adoption: August 7, 2011
For further information, please call: (512) 542-6438

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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 16. ECONOMIC REGULATION

PART 8. TEXAS RACING COMMISSION

CHAPTER 321. PARI-MUTUEL WAGERING

SUBCHAPTER C. REGULATION OF LIVE WAGERING

DIVISION 2. DISTRIBUTION OF PARI-MUTUEL POOLS

16 TAC §321.313, §321.319

The Texas Racing Commission withdraws the proposed amendment to §321.313 and proposed new §321.319 which appeared in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11463).

Filed with the Office of the Secretary of State on June 24, 2011.

TRD-201102377
Mark Fenner
General Counsel
Texas Racing Commission
Effective date: June 24, 2011
For further information, please call: (512) 833-6699

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 53. FINANCE

SUBCHAPTER A. FEES

DIVISION 1. LICENSE, PERMIT, AND BOAT AND MOTOR FEES

31 TAC §53.15

Proposed amended §53.15, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11518), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102404

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CHAPTER 70. PLANTS

SUBCHAPTER A. EXOTIC AQUATIC VASCULAR PLANTS AND MACROALGAE

31 TAC §§70.1 - 70.19

Proposed new §§70.1 - 70.19, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11522), are withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102405

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SUBCHAPTER B. EXOTIC MICROALGAE

31 TAC §§70.51 - 70.67

Proposed new §§70.51 - 70.67, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11540), are withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102406

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 9. TEXAS COMMISSION ON JAIL STANDARDS

CHAPTER 265. ADMISSION

37 TAC §265.1

Proposed amended §265.1, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11561), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102407

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37 TAC §265.2

Proposed amended §265.2, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11561), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102408

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37 TAC §265.11

Proposed amended §265.11, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11562), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102409

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CHAPTER 271. CLASSIFICATION AND SEPARATION OF INMATES

37 TAC §271.3

Proposed amended §271.3, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11562), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102410

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CHAPTER 273. HEALTH SERVICES

37 TAC §273.8

Proposed amended §273.8, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11563), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102411

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CHAPTER 275. SUPERVISION OF INMATES

37 TAC §275.1

Proposed amended §275.1, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11563), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102412

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37 TAC §275.5

Proposed amended §275.5, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11564), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102413

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37 TAC §275.8

Proposed new §275.8, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11564), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102414

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CHAPTER 279. SANITATION

37 TAC §279.1

Proposed amended §279.1, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11565), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102415

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CHAPTER 289. WORK ASSIGNMENTS

37 TAC §289.4

Proposed amended §289.4, published in the December 24, 2010, issue of the *Texas Register* (35 TexReg 11565), is withdrawn. The agency failed to adopt the proposal within six months of publication. (See Government Code, §2001.027, and 1 TAC §91.38(d).)

Filed with the Office of the Secretary of State on June 27, 2011.

TRD-201102416

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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 16. ECONOMIC REGULATION

PART 1. RAILROAD COMMISSION OF TEXAS

CHAPTER 5. CARBON DIOXIDE (CO_2) SUBCHAPTER C. CERTIFICATION OF GEOLOGIC STORAGE OF ANTHROPOGENIC CARBON DIOXIDE (CO_2) INCIDENTAL TO ENHANCED RECOVERY OF OIL, GAS, OR GEOTHERMAL RESOURCES

16 TAC §§5.301 - 5.308

The Railroad Commission of Texas (Commission) adopts a new subchapter in Chapter 5, new Subchapter C, relating to Certification of Geologic Storage of Anthropogenic Carbon Dioxide Incidental to Enhanced Recovery of Oil, Gas, or Geothermal Resources. Section 5.308 is adopted without changes, and the remaining sections are adopted with changes to the proposed versions published in the December 31, 2010, issue of the *Texas Register* (35 TexReg 11780). The Commission adopts the new subchapter 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). The purpose of the new rules is to provide for certification of geologic storage of anthropogenic carbon dioxide incidental to enhanced recovery of oil, gas, or geothermal resources.

Senate Bill 1387 requires the Commission to adopt rules for geologic storage and associated injection of CO_2 in connection with enhanced recovery operations for which: (1) there is a reasonable expectation of more than insignificant future production volumes or rates as a result of the injection of anthropogenic CO_2; and (2) operating pressures are not higher than reasonably necessary for enhanced recovery.

The Commission received comments from Denbury Resources, Inc. (Denbury), the Texas Oil & Gas Association (TxOGA) and the Texas Carbon Capture and Storage Association (TxCCSA). The TxCCSA comments supported the comments of the TxOGA. Neither of the associations stated support or opposition to the proposed rules in their entirety, but offered suggestions for revisions to some of the rule provisions.

TxOGA commended staff on drafting a proposal that is relatively technically sound, as well as simple and cost effective. The Commission appreciates this comment.

TxOGA recommended that the Commission substitute "an operator" for "a person" in §5.301(e). The Commission agrees with this comment and has made the recommended change.

TxOGA recommended that the Commission delete the phrase "and CO_2 contained in acid gas produced in association with the processing of natural gas" in §5.302(1), relating to the definition of "anthropogenic carbon dioxide." TxOGA did not explain its reasoning; however, the Commission deleted the language as requested for consistency with other sections in Chapter 5.

TxOGA commented that the Commission should include a definition for "continuous monitoring devices" to mean "industry-acceptable devices that continuously record or monitor operating conditions for compliance with this chapter. In the event of temporary removal, incidental upsets, failures or malfunctions, the missing data procedures in §5.309 shall be followed to maintain compliance with this chapter." The Commission does not agree with this comment. The Commission does not agree with use of the term "industry-acceptable devices." In addition, the last sentence is not appropriate for a definition. However, as discussed later in this preamble, the Commission does agree that it would be prudent to include in the new subchapter language regarding missing data procedures.

TxOGA recommended a grammatical correction in §5.303(b). The Commission agrees with this comment and has made the recommended change.

TxOGA and Denbury recommended that in §5.304, the Commission replace the proposed annual fee of $0.025 per metric ton of anthropogenic carbon dioxide injected into each enhanced recovery facility registered under this subchapter with an annual certification fee of $10,000 per registered facility. The Commission agrees with this recommendation and makes the change in the adopted rule.

TxOGA recommended that the Commission replace the phrase "a person" with "an operator" in §5.305. The Commission agrees with this comment and has made the recommended change.

TxOGA recommended that the Commission delete the word "stream" in §5.305(1)(A). The Commission does not agree with this comment. The CO_2 stream must be analyzed to determine the percentages of carbon dioxide and other gases that are to be injected. The Commission made no change in response to this comment.

TxOGA recommended changes to the language of §5.305(1)(B) to read as follows: "installation of continuous monitoring devices (including digital devices to capture periodic data) to monitor *injection* pressure, rate *of injected CO_2,* and volume. *Monitoring of* daily pressure on the annulus between the tubing and the long string casing *shall be performed by either continuous monitoring device or by using a pressure gauge with a rupture disk with automated alarm to signal pressures outside acceptable operating*

range. These devices may be removed during well workovers but must be reinstalled at the completion of the workover; *alternative methods of monitoring the tubing and longstring annulus may be approved by the Commission when considering injection well construction, operating pressures and the oil and gas reservoir."* The Commission agrees with this comment and has made this clarifying change, but amending the suggested passive voice language to active voice.

TxOGA recommended changes to the language in §5.305(1)(C) to delete a reference to "oxygen reactivation" so the wording would read: "demonstration of external mechanical integrity by one of the following, or another approved, method: *oxygen-activation log,* tracer survey, temperature log, noise log, or casing inspection log *if the operator detects a problem, or once every five years,* until the well is permanently plugged." The Commission agrees with this comment and has made this clarifying change.

TxOGA recommended changes to the language in §5.305(1)(D) to require corrosion monitoring only when the injected anthropogenic CO_2 is not dehydrated. The Commission does not agree with this comment. As the Commission noted in the response to comments on proposed Subchapters A and B of Chapter 5, dehydration of the CO_2 stream prior to injection may be sufficient to protect the tubing and packer on 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 the corrosive properties of the re-hydrated injectate. The Commission made no change in response to this comment.

TxOGA also recommended that corrosion monitoring be allowed at one designated test site typical for the enhanced recovery facility. The Commission partly agrees with this recommendation. One designated test site may be appropriate for some, but not all, projects. However, the Commission agrees that a limited number of test sites may be representative of the corrosion monitoring at a particular facility and has modified the language.

TxOGA recommended changes to the language in §5.305(1)(E): "annual monitoring of the injection zone pressure in the productive reservoir, including at a minimum, at least once every five years, a shut-down of *each injection* well for a time sufficient to estimate reservoir pressure *at the site."* The Commission agrees with these comments and has made the changes.

TxOGA recommended that the Commission delete the proposed language in §5.305(1)(F), which requires monitoring wells as needed for continuous monitoring for pressure changes in an appropriately porous and permeable formation above the confining zone and states that, for each well installed, the operator must set forth the specified frequency of sampling the interval and analyzing the constituents as specified in the plan. The Commission does not agree with this recommendation and made no changes. Such monitoring requirements are reasonable to verify that injected carbon dioxide is not escaping the permitted injection zone.

TxOGA recommended that the Commission delete the proposed language in §5.305(1)(H), which allows the use of indirect, geophysical techniques to determine the position of the CO_2 fluid front, or to provide other site-specific data. TxOGA offered no reason for requesting that the Commission delete this language. The Commission does not agree with this comment and has made no changes.

TxOGA recommended changes to the language in §5.306(a) to insert the word "operating" to clarify that the operating requirements of the subchapter apply in addition to the requirements of §3.46 of this title (relating to Fluid Injection into Productive Reservoirs) and any permit conditions to which the Commission has subjected the injection wells. The Commission does not agree with this comment and has made no changes. An operator who opts to be subject to this subchapter must comply with all requirements of §3.46, not just the operating requirements of that rule.

TxOGA recommended changes to the language in §5.306(b), which requires that the total volume of anthropogenic CO_2 injected into the enhanced recovery facility be metered through a master meter or a series of master meters and the volume of anthropogenic CO_2 injected into each injection well must be metered through an individual well meter. TxOGA recommended that the Commission add the following language: "When anthropogenic CO_2 is commingled outside the enhanced recovery facility with other CO_2, the total volume of anthropogenic CO_2 in the mixed stream shall be reported, and the anthropogenic CO_2 for the master meter and injected well volumes may be accounted for on an allocated basis." The Commission agrees with this comment and has made this clarifying change.

TxOGA recommended changes to the language in §5.306(g) to insert the word "operating" to clarify that the requirements are in addition to the *operating* requirements of §3.14 of this title (relating to Plugging). The Commission does not agree with this comment. Section 3.14 includes other requirements, such as reporting requirements, with which an operator must comply.

TxOGA recommended changes to the language in §5.306(h) to allow, rather than require, the director to impose terms and conditions reasonably necessary to prevent the escape of CO_2 in any registration for geologic storage of anthropogenic CO_2 incidental to enhanced recovery. The Commission does not agree with this recommendation. If conditions are necessary to prevent the escape of CO_2, the director must impose those conditions to prevent it; otherwise, the director cannot issue the certification. The Commission made no change in response to this comment.

TxOGA recommended numerous changes to the language in §5.308, relating to requirements for certification. TxOGA did not discuss the recommended changes. TxOGA's language changes would require that the Commission issue a certification validating the geologic storage of anthropogenic CO_2 incidental to enhanced recovery at the registered facility when an operator of an enhanced recovery facility has registered for certification, paid the fee, and submitted an approved monitoring, sampling, and testing plan. TxOGA recommended deleting the language that states that to "verify geologic storage of CO_2 incidental to enhanced recovery operations, the operator must maintain, and be in compliance with, the approved testing, monitoring, and reporting plan required by §5.305 of this subchapter (relating to Monitoring, Sampling, and Testing Plan)." The Commission does not agree with this comment. The act of submitting the paperwork and paying the required fee does not validate the geologic storage of the CO_2. The Commission made no changes in response to this comment.

TxOGA recommended deleting the language proposed in §5.308(b) in its entirety. That language stated that the Commission may issue a certification to the operator validating the geologic storage of anthropogenic CO_2 incidental to enhanced recovery at the registered facility annually. The Commission does not agree with this comment. The schema of this subchap-

ter envisions an annual review of the reporting information to validate that the facility is geologically sequestering the anthropogenic CO_2. The Commission made no change in response to this comment.

TxOGA recommended changing the language in §5.308(c) to read: "Certifications issued under this subchapter continue in effect *and shall not be suspended or revoked so long as the operator remains in compliance,"* deleting the words "until revoked, modified, or suspended by the Commission. The operator must comply" and continuing "with each requirement set forth in this subchapter as a condition of the certification unless modified by *the Commission"* and deleting the words "the terms of the certification." TxOGA offered no reason for the changes. The Commission does not agree that the changes are necessary.

TxOGA recommended that the Commission include two new subsections in §5.308. The first subsection would state that no certification under this subchapter shall be suspended or revoked due to an operator's failure to comply with any requirement of this subchapter unless the operator fails to cure the noncompliance within 60 days after the operator received written notice from the Commission of its noncompliance. The second recommended subsection would state that any suspension or revocation of a certification under this subchapter shall apply only to the enhanced recovery facility covered by the certification, and shall have no effect on any other certification held by the operator covering other enhanced recovery facilities. The Commission does not agree that these new subsections are necessary. The Commission's general policy is to provide an operator with a reasonable amount of time to remedy any noncompliance issues, unless there is an imminent danger or other serious emergency, health, or environmental reason to require immediate remedy. And, the Commission would not suspend or revoke a Statewide Rule 46 permit for a violation of this new subsection unless there already exists a violation of Statewide Rule 46 and/or a condition of a permit issued pursuant to Statewide Rule 46. The Commission made no change in response to this comment.

TxOGA recommended that the Commission include a new section, §5.309, relating to Procedures for Missing Data. The Commission agrees with this comment in general, but adopts new language in §5.307(d) that clarifies the procedures an operator is to use in the event the operator is unable to collect data in accordance with the approved plan.

The Commission adopts new §5.301, relating to Applicability, which sets out the applicability of the new subchapter and establishes the requirements for certification of the injection and incidental storage of anthropogenic carbon dioxide into productive reservoirs associated with enhanced recovery of oil, gas, or geothermal resources, and for which the operator requests certification from the Commission that the anthropogenic carbon dioxide is permanently stored.

The Commission adopts new §5.302, relating to Definitions. This new section defines anthropogenic carbon dioxide as it is defined in the Texas Water Code, §27.002(19)(A). The new section further includes definitions for "anthropogenic carbon dioxide stream," "carbon dioxide injection well," "certification," "enhanced recovery," "enhanced recovery facility," "geologic storage," and "productive reservoir."

The Commission adopts new §5.303, relating to Registration for Certification. The section requires that the operator or the proposed operator of an enhanced recovery facility for which the operator proposes to document geologic storage of anthropogenic carbon dioxide incidental to enhanced recovery register with the Commission in Austin. The section further establishes the registration application requirements, including a registration fee. The section further states that, within 90 days of receipt of a complete registration application, the director will approve or deny the registration application.

The Commission adopts new §5.304, relating to Fees. The new section requires a non-refundable registration fee of $500 for each enhanced recovery facility to be registered and a non-refundable annual certification fee of $10,000 for each enhanced recovery facility registered under this subchapter.

The Commission adopts new §5.305, relating to Monitoring, Sampling, and Testing Plan, which establishes requirements for the monitoring, sampling, and testing plan in order to allow a determination by mass balancing or actual system modeling of the quantities of anthropogenic carbon dioxide permanently stored within the enhanced recovery reservoir for documentation to the Commission. The section further states that any person registering an enhanced recovery facility under this subchapter may comply with the sampling, monitoring, and reporting requirements of this subchapter by complying with, and submitting to the Commission a copy of the information submitted to the United States Environmental Protection Agency under, subparts RR or UU of 40 CFR Part 98, Mandatory Reporting of Greenhouse Gases: Injection and Geologic Sequestration of Carbon Dioxide.

The Commission adopts new §5.306, relating to Standards for Certification, which establishes the standards for certification.

The Commission adopts new §5.307, relating to Reporting and Recordkeeping, which establishes the reporting and recordkeeping requirements for the subchapter.

The Commission adopts new §5.308, relating to Requirements for Certification, which states that, to verify geologic storage of carbon dioxide incidental to enhanced recovery operations, the operator must maintain, and be in compliance with, the approved testing, monitoring, and reporting plan required by §5.305 of this subchapter. The section further states that, annually, the Commission may issue a certification to the operator validating the geologic storage of anthropogenic carbon dioxide incidental to enhanced recovery at the registered facility and that certifications 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 certification unless modified by the terms of the certification.

The Commission adopts the rules in new Subchapter C 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 carbon dioxide in, and the injection of carbon dioxide 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 Stor-

age 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 incidental to geologic storage facilities and associated anthropogenic carbon dioxide injection wells.

Texas Natural Resources Code, §81.051, §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, §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, §81.052; Texas Natural Resources Code, Chapter 91, Subchapter R; and Texas Water Code, Chapters 27 and 120.

Issued in Austin, Texas, on June 27, 2011.

§5.301. Applicability.

(a) This subchapter establishes the requirements for certification of the injection, and incidental storage, of anthropogenic CO_2 into productive reservoirs for the purpose of enhanced recovery of oil, gas, or geothermal resources, and for which the operator requests certification from the Commission that the anthropogenic CO_2 is permanently stored.

(b) This subchapter applies to the injection of anthropogenic CO_2 in a reservoir in connection with enhanced recovery for which:

(1) there is a reasonable expectation of more than insignificant future production of oil, gas, or geothermal volumes or rates as a result of the injection of CO_2; and

(2) using operating pressures not anticipated to be higher than reasonably necessary to produce such production of oil, gas, or geothermal volumes and rates are covered by this rule, and the wells used in such enhanced recovery continue to be covered in accordance with the requirements of §3.46 of this title (relating to Fluid Injection into Productive Reservoirs).

(c) For the purposes of this subsection, the CO_2 stream injected into a productive reservoir may include any proportion of anthropogenic CO_2 and naturally sourced CO_2.

(d) The operator of an enhanced recovery facility registering for certification of geologic storage of anthropogenic CO_2 incidental to enhanced recovery operations is subject to the monitoring provisions of this subchapter.

(e) No permit is required for an operator to register with, or obtain a certification from, the Commission for geologic storage of anthropogenic CO_2 incidental to enhanced recovery under this subchapter. Registration for certification by an operator under this subchapter is separate and distinct from an application for a Geologic Storage Facility under Subchapter B of this chapter (relating to Geologic Storage and Associated Injection of Anthropogenic Carbon Dioxide (CO_2)). The wells into which CO_2 is injected for the purpose of enhanced recovery continue to be covered by §3.46 of this title.

(f) Registration under this subchapter is voluntary. An enhanced recovery facility may register under this subchapter to account for geologic sequestration of anthropogenic CO_2. Additionally, this subchapter does not preclude the operator of an enhanced recovery project from opting into a regulatory program that provides carbon credit for the geologic storage of anthropogenic CO_2 incidental to enhanced recovery.

(g) An enhanced recovery facility subject to this subchapter includes all structures associated with injection and production located between the injection/production wells and the separators, but does not include the following:

(1) storage of CO_2 above ground;

(2) temporary storage of CO_2 below ground;

(3) transportation or distribution of CO_2;

(4) purification, compression, or processing of CO_2 at the surface;

(5) capture of CO_2; or

(6) CO_2 in cement, precipitated calcium carbonate, or any other technique that does not involve injection of CO_2 into the subsurface.

(h) Conflict with other requirements. If a provision of this section conflicts with any provision or term of a Commission order, field rule, or permit, the provision of such order, field rule, or permit controls.

§5.302. Definitions.

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

(1) Anthropogenic carbon dioxide (CO_2)--Anthropogenic CO_2 as defined in the Texas Water Code, §27.002(19)(A). The term does not include naturally occurring CO_2 that is produced, acquired, recaptured, recycled, and reinjected as part of enhanced recovery. The use of the term "CO_2" in this subchapter includes anthropogenic CO_2.

(2) Anthropogenic CO_2 stream--CO_2 that has been captured from an emission source, incidental associated substances derived from the source materials and the capture process, and any substances added to the stream to enable or improve the injection process. The term does not include any CO_2 stream that meets the definition of a hazardous waste under 40 Code of Federal Regulations Part 261.

(3) CO_2 injection well--An injection well used to inject or transmit CO_2 into an enhanced recovery reservoir.

(4) Certification--As used in this subchapter, a document issued annually by the director validating the geologic storage of anthropogenic CO_2 incidental to enhanced recovery at a facility registered under this subchapter.

(5) Enhanced recovery--Any process to displace hydrocarbons from a reservoir other than by primary recovery, including using any physical, chemical, thermal, or biological process and any co-production project. This term does not include pressure maintenance or disposal projects.

(6) Enhanced recovery facility--The underground reservoir, underground equipment, injection wells, and surface buildings and equipment and all surface and subsurface rights and appurtenances necessary to an enhanced recovery operation.

(7) Geologic storage--The incidental underground storage of CO_2 in a productive reservoir that occurs incidental to enhanced recovery.

(8) Productive reservoir--A reservoir that is productive of oil, gas and geothermal resources and for which:

(A) there is a reasonable expectation of more than insignificant future production of oil, gas or geothermal volumes or rates as a result of the injection of CO_2; and

(B) using operating pressures not anticipated to be higher than reasonably necessary to produce such production of oil, gas or geothermal volumes and rates.

§5.303. Registration for Certification.

(a) The operator or the proposed operator of an enhanced recovery facility for which the operator proposes to document geologic storage of anthropogenic CO_2 incidental to enhanced recovery must register with the Commission in Austin.

(1) The operator or proposed operator must include the prescribed fee with the registration application and must ensure that the registration application is executed by a party having knowledge of the facts entered on the registration.

(2) The operator or proposed operator must include with the registration application the following:

(A) 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;

(B) a demonstration that the reservoir is undergoing enhanced recovery using injection of anthropogenic CO_2, including:

(i) the Commission field designation;

(ii) the Commission order approving such enhanced recovery project and a plat of the designated area;

(iii) a list of all injection wells permitted under §3.46 of this title (relating to Fluid Injection into Productive Reservoirs) within the enhanced recovery facility; and

(iv) information regarding the period of time for which CO_2 injection has been conducted, or is expected to be conducted, together with the total anticipated volume of anthropogenic CO_2 to be injected; and

(C) a testing, monitoring, and reporting plan.

(b) Within 90 days of receipt of a complete registration application, the director will approve or deny the registration application. If the director approves the registration application, the acknowledgment will include the conditions for certification, including conditions for monitoring and reporting.

§5.304. Fees.

The operator or proposed operator must remit the following non-refundable fees to the Commission with each registration application under this subchapter:

(1) a non-refundable fee of $500 for each enhanced recovery facility to be registered; and

(2) annually, a non-refundable certification fee of $10,000 for each enhanced recovery facility registered under this subchapter.

§5.305. Monitoring, Sampling, and Testing Plan.

An operator registering for certification under this subchapter must submit a monitoring, sampling, and testing plan to verify geologic storage of the anthropogenic CO_2 incidental to enhanced recovery.

(1) The monitoring, sampling, and testing plan must include the following:

(A) an analysis of the CO_2 stream at a frequency sufficient to yield data representative of its chemical and physical characteristics;

(B) installation of continuous monitoring devices (including digital devices to capture periodic data) to monitor injection pressure, rate of injected CO_2, and volume of injected CO_2. The operator shall perform monitoring of daily pressure on the annulus between the tubing and the long string casing by use of either continuous monitoring device or by using a pressure gauge with a rupture disk with automated alarm to signal pressures outside of the permitted operating range. The operator may remove these devices during well workovers but must reinstall them at the completion of the workover; the Commission may approve alternative methods of monitoring the annulus between the tubing and long string casing when considering injection well construction, operating pressures, and the oil and gas reservoir;

(C) demonstration of external mechanical integrity by one of the following, or another approved, method: oxygen-activation log survey, temperature log, noise log, or casing inspection log if the operator detects a problem, or once every five years, until the well is permanently plugged;

(D) corrosion monitoring of the well materials that will come into contact with water for loss of mass, thickness, cracking, pitting, and other signs of corrosion. The operator shall perform corrosion monitoring at one or more designated representative test sites typical of the enhanced recovery facility initially and quarterly, and the operator shall report quarterly, but may be modified to a less frequent schedule as approved by the Commission, based on the construction materials, operating conditions, and monitoring history that show the well components meet minimum standards and performance by:

(i) analyzing coupons of the well construction materials placed in contact with the CO_2 stream; or

(ii) routing the CO_2 stream through a closed loop constructed with the material used in the well and inspecting the material in the loop; or

(iii) using an alternative method, materials, or time period approved by the Commission;

(E) annual monitoring of the injection zone pressure in the productive reservoir, including at a minimum, at least once every five years, a shut-down of each injection well for a time sufficient to estimate reservoir pressure at the site;

(F) monitoring wells as needed for continuous monitoring for pressure changes in an appropriately porous and permeable formation above the confining zone. For each well installed, the operator must set forth the specified frequency of sampling the interval and analyzing the constituents as specified in the plan;

(G) periodic monitoring of the useable quality water strata overlying the productive reservoir to monitor for changes in quality due to CO_2 injection; and

(H) the use of indirect, geophysical techniques to determine the position of the CO_2 fluid front, or to provide other site-specific data.

(2) For an operator to make a determination by mass balancing or actual system modeling of the quantities of anthropogenic CO_2 permanently stored within the enhanced recovery reservoir for documentation to the Commission, the testing, monitoring, and reporting plan must:

(A) be based upon a site-specific assessment and may include monitoring wells or other monitoring devices to ensure that the injected anthropogenic CO_2 is confined to the productive reservoir; and

(B) include a methodology for accounting for the following:

(i) the volumes of anthropogenic CO_2 injected into the productive reservoir;

(ii) the anthropogenic CO_2 separated from the enhanced recovery production;

(iii) the anthropogenic CO_2 entrained in the production;

(iv) the volume of produced anthropogenic CO_2 recycled for injection into the reservoir;

(v) any *de minimis* losses of anthropogenic CO_2; and

(vi) the volume of make-up anthropogenic CO_2 injected to the enhanced recovery project.

(3) Any person registering an enhanced recovery facility under this subchapter may comply with the sampling, monitoring, and reporting requirements of this subchapter by complying with, and submitting to the Commission a copy of the information submitted to the United States Environmental Protection Agency under, Subparts RR or UU of 40 CFR Part 98, Mandatory Reporting of Greenhouse Gases: Injection and Geologic Sequestration of Carbon Dioxide.

§5.306. Standards for Certification.

(a) The requirements of this subchapter apply in addition to the requirements of §3.46 of this title (relating to Fluid Injection into Productive Reservoirs) and any permit conditions to which the Commission has subjected the injection wells.

(b) The operator must use a master meter or a series of master meters to meter the total volume of anthropogenic CO_2 injected into the enhanced recovery facility. The operator must use an individual well meter to meter the volume of anthropogenic CO_2 injected into each injection well. When anthropogenic CO_2 is commingled outside the enhanced recovery facility with other CO_2, the operator shall report the total volume of anthropogenic CO_2 in the mixed stream and may account for the anthropogenic CO_2 for the master meter and injected well volumes on an allocated basis.

(c) 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.

(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 of an injection well subject to this subchapter must maintain and comply with the approved monitoring, sampling, and testing plan to verify that the 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 determine compliance with the intent of this subchapter.

(f) An operator registered under this subchapter must submit, as applicable, a description of any proposed well stimulation program and a determination that well stimulation will not compromise containment.

(g) In addition to the requirements of §3.14 of this title (relating to Plugging), the operator of an enhanced recovery facility subject to this subchapter must, prior to plugging:

(1) flush each injection well with a buffer fluid;

(2) measure to determine bottomhole reservoir pressure;

(3) perform final tests to assess mechanical integrity; and

(4) ensure that the material to be used in plugging is compatible with the CO_2 stream and the formation fluids.

(h) In any registration for geologic storage of anthropogenic CO_2 incidental to enhanced recovery, the director shall impose terms and conditions reasonably necessary to prevent the escape of CO_2.

§5.307. Reporting and Recordkeeping.

(a) The operator of a facility registered under this subchapter must provide, at a minimum, an annual statement, signed by an appropriate company official, confirming that the operator has complied with the requirements of this subchapter.

(b) 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.

(c) The operator must retain all wellhead pressure records, metering records, and integrity test results for a minimum of five years.

(d) In the event the operator is unable to collect data in accordance with the approved testing, monitoring, and reporting plan, the operator shall determine the length of the specific period, such as periods of maintenance, equipment failure, or power outages, during which data were unavailable, and shall use the following procedures to estimate the data for that period.

(1) The operator shall estimate the quantity of new CO_2 transferred to the enhanced recovery facility from the supplier using the quantity of new CO_2 flow based upon the metering data.

(2) The operator shall estimate the quantity of CO_2 metered for all CO_2, except for new CO_2 transferred to the enhanced recovery facility, using the quantity of CO_2 metered under similar conditions from the nearest previous time period.

(3) The operator shall estimate the CO_2 concentration values using a concentration value under similar conditions from the nearest previous time period.

(4) The operator shall estimate values for fugitive or vented CO_2 emission volumes from surface equipment at the enhanced recovery facility using methods specified in Subpart W of the United States Environmental Protection Agency's Greenhouse Gas Reporting Rule, 40 Code of Federal Regulations, Part 98.

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 June 27, 2011.

TRD-201102420
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Effective date: July 17, 2011
Proposal publication date: December 31, 2010
For further information, please call: (512) 475-1295

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TITLE 22. EXAMINING BOARDS

PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 291. PHARMACIES
SUBCHAPTER B. COMMUNITY PHARMACY (CLASS A)

22 TAC §291.34

The Texas State Board of Pharmacy adopts amendments to §291.34, concerning Records. The amendments are adopted with changes to the proposed text as published in the April 8, 2011, issue of the *Texas Register* (36 TexReg 2211), as noted below.

The adopted amendments to §291.34 clarify requirements for making alterations to prescription records following a dispensing error and correct references.

The National Association of Chain Drug Stores and Texas Federation of Drug Stores commented on the proposed changes indicating that the definition of a dispensing error is too broad and the provisions for alteration of prescription information are not clear. The Board agrees with the comment regarding the definition of a dispensing error and changed the definition accordingly. The Board disagrees with the comment regarding the alteration of the prescription information and believes the requirements are necessary in order to have accurate information when an error is made. Additional comments were made regarding amendments that were not proposed by the Board.

The amendments are adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

§291.34. Records.

(a) Maintenance of records.

(1) Every inventory or other record required to be kept under the provisions of §291.31 of this title (relating to Definitions), §291.32 of this title (relating to Personnel), §291.33 of this title (relating to Operational Standards), §291.34 of this title (relating to Records), and §291.35 of this title (relating to Official Prescription Requirements), contained in Community Pharmacy (Class A) shall be:

(A) kept by the pharmacy and be available, for at least two years from the date of such inventory or record, for inspecting and copying by the board or its representative and to other authorized local, state, or federal law enforcement agencies; and

(B) supplied by the pharmacy within 72 hours, if requested by an authorized agent of the Texas State Board of Pharmacy. If the pharmacy maintains the records in an electronic format, the requested records must be provided in a mutually agreeable electronic format if specifically requested by the board or its representative. Failure to provide the records set out in this section, either on site or within 72 hours, constitutes prima facie evidence of failure to keep and maintain records in violation of the Act.

(2) Records of controlled substances listed in Schedules I and II shall be maintained separately from all other records of the pharmacy.

(3) Records of controlled substances, other than prescription drug orders, listed in Schedules III-V shall be maintained separately or readily retrievable from all other records of the pharmacy. For purposes of this subsection, readily retrievable means that the controlled substances shall be asterisked, red-lined, or in some other manner readily identifiable apart from all other items appearing on the record.

(4) Records, except when specifically required to be maintained in original or hard-copy form, may be maintained in an alternative data retention system, such as a data processing system or direct imaging system provided:

(A) the records maintained in the alternative system contain all of the information required on the manual record; and

(B) the data processing system is capable of producing a hard copy of the record upon the request of the board, its representative, or other authorized local, state, or federal law enforcement or regulatory agencies.

(b) Prescriptions.

(1) Professional responsibility.

(A) Pharmacists shall exercise sound professional judgment with respect to the accuracy and authenticity of any prescription drug order they dispense. If the pharmacist questions the accuracy or authenticity of a prescription drug order, he/she shall verify the order with the practitioner prior to dispensing.

(B) Prior to dispensing a prescription, pharmacists shall determine, in the exercise of sound professional judgment, that the prescription is a valid prescription. A pharmacist may not dispense a prescription drug if the pharmacist knows or should have known that the prescription was issued on the basis of an Internet-based or telephonic consultation without a valid patient-practitioner relationship.

(C) Subparagraph (B) of this paragraph does not prohibit a pharmacist from dispensing a prescription when a valid patient-practitioner relationship is not present in an emergency situation (e.g. a practitioner taking calls for the patient's regular practitioner).

(2) Written prescription drug orders.

(A) Practitioner's signature.

(i) Except as noted in clause (ii) of this subparagraph, written prescription drug orders shall be:

(I) manually signed by the practitioner; or

(II) electronically signed by the practitioner using a system which electronically replicates the practitioner's manual signature on the written prescription, provided:

(-a-) that security features of the system require the practitioner to authorize each use; and

(-b-) the prescription is printed on paper that is designed to prevent unauthorized copying of a completed prescription and to prevent the erasure or modification of information written on the prescription by the prescribing practitioner. (For example, the paper contains security provisions against copying that results in some indication on the copy that it is a copy and therefore render the prescription null and void.)

(ii) Prescription drug orders for Schedule II controlled substances shall be issued on an official prescription form as required by the Texas Controlled Substances Act, §481.075, and be manually signed by the practitioner.

(iii) A practitioner may sign a prescription drug order in the same manner as he would sign a check or legal document, e.g. J.H. Smith or John H. Smith.

(iv) Rubber stamped or otherwise reproduced signatures may not be used except as authorized in clause (i) of this subparagraph.

(v) The prescription drug order may not be signed by a practitioner's agent but may be prepared by an agent for the signature of a practitioner. However, the prescribing practitioner is responsible in case the prescription drug order does not conform in all essential respects to the law and regulations.

(B) Prescription drug orders written by practitioners in another state.

(i) Dangerous drug prescription orders. A pharmacist may dispense a prescription drug order for dangerous drugs issued by practitioners in a state other than Texas in the same manner as prescription drug orders for dangerous drugs issued by practitioners in Texas are dispensed.

(ii) Controlled substance prescription drug orders.

(I) A pharmacist may dispense prescription drug order for controlled substances in Schedule II issued by a practitioner in another state provided:

(-a-) the prescription is filled in compliance with a written plan approved by the Director of the Texas Department of Public Safety in consultation with the Board, which provides the manner in which the dispensing pharmacy may fill a prescription for a Schedule II controlled substance;

(-b-) the prescription drug order is an original written prescription issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal Drug Enforcement Administration (DEA) registration number, and who may legally prescribe Schedule II controlled substances in such other state; and

(-c-) the prescription drug order is not dispensed after the end of the seventh day after the date on which the prescription is issued.

(II) A pharmacist may dispense prescription drug orders for controlled substances in Schedule III, IV, or V issued by a physician, dentist, veterinarian, or podiatrist in another state provided:

(-a-) the prescription drug order is a written, oral, or telephonically or electronically communicated prescription, as allowed by the DEA issued by a person practicing in another state and licensed by another state as a physician, dentist, veterinarian, or podiatrist, who has a current federal DEA registration number, and who may legally prescribe Schedule III, IV, or V controlled substances in such other state;

(-b-) the prescription drug order is not dispensed or refilled more than six months from the initial date of issuance and may not be refilled more than five times; and

(-c-) if there are no refill instructions on the original prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original prescription drug order have been dispensed, a new prescription drug order is obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(C) Prescription drug orders written by practitioners in the United Mexican States or the Dominion of Canada.

(i) Controlled substance prescription drug orders. A pharmacist may not dispense a prescription drug order for a Schedule II, III, IV, or V controlled substance issued by a practitioner in the Dominion of Canada or the United Mexican States.

(ii) Dangerous drug prescription drug orders. A pharmacist may dispense a dangerous drug prescription issued by a person licensed in the Dominion of Canada or the United Mexican States as a physician, dentist, veterinarian, or podiatrist provided:

(I) the prescription drug order is an original written prescription; and

(II) if there are no refill instructions on the original written prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original written prescription drug order have been dispensed, a new written prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of dangerous drugs.

(D) Prescription drug orders carried out or signed by an advanced practice nurse, physician assistant, or pharmacist.

(i) A pharmacist may dispense a prescription drug order which is:

(I) carried out or signed by an advanced practice nurse or physician assistant provided the advanced practice nurse or physician assistant is practicing in accordance with Subtitle B, Chapter 157, Occupations Code, and

(II) for a dangerous drug and signed by a pharmacist under delegated authority of a physician as specified in Subtitle B, Chapter 157, Occupations Code.

(ii) Each practitioner shall designate in writing the name of each advanced practice nurse or physician assistant authorized to carry out or sign a prescription drug order pursuant to Subtitle B, Chapter 157, Occupations Code. A list of the advanced practice nurses or physician assistants designated by the practitioner must be maintained in the practitioner's usual place of business. On request by a pharmacist, a practitioner shall furnish the pharmacist with a copy of the written authorization for a specific advanced practice nurse or physician assistant.

(E) Prescription drug orders for Schedule II controlled substances. No Schedule II controlled substance may be dispensed without a written prescription drug order of a practitioner on an official prescription form as required by the Texas Controlled Substances Act, §481.075.

(3) Verbal prescription drug orders.

(A) A verbal prescription drug order from a practitioner or a practitioner's designated agent may only be received by a pharmacist or a pharmacist-intern under the direct supervision of a pharmacist.

(B) A practitioner shall designate in writing the name of each agent authorized by the practitioner to communicate prescriptions verbally for the practitioner. The practitioner shall maintain at the practitioner's usual place of business a list of the designated agents. The practitioner shall provide a pharmacist with a copy of the practitioner's written authorization for a specific agent on the pharmacist's request.

(C) A pharmacist may not dispense a verbal prescription drug order for a dangerous drug or a controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(4) Electronic prescription drug orders. For the purpose of this subsection, prescription drug orders shall be considered the same as verbal prescription drug orders.

(A) An electronic prescription drug order may be transmitted by a practitioner or a practitioner's designated agent:

(i) directly to a pharmacy; or

(ii) through the use of a data communication device provided:

(I) the confidential prescription information is not altered during transmission; and

(II) confidential patient information is not accessed or maintained by the operator of the data communication device other than for legal purposes under federal and state law.

(B) A practitioner shall designate in writing the name of each agent authorized by the practitioner to electronically transmit prescriptions for the practitioner. The practitioner shall maintain at the practitioner's usual place of business a list of the designated agents. The practitioner shall provide a pharmacist with a copy of the practitioner's written authorization for a specific agent on the pharmacist's request.

(C) A pharmacist may not dispense an electronic prescription drug order for a:

(i) Schedule II controlled substance, except as authorized for faxed prescriptions in §481.074, Health and Safety Code; or

(ii) dangerous drug or controlled substance issued by a practitioner licensed in the Dominion of Canada or the United Mexican States unless the practitioner is also licensed in Texas.

(5) Original prescription drug order records.

(A) Original prescriptions may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order including clarifications to the order given to the pharmacist by the practitioner or the practitioner's agent and recorded on the prescription.

(B) Original prescriptions shall be maintained by the pharmacy in numerical order and remain legible for a period of two years from the date of filling or the date of the last refill dispensed.

(C) If an original prescription drug order is changed, such prescription order shall be invalid and of no further force and effect; if additional drugs are to be dispensed, a new prescription drug order with a new and separate number is required.

(D) Original prescriptions shall be maintained in three separate files as follows:

(i) prescriptions for controlled substances listed in Schedule II;

(ii) prescriptions for controlled substances listed in Schedules III-V; and

(iii) prescriptions for dangerous drugs and nonprescription drugs.

(E) Original prescription records other than prescriptions for Schedule II controlled substances may be stored on microfilm, microfiche, or other system which is capable of producing a direct image of the original prescription record, e.g., digitalized imaging system. If original prescription records are stored in a direct imaging system, the following is applicable:

(i) the record of refills recorded on the original prescription must also be stored in this system;

(ii) the original prescription records must be maintained in numerical order and separated in three files as specified in subparagraph (D) of this paragraph; and

(iii) the pharmacy must provide immediate access to equipment necessary to render the records easily readable.

(6) Prescription drug order information.

(A) All original prescriptions shall bear:

(i) name of the patient, or if such drug is for an animal, the species of such animal and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) intended use for the drug unless the practitioner determines the furnishing of this information is not in the best interest of the patient; and

(viii) date of issuance.

(B) All original electronic prescription drug orders shall bear:

(i) name of the patient, if such drug is for an animal, the species of such animal, and the name of the owner;

(ii) address of the patient, provided, however, a prescription for a dangerous drug is not required to bear the address of the patient if such address is readily retrievable on another appropriate, uniformly maintained pharmacy record, such as medication records;

(iii) name, and if for a controlled substance, the address and DEA registration number of the practitioner;

(iv) name and strength of the drug prescribed;

(v) quantity prescribed;

(vi) directions for use;

(vii) indications for use, unless the practitioner determines the furnishing of this information is not in the best interest of the patient;

(viii) date of issuance;

(ix) if a faxed prescription, a statement which indicates that the prescription has been faxed (e.g., Faxed to);

(x) telephone number of the prescribing practitioner;

(xi) date the prescription drug order was electronically transmitted to the pharmacy, if different from the date of issuance of the prescription; and

(xii) if transmitted by a designated agent, the full name of the designated agent.

(C) All original written prescriptions carried out or signed by an advanced practice nurse or physician assistant in accordance with Subtitle B, Chapter 157, Occupations Code, shall bear:

(i) name and address of the patient;

(ii) name, address, telephone number, and if the prescription is for a controlled substance, the DEA number of the supervising practitioner;

(iii) name, identification number, original signature and if the prescription is for a controlled substance, the DEA number of the advanced practice nurse or physician assistant;

(iv) address and telephone number of the clinic at which the prescription drug order was carried out or signed;

(v) name, strength, and quantity of the drug;

(vi) directions for use;

(vii) indications for use, if appropriate;

(viii) date of issuance; and

(ix) number of refills authorized.

(D) At the time of dispensing, a pharmacist is responsible for documenting the following information on either the original hard-copy prescription or in the pharmacy's data processing system:

(i) unique identification number of the prescription drug order;

(ii) initials or identification code of the dispensing pharmacist;

(iii) effective January 1, 2009, initials or identification code of the pharmacy technician or pharmacy technician trainee performing data entry of the prescription, if applicable;

(iv) quantity dispensed, if different from the quantity prescribed;

(v) date of dispensing, if different from the date of issuance;

(vi) brand name or manufacturer of the drug product actually dispensed, if the drug was prescribed by generic name or if a drug product other than the one prescribed was dispensed pursuant to the provisions of the Act, Chapters 562 and 563; and

(vii) effective June 1, 2010, for each new prescription the initials or identification code of the pharmacist responsible for providing counseling.

(7) Refills.

(A) Refills may be dispensed only in accordance with the prescriber's authorization as indicated on the original prescription drug order.

(B) If there are no refill instructions on the original prescription drug order (which shall be interpreted as no refills authorized) or if all refills authorized on the original prescription drug order have been dispensed, authorization from the prescribing practitioner shall be obtained prior to dispensing any refills.

(C) Refills of prescription drug orders for dangerous drugs or nonprescription drugs.

(i) Prescription drug orders for dangerous drugs or nonprescription drugs may not be refilled after one year from the date of issuance of the original prescription drug order.

(ii) If one year has expired from the date of issuance of an original prescription drug order for a dangerous drug or nonprescription drug, authorization shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of the drug.

(D) Refills of prescription drug orders for Schedules III-V controlled substances.

(i) Prescription drug orders for Schedules III-V controlled substances may not be refilled more than five times or after six months from the date of issuance of the original prescription drug order, whichever occurs first.

(ii) If a prescription drug order for a Schedule III, IV, or V controlled substance has been refilled a total of five times or if six months have expired from the date of issuance of the original prescription drug order, whichever occurs first, a new and separate prescription drug order shall be obtained from the prescribing practitioner prior to dispensing any additional quantities of controlled substances.

(E) If a pharmacist is unable to contact the prescribing practitioner after a reasonable effort, a pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(i) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(ii) the quantity of prescription drug dispensed does not exceed a 72-hour supply;

(iii) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(iv) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(v) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection;

(vi) the pharmacist affixes a label to the dispensing container as specified in §291.33(c)(7) of this title; and

(vii) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(I) the patient has the prescription container, label, receipt or other documentation from the other pharmacy which contains the essential information;

(II) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(III) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of clause (i) of this subparagraph; and

(IV) the pharmacist complies with the requirements of clauses (ii) - (vi) of this subparagraph.

(F) If a natural or manmade disaster has occurred that prohibits the pharmacist from being able to contact the practitioner, a pharmacist may exercise his professional judgment in refilling a prescription drug order for a drug, other than a controlled substance listed in Schedule II, without the authorization of the prescribing practitioner, provided:

(i) failure to refill the prescription might result in an interruption of a therapeutic regimen or create patient suffering;

(ii) the quantity of prescription drug dispensed does not exceed a 30-day supply;

(iii) the governor has declared a state of disaster;

(iv) the board, through the executive director, has notified pharmacies that pharmacists may dispense up to a 30-day supply of prescription drugs;

(v) the pharmacist informs the patient or the patient's agent at the time of dispensing that the refill is being provided without such authorization and that authorization of the practitioner is required for future refills;

(vi) the pharmacist informs the practitioner of the emergency refill at the earliest reasonable time;

(vii) the pharmacist maintains a record of the emergency refill containing the information required to be maintained on a prescription as specified in this subsection;

(viii) the pharmacist affixes a label to the dispensing container as specified in §291.33(c)(7) of this title; and

(ix) if the prescription was initially filled at another pharmacy, the pharmacist may exercise his professional judgment in refilling the prescription provided:

(I) the patient has the prescription container, label, receipt or other documentation from the other pharmacy which contains the essential information;

(II) after a reasonable effort, the pharmacist is unable to contact the other pharmacy to transfer the remaining prescription refills or there are no refills remaining on the prescription;

(III) the pharmacist, in his professional judgment, determines that such a request for an emergency refill is appropriate and meets the requirements of clause (i) of this subparagraph; and

(IV) the pharmacist complies with the requirements of clauses (ii) - (viii) of this subparagraph.

(8) Records Relating to Dispensing Errors.

(A) For purposes of this subsection, a dispensing error is defined as an action committed by a pharmacist or other pharmacy personnel that causes the patient or patient's agent to take possession of a dispensed prescription drug and an individual subsequently discovers that the patient has received an incorrect drug product, which includes incorrect strength, incorrect dosage form, and/or incorrect directions for use.

(B) If a dispensing error occurs, the following is applicable.

(i) Original prescription drug orders:

(I) shall not be destroyed and must be maintained in accordance with subsection (a) of this section; and

(II) shall not be altered. Altering includes placing a label or any other item over any of the information on the prescription drug order (e.g., a dispensing tag or label that is affixed to back of a prescription drug order must not be affixed on top of another dispensing tag or label in such a manner as to obliterate the information relating to the error).

(ii) Prescription drug order records maintained in a data processing system:

(I) shall not be deleted and must be maintained in accordance with subsection (a) of this section;

(II) may be changed only in compliance with subsection (e)(2)(B) of this section; and

(III) if the error involved incorrect data entry into the pharmacy's data processing system, this record must be either voided or cancelled in the data processing system, so that the incorrectly entered prescription drug order may not be dispensed, or the data processing system must be capable of maintaining an audit trail showing any changes made to the data in the system.

(c) Patient medication records.

(1) A patient medication record system shall be maintained by the pharmacy for patients to whom prescription drug orders are dispensed.

(2) The patient medication record system shall provide for the immediate retrieval of information for the previous 12 months which is necessary for the dispensing pharmacist to conduct a prospective drug regimen review at the time a prescription drug order is presented for dispensing.

(3) The pharmacist-in-charge shall assure that a reasonable effort is made to obtain and record in the patient medication record at least the following information:

(A) full name of the patient for whom the drug is prescribed;

(B) address and telephone number of the patient;

(C) patient's age or date of birth;

(D) patient's gender;

(E) any known allergies, drug reactions, idiosyncrasies, and chronic conditions or disease states of the patient and the identity of any other drugs currently being used by the patient which may relate to prospective drug regimen review;

(F) pharmacist's comments relevant to the individual's drug therapy, including any other information unique to the specific patient or drug; and

(G) a list of all prescription drug orders dispensed (new and refill) to the patient by the pharmacy during the last two years. Such list shall contain the following information:

(i) date dispensed;

(ii) name, strength, and quantity of the drug dispensed;

(iii) prescribing practitioner's name;

(iv) unique identification number of the prescription; and

(v) name or initials of the dispensing pharmacists.

(4) A patient medication record shall be maintained in the pharmacy for two years. If patient medication records are maintained in a data processing system, all of the information specified in this subsection shall be maintained in a retrievable form for two years and information for the previous 12 months shall be maintained on-line. A patient medication record must contain documentation of any modification, change, or manipulation to a patient profile.

(5) Nothing in this subsection shall be construed as requiring a pharmacist to obtain, record, and maintain patient information other than prescription drug order information when a patient or patient's agent refuses to provide the necessary information for such patient medication records.

(d) Prescription drug order records maintained in a manual system.

(1) Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(D) of this section.

(2) Refills.

(A) Each time a prescription drug order is refilled, a record of such refill shall be made:

(i) on the back of the prescription by recording the date of dispensing, the written initials or identification code of the dispensing pharmacist, the initials or identification code of the pharmacy technician or pharmacy technician trainee preparing the prescription label, if applicable, and the amount dispensed. (If the pharmacist merely initials and dates the back of the prescription drug order, he or she shall be deemed to have dispensed a refill for the full face amount of the prescription drug order); or

(ii) on another appropriate, uniformly maintained, readily retrievable record, such as medication records, which indicates by patient name the following information:

(I) unique identification number of the prescription;

(II) name and strength of the drug dispensed;

(III) date of each dispensing;

(IV) quantity dispensed at each dispensing;

(V) initials or identification code of the dispensing pharmacist;

(VI) initials or identification code of the pharmacy technician or pharmacy technician trainee preparing the prescription label, if applicable; and

(VII) total number of refills for the prescription.

(B) If refill records are maintained in accordance with subparagraph (A)(ii) of this paragraph, refill records for controlled substances in Schedules III-V shall be maintained separately from refill records of dangerous drugs and nonprescription drugs.

(3) Authorization of refills. Practitioner authorization for additional refills of a prescription drug order shall be noted on the original prescription, in addition to the documentation of dispensing the refill.

(4) Transfer of prescription drug order information. For the purpose of refill or initial dispensing, the transfer of original prescription drug order information is permissible between pharmacies, subject to the following requirements:

(A) the transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis;

(B) the transfer of original prescription drug order information for dangerous drugs is permissible between pharmacies without limitation up to the number of originally authorized refills;

(C) the transfer is communicated directly between pharmacists and/or pharmacist interns;

(D) both the original and the transferred prescription drug order are maintained for a period of two years from the date of last refill;

(E) the pharmacist or pharmacist intern transferring the prescription drug order information shall:

(i) write the word "void" on the face of the invalidated prescription drug order; and

(ii) record on the reverse of the invalidated prescription drug order the following information:

(I) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription drug order is transferred;

(II) the name of the pharmacist or pharmacist intern receiving the prescription drug order information;

(III) the name of the pharmacist or pharmacist intern transferring the prescription drug order information; and

(IV) the date of the transfer;

(F) the pharmacist or pharmacist intern receiving the transferred prescription drug order information shall:

(i) write the word "transfer" on the face of the transferred prescription drug order; and

(ii) record on the transferred prescription drug order the following information:

(I) original date of issuance and date of dispensing or receipt, if different from date of issuance;

(II) original prescription number and the number of refills authorized on the original prescription drug order;

(III) number of valid refills remaining and the date of last refill, if applicable;

(IV) name, address, and if a controlled substance, the DEA registration number of the pharmacy from which such prescription information is transferred; and

(V) name of the pharmacist or pharmacist intern transferring the prescription drug order information.

(5) A pharmacist or pharmacist intern may not refuse to transfer original prescription information to another pharmacist or pharmacist intern who is acting on behalf of a patient and who is making a request for this information as specified in paragraph (4) of this subsection.

(6) Each time a modification, change, or manipulation is made to a record of dispensing, documentation of such change shall be recorded on the back of the prescription or on another appropriate, uniformly maintained, readily retrievable record, such as medication records. The documentation of any modification, change, or manipulation to a record of dispensing shall include the identification of the individual responsible for the alteration.

(e) Prescription drug order records maintained in a data processing system.

(1) General requirements for records maintained in a data processing system.

(A) Compliance with data processing system requirements. If a Class A (community) pharmacy's data processing system is not in compliance with this subsection, the pharmacy must maintain a manual recordkeeping system as specified in subsection (d) of this section.

(B) Original prescriptions. Original prescriptions shall be maintained in three files as specified in subsection (b)(5)(D) of this section.

(C) Requirements for backup systems.

(i) The pharmacy shall maintain a backup copy of information stored in the data processing system using disk, tape, or

other electronic backup system and update this backup copy on a regular basis, at least monthly, to assure that data is not lost due to system failure.

(ii) Data processing systems shall have a workable (electronic) data retention system which can produce an audit trail of drug usage for the preceding two years as specified in paragraph (2)(H) of this subsection.

(D) Change or discontinuance of a data processing system.

(i) Records of dispensing. A pharmacy that changes or discontinues use of a data processing system must:

(I) transfer the records of dispensing to the new data processing system; or

(II) purge the records of dispensing to a printout which contains the same information required on the daily printout as specified in paragraph (2)(C) of this subsection. The information on this hard-copy printout shall be sorted and printed by prescription number and list each dispensing for this prescription chronologically.

(ii) Other records. A pharmacy that changes or discontinues use of a data processing system must:

(I) transfer the records to the new data processing system; or

(II) purge the records to a printout which contains all of the information required on the original document.

(iii) Maintenance of purged records. Information purged from a data processing system must be maintained by the pharmacy for two years from the date of initial entry into the data processing system.

(E) Loss of data. The pharmacist-in-charge shall report to the board in writing any significant loss of information from the data processing system within 10 days of discovery of the loss.

(2) Records of dispensing.

(A) Each time a prescription drug order is filled or refilled, a record of such dispensing shall be entered into the data processing system.

(B) Each time a modification, change or manipulation is made to a record of dispensing, documentation of such change shall be recorded in the data processing system. The documentation of any modification, change, or manipulation to a record of dispensing shall include the identification of the individual responsible for the alteration. Should the data processing system not be able to record a modification, change, or manipulation to a record of dispensing, the information should be clearly documented on the hardcopy prescription.

(C) The data processing system shall have the capacity to produce a daily hard-copy printout of all original prescriptions dispensed and refilled. This hard-copy printout shall contain the following information:

(i) unique identification number of the prescription;

(ii) date of dispensing;

(iii) patient name;

(iv) prescribing practitioner's name;

(v) name and strength of the drug product actually dispensed; if generic product, the brand name or manufacturer of drug dispensed;

(vi) quantity dispensed;

(vii) initials or an identification code of the dispensing pharmacist;

(viii) initials or an identification code of the pharmacy technician or pharmacy technician trainee performing data entry of the prescription, if applicable;

(ix) if not immediately retrievable via CRT display, the following shall also be included on the hard-copy printout:

(I) patient's address;

(II) prescribing practitioner's address;

(III) practitioner's DEA registration number, if the prescription drug order is for a controlled substance;

(IV) quantity prescribed, if different from the quantity dispensed;

(V) date of issuance of the prescription drug order, if different from the date of dispensing; and

(VI) total number of refills dispensed to date for that prescription drug order; and

(x) any changes made to a record of dispensing.

(D) The daily hard-copy printout shall be produced within 72 hours of the date on which the prescription drug orders were dispensed and shall be maintained in a separate file at the pharmacy. Records of controlled substances shall be readily retrievable from records of noncontrolled substances.

(E) Each individual pharmacist who dispenses or refills a prescription drug order shall verify that the data indicated on the daily hard-copy printout is correct, by dating and signing such document in the same manner as signing a check or legal document (e.g., J.H. Smith, or John H. Smith) within seven days from the date of dispensing.

(F) In lieu of the printout described in subparagraph (C) of this paragraph, the pharmacy shall maintain a log book in which each individual pharmacist using the data processing system shall sign a statement each day, attesting to the fact that the information entered into the data processing system that day has been reviewed by him or her and is correct as entered. Such log book shall be maintained at the pharmacy employing such a system for a period of two years after the date of dispensing; provided, however, that the data processing system can produce the hard-copy printout on demand by an authorized agent of the Texas State Board of Pharmacy. If no printer is available on site, the hard-copy printout shall be available within 72 hours with a certification by the individual providing the printout, which states that the printout is true and correct as of the date of entry and such information has not been altered, amended, or modified.

(G) The pharmacist-in-charge is responsible for the proper maintenance of such records and responsible that such data processing system can produce the records outlined in this section and that such system is in compliance with this subsection.

(H) The data processing system shall be capable of producing a hard-copy printout of an audit trail for all dispensings (original and refill) of any specified strength and dosage form of a drug (by either brand or generic name or both) during a specified time period.

(i) Such audit trail shall contain all of the information required on the daily printout as set out in subparagraph (C) of this paragraph.

(ii) The audit trail required in this subparagraph shall be supplied by the pharmacy within 72 hours, if requested by an authorized agent of the Texas State Board of Pharmacy.

(I) Failure to provide the records set out in this subsection, either on site or within 72 hours constitutes prima facie evidence of failure to keep and maintain records in violation of the Act.

(J) The data processing system shall provide on-line retrieval (via CRT display or hard-copy printout) of the information set out in subparagraph (C) of this paragraph of:

(i) the original controlled substance prescription drug orders currently authorized for refilling; and

(ii) the current refill history for Schedules III, IV, and V controlled substances for the immediately preceding six-month period.

(K) In the event that a pharmacy which uses a data processing system experiences system downtime, the following is applicable:

(i) an auxiliary procedure shall ensure that refills are authorized by the original prescription drug order and that the maximum number of refills has not been exceeded or authorization from the prescribing practitioner shall be obtained prior to dispensing a refill; and

(ii) all of the appropriate data shall be retained for on-line data entry as soon as the system is available for use again.

(3) Authorization of refills. Practitioner authorization for additional refills of a prescription drug order shall be noted as follows:

(A) on the hard-copy prescription drug order;

(B) on the daily hard-copy printout; or

(C) via the CRT display.

(4) Transfer of prescription drug order information. For the purpose of refill or initial dispensing, the transfer of original prescription drug order information is permissible between pharmacies, subject to the following requirements.

(A) The transfer of original prescription drug order information for controlled substances listed in Schedule III, IV, or V is permissible between pharmacies on a one-time basis only. However, pharmacies electronically sharing a real-time, on-line database may transfer up to the maximum refills permitted by law and the prescriber's authorization.

(B) The transfer of original prescription drug order information for dangerous drugs is permissible between pharmacies without limitation up to the number of originally authorized refills.

(C) The transfer is communicated directly between pharmacists and/or pharmacist interns orally by telephone or via facsimile or as authorized in paragraph (5) of this subsection. A transfer completed as authorized in paragraph (5) of this subsection may be initiated by a pharmacy technician or pharmacy technician trainee acting under the direct supervision of a pharmacist.

(D) Both the original and the transferred prescription drug orders are maintained for a period of two years from the date of last refill.

(E) The pharmacist or pharmacist intern transferring the prescription drug order information shall:

(i) write the word "void" on the face of the invalidated prescription drug order; and

(ii) record on the reverse of the invalidated prescription drug order the following information:

(I) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;

(II) the name of the pharmacist or pharmacist intern receiving the prescription drug order information;

(III) the name of the pharmacist or pharmacist intern transferring the prescription drug order information; and

(IV) the date of the transfer.

(F) The pharmacist or pharmacist intern receiving the transferred prescription drug order information shall:

(i) write the word "transfer" on the face of the transferred prescription drug order; and

(ii) record on the transferred prescription drug order the following information:

(I) original date of issuance and date of dispensing or receipt, if different from date of issuance;

(II) original prescription number and the number of refills authorized on the original prescription drug order;

(III) number of valid refills remaining and the date of last refill, if applicable;

(IV) name, address, and if a controlled substance, the DEA registration number of the pharmacy from which such prescription drug order information is transferred; and

(V) name of the pharmacist or pharmacist intern transferring the prescription drug order information.

(G) Prescription drug orders may not be transferred by non-electronic means during periods of downtime except on consultation with and authorization by a prescribing practitioner; provided however, during downtime, a hard copy of a prescription drug order may be made available for informational purposes only, to the patient, a pharmacist or pharmacist intern, and the prescription may be read to a pharmacist or pharmacist intern by telephone.

(H) The original prescription drug order shall be invalidated in the data processing system for purposes of filling or refilling, but shall be maintained in the data processing system for refill history purposes.

(I) If the data processing system has the capacity to store all the information required in subparagraphs (E) and (F) of this paragraph, the pharmacist is not required to record this information on the original or transferred prescription drug order.

(J) The data processing system shall have a mechanism to prohibit the transfer or refilling of controlled substance prescription drug orders which have been previously transferred.

(5) Electronic transfer of prescription drug order information between pharmacies. Pharmacies electronically accessing the same prescription drug order records may electronically transfer prescription information if the following requirements are met.

(A) The original prescription is voided and the following information is documented in the records of the transferring pharmacy:

(i) the name, address, and if a controlled substance, the DEA registration number of the pharmacy to which such prescription is transferred;

(ii) the name of the pharmacist or pharmacist intern receiving the prescription drug order information; and

(iii) the date of the transfer.

(B) Pharmacies not owned by the same person may electronically access the same prescription drug order records, provided the owner or chief executive officer of each pharmacy signs an agreement allowing access to such prescription drug order records.

(C) An electronic transfer between pharmacies may be initiated by a pharmacy technician or pharmacy technician trainee acting under the direct supervision of a pharmacist.

(6) A pharmacist or pharmacist intern may not refuse to transfer original prescription information to another pharmacist or pharmacist intern who is acting on behalf of a patient and who is making a request for this information as specified in paragraphs (4) and (5) of this subsection.

(f) Limitation to one type of recordkeeping system. When filing prescription drug order information a pharmacy may use only one of the two systems described in subsection (d) or (e) of this section.

(g) Distribution of controlled substances to another registrant. A pharmacy may distribute controlled substances to a practitioner, another pharmacy, or other registrant, without being registered to distribute, under the following conditions.

(1) The registrant to whom the controlled substance is to be distributed is registered under the Controlled Substances Act to dispense that controlled substance.

(2) The total number of dosage units of controlled substances distributed by a pharmacy may not exceed 5.0% of all controlled substances dispensed and distributed by the pharmacy during the 12-month period in which the pharmacy is registered; if at any time it does exceed 5.0%, the pharmacy is required to obtain an additional registration to distribute controlled substances.

(3) If the distribution is for a Schedule III, IV, or V controlled substance, a record shall be maintained which indicates:

(A) the actual date of distribution;

(B) the name, strength, and quantity of controlled substances distributed;

(C) the name, address, and DEA registration number of the distributing pharmacy; and

(D) the name, address, and DEA registration number of the pharmacy, practitioner, or other registrant to whom the controlled substances are distributed.

(4) If the distribution is for a Schedule I or II controlled substance, the following is applicable.

(A) The pharmacy, practitioner, or other registrant who is receiving the controlled substances shall issue Copy 1 and Copy 2 of a DEA order form (DEA 222C) to the distributing pharmacy.

(B) The distributing pharmacy shall:

(i) complete the area on the DEA order form (DEA 222C) titled "To Be Filled in by Supplier";

(ii) maintain Copy 1 of the DEA order form (DEA 222C) at the pharmacy for two years; and

(iii) forward Copy 2 of the DEA order form (DEA 222C) to the Divisional Office of the Drug Enforcement Administration.

(h) Other records. Other records to be maintained by a pharmacy:

(1) a permanent log of the initials or identification codes which will identify each dispensing pharmacist by name (the initials or identification code shall be unique to ensure that each pharmacist can be identified, i.e., identical initials or identification codes shall not be used);

(2) Copy 3 of DEA order form (DEA 222C) which has been properly dated, initialed, and filed, and all copies of each unaccepted or defective order form and any attached statements or other documents;

(3) a hard copy of the power of attorney to sign DEA 222C order forms (if applicable);

(4) suppliers' invoices of dangerous drugs and controlled substances; a pharmacist shall verify that the controlled drugs listed on the invoices were actually received by clearly recording his/her initials and the actual date of receipt of the controlled substances;

(5) suppliers' credit memos for controlled substances and dangerous drugs;

(6) a hard copy of inventories required by §291.17 of this title (relating to Inventory Requirements);

(7) hard-copy reports of surrender or destruction of controlled substances and/or dangerous drugs to an appropriate state or federal agency;

(8) a hard copy of the Schedule V nonprescription register book;

(9) records of distribution of controlled substances and/or dangerous drugs to other pharmacies, practitioners, or registrants; and

(10) a hard copy of any notification required by the Texas Pharmacy Act or the sections in this chapter, including, but not limited to, the following:

(A) reports of theft or significant loss of controlled substances to DEA, Department of Public Safety, and the board;

(B) notifications of a change in pharmacist-in-charge of a pharmacy; and

(C) reports of a fire or other disaster which may affect the strength, purity, or labeling of drugs, medications, devices, or other materials used in the diagnosis or treatment of injury, illness, and disease.

(i) Permission to maintain central records. Any pharmacy that uses a centralized recordkeeping system for invoices and financial data shall comply with the following procedures.

(1) Controlled substance records. Invoices and financial data for controlled substances may be maintained at a central location provided the following conditions are met.

(A) Prior to the initiation of central recordkeeping, the pharmacy submits written notification by registered or certified mail to the divisional director of the Drug Enforcement Administration as required by Title 21, Code of Federal Regulations, §1304.04(a), and submits a copy of this written notification to the Texas State Board of Pharmacy. Unless the registrant is informed by the divisional director of the Drug Enforcement Administration that permission to keep central records is denied, the pharmacy may maintain central records commencing 14 days after receipt of notification by the divisional director.

(B) The pharmacy maintains a copy of the notification required in subparagraph (A) of this paragraph.

(C) The records to be maintained at the central record location shall not include executed DEA order forms, prescription drug orders, or controlled substance inventories, which shall be maintained at the pharmacy.

(2) Dangerous drug records. Invoices and financial data for dangerous drugs may be maintained at a central location.

(3) Access to records. If the records are kept on microfilm, computer media, or in any form requiring special equipment to render the records easily readable, the pharmacy shall provide access to such equipment with the records.

(4) Delivery of records. The pharmacy agrees to deliver all or any part of such records to the pharmacy location within two business days of written request of a board agent or any other authorized official.

(j) Ownership of pharmacy records. For the purposes of these sections, a pharmacy licensed under the Act is the only entity which may legally own and maintain prescription drug records.

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 June 21, 2011.

TRD-201102308
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: July 11, 2011
Proposal publication date: April 8, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER D. INSTITUTIONAL PHARMACY (CLASS C)

22 TAC §291.74

The Texas State Board of Pharmacy adopts amendments to §291.74, concerning Operational Standards. The amendments are adopted without changes to the proposed text as published in the March 25, 2011, issue of the *Texas Register* (36 TexReg 1952).

The adopted amendments clarify requirements for pharmacy technicians and pharmacy technician trainees stocking automated medication supply systems.

No comments were received regarding the amendments.

The amendments are adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 21, 2011.

TRD-201102309
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: July 11, 2011
Proposal publication date: March 25, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER E. CLINIC PHARMACY (CLASS D)

22 TAC §291.91

The Texas State Board of Pharmacy adopts amendments to §291.91, concerning Definitions. The amendments are adopted without changes to the proposed text as published in the March 25, 2011, issue of the *Texas Register* (36 TexReg 1953).

The adopted amendments clarify the definitions of unit of use and prepackaging as used in Class D pharmacies.

No comments were received regarding the amendments.

The amendments are adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 21, 2011.

TRD-201102310
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: July 11, 2011
Proposal publication date: March 25, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER G. SERVICES PROVIDED BY PHARMACIES

22 TAC §291.133

The Texas State Board of Pharmacy adopts amendments to §291.133, concerning Pharmacies Compounding Sterile Preparations. The amendments are adopted without changes to the proposed text as published in the March 25, 2011, issue of the *Texas Register* (36 TexReg 1953).

The adopted amendments clarify the compounding requirements for facilities that prepare a low volume of cytotoxic drugs.

No comments were received regarding the amendments.

The amendments are adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 21, 2011.

TRD-201102311
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: July 11, 2011
Proposal publication date: March 25, 2011
For further information, please call: (512) 305-8028

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SUBCHAPTER H. OTHER CLASSES OF PHARMACY

22 TAC §291.153

The Texas State Board of Pharmacy adopts amendments to §291.153, concerning Central Prescription Drug or Medication Order Processing Pharmacy (Class G). The amendments are adopted without changes to the proposed text as published in the March 25, 2011, issue of the *Texas Register* (36 TexReg 1954).

The adopted amendments provide requirements for pharmacists providing cognitive services and electronic verification of prescriptions from remote sites.

No comments were received regarding the amendments.

The amendments are adopted under §551.002 and §554.051 of the Texas Pharmacy Act (Chapters 551 - 566 and 568 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by the amendments: Texas Pharmacy Act, Chapters 551 - 566 and 568 - 569, Texas Occupations Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on June 21, 2011.

TRD-201102312
Gay Dodson, R.Ph.
Executive Director/Secretary
Texas State Board of Pharmacy
Effective date: July 11, 2011
Proposal publication date: March 25, 2011
For further information, please call: (512) 305-8028

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TITLE 30. ENVIRONMENTAL QUALITY

PART 1. TEXAS COMMISSION ON ENVIRONMENTAL QUALITY

CHAPTER 293. WATER DISTRICTS

SUBCHAPTER E. ISSUANCE OF BONDS

30 TAC §293.44

The Texas Commission on Environmental Quality (TCEQ, agency, or commission) adopts the amendment to §293.44.

Section 293.44 is adopted *without changes* to the proposed text as published in the February 11, 2011, issue of the *Texas Register* (36 TexReg 713) and will not be republished.

Background and Summary of the Factual Basis for the Adopted Rule

On May 28, 2010, Paloma Lake Municipal Utility District (MUD) Number 1, Paloma Lake MUD Number 2, Parkside at Mayfield Ranch MUD, and Armbrust & Brown, L.L.P., on behalf of Greenhawe Water Control and Improvement District Number 2, Lakeside MUD Number 3, Moore's Crossing MUD, Travis County MUD Number 4, Travis County MUD Number 7, Travis County MUD Number 9, West Williamson County MUD Number 1, and Williamson County Water Sewer Irrigation and Drainage District Number 3 (Petitioner) proposed an amendment to §293.44 to facilitate regionalization and cooperative planning among water districts and other local government entities by providing clear authorization in the TCEQ's rules to provide a mechanism for allowing the cost incurred by a district to construct or acquire capacity in regional water, wastewater, and drainage facilities to be bonded or reimbursed so long as that cost did not exceed the cost the district would have incurred to construct the facilities required to provide the same service on its own. The Petitioner stated that the proposed amendment ". . .would further be consistent with the state's policy, as set forth in Texas Water Code, §49.230 to encourage the development and use of integrated area-wide wastewater collection, treatment and disposal systems to serve the wastewater disposal needs of the citizens of the state whenever it is economically feasible and competitive to do so. . .." The commission approved the petition (Project No. 2010-029-PET-NR) during its July 28, 2010 agenda and directed the executive director to initiate the rulemaking process. This adopted rulemaking is in response to that direction.

Section Discussion

The commission adopts the amendment to §293.44, Special Considerations. The commission amends the rule by adding §293.44(a)(8)(D) to allow the commission, or executive director on behalf of the commission to approve bonds for oversized facilities serving areas outside the district if the district or a developer in the district has entered into an agreement with certain local government entities and the oversizing is more cost-effective than alternative facilities to serve the district only. The adopted amendment defines regional water or wastewater provider for the purpose of this subparagraph and specifies the information that must be provided by the applicant before the executive director will review the request. The adopted amendment is intended to facilitate cooperation and coordination between water districts for regional water, wastewater, or drainage facilities by allowing a district to fund the *pro rata*

share of oversized facilities serving areas outside the district so long as it is the most cost-effective means of providing service. The adopted amendment may, depending on action by each district's board of directors, provide for a district to fund more than the existing rules allow. The commission adopts §293.44 by revising references to "sewer" and "sewage" to refer instead to "wastewater," to reflect current terminology and maintain uniform usage. Additionally, the commission adopts §293.44(b)(7) to correct a cross-reference to Chapter 291, Subchapter G, Certificates of Convenience and Necessity.

Final Regulatory Impact Analysis Determination

The commission reviewed the adopted rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined that the rulemaking does not meet the definition of a "major environmental rule" as defined by that statute. A "major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state.

This rulemaking does not meet the statutory definition of a "major environmental rule" because it is not the specific intent of this rule to protect the environment or reduce risks to human health from environmental exposure. The specific intent of this rule is to provide clear authorization in the TCEQ's rules for a determination of a district's allowable cost participation for oversized facilities serving areas outside the district based on a cost-benefit analysis. The rule is not required by federal regulations.

The adopted amendment to Chapter 293 authorizes the executive director to approve bonds for oversized facilities serving areas outside the district if the district or a developer in the district has entered into an agreement with certain local government entities and the oversizing is more cost-effective than alternative facilities to serve the district only. Further, this rulemaking does not meet the statutory definition of a "major environmental rule" because the adopted amendment would not adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or public health and safety of the state or a sector of the state. It is not anticipated that the cost of complying with the adopted amendment will be significant with respect to the economy as a whole; therefore, the adopted amendment will not adversely affect in a material way the economy, a sector of the economy, competition, or jobs.

Additionally, this rulemaking does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). This section only applies to a major environmental rule, the result of which is to: 1) exceed a standard set by federal law, unless the rule is specifically required by state law; 2) exceed an express requirement of state law, unless the rule is specifically required by federal law; 3) exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopt a rule solely under the general powers of the agency instead of under a specific state law. This rulemaking does not meet any of these four applicability requirements because this rulemaking: 1) does not exceed any standard set by federal law for treatment of water used in public water systems and is specifically required by state law; 2) does not exceed the requirements of state law under Texas Water Code (TWC), Chapter 49, Subchapter F; 3) does not exceed a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement any state and federal program on treatment of water used in public water systems, but rather is adopted to provide clear authorization under state law for the approval of bonds in certain circumstances; and 4) is not adopted solely under the general powers of the agency, but rather specifically under TWC, §12.081, which allows the commission to issue rules necessary to supervise districts and authorities. Under Texas Government Code, §2001.0225, only a major environmental rule requires a regulatory impact analysis. Because this adoption does not constitute a major environmental rule, a regulatory impact analysis is not required.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period. The commission did not receive any comments regarding the draft regulatory impact analysis determination.

Takings Impact Assessment

The commission evaluated the adopted amendment to Chapter 293 and performed a preliminary assessment of whether it constitutes a taking under Texas Government Code, Chapter 2007. The primary purpose of the adopted amendment is to clarify the executive director's authority in approving bonds in certain circumstances and to further the state's regionalization policy.

Promulgation of the adopted amendment would constitute neither a statutory nor a constitutional taking of private real property. There is no burden imposed on private real property under this rule because the adopted amendment neither relates to, nor has any impact on the use or enjoyment of private real property, and there would be no reduction in property value as a result of this rule. The adopted rule allows the district to reimburse a developer through bonds for oversized facilities serving areas outside the district if the district or a developer has entered into an agreement with certain types of local government entities.

Consistency with the Coastal Management Program

The commission reviewed the adopted rulemaking and found the adoption is a rulemaking identified in the Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(4) relating to rules subject to the Coastal Management Program (CMP), and did, therefore, require that goals and policies of the CMP be considered during the rulemaking process.

The commission reviewed this rulemaking for consistency with the CMP goals and policies in accordance with the regulations of the Coastal Coordination Council and determined that the rulemaking is procedural in nature and will have no substantive effect on commission actions subject to the CMP and is, therefore, consistent with CMP goals and policies.

The commission invited public comment regarding consistency with the CMP during the public comment period. The commission did not receive any comments regarding the consistency with the CMP.

Public Comment

The commission held a public hearing on March 8, 2011. The comment period closed on March 14, 2011. The commission did not receive any comments on this rulemaking.

Statutory Authority

The amendment is adopted under the authority of Texas Water Code (TWC), §5.103, which provides the commission's authority to adopt any rules necessary to carry out its powers and du-

ties under the laws of the state; and §12.081, which provides the commission authority to issue rules necessary to supervise districts and authorities created under Article III, §52 and Article XVI, §59, of the Texas Constitution.

The adopted amendment implements TWC, §5.103 and §12.081.

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 June 24, 2011.

TRD-201102372
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: July 14, 2011
Proposal publication date: February 11, 2011
For further information, please call: (512) 239-0779

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CHAPTER 328. WASTE MINIMIZATION AND RECYCLING

SUBCHAPTER F. MANAGEMENT OF USED OR SCRAP TIRES

30 TAC §328.66

The Texas Commission on Environmental Quality (commission or agency) adopts the amendment to §328.66 *without changes* as published in the February 11, 2011, issue of the *Texas Register* (36 TexReg 719), and will not be republished.

Background and Summary of the Factual Basis for the Adopted Rule

At the Commissioner's Agenda held on September 15, 2010, the commissioners directed the executive director to initiate a rulemaking to remove the requirement for applicants for Land Reclamation Projects Using Tires (LRPUT) to publish public notice in adjacent counties. The amended rule will require public notice to be published only in the county in which the facility is to be located.

Section Discussion

§328.66, Land Reclamation Projects Using Tires (LRPUT)

The amendment to §328.66(a)(11) would remove the requirement for applicants of a LRPUT to publish public notice in all adjacent counties of the proposed facility location. LRPUT applicants would only need to publish public notice in the county in which the proposed facility is to be located.

Final Regulatory Impact Analysis Determination

The commission reviewed the rulemaking in light of the regulatory analysis requirements of Texas Government Code, §2001.0225, and determined the rule does not meet the definition of a "major environmental rule." Under Texas Government Code, §2001.0225, "major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure, and that may adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The rulemaking is intended to reduce the burden on LRPUT applicants regarding public notice and to bring the notice requirements in line with other programs notice requirements. This rule reduces the cost of preparing an application for a LRPUT because notice is required in only one county as opposed to all adjoining counties.

Furthermore, the amendment does not meet any of the four applicability requirements listed in Texas Government Code, §2001.0225(a). Texas Government Code, §2001.0225 only applies to a major environmental rule which: 1) exceeds a standard set by federal law, unless the rule is specifically required by state law; 2) exceeds an express requirement of state law, unless the rule is specifically required by federal law; 3) exceeds a requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program; or 4) adopts a rule solely under the general powers of the agency instead of under a specific state law.

In this case, the rule does not meet any of these applicability requirements. First, there are no standards set for authorizing these types of facilities by federal law and the proposal is not required by state law. Second, the amendment does not exceed an express requirement of state law. There are no specific statutory requirements for authorizing these types of facilities. Third, the rule does not exceed an express requirement of a delegation agreement or contract between the state and an agency or representative of the federal government to implement a state and federal program. Fourth, the commission does not propose the rule solely under the general powers of the agency, but rather under the authority of: Texas Health and Safety Code (THSC), §361.011, which establishes the commission's jurisdiction over all aspects of the management of municipal solid waste; THSC, §361.024, which provides the commission with rulemaking authority; THSC, §361.061, which authorizes the commission to require and issue permits governing the construction, operation, and maintenance of solid waste facilities used to store, process, or dispose of solid waste; and, THSC, §361.112, which governs the storage, transportation, and disposal of used or scrap tires. Therefore, the commission does not propose the adoption of the rule solely under the commission's general powers.

The commission invited public comment regarding the draft regulatory impact analysis determination during the public comment period. No comments were received.

Takings Impact Assessment

The commission evaluated the rulemaking and performed an assessment of whether the rulemaking constitutes a taking under Texas Government Code, Chapter 2007. The specific intent of the amendment is to reduce the burden on LRPUT applicants regarding public notice and to bring the notice requirements in line with other programs notice requirements.

The amendment does not impose a burden on a recognized real property interest and therefore does not constitute a taking. The promulgation of the rulemaking is neither a statutory nor a constitutional taking of private real property by the commission. Specifically, the rulemaking does not affect a landowner's rights in a recognized private real property interest because this rulemaking neither: burdens (constitutionally), restricts, or limits the owner's right to the property that would otherwise exist in the absence of this rulemaking; nor would it reduce its value by 25% or more beyond that value which would exist in the absence of the

rule. Therefore, the rulemaking will not constitute a taking under Texas Government Code, Chapter 2007.

Consistency with the Coastal Management Program

The commission reviewed the rule and found that it is neither identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(b)(2) or (4), nor would it affect any action/authorization identified in Coastal Coordination Act Implementation Rules, 31 TAC §505.11(a)(6). Therefore, the rule is not subject to the Texas Coastal Management Program.

The commission invited public comment regarding the consistency with the coastal management program during the public comment period. No comments were received.

Public Comment

The commission held a public hearing on March 1, 2011. The comment period closed on March 11, 2011. The commission did not receive any comments on the rule.

Statutory Authority

The amendment is adopted under the authority of: Texas Health and Safety Code (THSC), §361.011, Commission's Jurisdiction: Municipal Solid Waste, which establishes the commission's jurisdiction over all aspects of the management of municipal solid waste; THSC, §361.024, Rules and Standards, which provides the commission with rulemaking authority; THSC, §361.061, Permits; Solid Waste Facility, which authorizes the commission to require and issue permits governing the construction, operation, and maintenance of solid waste facilities used to store, process, or dispose of solid waste; and, THSC, §361.112, Storage, Transportation, and Disposal of Used or Scrap Tires, which governs the storage, transportation, and disposal of used or scrap tires.

The amendment implements THSC, §361.061 and §361.112.

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 June 24, 2011.

TRD-201102373
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Effective date: July 14, 2011
Proposal publication date: February 11, 2011
For further information, please call: (512) 239-2548

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 3. TEXAS YOUTH COMMISSION

CHAPTER 110. CONTRACTS

37 TAC §§110.1, 110.5, 110.9, 110.11

The Texas Youth Commission (TYC) adopts new §110.1, concerning contract authority and responsibilities; §110.5, concerning contract monitoring; §110.9, concerning protests; and §110.11, concerning negotiation and mediation of contract disputes. Section 110.1 is adopted without changes to the proposed text as published in the April 29, 2011, issue of the *Texas Register* (36 TexReg 2706). Sections 110.5, 110.9, and 110.11 are adopted with changes to the proposed text as published. The sections are adopted with changes to correct typographical errors.

New §110.1 is adopted to establish the approval authority and responsibilities for executing contracts required by TYC.

New §110.5 is adopted to establish the contract monitoring roles and responsibilities of TYC staff, including the monitoring system used by TYC to ensure compliance with contract and service delivery requirements by service providers.

New §110.9 is adopted to establish the process by which an actual or prospective bidder, offeror, or contractor who considers himself/herself to have been aggrieved in connection with TYC's solicitation, evaluation, or award of a contract may formally protest.

New §110.11 is adopted to establish the process for TYC and its contractors to engage in negotiation and/or mediation procedures to resolve certain disputes involving claims of breach of a written contract.

No comments were received regarding adoption of the rules.

The new rules are adopted under: (1) Human Resources Code §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions; (2) Human Resources Code §61.048, which requires the commission to promulgate rules relating to the award of contracts for the construction of buildings and improvements; (3) Texas Government Code §2155.076, which requires each state agency to promulgate by rule protest procedures for resolving vendor protests relating to purchasing issues; (4) Texas Government Code §2260.052, which requires each unit of state government with rulemaking authority to promulgate rules to govern the negotiation and mediation of contract disputes; and (5) Texas Government Code §2261.202, which requires each state agency that makes procurements to promulgate rules that clearly define the contract monitoring roles and responsibilities, if any, of internal audit staff and other inspection, investigative, or audit staff.

The adopted rules implement Human Resources Code, §61.034.

§110.5. Contract Monitoring.

(a) Purpose. The purpose of this rule is to establish the contract monitoring roles and responsibilities of the Texas Youth Commission (TYC) staff, including the monitoring system used by TYC to ensure compliance with contract and service delivery requirements by service providers.

(b) Applicability. This rule applies to all public or private entities with which TYC has a contract.

(c) General Provisions.

(1) TYC will periodically monitor all public and private entities which contract with TYC.

(2) TYC will establish a monitoring schedule based on a risk assessment methodology. Higher risk contracts shall be monitored more frequently and more comprehensively than lower risk contracts.

(3) For residential program-related client services contracts, TYC will obtain and evaluate program cost information to ensure that each cost, including an administrative cost, is reasonable and necessary to achieve program objectives.

(d) Contract Monitoring Roles and Responsibilities.

(1) The TYC Internal Audit department audits contracted services and oversight monitoring activity in accordance with Human Resources Code §61.0331 and based on the results of the annual risk assessment.

(2) Quality assurance staff will conduct program reviews of all residential facilities and parole programs operated under contract with TYC to ensure operations comply with applicable statutes, policies, procedures, and standards.

(3) Individual program areas will:

(A) provide day-to-day monitoring activities regarding financial and performance requirements;

(B) provide technical assistance to providers; and

(C) initiate corrective action and/or sanctions for noncompliance when appropriate.

§110.9. Protests.

(a) Purpose. The purpose of this rule is to establish the process for which actual or prospective bidders, offerors, or contractors may formally protest.

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

(1) Agency--The Texas Youth Commission.

(2) Interested parties--All vendors who have submitted bids or proposals for the provision of goods or services pursuant to a contract with the Texas Youth Commission.

(c) General Provisions.

(1) Any actual or prospective bidder, offeror, or contractor who considers himself/herself to have been aggrieved in connection with the agency's solicitation, evaluation, or award of a contract may formally protest to the procurement director. Such protests must be made in writing and received in the office of the procurement director within ten working days after the protesting party knows, or should have known, of the occurrence of the action that is protested. Formal protests must conform to the requirements of this subsection and subsection (d) of this section, and will be resolved through use of the procedures that are described in subsections (e) - (g) of this section. The protesting party must mail or deliver copies of the protest to the agency and other interested parties.

(2) In the event of a timely protest under this rule, the agency will not proceed further with the solicitation or award of the contract unless the deputy executive director, after consultation with appropriate staff, makes a written determination that the contract must be awarded without delay to protect the best interests of the agency.

(d) Protests. A formal protest must be sworn and contain:

(1) a specific identification of the statutory or regulatory provision that the protesting party alleges has been violated;

(2) a specific description of each action by the agency that the protesting party alleges to be a violation of the statutory or regulatory provision that the protesting party has identified pursuant to paragraph (1) of this subsection;

(3) a precise statement of the relevant facts;

(4) a statement of any issues of law or fact that the protesting party contends must be resolved;

(5) a statement of the argument and authorities that the protesting party offers in support of the protest; and

(6) a statement that copies of the protest have been mailed or delivered to the agency and all other identifiable interested parties.

(e) Resolving Protests.

(1) The procurement director may settle and resolve the dispute over the solicitation or award of a contract at any time before the matter is submitted on appeal to the agency's general counsel or his/her designee. The procurement director may solicit written responses to the protest from other interested parties.

(2) If the protest is not resolved by mutual agreement, the chief financial officer (CFO) will consult with the office of general counsel to issue a written determination that resolves the protest.

(3) If the CFO, after consultation with the office of general counsel, determines that no violation of statutory or regulatory provisions has occurred, then he/she shall inform the protesting party and any other interested parties by letter that sets forth the reasons for the determination.

(4) If the CFO, after consultation with the office of general counsel, determines that a violation of any statutory or regulatory provisions has occurred in a situation in which a contract has not been awarded, then he/she shall inform the protesting party and any other interested parties of that determination by letter that details the reasons for the determination and the appropriate remedy.

(5) If the CFO, after consultation with the office of general counsel, determines that a violation of any statutory or regulatory provisions has occurred in a situation in which a contract has been awarded, then he/she shall inform the protesting party and any other interested parties of that determination by letter that details the reasons for the determination. This letter may include an order that declares the contract void.

(f) Appealing a Protest.

(1) The protesting party may appeal a determination of a protest by the CFO to the general counsel or his/her designee. An appeal of the CFO's determination must be in writing and received by the general counsel not later than ten working days after the date on which the CFO has sent written notice of his/her determination. The scope of the appeal will be limited to review of the CFO's determination. The protesting party must mail or deliver to the agency and all other interested parties a copy of the appeal, which must contain a certified statement that such copies have been provided.

(2) The general counsel or his/her designee may refer the matter to the executive director for consideration or may issue a written decision that resolves the protest.

(g) Referral of a Protest to the Executive Director. The following requirements shall apply to a protest that the general counsel or his/her designee refers to the executive director.

(1) The general counsel or his/her designee will deliver copies of the appeal and any responses by interested parties to the executive director.

(2) The executive director may consider any documents that agency staff or interested parties have submitted.

(3) The executive director will issue a written letter of determination of the appeal to the parties which shall be final.

(A) A protest or appeal that is not filed timely will not be considered unless good cause for delay is shown or the executive

director determines that an appeal raises issues that are significant to agency procurement practices or procedures in general.

(B) A written decision that either the executive director or the general counsel or his/her designee has issued shall be the final administrative action of the agency.

(h) Documentation Requirements. The agency will maintain all documentation on the purchasing process that is the subject of a protest or appeal in accordance with the agency's retention schedule.

§110.11. Negotiation and Mediation of Contract Disputes.

(a) Purpose. In accordance with Texas Government Code Chapter 2260, the purpose of this rule is to establish procedures for the Texas Youth Commission (TYC) and its contractors to engage in negotiation and/or mediation procedures to resolve certain disputes involving claims of breach of written contract. These procedures are not intended to replace the process to resolve any disagreement concerning the contract in the ordinary course of contract administration under less formal procedures specified in the parties' contract.

(b) Applicability.

(1) This rule applies to TYC and its contractors, as defined in Texas Government Code §2260.001.

(2) This rule does not apply to:

(A) a claim for personal injury or wrongful death arising from a breach of contract;

(B) an action of TYC for which a contractor is entitled to a specific remedy pursuant to state or federal constitution or statute;

(C) a contract action proposed or taken by TYC for which a contractor receiving Medicaid funds under that contract is entitled by state statute or rule to a hearing conducted in accordance with Chapter 2001 of the Texas Government Code;

(D) a contract that is solely and entirely funded by federal grant monies other than for a project defined in Texas Government Code §2166.001;

(E) a contract between TYC and the federal government or its agencies, another state, or another nation;

(F) a contract between TYC and another unit of state government;

(G) a contract between TYC and a local governmental body or a political subdivision of another state;

(H) a claim from a contractor's subcontractor, officer, employee, agent, or other persons furnishing goods or services to a contractor;

(I) a contract within the exclusive jurisdiction of state or local regulatory bodies; or

(J) a contract within the exclusive jurisdiction of federal courts or regulatory bodies.

(c) Sovereign Immunity.

(1) This rule does not waive TYC's sovereign immunity to suit or liability.

(2) The procedures contained in this rule are exclusive and required prerequisites to suit under Texas Civil Practice and Remedies Code, Chapter 107, and the Texas Government Code, Chapter 2260.

(d) Contract Claims.

(1) Notice of Claim of Breach of Contract.

(A) A contractor asserting a claim for breach of contract under Texas Government Code Chapter 2260 shall file notice of the claim as provided by this subsection.

(B) The notice of claim shall:

(i) be submitted no later than 180 days after the date of the event that the contractor asserts as the basis of the claim;

(ii) be delivered by hand, certified mail return receipt requested, or other verifiable delivery service to the individual stated in the contract or to the executive director if no individual is identified; and

(iii) state in detail:

(I) the nature of the alleged breach of contract, including the date of the event that the contractor asserts as the basis of the claim and each contractual provision allegedly breached;

(II) a description of damages that resulted from the alleged breach, including the amount and method used to calculate those damages; and

(III) the legal theory of recovery, i.e., breach of contract, including the causal relationship between the alleged breach and the damages claimed; and

(iv) provide supporting documentation or other tangible evidence to facilitate TYC's evaluation of the claim; and

(v) be signed by the contractor or the contractor's authorized representative.

(2) Counterclaim by the Commission.

(A) In order to assert a counterclaim, TYC shall file notice of the counterclaim not later than 60 days after the date of the contractor's notice of claim.

(B) The notice of counterclaim shall:

(i) be submitted in writing;

(ii) be delivered by hand, certified mail return receipt requested, or other verifiable delivery service to the contractor or representative of the contractor; and

(iii) state in detail:

(I) the nature of the counterclaim;

(II) a description of damages or offsets sought, including the amount and method used to calculate those damages or offsets; and

(III) the legal theory supporting the counterclaim recovery, i.e., breach of contract, including the causal relationship between the alleged breach and the damages claimed; and

(iv) provide supporting documentation or other tangible evidence to facilitate the contractor's evaluation of TYC's counterclaim; and

(v) be signed by the executive director or his/her designee.

(C) Nothing herein precludes TYC from initiating a lawsuit for damages against the contractor in a court of competent jurisdiction.

(e) Negotiation.

(1) The parties may conduct negotiations of claims and counterclaims within a reasonable period of time as long as the negotiations start prior to the 120th day following the date TYC receives the contractor's notice of claim.

(2) The parties shall complete the negotiations as provided by this rule as a prerequisite to a contractor's request for contested case hearing no later than 270 days after TYC receives the contractor's notice of claim unless the parties agree in writing to extend the time for negotiations.

(3) The parties may conduct negotiations with the assistance of one or more neutral third parties.

(4) To facilitate the meaningful evaluation and negotiation of the claim(s) and any counterclaim(s), the parties may exchange relevant documents that support their respective claims, defenses, counterclaims, or positions.

(5) Material submitted pursuant to this subsection and claimed to be confidential by the contractor shall be handled pursuant to the requirements of the Public Information Act.

(6) The agreement may resolve an entire claim or counterclaim or any designated and severable portion of a claim.

(7) The agreement must be in writing and signed by representatives of the contractor and TYC who have authority to bind each respective party.

(8) A partial settlement does not waive a party's rights under Texas Government Code Chapter 2260 to proceed on the parts of the claims or counterclaims that are not resolved.

(9) Unless the parties agree otherwise, each party shall be responsible for its own costs incurred in connection with a negotiation, including, without limitation, the costs of attorney's fees, consultant's fees, and expert's fees.

(f) Mediation.

(1) The parties may agree to mediate the dispute at any time before the 120th day after TYC receives the contractor's notice of claim or before the expiration of any written extension agreed to by the parties.

(2) The parties may mediate the dispute even after the case has been referred to the State Office of Administrative Hearings (SOAH) for a contested case. The SOAH may also refer a contested case for mediation pursuant to its own rules and guidelines, whether or not the parties have previously attempted mediation.

(3) The mediation is subject to the provisions of the Governmental Dispute Resolution Act, Texas Government Code, Chapter 2009. For purposes of this rule, mediation is assigned the meaning set forth in the Texas Civil Practice and Remedies Code §154.023.

(4) To facilitate a meaningful opportunity for settlement, the parties shall, to the extent possible, select representatives who:

(A) are knowledgeable about the dispute;

(B) are in a position to reach agreement; or

(C) can credibly recommend approval of an agreement.

(5) Sources of mediators shall include governmental officers or employees who are qualified as mediators under §154.052, Texas Civil Practice and Remedies Code, private mediators, SOAH, the Center for Public Policy Dispute Resolution at the University of Texas School of Law, an alternative dispute resolution system created under Chapter 152, Texas Civil Practice and Remedies Code, or another state or federal agency or through a pooling agreement with several state agencies.

(6) The confidentiality of a final settlement agreement to which TYC is a signatory that is reached as a result of the mediation is governed by Texas Government Code, Chapter 552.

(7) Each party shall be responsible for its own costs incurred in connection with the mediation, including costs of document reproduction for documents requested by such party, attorney's fees, and consultant or expert fees. The costs of the mediation process itself shall be divided equally between the parties.

(g) Settlement Agreement.

(1) A settlement agreement reached as a result of negotiation or mediation that resolves an entire claim or counterclaim or any designated and severable portion of a claim or counterclaim shall be in writing and signed by the representatives of the contractor and TYC who have authority to bind each respective party.

(2) If the settlement agreement does not resolve all issues raised by the claim and counterclaim, the agreement shall identify the issues that are not resolved.

(3) A partial settlement does not waive a contractor's rights under the Government Code, Chapter 2260, as to the parts of the claim that are not resolved.

(h) Referral to the State Office of Administrative Hearings.

(1) The contractor may request a contested case hearing before the SOAH after the 270th day after TYC receives the contractor's notice of claim, or the expiration of any written extension.

(2) If a claim for breach of contract is not resolved in its entirety through negotiation or mediation in accordance with this rule on or before the 270th day after TYC receives notice of claim, or after the expiration of any written extension agreed to by the parties, the contractor may file a request with TYC for a contested case hearing before SOAH.

(3) A request for a contested case hearing shall state the legal and factual basis for the claim, and shall be delivered to the executive director of TYC or other officer designated in the contract to receive notice within a reasonable time after the 270th day or the expiration of any written extension agreed to by the parties.

(4) TYC shall forward the contractor's request for contested case hearing to SOAH within a reasonable period of time, not to exceed 30 days after receipt of the request.

(5) The parties may agree to submit the case to SOAH before the 270th day after the notice of claim is received by TYC if they have achieved a partial resolution of the claim or if an impasse has been reached in the negotiations and proceeding to a contested case hearing would serve the interests of justice.

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 June 22, 2011.

TRD-201102344
Cheryln K. Townsend
Executive Director
Texas Youth Commission
Effective date: July 15, 2011
Proposal publication date: April 29, 2011
For further information, please call: (512) 424-6475

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CHAPTER 111. CONTRACTS

The Texas Youth Commission adopts the repeal of §111.1, concerning purchasing youth services; §111.7, concerning rate setting for youth service contracts; §111.9, concerning request for proposal; §111.11, concerning start-up funds; §111.13, concerning quality assurance of contract programs; §111.15, concerning variance/waiver requests; §111.17, concerning private sector involvement; §111.31, concerning contracting for services; §111.37, concerning professional and consultant contracts; §111.39, concerning architect and engineer contracts; §111.45, concerning construction contracts; §111.49, concerning construction contract change order approval; §111.51, concerning construction project operations management process and resolution forum; §111.57, concerning training and education contracts; §111.61, concerning student intern contracts; §111.73, concerning problem solving mechanism; §111.77, concerning negotiation and mediation of contract disputes; §111.81, concerning historically underutilized businesses; and §111.87, concerning 1st choice-recycled content product; without changes to the proposal as published in the April 29, 2011, issue of the *Texas Register* (36 TexReg 2710).

The adoption of the repeals will allow for the adoption of new Chapter 110, §§110.1, 110.5, 110.9, and 110.11, as published in the Adopted Rules section of this issue of the *Texas Register.*

No comments were received regarding adoption of the repeal of these rules.

SUBCHAPTER A. CONTRACTS FOR YOUTH SERVICES

37 TAC §§111.1, 111.7, 111.9, 111.11, 111.13, 111.15, 111.17

The repeals are adopted under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The adopted repeals implement the Human Resources Code, §61.034.

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 June 22, 2011.

TRD-201102345
Cheryln K. Townsend
Executive Director
Texas Youth Commission
Effective date: July 15, 2011
Proposal publication date: April 29, 2011
For further information, please call: (512) 424-6475

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SUBCHAPTER B. CONTRACTS FOR OTHER THAN YOUTH SERVICES

37 TAC §§111.31, 111.37, 111.39, 111.45, 111.49, 111.51, 111.57, 111.61

The repeals are adopted under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The adopted repeals implement the Human Resources Code, §61.034.

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 June 22, 2011.

TRD-201102346
Cheryln K. Townsend
Executive Director
Texas Youth Commission
Effective date: July 15, 2011
Proposal publication date: April 29, 2011
For further information, please call: (512) 424-6475

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SUBCHAPTER C. MISCELLANEOUS

37 TAC §§111.73, 111.77, 111.81, 111.87

The repeals are adopted under the Human Resources Code, §61.034, which provides the commission with the authority to make rules appropriate to the proper accomplishment of its functions.

The adopted repeals implement the Human Resources Code, §61.034.

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 June 22, 2011.

TRD-201102347
Cheryln K. Townsend
Executive Director
Texas Youth Commission
Effective date: July 15, 2011
Proposal publication date: April 29, 2011
For further information, please call: (512) 424-6475

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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

Credit Union Department

Title 7, Part 6

The Texas Credit Union Commission will review and consider for re-adoption, revision, or repeal Chapter 91, §91.6001 (Fiduciary Duties), §91.6002 (Fiduciary Capacities), §91.6003 (Notice Requirements), §91.6004 (Exercise of Fiduciary Powers), §91.6005 (Exemption from Notice), §91.6006 (Policies and Procedures), §91.6007 (Review of Fiduciary Accounts), §91.6008 (Recordkeeping), §91.6009 (Audit), §91.6010 (Custody of Fiduciary Assets), §91.6011 (Trust Funds), §91.6012 (Compensation, Gifts, and Bequests), §91.6013 (Bond Coverage), §91.6014 (Errors and Omissions Insurance), and §91.6015 (Litigation File) of Title 7, Part 6 of the Texas Administrative Code in preparation for the Commission's Rule Review as required by §2001.039, Government Code.

An assessment will be made by the Commission as to whether the reasons for adopting or readopting these rules continue to exist. Each rule will be reviewed to determine whether it is obsolete, whether the rule reflects current legal and policy considerations, and whether the rule reflects current procedures of the Credit Union Department.

Comments or questions regarding these rules may be submitted in writing to, Credit Union Department, 914 East Anderson Lane, Austin, Texas 78752-1699, or electronically to info@tcud.state.tx.us. The deadline for comments is August 4, 2011.

The Commission also invites your comments on how to make these rules easier to understand. For example:

* Do the rules organize the material to suit your needs? If not, how could the material be better organized?

* Do the rules clearly state the requirements? If not, how could the rule be more clearly stated?

* Do the rules contain technical language or jargon that isn't clear? If so, what language requires clarification?

* Would a different format (grouping and order of sections, use of headings, paragraphing) make the rule easier to understand? If so, what changes to the format would make the rule easier to understand?

* Would more (but shorter) sections be better in any of the rules? If so, what sections should be changed?

Any proposed changes to these rules as a result of the rule review will be published in the Proposed Rule Section of the *Texas Register.* The proposed rules will be open for public comment prior to final adoption by the Commission.

TRD-201102433
Harold E. Feeney
Commissioner
Credit Union Department
Filed: June 28, 2011

♦ ♦ ♦

State Board for Educator Certification

Title 19, Part 7

The State Board for Educator Certification (SBEC) proposes the review of Title 19, Texas Administrative Code (TAC), Chapter 230, Professional Educator Preparation and Certification, pursuant to the Texas Government Code, §2001.039. The rules being reviewed by the SBEC in 19 TAC Chapter 230 are organized under the following subchapters: Subchapter A, Definitions; Subchapter B, Assessment of Educators; Subchapter M, Certification of Educators in General; Subchapter N, Certificate Issuance Procedures; Subchapter O, Texas Educator Certificates Based on Certification and College Credentials from Other States or Territories of the United States; Subchapter P, Requirements for Standard Certificates and Specialized Assignments or Programs; Subchapter Q, Permits; Subchapter S, Educational Aide Certificate; and Subchapter V, Induction Training for Beginning Teachers.

As required by the Texas Government Code, §2001.039, the SBEC will accept comments as to whether the reasons for adopting 19 TAC Chapter 230, Subchapters A, B, M-Q, S, and V, continue to exist. The comment period begins July 8, 2011, and ends following receipt of public comments on the rule review of 19 TAC Chapter 230 at the next regularly scheduled SBEC meeting to be held on August 12, 2011.

Comments or questions regarding this rule review may be submitted to Cristina De La Fuente-Valadez, Policy Coordination Division, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701-1494, (512) 475-1497. Comments may also be submitted electronically to sbecrules@tea.state.tx.us or faxed to (512) 463-0028. Comments should be identified as "SBEC Rule Review."

TRD-201102453
Cristina De La Fuente-Valadez
Director, Policy Coordination, Texas Education Agency
State Board for Educator Certification
Filed: June 29, 2011

♦ ♦ ♦

The State Board for Educator Certification (SBEC) proposes the review of Title 19, Texas Administrative Code (TAC), Chapter 232, General Certification Provisions, pursuant to the Texas Government Code,

§2001.039. The rules being reviewed by the SBEC in 19 TAC Chapter 232 are organized under the following subchapters: Subchapter A, Types and Classes of Certificates Issued; Subchapter B, Certificate Renewal and Continuing Professional Education Requirements; and Subchapter C, National Criminal History Record Information Review of Active Certificate Holders.

As required by the Texas Government Code, §2001.039, the SBEC will accept comments as to whether the reasons for adopting 19 TAC Chapter 232, Subchapters A-C, continue to exist. The comment period begins July 8, 2011, and ends following receipt of public comments on the rule review of 19 TAC Chapter 232 at the next regularly scheduled SBEC meeting to be held on August 12, 2011.

Comments or questions regarding this rule review may be submitted to Cristina De La Fuente-Valadez, Policy Coordination Division, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701-1494, (512) 475-1497. Comments may also be submitted electronically to sbecrules@tea.state.tx.us or faxed to (512) 463-0028. Comments should be identified as "SBEC Rule Review."

TRD-201102454
Cristina De La Fuente-Valadez
Director, Policy Coordination, Texas Education Agency
State Board for Educator Certification
Filed: June 29, 2011

♦ ♦ ♦

The State Board for Educator Certification (SBEC) proposes the review of Title 19, Texas Administrative Code (TAC), Chapter 233, Categories of Classroom Teaching Certificates, pursuant to the Texas Government Code, §2001.039.

As required by the Texas Government Code, §2001.039, the SBEC will accept comments as to whether the reasons for adopting 19 TAC Chapter 233 continue to exist. The comment period begins July 8, 2011, and ends following receipt of public comments on the rule review of 19 TAC Chapter 233 at the next regularly scheduled SBEC meeting to be held on August 12, 2011.

Comments or questions regarding this rule review may be submitted to Cristina De La Fuente-Valadez, Policy Coordination Division, Texas Education Agency, 1701 North Congress Avenue, Austin, Texas 78701-1494, (512) 475-1497. Comments may also be submitted electronically to sbecrules@tea.state.tx.us or faxed to (512) 463-0028. Comments should be identified as "SBEC Rule Review."

TRD-201102455
Cristina De La Fuente-Valadez
Director, Policy Coordination, Texas Education Agency
State Board for Educator Certification
Filed: June 29, 2011

♦ ♦ ♦

Texas Department of Insurance, Division of Workers' Compensation

Title 28, Part 2

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) will review and consider for readoption, revision, or repeal all sections of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with the Texas Government Code §2001.039: Chapter 47, Employee Notice of Injury or Death and Claim for Benefits.

§47.5. Information Constituting Claim

§47.10. Signature of Claimant

§47.15. Employer Advances Compensation

§47.20. Beneficiaries Filing Claim

The Division will consider whether the reasons for initially adopting these rules continue to exist and whether these rules should be repealed, readopted, or readopted with amendments. Any repeals or necessary amendments identified during the review of these rules will be proposed and published in the *Texas Register* in accordance with the Administrative Procedure Act, Texas Government Code Chapter 2001.

To be considered, written comments relating to whether these rules should be repealed, readopted, or readopted with amendments must be submitted within 30 days following the publication of this notice in the *Texas Register.* Comments may be submitted by email at rulecomments@tdi.state.tx.us or by mailing or delivering your comments to Maria Jimenez, Legal Services, MS-4D, Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645.

Comments should clearly specify the particular section of the rule to which they apply. Comments should include proposed alternative language as appropriate. General comments should be designated as such.

TRD-201102379
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: June 24, 2011

♦ ♦ ♦

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) will review and consider for readoption, revision, or repeal all sections of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with the Texas Government Code §2001.039: Chapter 51, Award of the Board.

§51.10. Joint Payment of Award

§51.15. Periodic Installments

§51.20. Lump Sum Payment

§51.25. Request for Review

§51.30. Review of Award

§51.50. Payments of Attorney's Fees

§51.65. Attorney Fees

The Division will consider whether the reasons for initially adopting these rules continue to exist and whether these rules should be repealed, readopted, or readopted with amendments. Any repeals or necessary amendments identified during the review of these rules will be proposed and published in the *Texas Register* in accordance with the Administrative Procedure Act, Texas Government Code Chapter 2001.

To be considered, written comments relating to whether these rules should be repealed, readopted, or readopted with amendments must be submitted within 30 days following the publication of this notice in the*Texas Register.* Comments may be submitted by email at rulecomments@tdi.state.tx.us or by mailing or delivering your comments to Maria Jimenez, Legal Services, MS-4D, Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645.

Comments should clearly specify the particular section of the rule to which they apply. Comments should include proposed alternative language as appropriate. General comments should be designated as such.

TRD-201102380
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: June 24, 2011

♦ ♦ ♦

Texas Racing Commission

Title 16, Part 8

The Texas Racing Commission files this notice of intent to review Chapter 301, Definitions, Chapter 303, General Provisions, and Chapter 319, Veterinary Practices and Drug Testing. This review is conducted pursuant to the Texas Government Code, §2001.039, which requires state agencies to review and consider for readoption their administrative rules every four years.

The review shall assess whether the reasons for initially adopting the rules within each chapter continue to exist and whether any changes to the rules should be made.

All comments or questions in response to this notice of rule reviews may be submitted in writing to Carolyn Weiss, Assistant to the Executive Director of the Texas Racing Commission, at P.O. Box 12080, Austin, Texas 78711-2080, telephone (512) 833-6699, or fax (512) 833-6907. The Commission will accept public comments regarding the chapter and the rules within it for 30 days following publication of this notice in the *Texas Register*.

Any proposed changes to the rules within Chapters 301, 303, and 319 as a result of the review will be published in the Proposed Rules section of the *Texas Register* and will be open for an additional 30-day public comment period prior to final adoption or repeal by the Commission.

TRD-201102395
Mark Fenner
General Counsel
Texas Racing Commission
Filed: June 24, 2011

♦ ♦ ♦

Adopted Rule Reviews

State Board for Educator Certification

Title 19, Part 7

The State Board for Educator Certification (SBEC) adopts the review of Title 19, Texas Administrative Code (TAC), Chapter 249, Disciplinary Proceedings, Sanctions, and Contested Cases, pursuant to the Texas Government Code, §2001.039. The rules reviewed by the SBEC in 19 TAC Chapter 249 are organized under the following subchapters: Subchapter A, General Provisions; Subchapter B, Enforcement Actions and Guidelines; Subchapter C, Prehearing Matters; Subchapter D, Hearing Procedures; and Subchapter E, Posthearing Matters. The SBEC proposed the review of 19 TAC Chapter 249 in the May 6, 2011, issue of the *Texas Register* (36 TexReg 2999).

Relating to the review of 19 TAC Chapter 249, the SBEC finds that the reasons for the adoption of Subchapters A-E continue to exist and readopts the rules. Changes are anticipated to the SBEC rules in 19 TAC Chapter 249 to update statutory and administrative rule references, as well as clarify and streamline the SBEC disciplinary procedures and standards. The Texas Education Agency staff plan to present proposed amendments at the August 2011 SBEC meeting.

The SBEC received no comments related to the rule review of 19 TAC Chapter 249.

This concludes the review of 19 TAC Chapter 249.

TRD-201102456
Cristina De La Fuente-Valadez
Director, Policy Coordination, Texas Education Agency
State Board for Educator Certification
Filed: June 29, 2011

♦ ♦ ♦

Texas Department of Insurance, Division of Workers' Compensation

Title 28, Part 2

Pursuant to the notice of proposed rule review published in the April 15, 2011, issue of the *Texas Register* (36 TexReg 2467), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 42, Medical Benefits.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 42. The completion of the review of this chapter concludes the rule review process.

TRD-201102385
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: June 24, 2011

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the May 6, 2011, issue of the *Texas Register* (36 TexReg 2999), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 49, Procedures for Formal Hearings by the Board.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 49. The completion of the review of this chapter concludes the rule review process.

TRD-201102381

Dirk Johnson

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

Filed: June 24, 2011

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the May 6, 2011, issue of the *Texas Register* (36 TexReg 3000), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 55, Lump Sum Payments.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 55. The completion of the review of this chapter concludes the rule review process.

TRD-201102382

Dirk Johnson

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

Filed: June 24, 2011

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the May 6, 2011, issue of the *Texas Register* (36 TexReg 3000), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 56, Structured Compromise Settlement Agreements.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 56. The completion of the review of this chapter concludes the rule review process.

TRD-201102386

Dirk Johnson

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

Filed: June 24, 2011

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the May 6, 2011, issue of the*Texas Register* (36 TexReg 3000), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 57, Request for Case Folders and Certifications of Actions of the Board.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 57. The completion of the review of this chapter concludes the rule review process.

TRD-201102383

Dirk Johnson

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

Filed: June 24, 2011

♦ ♦ ♦

Pursuant to the notice of proposed rule review published in the May 6, 2011, issue of the *Texas Register* (36 TexReg 3001), the Texas Department of Insurance, Division of Workers' Compensation has reviewed and considered for readoption, revision or repeal all sections as they existed on June 15, 2011, of the following chapter of Title 28, Part 2 of the Texas Administrative Code, in accordance with Texas Government Code §2001.039: Chapter 59, Notices of Intention to Appeal.

The Department considered, among other things, whether the reasons for adoption of these rules continue to exist. The Department received no written comments regarding the review of its rules.

The Department has determined that the reasons for adopting the remaining sections continue to exist and these sections are retained in their present form. However, any such revisions in the future will be accomplished in accordance with the Texas Administrative Procedure Act.

This concludes the Department's review of Chapter 59. The completion of the review of this chapter concludes the rule review process.

TRD-201102384

Dirk Johnson

General Counsel

Texas Department of Insurance, Division of Workers' Compensation

Filed: June 24, 2011

♦ ♦ ♦

Texas Racing Commission

Title 16, Part 8

The Texas Racing Commission has completed its reviews of Chapter 307, Proceedings Before the Commission, Chapter 321, Pari-Mutuel Wagering, and Chapter 323, Disciplinary Action and Enforcement. This review is conducted pursuant to the Texas Government Code, §2001.039, which requires state agencies to review and consider for readoption their administrative rules every four years.

Notice of the rule reviews was published in the January 1, 2010, issue of the *Texas Register* (35 TexReg 113). During the review, the Commission proposed and adopted amendments to 16 TAC §§307.62, 321.15, 321.23, 321.211, 321.312, 321.417, 321.503, and 321.605. The Com-

mission also proposed and adopted new §§321.12, 321.46, 321.320, and 321.321.

The commission received no comments on the rule review in response to the notice other than the comments received in response to individual rule proposals.

The commission has determined that the reasons for initially adopting each rule within the chapters continue to exist and readopts the chapters with the amended rules as referenced above.

This completes the review of 16 TAC Part 8, Chapters 307, 321, and 323.

TRD-201102394
Mark Fenner
General Counsel
Texas Racing Commission
Filed: June 24, 2011

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: 13 TAC §121.15(d)

Independent Auditor's Report
(Independent Certified Public Accountant's Letterhead)
Applicant's Name
Address, City, State, and Zip

We have examined management's assertion that the accompanying Expended Budget of Applicant for the Project _____ [Project Name], ended _____ [Date], is presented in accordance with the accounting and reporting requirements of Texas Administrative Code, Title 13, Part 8, Chapter 121 and the guidelines furnished to the Applicant upon receipt of its application by the Texas Film Commission. The Applicant's management is responsible for the assertion. Our responsibility is to express an opinion on the assertion based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and, accordingly, included examining, on a test basis, evidence supporting the Expended Budget, and performing such other procedures as we considered necessary in the circumstances. We believe that our examination provides a reasonable basis for our opinion.

In our opinion, the Expended Budget referred to above presents fairly, in all material aspects, the results of the Applicant expenditures in Texas for _____ [Project Name], ended _____ [Date], based on the accounting and reporting requirements of Texas Administrative Code, Title 13, Part 8, Chapter 121 and the guidelines furnished to the Applicant upon receipt of its application by the Texas Film Commission.

Firm's signature / City, State
Report Date

EXHIBIT I

Expended Budget:

Attach the Expended Budget detailing the Applicant name, Project Name and the period reviewed.

Notes to the Expended Budget:

This Expended Budget represents the production costs attributable to the production entitled "_____" produced by [Applicant Name]. The Expended Budget represents the following Texas expenditures:

TEXAS EXPENDITURE VERIFICATION

Eligible Payroll Expenditures: $_____
Eligible AP Expenditures: $_____
Eligible PC Expenditures: $_____
Total Eligible Expenditures: $_____

TEXAS RESIDENCY VERIFICATION

Total Crew: _____ Total Cast: _____
Texas Crew: _____ Texas Cast: _____
Texas Crew Pct: _____%
Texas Cast Pct: _____%

TEXAS PRODUCTION DAYS VERIFICATION

Total Production (Shoot) Days: _____
Texas Production (Shoot) Days: _____
Texas Production Days Percentage: _____%

Figure: 28 TAC Chapter 19--Preamble

Existing Sections	New Sections
§19.1702(b) deleted	N/A
§19.1702(c) redesignated as	§19.1702(b)
§19.1703(1) deleted	N/A
§19.1703(2) deleted	N/A
§19.1703(3) - (8) redesignated as	§19.1703(1) - (6)
§19.1703(9) redesignated as	§19.1703(8)
§19.1703(10) deleted and moved to	§19.1703(11)
§19.1703(11) - (12) redesignated as	§19.1703(9) - (10)
§19.1703(13) - (14) redesignated as	§19.1703(14) - (15)
§19.1703(15) redesignated as	§19.1703(17)
§19.1703(16) redesignated as	§19.1703(19)
§19.1703(17) redesignated as	§19.1703(21)
§19.1703(18) deleted	N/A
§19.1703(19) redesignated as	§19.1703(25)
§19.1703(20) redesignated as	§19.1703(28)
§19.1703(21) redesignated as	§19.1703(29)
§19.1703(21)(G) deleted	N/A
§19.1703(21)(H) - (N) redesignated as	§19.1703(29)(G) - (M)
§19.1703(22) redesignated as	§19.1703(30)
§19.1703(23) redesignated as	§19.1703(31)
§19.1703(24) - (25) deleted	N/A
§19.1703(26) redesignated as	§19.1703(32)
§19.1703(27) - (31) redesignated as	§19.1703(34) - (38)
§19.1703(32) - (35) redesignated as	§19.1703(40) - (43)
§19.1703(36) - (40) redesignated as	§19.1703(45) - (49)
§19.1704(a) redesignated as	§19.1704(c)(1)(A) and (3)
§19.1704(b) deleted and moved to	§19.1704(c)(3)
§19.1704(c) redesignated as	§19.1704(d)
§19.1704(c)(1) redesignated as	§19.1704(d)(1)
§19.1704(c)(2) deleted and replaced with	§19.1704(d)(2)(H)
§19.1704(c)(3) deleted and replaced with	§19.1704(d)(2)(L)
§19.1704(c)(4) deleted and replaced with	§19.1704(d)(2)(J)
§19.1704(c)(5) redesignated as	§19.1704(d)(6)
§19.1704(c)(6) deleted and replaced with	§19.1704(d)(2)(B)
§19.1704(c)(7) deleted and replaced with	§19.1704(d)(2)(I)
§19.1704(c)(8) deleted and replaced with	§19.1704(d)(3)
§19.1704(c)(9) deleted and replaced with	§19.1704(d)(2)(B)
§19.1704(c)(10) deleted and replaced with	§19.1706(b)
§19.1704(c)(11) deleted and replaced with	§19.1704(d)(4)
§19.1704(c)(12) deleted and moved to	§19.1704(d)(5)
§19.1704(d) deleted and replaced with	§19.1716(a)
§19.1704(f) redesignated as	§19.1704(f)(1) and (2)
§19.1704(h)(1) deleted and replaced with	§19.1706(a)(3)
§19.1704(h)(2) deleted and replaced with	§19.1704(d)(6)
§19.1704(h)(3) deleted and replaced with	§19.1704(d)(2)(J)

Existing Sections	New Sections
§19.1704(h)(4) deleted and replaced with	§19.1704(d)(2)(I)
§19.1704(i) deleted	N/A
§19.1705 introductory paragraph redesignated as	§19.1705(a)
§19.1705(1) - (3) deleted and replaced with	§19.1705(b) - (g)
§19.1705(4) redesignated as	§19.1705(f)
§19.1706(a) redesignated as	§19.1706(a)(1) and (3)
§19.1706(b) redesignated as	§19.1706(b)(1) - (3)
§19.1706(c) redesignated as	§19.1706(d) and (e)(1)
§19.1706(d) redesignated as	§19.1706(g)
§19.1706(e) deleted and replaced with	§19.1720(c)
§19.1709(b) redesignated as	§19.1709(b), (c)(1) and (2)
§19.1710(b) redesignated as	§19.1710(b)(1)
§19.1710(c)(1) - (4) redesignated as	§19.1710(c)(1)(A) - (C), and (F)
§19.1710(c)(5) deleted and replaced with	§19.1710(c)(1)(I)
§19.1710(d)(1) - (3) redesignated as	§19.1710(c)(4)(A) - (C)
§19.1710(e) deleted and replaced with	§19.1721
§19.1711 redesignated as	§19.1711(b)(1) and (3)
§19.1712(a) - (c) redesignated as	§19.1712(a)(1) - (3)
§19.1712(b)(1) and (2) deleted and replaced with	§19.1712(a)(2)(B) and (C)
§19.1712(b)(3) redesignated as	§19.1712(a)(2)(D) and (F)
§19.1712(b)(4) redesignated as	§19.1712(a)(2)(G)
§19.1712(b)(5) redesignated as	§19.1712(a)(2)(H)
§19.1712(b)(5)(A) redesignated as	§19.1712(a)(2)(H)(i)
§19.1712(b)(6) redesignated as	§19.1712(a)(2)(I)
§19.1712(c) redesignated as	§19.1712(a)(3)
§19.1714(a) - (j) redesignated as	§19.1714(a)(1) - (10)
§19.1714(k) deleted and moved to	§19.1714(b)
§19.1714(l) - (n) redesignated as	§19.1714(a)(11) - (13)
§19.1715(b) deleted and replaced with	§19.1712
§19.1715(c) redesignated as	§19.1715(b)(3)
§19.1716(a) deleted and replaced with	§19.1705(g)
§19.1716(b) introductory paragraph is redesignated as	§19.1716(b)(1) - (3)
§19.1716(b)(1) - (3) redesignated as	§19.1716(b)(3)(A) - (C)
§19.1716(b)(4) deleted	N/A
§19.1716(b)(5) - (6) redesignated as	§19.1716(b)(3)(D) - (E)
§19.1716(b)(6)(A) - (C) redesignated as	§19.1716(b)(3)(E)(i) - (iii)
§19.1716(c)(1) - (5) deleted and replaced with	§19.1716(c)
§19.1716(d) deleted and replaced with	N/A
§19.1716(e) deleted	N/A
§19.1716(f) deleted	N/A

Existing Sections	New Sections
§19.1716(g) redesignated as	§19.1716(e)
§19.1716(g)(1) redesignated as	§19.1716(e)(1)(A)
§19.1716(g)(2) redesignated as	§19.1716(e)(2)
§19.1716(g)(3) deleted and replaced with	§19.1716(e)(1)(C)
§19.1716(g)(4) deleted	N/A
§19.1717(e) deleted and replaced with	§19.1717(a) and (d)
§19.1717(f) redesignated as	§19.1717(e)
§19.1718 is repealed	N/A
§19.1719(a)(1) deleted	N/A
§19.1719(b)(1) redesignated as	§19.1719(b)(2)
§19.1719(b)(2) deleted	N/A
§19.1719(b)(4) deleted	N/A
§19.1719(b)(3) redesignated as	§19.1719(b)(4)
§19.1720(a) and (b) redesignated as	§19.1720(b)(1) and (2)
§19.1720(d) and (e) deleted and replaced with	§19.1720(e)
§19.1720(f) redesignated as	§19.1720(d)(1) and (3)
§19.1720(h) redesignated as	§19.1720(h)(1)(A)
§19.1721(a), (b), and (c) redesignated as	§19.1721(a)
§19.1721(c)(1) - (3) deleted and replaced with	§19.1721(a)(1)(B)
§19.1721(d), (e), and (g) - (i) redesignated as	§19.1721(b)(1) - (4)
§19.1721(f) deleted	N/A
§19.1721(j) and (k) redesignated as	§19.1721(b)(5)(A) and (B)
§19.1722 repealed	N/A
§19.2002 introductory paragraph redesignated as	§19.2002(a)
§19.2002 last sentence of introductory paragraph and §19.2002(1) redesignated as	§19.2002(c)
§19.2002(2) and (3) deleted	N/A
§19.2003(1) - (3) deleted	N/A
§19.2003(4) - (9) redesignated as	§19.2003(2) - (7)
§19.2003(10) deleted and moved to	§19.2003(10)
§19.2003(11) redesignated as	§19.2003(9)
§19.2003(13) - (15) redesignated as	§19.2003(14) - (16)
§19.2003(16) deleted	N/A
§19.2003(17) deleted	N/A
§19.2003(18) redesignated as	§19.2003(17)
§19.2003(19) deleted and replaced with	§19.2003(17)
§19.2003(20) - (21) redesignated as	§19.2003(19) - (20)
§19.2003(23) redesignated as	§19.2003(26)
§19.2003(24) deleted	N/A
§19.2003(25) - (27) redesignated as	§19.2003(29) - (31)

Existing Sections	New Sections
§19.2003(28) - (29) redesignated as	§19.2003(34) - (35)
§19.2003(30) - (31) redesignated as	§19.2003(38) - (39)
§19.2003(32) deleted	N/A
§19.2003(33) - (35) redesignated as	§19.2003(40) - (42)
§19.2003(36) redesignated as	§19.2003(47)
§19.2003(37) deleted and moved to	§19.2003(44)
§19.2003(38) deleted and moved to	§19.2003(8)
§19.2004(a) deleted and moved to	§19.2004(b)(3)
§19.2004(b) deleted and moved to	§19.2004(b)(3)
§19.2004(c)(2) deleted and replaced with	§19.2004(c)(2)(H)
§19.2004(c)(3) deleted in part and replaced with	§19.2004(c)(2)(A) and (L)
§19.2004(c)(4) deleted in part and replaced with	§19.2004(c)(2)(J)
§19.2004(c)(5) redesignated as	§19.2004(c)(7)
§19.2004(c)(6) deleted and replaced with	§19.2004(c)(2)(B)
§19.2004(c)(7) deleted and replaced with	§19.2004(c)(2)(I)
§19.2004(c)(8) deleted and replaced with	§19.2004(c)(4)
§19.2004(c)(9) deleted and replaced with	§19.2004(c)(2)(B)
§19.2004(c)(10) deleted and replaced with	§19.2006(b) and §19.2004(c)(7)
§19.2004(c)(11)(A) - (D) deleted and replaced with	§19.2004(c)(2)(B) and (c)(5)
§19.2004(c)(12) deleted and moved to	§19.2004(c)(6)
§19.2004(d) deleted and moved to	§19.2016(a)
§19.2004(e)(1) - (4) redesignated as	§19.2004(d)(1) - (4)
§19.2004(f)(1) deleted and replaced with	§19.2004(c)(2)(B)
§19.2004(f)(2) deleted and replaced with	§19.2004(c)(7)
§19.2004(f)(3) deleted and replaced with	§19.2004(c)(2)(J)
§19.2004(f)(4) deleted and replaced with	§19.2004(c)(2)(I)
§19.2004(g) redesignated as	§19.2004(e)(1) and (2)
§19.2004(h) redesignated as	§19.2004(f)
§19.2004(i) deleted	N/A
§19.2004(j) deleted	N/A
§19.2005 introductory paragraph redesignated as	§19.2005(a)
§19.2005(1) - (3) deleted and replaced with	§19.2005(b) - (g)
§19.2005(4) redesignated as	§19.2005(f)
§19.2006(a) redesignated as	§19.2006(a)(1) and (3)
§19.2006(b) redesignated as	§19.2006(b)(1) - (3)
§19.2006(c) first sentence redesignated as	§19.2006(d)
§19.2006(c) second sentence redesignated as	§19.2006(e)(1)
§19.2006(d) redesignated as	§19.2006(f)
§19.2006(e) deleted	N/A

Existing Sections	New Sections
§19.2009(b) redesignated as	§19.2009(b) and §19.2009(c)(1) and (2)
§19.2010(b) deleted and replaced with	§19.2010(a)(1) and (2); §19.2010(b)(1)(A) and (B); and §19.2010(c)(3)
§19.2010(c)(1) and (2) redesignated as	§19.2010(c)(1)(A)(i) and (ii)
§19.2010(c)(4) redesignated as	§19.2010(c)(1)(A)(iv)
§19.2010(c)(3) deleted and replaced with	§19.2010(c)(1)(B) and (C)
§19.2010(c)(5) deleted and replaced with	§19.2010(c)(1)(A)(vii)
§19.2011 redesignated as	§19.2011(b)(1) and (3)
§19.2012 repealed and replaced with	§19.2012
§19.2014(a) - (j); (l), (m), and (n) redesignated as	§19.2014(a)(1) - (13)
§19.2014(k) deleted and moved to	§19.2014(b)
§19.2015 repealed and replaced with	§19.2015
§19.2016(a) deleted and replaced with	§19.2005(g)
§19.2016(b) introductory paragraph redesignated as	§19.2016(b)(1)
§19.2016(b)(1) - (3) deleted and moved to	§19.2016(b)(3)(E)(i) - (iii)
§19.2016(c)(1) - (3) redesignated as	§19.2016(b)(3)(A) - (C)
§19.2016(d)(1) - (4) deleted and replaced with	§19.2016(c)
§19.2016(f) deleted and replaced with	§19.2016(d)
§19.2016(g) deleted	N/A
§19.2016(h) redesignated as	§19.2016(f)
§19.2016(h)(4) deleted	N/A
§19.2017(a) - (e) redesignated as	§19.2017(a)(1) - (4)
§19.2018 repealed	N/A
§19.2019(a) deleted and replaced with	§19.2019(a)
§19.2020(a) and (b)	§19.2020(b)(1) and (2)
§19.2020(d) and (e) deleted and replaced with	§19.2020(e)
§19.2020(f) first two sentences deleted and moved to	§19.2020(d)(1)
§19.2020(f), other than first two sentences, redesignated as	§19.2020(d)(3)
§19.2021 repealed and replaced with	§19.2021

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.

Department of Aging and Disability Services

Public Hearing Regarding Proposed Amendments to Texas Administrative Code, Title 40, Part 1, Chapter 48, Subchapter J, Governing the Community Based Alternatives Program

The Department of Aging and Disability Services (DADS) will hold a public hearing in conjunction with a meeting of the Aging and Disability Services Council on July 20, 2011, at 8:30 a.m. in the Public Hearing Room of the John H. Winters Building, 701 W. 51st Street, Austin, Texas. At the hearing, DADS will receive public comment regarding proposed amendments to §48.6002, concerning community based alternatives (CBA) definitions, §48.6026, concerning home and community support services provider qualifications, §48.6040, concerning registered nurse (RN) delegation of nursing tasks, §48.6050, concerning service array for home and community support services (HCSS), and §48.6078, concerning billable units, in Chapter 48, Community Care for Aged and Disabled, Subchapter J, Community Based Alternatives (CBA) Program. The proposed amendments were published in the July 1, 2011, issue of the *Texas Register* (36 TexReg 4098). The hearing is being held to comply with the requirements of Texas Government Code, §2001.029(b), in the event a request is made in accordance with that subsection.

Persons with disabilities who will need auxiliary aids or services at the hearing are asked to call the Center for Consumer and External Affairs at (512) 438-4563, at least three days before the date of the hearing so appropriate arrangements can be made.

TRD-201102437
Kenneth L. Owens
General Counsel
Department of Aging and Disability Services
Filed: June 28, 2011

♦ ♦ ♦

Texas Department of Agriculture

Request for Proposals: Parallel Pathways to Success Grant

Statement of Purpose. The Texas Department of Agriculture (TDA) is requesting proposals for projects for the Parallel Pathways to Success Grant Program. The pilot program is administered by the Rural Economic Development Division (RED) of TDA and requires grant recipients to provide matching funds not less than 10% of the overall grant award. The purpose of this grant is to provide alternative educational resources to meet local workforce needs. While traditional 2 or 4-year degree programs are not necessarily excluded from participation, the focus of the program is on job training or educational programs that result in vocational or career certifications for eligible students. Projects are expected to achieve quantifiable and measurable results by the end of the contract term (August 31, 2013).

Submission Dates/Locations. Forms required for submitting a proposal are available by accessing TDA's website at: www.texasagriculture.gov, or by e-mailing RED at: finance@texasagriculture.gov. One hard copy and one electronic copy of the proposal in Microsoft Word format must arrive no later than 5:00 p.m. on **July 21, 2011,** to one of the following:

Physical Address: Texas Department of Agriculture, Rural Economic Development1700 N. Congress Ave., 11th Floor, Austin, TX 78701, Attn: Rick Rhodes.

Mailing Address: Texas Department of Agriculture, Rural Economic Development, P.O. Box 12847, Austin, TX 78711, Attn: Rick Rhodes

The electronic copy should be e-mailed to: Rick.Rhodes@TexasAgriculture.gov.

Eligibility. Grant proposals will be accepted from any accredited high school, institution of higher learning, chambers of commerce, economic development commissions or similar organizations located in the State of Texas.

Proposal Requirements.

Funding Parameters:

It is anticipated that selected projects will be funded in a range of $25,000 - $100,000. Projects will be awarded with a contract term commencing August 31, 2011 and ending August 31, 2013. All awards require matching funding at not less than 10% of the overall grant award.

TDA reserves the right to fund proposals partially or fully. Where more than one proposal for a geographical region is found acceptable for funding, TDA may request cooperation between grantees or revision/adjustment to a proposal in order to avoid duplication and to realize the maximum benefit to the state.

Form Requirements:

Proposals must be submitted on form RED-200 for consideration. RED-200 shall not exceed 6 pages. (2 pages for Personnel/contact information, 3 pages for proposal, and 1 page for budget information.)

The required forms are available by accessing TDA's website at http://www.texasagriculture.gov or by e-mailing the RED at: finance@texasagriculture.gov.

Technical Requirements:

Include the following items:

1. **Project Director Information - Do Not Exceed Two Pages.** Include title, performing institutions, lead contact information and experience, responsible contracts officer information.

2. **Project Financial Officer Information - Do Not Exceed Two Pages.** Include title, contact information, and experience.

3. **Project Summary - Do Not Exceed 200 Words.** Briefly summarize the program for which you are requesting funding.

4. **Project Proposal - Do Not Exceed Three Pages.** Include the following:

A. Background - Statement of program including the institutions that the program will be offered through; any history regarding this particular program; how the program will meet the purposes of the Parallel Pathways Grant; and how the program will serve the needs of the students in its community.

B. Objectives - Concise outline of what the program will offer students including curriculum, any degrees or certificates offered, criteria for acceptance into program; specific goals and performance measures and how those will be measured.

C. Benefits - Description of the expected results and their anticipated contributions to students and meeting the needs of the workforce in rural Texas.

D. Anticipated Job Placement - Description of how the program will measure jobs obtained as a result of the grant.

5. **Performance and Budget Information.** Include the following:

A. Project Budget - Include categories of Salary, Travel, Materials and Operating Expenses, Equipment, Other, Contracts, and Indirect (not to exceed 10%) and matching funds. Round budget items to the nearest $100;

B. Matching Funds Table - This grant requires matching funds of not less than 10% of the grant award. The ability of a project to claim supporting or leveraged funds in excess of the minimum percentage will be a positive factor in the review process. Matching funds must be documented on the budget submission form and reported on a quarterly basis; and

C. Indirect Costs - Under this grant 10% of the grant award amount will be allowed to be used for the reimbursement of indirect costs.

Budget Information: This grant will be paid on a cost reimbursement basis after matching funds have been documented. In certain circumstances TDA will consider providing a reasonable advance to assist with project start-up. TDA has sole discretion to determine whether it will provide a project advance, including the amount of such advance. In the event respondent makes any misrepresentation in connection with its grant proposal or other documentation submitted to TDA; fails to abide by the terms of its grant agreement with TDA, including applicable reporting requirements; or fails to comply with state law, including the Uniform Grant Management Standards, in connection with its administration and/or utilization of a grant, TDA will pursue all available remedies available under its grant agreement and/or state law, including, without limitation, seeking full reimbursement of any advance payments made to assist in project start-up.

1. **Eligible Expenses.** Generally, expenses that are necessary and reasonable for proper and efficient performance and administration of a project are eligible. Expenses must be properly documented with sufficient backup detail, including copies of invoices. Examples of eligible expenditures are:

Personnel costs - both salary and benefits;

Travel - domestic (Reimbursement for foreign travel is discouraged);

Equipment, materials and direct operating expenses - items that costs less than $5,000 per unit with a useful life of less than one year, office supplies, postage, telecommunications, printing, etc.;

Other expenses - any expenses that do not fall into the above categories;

Contracts - agreements made with other universities or private parties to perform a portion of the award; and

Indirect expenses - limited to 10% of the grant award.

2. **Ineligible Expenses.** Expenses that are prohibited by state or federal law are ineligible. Examples of these expenditures are:

Alcoholic beverages;

Entertainment;

Contributions, charitable or political;

Expenses falling outside of the contract period;

Expenses for expenditures not listed in the project budget;

Tangible personal property costing over $5,000 per unit and having a useful life over one year; and

Expenses that are not adequately documented.

3. **Description of the Budget.** Present an overall project budget and include the following items in the budget description:

A. *Personnel services:* Grant funds may be used for directly supporting salaries and wages of teachers, administrative assistances and other support personnel.

B. *Travel:* Grant funds used for travel expenses, domestic or foreign, must be limited to the State of Texas established mileage, per diem, and lodging policies. Reimbursement for foreign travel is discouraged, but may be paid on a case-by-case basis. To be eligible for reimbursement, foreign travel shall be approved in advance by the Commissioner or his designee.

C. *Materials and Direct Operating Expenses:* Expenses that are directly related to the grantee's day-to-day operation of the grant project that are not included in any of the Grantee's other standard budget categories and has an acquisition cost of less than $5,000 per unit. Grantees must allocate costs on a prorated basis for shared usage, including office supplies, postage, telecommunications, and printing.

D. *Professional/Contractual:* Any contract or agreement entered into by a grantee and a third party that obligates grant funds must be in writing and consistent with Texas law. Grantees must maintain adequate documentation supporting budget items for a contractor's time, services, and rates of compensation.

E. *Indirect Expenses:* Grant funds may be used for indirect costs up to 10% of the grant award amount.

F. *Matching Funds:* Please identify all funding, including amount and payor, received for this project or funding anticipated to be received during the two-year grant term.

G. *Additional Budget Information:* Provide any additional information you think would be helpful to the review committee including equipment justification, subcontract recipients and amounts, list of key personnel to be paid, or description of other large item expenditures.

Evaluation of Proposals.

The proposals will be evaluated based on the scoring and selection criteria included in Attachment A to this RFP.

Award Information and Notification.

TDA will approve projects for funding. TDA reserves the right to accept or reject any or all proposals submitted. TDA is under no legal or other obligation to award a grant on the basis of a proposal submitted in response to this RFP. TDA shall not pay for any costs incurred by any entity in responding to this RFP.

It is the responsibility of the applicant to examine the entire proposal package, seek clarification of any item or requirement that may not be clear, fully inform itself as to the conditions, requirements, and specifications of this RFP and check all responses for accuracy before submitting proposals; failure to do so will be at the applicant's own risk, and applicant cannot secure relief on plea of error.

All grant recipients will have to execute a grant agreement with TDA no later than August 31, 2011.

General Compliance Information.

1. Prior to accepting the grant and signing the grant agreement, applicants will be provided a copy of the TDA reporting requirements for their review. This document will explain billing procedures, quarterly and annual reporting requirements, procedures for requesting a change in the project scope or budget, and other miscellaneous items.

2. Any delegation by the Grantee to a subcontractor regarding any duties and responsibilities imposed by the grant award shall be approved in advance by TDA and shall not relieve the Grantee of its responsibilities to TDA for their performance.

3. All grant awards are subject to the availability of appropriations and authorizations by the Texas Legislature and TDA.

4. Any information or documentation submitted to TDA as part of the project grant proposal is subject to disclosure under the Texas Public Information Act.

5. While TDA attempts to observe the strictest confidence in handling the proposals, it cannot guarantee complete confidentiality on any matters that lie beyond its control. The confidentiality of recipient's "proprietary data" so designated shall be strictly observed to the extent permitted by appropriate Texas laws, including the Texas Public Information Act.

6. Control of the ownership and disposition of all patentable products and inventories shall be agreed to by Grantee and TDA.

7. Awarded grant projects must remain in full compliance with state and federal laws and regulations. Noncompliance with such law may result in termination by TDA.

8. Grant recipients must keep a separate bookkeeping account with a complete record of all expenditures relating to the project. Records shall be maintained for three years after the completion of the project or as otherwise agreed upon with TDA. TDA and the Texas State Auditor's Office reserve the right to examine all books, documents, records, and accounts relating to the project at any time throughout the duration of the agreement and for three years immediately following completion of the project. If there has been any litigation, claim, negotiation, audit or other action started prior to the expiration of the three-year period involving the records, then the records must be retained until the completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later. TDA and the Texas State Auditor's Office reserve the right to inspect the project location(s) and to obtain full information regarding all project activities.

9. If the Grantee has a financial audit performed in any year during which Grantee receives funds from Grantor, and if the Grantor requests information about the audit, the Grantee shall provide such information to TDA or provide information as to where the audit report can be publicly viewed, including the audit transmittal letter, management letter, and any schedules in which the Grantee's funds are included.

10. Grant awards to shall comply in all respects with the Uniform Grant Management Standards (UGMS). A copy may be downloaded from the following website: www.governor.state.tx.us/divisions/stategrants/guidelines/files/U GMS012001.doc

11. Grant management guidelines will be provided to grantees once an award is made.

For any questions:

Please contact Rick Rhodes, Assistant Commissioner for Rural Economic Development, at (512) 463-7577 or by e-mail at: rick.rhodes@texasagriculture.gov.

Attachment A

Parallel Pathways to Success Grant Program

Scoring and Selection Criteria

1. Quality of Application - 25 Points

a. Rigorousness and relevancy of training; program's ability to provide student with a marketable skill

b. The feasibility of the objectives

2. Implementation of Program - 25 Points

a. The merits of the plan in regard to bridging the gap to higher education for rural high school students

b. Description of quantifiable and measurable results to be achieved by the end of the contract term (August 31, 2013).

3. Sustainability - 20 Points

a. The anticipated benefits to the workforce in rural Texas

b. Demonstration of how the program will sustain itself once grant funds are exhausted

4. Budget - 25 Points

a. The requested budget in relation to expected benefits

b. The ability to provide 10 % matching funds

5. New Applicant - 5 Points (In order to encourage additional participation in the Parallel Pathways program, 5 points will be awarded to applicants who previously have not received an award for a Parallel Pathways grant.)

6. Past Performance - TDA may deduct up to 5 points from an application for poor performance under a previous Parallel Pathway's grant.

Awards Process.

The scoring of application information will be conducted by TDA.

Grants will be awarded based upon the above criteria and on the availability of funds. The number and amount of awards will be based on responses received.

TRD-201102449
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: June 29, 2011

♦ ♦ ♦

Requests for Proposals: Texans Feeding Texans: Hogs Reducing Hunger Pilot Grant Program

Purpose: Pursuant to the Texas Legislature, by the enactment of Senate Bill 1, 81st Regular Session, 2009 Article VI, Rider 23, the Texas Department of Agriculture (TDA) hereby requests proposals for a grant program to implement a pilot project for harvesting feral hogs and distributing pork products to feed food-insecure Texans. An appropriate response is an integrated program that addresses the trapping, disease testing, processing, and distribution of end products to needy persons or distribution organizations.

Information regarding the complete Request for Proposals and submission process is available on the TDA website at www.TexasAgriculture.gov, under the Grants/Funding link.

Questions: For questions or requests for additional information, organizations may contact Ms. Karen Reichek at (512) 936-2450 or by email at: Grants@TexasAgriculture.gov.

TRD-201102462
Dolores Alvarado Hibbs
General Counsel
Texas Department of Agriculture
Filed: June 29, 2011

♦ ♦ ♦

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 June 15, 2011, through June 23, 2011. 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 website. The notice was published on the website on June 29, 2011. The public comment period for this project will close at 5:00 p.m. on July 29, 2011.

FEDERAL AGENCY ACTIONS:

Applicant: Galveston Bay Aquaculture; Location: The project site contains uplands and open water and is located in Galveston Bay, near the Galveston Ship Channel, just west of the Pelican Island Causeway, at 111 Pelican Island Causeway, in Galveston, Galveston County Texas. The project can be located on the U.S.G.S. quadrangle map titled: Galveston, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone 15; Easting: 322498; Northing: 3243058. Project Description: The applicant proposes to dredge approximately 10,864 cubic yards of material from a 97,780-square-foot (sq ft) area to be used as fill material in 72,175-sq-ft area of open water (Plan Views 2-4) adjacent to existing uplands. This 792-foot-long by 420-foot-wide open water/upland area will be surrounded by a riprap breakwater to prevent damage to the marsh creation project. In addition, the open water area and existing uplands will support dry boat storage, an aquaculture facility and trailer parking. The applicant also proposes to install 3 additional breakwaters and marina docks. The project impacts total 4.08 acres of fill and 14.27 acres of dredging. From the north end of this section and toward the Galveston Channel, an East, North, and West riprap breakwater along with 5 docks will be installed. CMP Project No.: 11-0282-F1. Type of Application: U.S.A.C.E. permit application #SWG-2007-01814 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). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: City of Seabrook; Location: The project site is located at the Pine Gully, Clear Creek and Galveston Bay intersection, east of State Highway 146, north of FM 2004 and south of NASA Road at Latitude 29.550781, Longitude -95.020948. The project site can be located on the U.S.G.S. quadrangle map titled: League City, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone XX; Easting: 304191; Northing: 3270713. Project Description: The applicant proposes to fill a total of 0.41 acre (358 linear feet) of jurisdictional waters. 2.45 acres of waters will be excavated, 0.27 acre of adjacent wetlands will be excavated and 707 cubic yards of fill material will be used to reconstruct 1,820 linear feet of Waterfront Street and 620 linear feet of Todville Road. The existing road will be rebuilt to a 30-foot-wide, 2-lane concrete base, including curbs, storm drain inlets, and underground storm sewers. The elevation will be 2 feet above its existing grade. A bulkhead is proposed along the southwestern portion of Waterfront Street. The purpose of this improvement is to re-align the existing road and adjacent facilities damaged by Hurricane Ike. To compensate for impacts to the waters of the United States, the applicant proposes to create 0.68 acre of wetland shelf along the southern bank on the Pine Gully. In addition, the applicant will convert approximately 5 acres of upland areas to a tidally-influenced surface waterbody. CMP Project No.: 11-0283-F1. Type of Application: U.S.A.C.E. permit application #SWG-2010-01129 is being evaluated under §404 of the Clean Water Act (33 U.S.C.A. §1344). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Chevron Phillips Chemical Company; Location: The project site is located in the East Turning Basin, near the confluence of Taylors Bayou, Sabine-Neches Canal, Port Arthur Canal, and Gulf Intracoastal Waterway, in Port Arthur, Jefferson County, Texas. The project site can be located on the U.S.G.S. quadrangle map titled: Port Arthur South, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone 15; Easting: 3301359; Northing: 407348. Project Description: The applicant proposes to remove 9,930 cubic yards of accumulated sediments from an existing slip in the vicinity of the of the firewater intake structure on the west bank of the slip. Additionally, the applicant proposes to modify Department of the Army (DA) Permit 14706 to install three (3) new dolphins, and extend the north end of the slip by 50 feet (from station 5+50 to station 6+00). The estimated dredge quantity associated with this extension is 3,000 cubic yards. Overall, 3.3 acres area of the slip will be dredged from approximately -3 to -13 Mean Low Tide, and the method of dredging will be hydraulic or mechanical. The dredged material will be placed in Dredged Material Placement Areas (DMPAs) 8, 9, 11 or in an upland location at the facility. CMP Project No.: 11-0288-F1. Type of Application: U.S.A.C.E. permit application #SWG-2010-01111 is being evaluated under §10 of the Rivers and Harbors Act of 1899 (33 U.S.C.A. §403).

Applicant: Port of Beaumont; Location: The project is located along the Neches River, at the Port of Beaumont Turning Basin, South of the intersection of Interstate Highway 10 and the Neches River, near Beaumont, in Orange County, Texas. The project site can be located on the U.S.G.S. quadrangle map entitled: Beaumont East, Texas. Approximate UTM Coordinates in NAD 83 (meters): Zone 15; Easting: 3327949; Northing: 395112. Project Description: The applicant proposes to discharge 45,000 cubic yards of fill into 13.81 acres of wetlands to develop a Port of Beaumont facility consisting of docks, a new rail track and additional access roadways at the existing dock. This project is needed for economic development in the area. To compensate for unavoidable impacts to the waters of the United States, the applicant will purchase 27.01 credits from the proposed Rose City Mitigation Bank. CMP Project No.: 11-0291-F1. Type of Application: U.S.A.C.E. permit application #SWG-1998-02472 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). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Mr. David Lind; Location: The project site is in Dickinson Bayou, at 4526 Bayou Bend Drive, in Dickinson, Galveston County, Texas. Approximate latitude and longitude: Latitude: 29.4570 degrees N; Longitude: -95.0208 degrees W. Project Description: The

applicant is seeking an after-the-fact authorization to replace 35 feet of an existing, dilapidated bulkhead, retain and bulkhead an excavated 30-foot by 28-foot by 4-foot boat basin that required the removal of 125 cubic yards of material, to create and retain a 6-footwide, 30-foot-long pier, and drive 8 pilings within the basin to create a 12.5-foot by 30-foot open uncovered boat lift within the basin adjacent to the pier. Additionally, the applicant constructed a 12-foot-wide concrete boat ramp that extends approximately 2 feet into the excavated boat basin. CMP Project No.: 11-0413-F1. Type of Application: U.S.A.C.E. permit application #SWG-2008-00019 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). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 of the Clean Water Act (33 U.S.C.A. §1344).

Applicant: Baryonyx Corporation, Inc.; Location: The project is located in Gulf of Mexico state waters, offshore Nueces, Kleberg, Kenedy, Willacy and Cameron Counties, Texas, in State tracts 740, 750, 772, 771, 770, 774, 775, 794, 793, 794, 838, 839, 840, 841, 842, 843, 859, 860, 862, 863, 864, 880, 881, 882, 883, 1068, 1069, 1085, 1086, 1087, 1088, 1089, 1090, 1126, 1127, 1129 and 1130. Project Description: The applicant proposes to construct a 500-turbine wind farm in three areas referred to as the Mustang Lease, North Rio Grande Lease and Rio Grande Lease. Due to a potential conflict with Naval Air Station Corpus Christi, an alternative lease site is also being evaluated for the Mustang Lease. Each lease site will be comprised of 120-200 wind turbine generators in a grid pattern (turbine array). The final locations will be determined by consultation with appropriate state and Federal agencies and consideration of constraints. Installation of up to 4 substations will be required in each lease to reduce the number of transmission lines to shore and reduce electricity loss. Prior to Construction, Baryonyx Corporation will conduct the necessary surveys and studies to describe and quantify natural resources. These studies will include geophysical geotechnical surveys, delineation of aquatic habitats, and cultural resources. Onshore construction and assembly will utilize existing port facilities. No new onshore or port facilities are anticipated to be constructed. The applicant has stated that wetlands and sensitive sea areas will be avoided where practicable. No surface areas or wetlands are proposed to be filled at this time other than temporary side-cast material from trench construction. Horizontal drilling for burial of cables will be considered under unavoidable wetlands, seagrass beds, reefs and dunes where practicable. CMP Project No.: 11-0415-F1. Type of Application: U.S.A.C.E. permit application #SWG-2011-00511 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). Note: The consistency review for this project will be conducted by the Texas Commission on Environmental Quality under §401 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-201102452
Larry L. Laine
Chief Clerk/Deputy Land Commissioner, General Land Office
Coastal Coordination Council
Filed: June 29, 2011

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Comptroller of Public Accounts

Notice of Request for Proposals

Pursuant to §§403.011, 2155.001, and 2156.121, Texas Government Code, and Chapter 54, Subchapter F, §§54.602, 54.611 - 54.618, and 54.636, Texas Education Code, the Comptroller of Public Accounts (Comptroller), on behalf of the Texas Prepaid Higher Education Tuition Board (Board), announces the issuance of its Request for Proposals (RFP No. 202b) for Transition Management Services ("Services") for the Board. The selected respondent will assist the Comptroller and the Board by providing the Services consistent with the Board's Investment Policy and Guidelines related to the Texas Guaranteed Tuition Program and Fund ("TTF I"), as described in this RFP and the contract, if any resulting from it ("Contract"). The prepaid tuition program currently has approximately $1.3 billion dollars in assets. The Comptroller and the Board reserve the right to award more than one contract under the RFP. If approved by the Board, the successful respondent(s) will be expected to begin performance of the contract on or about September 1, 2011.

Contact: Parties interested in submitting a proposal should contact William Clay Harris, Assistant General Counsel, Contracts, Comptroller of Public Accounts, 111 E. 17th St., Room 201, Austin, Texas 78774, (512) 305-8673, to obtain a complete copy of the RFP. The Comptroller will mail copies of the RFP only to those parties specifically requesting a copy. The RFP will be available for pick-up at the above referenced address on Friday, July 8, 2011, after 10:00 a.m. Central Standard Time (CT), and during normal business hours thereafter. The Comptroller will also make the entire RFP available electronically on the Electronic State Business Daily (ESBD) after 10:00 a.m. CT on Friday, July 8, 2011, at the following website address: http://esbd.cpa.state.tx.us.

Questions and Non-Mandatory Letters of Intent: All written inquiries, questions, and non-mandatory Letters of Intent to propose must be received at the above-referenced address not later than 2:00 p.m. (CT) on Friday, July 15, 2011. Prospective respondents are encouraged to fax non-mandatory Letters of Intent and Questions to (512) 463-3669 to ensure timely receipt. The Letter of Intent must be addressed to William Clay Harris, Assistant General Counsel, Contracts, and must contain the information as stated in the corresponding Section of the RFP and be signed by an official of that entity. Non-mandatory Letters of Intent and Questions received after this time and date will not be considered. On or before Friday, July 22, 2011, the Comptroller expects to post responses to questions as a revision to the ESBD notice on the issuance of this RFP.

Closing Date: All Proposals must be received to the Office of the Assistant General Counsel, Contracts, at the location specified above (Room 201), no later than 2:00 p.m. (CT), on Friday, July 29, 2011. Proposals received after this time and date will not be considered regardless of the reason for the late delivery and receipt. Respondents are solely responsible for verifying timely receipt of proposals in the Issuing Office by the deadline set forth above.

Evaluation Criteria: Proposals will be evaluated under the evaluation criteria outlined in the RFP. The Board shall make the final decision on any contract award or awards resulting from this RFP. The Comptroller and the Board each reserve the right, in their sole discretion, to accept

or reject any or all proposals submitted. The Comptroller and the Board are not obligated to execute any contracts on the basis of this notice or the distribution of any RFP. The Comptroller and the Board shall not pay for any costs incurred by any entity in responding to this notice or the RFP.

The anticipated schedule of events pertaining to this solicitation is as follows: Issuance of RFP - July 8, 2011, after 10:00 a.m. CT; Non-Mandatory Letters of Intent to propose and Questions Due - July 15, 2011, 2:00 p.m. CT; Official Responses to Questions posted - July 22, 2011; Proposals Due - July 29, 2011, 2:00 p.m. CT; Contract Execution - September 1, 2011, or as soon thereafter as practical; Commencement of Project Activities - September 1, 2011, or as soon thereafter as practical.

TRD-201102465
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: June 29, 2011

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 07/04/11 - 07/10/11 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 07/04/11 - 07/10/11 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.

TRD-201102428
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: June 28, 2011

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East Texas Council of Governments

Public Notice

The East Texas Council of Governments (ETCOG), a political subdivision of the State of Texas covering the 14-County Uniform Planning Region 6, is soliciting requests for proposals (RFPs) for independent audit services for fiscal year 2010-11. The Audit will cover federal and state grants and all other programs administered by ETCOG for the twelve-month period ending September 30, 2011. The Audit must comply with the Single Audit Act and related amendments as well as applicable Office of Management and Budget Circulars. Potential respondents may obtain a copy of the RFP by contacting Charles Cunningham, Director of Finance, East Texas Council of Governments, 3800 Stone Road, Kilgore, Texas 75662 or by calling (903) 984-8641. The RFP is also posted on the ETCOG website www.etcog.org under "About Us" on the Request for Proposals page. The deadline for submission is 5:00 p.m. on July 22, 2011.

TRD-201102389
Lindsay Vanderbilt
Communications Manager
East Texas Council of Governments
Filed: June 24, 2011

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Employees Retirement System of Texas

Contract Award Announcement

This contract award notice is being filed by the Employees Retirement System of Texas in relation to a contract awarded for specified Health Maintenance Organizations ("HMOs") to provide Medicare Advantage HMO services under the Texas Employees Group Benefits Program for FY 2012. The selected contractor is KS Plan Administrators, LLC, 8900 Lakes at 610 Drive, Suite 1100, Houston, Texas 77054. The cost of the contract for FY 2012 is estimated to be no greater than $13.5 million. The contract was executed on June 17, 2011, and is for a term of September 1, 2011 through August 31, 2012.

TRD-201102370
Paula A. Jones
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Filed: June 23, 2011

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Contract Award Announcement

This contract award notice is being filed by the Employees Retirement System of Texas in relation to a contract award for auditing services of the Texas Employees Group Benefits Health and Welfare Programs. The contractor is Clifton Gunderson, LLP, 11044 Research Boulevard, Suite C-500, Austin, Texas, 78759. Clifton Gunderson will provide a GBP statistical audit for FY 2010 through FY 2012. The cost of the contract is approximately $200,000. The contract was executed on June 28, 2011, and the term of the contract is through August 31, 2013.

TRD-201102443
Paula A. Jones
General Counsel and Chief Compliance Officer
Employees Retirement System of Texas
Filed: June 29, 2011

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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 (TWC), §7.075. TWC, §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. TWC, §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 August 8, 2011. TWC, §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 August 8, 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, TWC, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Ballard Exploration Company, Incorporated; DOCKET NUMBER: 2011-0352-AIR-E; IDENTIFIER: RN106063019; LOCATION: Raywood, Liberty County; TYPE OF FACILITY: oil and gas production; RULE VIOLATED: 30 TAC §115.112(d)(5) and Texas Health and Safety Code (THSC), §382.085(b), by failing to meet the control requirements for the storage of volatile organic compounds; 30 TAC §116.110(a)(1), THSC, §382.085(b) and §381.0518(a), by failing to obtain authorization to construct and operate a source of air emissions; and 30 TAC §122.121 and §122.130 and THSC, §382.054 and §382.085(b), by failing to obtain a federal operating permit; PENALTY: $32,500; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(2) COMPANY: Ballard Exploration Company, Incorporated; DOCKET NUMBER: 2011-0353-AIR-E; IDENTIFIER: RN106062847; LOCATION: Raywood, Liberty County; TYPE OF FACILITY: oil and gas production; RULE VIOLATED: 30 TAC §115.112(d)(4) and Texas Health and Safety Code (THSC), §382.085(b), by failing to meet the control requirements for the storage of volatile organic compounds; 30 TAC §116.110(a)(1) and THSC, §382.085(b) and §381.0518(a), by failing to obtain authorization to construct and operate a source of air emissions; and 30 TAC §122.121 and §122.130 and THSC, §382.054 and §382.085(b), by failing to obtain a federal operating permit; PENALTY: $32,500; ENFORCEMENT COORDINATOR: Todd Huddleson, (512) 239-2541; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(3) COMPANY: Bar Constructors, Incorporated; DOCKET NUMBER: 2011-0577-AIR-E; IDENTIFIER: RN105598809; LOCATION: Kaufman County; TYPE OF FACILITY: trench burner; RULE VIOLATED: 30 TAC §122.143(4) and §122.146(2), General Operating Permit (GOP) O-3089/Air Curtain Incinerator GOP Number 518 Terms and Conditions (b)(2), and Texas Health and Safety Code (THSC), §382.085(b), by failing to submit a Permit Compliance Certification within 30 days after the end of the certification period; 30 TAC §122.143(4) and §122.145(2)(C), GOP O-3089/Air Curtain Incinerator GOP Number 518 Terms and Conditions (b)(2), and THSC, §382.085(b), by failing to submit a semiannual deviation report within 30 days after the end of the reporting period; PENALTY: $2,100; Supplemental Environmental Project offset amount of $840 applied to North Central Texas Council of Governments, North Central Texas Clean School Program; ENFORCEMENT COORDINATOR: Samuel Short, (512) 239-5363; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: Bloomington Independent School District; DOCKET NUMBER: 2011-0895-MWD-E; IDENTIFIER: RN101274140; LOCATION: Victoria County; TYPE OF FACILITY: wastewater treatment facility; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0014578001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permit effluent limits; and 30 TAC §305.125(17) and §319.7(d) and TPDES Permit Number WQ0014578001, Monitoring and Reporting Requirements Number 1, by failing to timely submit the discharge monitoring reports; PENALTY: $3,008; ENFORCEMENT COORDINATOR: Merrilee Hupp, (512) 239-4490; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(5) COMPANY: BP Amoco Chemical Company; DOCKET NUMBER: 2011-0461-AIR-E; IDENTIFIER: RN102536307; LOCATION: Texas City, Galveston County; TYPE OF FACILITY: petrochemical plant; RULE VIOLATED: 30 TAC §113.120 and §122.143(4), 40 Code of Federal Regulations §63.116(a)(2), Texas Health and Safety Code (THSC), §382.085(b), and Federal Operating Permit (FOP) Number O1513, General Terms and Conditions and Special Terms and Conditions (STC) Number 1A, by failing to conduct a performance test to determine the net heating value of the gas being combusted at the Paraxylene Unit 1 Flare by November 20, 2009; 30 TAC §122.145(2)(A), THSC, §382.085(b), and FOP Number O1513, STC Number 1A, by failing to report a deviation; PENALTY: $2,354; ENFORCEMENT COORDINATOR: Trina Grieco, (210) 403-4006; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(6) COMPANY: City of Bogata; DOCKET NUMBER: 2011-0327-MWD-E; IDENTIFIER: RN101721157; LOCATION: Red River County; TYPE OF FACILITY: water reclamation wastewater treatment facility; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010065001, Final Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; 30 TAC §305.125(17) and §319.1 and TPDES Permit Number WQ0010065001, Monitoring and Reporting Requirements Number 1, by failing to timely submit discharge monitoring reports for the monitoring periods ending July 31, 2010 - October 31, 2010; and 30 TAC §305.125(17), and TPDES Permit Number WQ0010065001, Sludge Provisions, by failing to timely submit the annual sludge report for the monitoring period ending July 31, 2010; PENALTY: $4,550; ENFORCEMENT COORDINATOR: Samuel Short, (512) 239-5363; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(7) COMPANY: City of Bridgeport; DOCKET NUMBER: 2010-1787-MWD-E; IDENTIFIER: RN102740230; LOCATION: Wise County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010389003, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; and 30 TAC §305.125(17) and TPDES Permit Number WQ0010389003, Sludge Provisions, by failing to submit a complete annual sludge report for the monitoring period ending July 31, 2010; PENALTY: $37,020; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(8) COMPANY: City of Tatum; DOCKET NUMBER: 2011-0528-MWD-E; IDENTIFIER: RN101918407; LOCATION: Rusk County; TYPE OF FACILITY: wastewater treatment facility; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0010850001, Effluent Limitations and Monitoring Requirements Numbers 1 and 3,

by failing to comply with permit effluent limits; PENALTY: $11,120; Supplemental Environmental Project offset amount of $8,896 applied to Caddo Lake Institute, Caddo Lake Watershed Enhanced Monitoring Program; ENFORCEMENT COORDINATOR: Merrilee Hupp, (512) 239-4490; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(9) COMPANY: COMMERCE QUICK STOP, INCORPORATED; DOCKET NUMBER: 2011-0398-PST-E; IDENTIFIER: RN102717154; LOCATION: Commerce, Hunt County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2), and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tank (UST) for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide release detection for the piping associated with the UST; PENALTY: $2,629; ENFORCEMENT COORDINATOR: Rajesh Acharya, (512) 239-0577; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(10) COMPANY: Edwin T. Morgenthaler dba Frontier Water Company; DOCKET NUMBER: 2011-0415-PWS-E; IDENTIFIER: RN101179976; LOCATION: Brazoria County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.109(c)(3)(A)(ii) and §290.122(c)(2)(A), by failing to collect a set of four repeat distribution coliform samples within 24 hours of being notified of a total coliform-positive result on a routine coliform sample collected during the months of October 2009 and May 2010; and by failing to provide public notice to persons served by the facility regarding the failure to collect repeat samples for the month of October 2009 and May 2010; 30 TAC §290.109(f)(3) and §290.122(b)(2)(A) and Texas Health and Safety Code, §341.031(a), by failing to comply with the Maximum Contaminant Level (MCL) for total coliform and by failing to provide public notification of the MCL exceedence for the month of March 2010; and 30 TAC §290.109(c)(2)(F) and §290.122(c)(2)(A), by failing to collect at least five routine distribution coliform samples the month following a coliform-positive sample result and failing to provide public notification of the failure to sample for the months of May and June 2010; PENALTY: $1,985; ENFORCEMENT COORDINATOR: Andrea Linson-Mgbeoduru, (512) 239-1482; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(11) COMPANY: Exide Technologies; DOCKET NUMBER: 2010-1818-IWD-E; IDENTIFIER: RN100218643; LOCATION: Frisco, Collin County; TYPE OF FACILITY: lead-acid battery recycling plant; RULE VIOLATED: 30 TAC §305.125(17) and §319.1, and Texas Pollutant Discharge Elimination System Permit Number WQ0002964000, Monitoring and Reporting Requirements Number 1, 48-Hour Acute Biomonitoring Requirements: Freshwater Number 3 and 24-Hour Acute Biomonitoring Requirements: Freshwater Number 3, by failing to submit effluent monitoring results at the intervals specified in the permit; PENALTY: $32,940; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(12) COMPANY: Hydro Conduit of Texas, LP; DOCKET NUMBER: 2011-0690-IWD-E; IDENTIFIER: RN101917060; LOCATION: Rosharon, Brazoria County; TYPE OF FACILITY: ready-mix concrete facility; RULE VIOLATED: 30 TAC §305.125(17) and §319.7(d) and Texas Pollutant Discharge Elimination System General Permit Number TXG110978, Part IV Standard Permit Conditions Number 7(f), by failing to timely submit monitoring results at intervals specified in the permit; PENALTY: $1,300; ENFORCEMENT COORDINATOR: Thomas Jecha, P.G., (512) 239-2576; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(13) COMPANY: Jarvis Christian College; DOCKET NUMBER: 2011-0609-MWD-E; IDENTIFIER: RN102075850; LOCATION: Hawkins, Wood County; TYPE OF FACILITY: wastewater treatment facility; RULE VIOLATED: 30 TAC §305.125(17) and §319.7(d) and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0011609001, Monitoring and Reporting Requirements Number 1, by failing to timely submit monitoring results at the intervals specified in the permit; and 30 TAC §305.125(17) and TPDES Permit Number WQ0011609001, Sludge Provisions, by failing to timely submit the annual sludge report for the monitoring period ending July 31, 2010 by September 1, 2010; PENALTY: $1,313; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5886; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(14) COMPANY: Jesse R. Daughtry, Sr.; DOCKET NUMBER: 2011-0925-WOC-E; IDENTIFIER: RN103411054; LOCATION: Waller, Waller County; TYPE OF FACILITY: occupational licensing; RULE VIOLATED: 30 TAC §30.5(a), by failing to obtain a required occupational license; PENALTY: $210; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(15) COMPANY: Kingsland Estates Water Supply Corporation; DOCKET NUMBER: 2011-0479-UTL-E; IDENTIFIER: RN102684313; LOCATION: Harris County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.39(o)(1) and §291.162(a) and (j) and TWC, §13.1395(b)(2), by failing to submit to the executive director for approval by the required deadline, an adoptable emergency preparedness plan that demonstrates the facility's ability to provide emergency operations; PENALTY: $472; ENFORCEMENT COORDINATOR: Katy Schumann, (512) 239-2602; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(16) COMPANY: Lake Municipal Utility District; DOCKET NUMBER: 2011-0455-MWD-E; IDENTIFIER: RN104007166; LOCATION: Harris County; TYPE OF FACILITY: wastewater treatment plant; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0014478001, Interim I Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limitations; PENALTY: $1,200; ENFORCEMENT COORDINATOR: Thomas Jecha, P.G., (512) 239-2576; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(17) COMPANY: Leon Junction Water Supply Corporation; DOCKET NUMBER: 2011-0082-PWS-E; IDENTIFIER: RN102953841; LOCATION: Flat and Leon Junction, Coryell County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.41(c)(3)(I), by failing to ensure that the well site is fine graded and free from depressions, reverse grades or areas too rough for proper ground maintenance that would prevent surface water from draining away from the well; 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 water supply and an emergency telephone number where a responsible official can be contacted; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of the facility's systems and equipment; 30 TAC §290.42(e)(4)(B), by failing to ensure that the gas chlorination equipment and chlorine cylinders are housed in a structure that protects them from adverse weather conditions and vandalism; 30 TAC §290.46(m)(1)(A), by failing to conduct an annual

inspection of the facility's ground storage tank; 30 TAC §290.46(s)(1), by failing to calibrate the well meters at least once every three years; 30 TAC §290.121(a) and (b), by failing to compile an up-to-date chemical and microbiological monitoring plan that identifies all sampling locations, describes the sampling frequency, and specifies the analytical procedures and laboratories that the facility will use to comply with the monitoring requirements; 30 TAC §290.46(d)(2)(A) and §290.110(b)(4), by failing to maintain a disinfectant residual concentration of at least 0.2 milligrams per liter free chlorine in the water within the distribution system; 30 TAC §290.46(f)(2) and (3)(D)(i), by failing to make water works operation and maintenance records available for review by commission personnel during the investigation; 30 TAC §290.41(c)(1)(F), by failing to provide a sanitary control easement that covers the land within 150 feet of the well location; 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 §290.46(n)(2), by failing to make available an up-to-date map of the distribution system so that valves and mains can be easily located during emergencies; and 30 TAC §290.42(l), by failing to compile a plant operations manual for operator review and reference; PENALTY: $1,288; ENFORCEMENT COORDINATOR: Rebecca Clausewitz, (210) 403-4012; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(18) COMPANY: Mewbourne Oil Company; DOCKET NUMBER: 2011-0936-WR-E; IDENTIFIER: RN101767754; LOCATION: Ochiltree County; TYPE OF FACILITY: fleet refueling; RULE VIOLATED: TWC, §11.081 and §11.121, by failing to obtain a required permit before impounding, diverting, or using state water; PENALTY: $350; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(19) COMPANY: Modisette Welding & Supply, LLC; DOCKET NUMBER: 2011-0657-AIR-E; IDENTIFIER: RN105661938; LOCATION: Kilgore, Gregg County; TYPE OF FACILITY: welding and oil field equipment repair; RULE VIOLATED: 30 TAC §116.110(a) and Texas Health and Safety Code, §382.0518(a) and §382.085(b), by failing to obtain permit authorization for a source of air emissions prior to the commencement of operations of a facility which emits air contaminants; PENALTY: $1,050; ENFORCEMENT COORDINATOR: Allison Fischer, (512) 239-2574; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(20) COMPANY: Quail Creek Municipal Utility District; DOCKET NUMBER: 2011-0443-MWD-E; IDENTIFIER: RN101700730; LOCATION: Victoria County; TYPE OF FACILITY: domestic wastewater treatment facility; RULE VIOLATED: 30 TAC §305.125(17) and §319.1, and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0012226001, Monitoring and Reporting Requirements Number 1, by failing to timely submit the discharge monitoring reports for the monitoring periods ending May 31, 2010 - October 31, 2010; and 30 TAC §305.125(17), and TPDES Permit Number WQ0012226001, Sludge Provisions, by failing to timely submit the annual sludge report for the monitoring period ending July 31, 2010 by the September 1, 2010 due date; PENALTY: $805; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3422; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(21) COMPANY: Ray W. Blair dba Last Resort Properties; DOCKET NUMBER: 2011-0434-PWS-E; IDENTIFIER: RN102689452; LOCATION: Little Elm, Denton County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.41(c)(1)(F), by failing to obtain a sanitary control easement that covers the land within 150 feet of the well; and 30 TAC §290.45(b)(1)(A)(i) and §290.45(g)(2) and Texas Health and Safety Code, §341.0315(a)(1), by failing to provide a well capacity of 1.5 gallons per minute per connection; PENALTY: $172; ENFORCEMENT COORDINATOR: Andrea Byington, (512) 239-2579; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(22) COMPANY: Red River Oilfield Services LLC; DOCKET NUMBER: 2011-0600-AIR-E; IDENTIFIER: RN105713226; LOCATION: Springtown, Parker County; TYPE OF FACILITY: oilfield services; RULE VIOLATED: 30 TAC §101.4 and Texas Health and Safety Code, §382.085(b), by failing to prevent nuisance dust emissions from impacting off property receptors; PENALTY: $800; ENFORCEMENT COORDINATOR: Audra Benoit, (409) 899-8799; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(23) COMPANY: Texas Parks and Wildlife Department; DOCKET NUMBER: 2011-0221-MWD-E; IDENTIFIER: RN101282317; LOCATION: Taylor County; TYPE OF FACILITY: recreational vehicle park and camp; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0011234001, Effluent Limitation and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; PENALTY: $1,380; Supplemental Environmental Project offset amount of $1,104 applied to Lake Abilene Southwest Shore Erosion Control Project; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3422; REGIONAL OFFICE: 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(24) COMPANY: The Premcor Refining Group Incorporated, Diamond Shamrock Refining Company, L.P. and Valero Refining-Texas, L.P.; DOCKET NUMBER: 2010-0909-MLM-E; IDENTIFIER: RN102584026; RN100210517; RN100219310; RN100211663; RN100214386; and RN100238386; LOCATIONS: Port Arthur, Jefferson County; McKee Plant, Moore County; Houston, Harris County; Corpus Christi, Nueces County; and Texas City, Galveston County; TYPE OF FACILITIES: petroleum refineries; RULE VIOLATED: 30 TAC §101.20(3) and §116.715(a), Texas Health and Safety Code (THSC), §382.085(b), and Flexible Permit Numbers 9708 and PSD-TX-861M2, Special Condition (SC) 2, by failing to prevent unauthorized emissions at the McKee Plant; 30 TAC §106.512(1), THSC, §382.085(b), and Federal Operating Permit (FOP) Number O-01555, Special Terms and Conditions (STC) 15, by failing to obtain authorization to operate a 450 horsepower compressor engine in the Number 1 Crude Unit at the McKee Plant; 40 Code of Federal Regulations (CFR) §60.692-2(a)(3), 30 TAC §101.20(1), THSC, §382.085(b), and FOP Number O-01555, STC 5B, by failing to conduct initial and weekly inspections of inactive drains for indications of low water levels or other problems that could result in volatile organic compounds (VOC) emissions (inspections are required initially upon taking the drain out of service and weekly thereafter) at the McKee Plant; 40 CFR §60.692-2(a)(2), 30 TAC §101.20(1), THSC, §382.085(b), and FOP Number O-01555, STC 5B, by failing to conduct initial and monthly inspections of active drains for indications of low water levels or other problems that could result in VOC emissions (inspections are required initially upon the drain being put into service and monthly thereafter) at the McKee Plant; 40 CFR §60.692-2(a)(5), 30 TAC §101.20(1), THSC, §382.085(b), and FOP Number O-01555, STC 5B, by failing to repair 70 drains within 24 hours after determining that low water levels or missing or improperly installed caps and plugs were identified (indicating that pollutants are being released) at the McKee Plant, as reported in the January 1 to June 30, 2009 semiannual deviation report; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Air Permit Numbers 9708 and

PSD-TX-861M2, STC 19D (formerly 23D), by failing to record the date and time of the audio, visual, and olfactory inspections for leaks in pipes, pumps, valves, and compressors in hydrogen sulfide (H2S), sulfur dioxide (SO2), and ammonia service at the McKee Plant; 40 CFR §60.18(f)(2) and §63.11(b)(5), 30 TAC §101.20(1) and (2), and THSC, §382.085(b), by failing to ensure that the pilot flame monitor is detecting the pilot flame for the Main Flare (EPN FL-1), the Fluid Catalytic Cracking Unit Flare (EPN FL-3), and the Hydrocarbon Unit Flare (EPN FL-4) intermittently between January 16, 2008 and January 12, 2010 at the McKee Plant; 40 CFR §63.6(e)(3)(viii), 30 TAC §101.20(2), and THSC, §382.085(b), by failing to update the Startup, Shutdown, and Malfunction Plan within 45 days after the April 2, 2009 malfunctions occurred at the Reheat Exchanger in the Number 2 Sulfur Recovery Unit, in order to include detailed procedures for operating and maintaining the source during similar malfunctions as well as a corrective action program at the McKee Plant; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Permit Numbers 9708 and PSD-TX-861M2, STC 2, by failing to prevent unauthorized emissions at the McKee Plant; 30 TAC §§101.20(3), 116.715(a) and (c)(7), and 122.143(4), Flexible Air Permit Numbers 6825A, PSD-TX-49, and N65, SC 1, FOP Number O-01498, General Terms and Conditions (GTC) and STC 18 and THSC, §382.085(b), by failing to prevent unauthorized emissions at the Port Arthur Refinery; 30 TAC §101.201(a)(1)(A) and (B) and §122.143(4), FOP Number O-01498, STC 2F and GTC, and THSC, §382.085(b), by failing to submit an initial report within 24 hours for Incident Number 134571 at the Port Arthur Refinery; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Permit Numbers 9708 and PSD-TX-861M2, STC 2, by failing to prevent unauthorized emissions at the McKee Plant; FOP Number O1381, STC Number 19, Standard Permit Registration Number 81979, SC (5)(B)(v), 30 TAC §116.115(c) and §122.143(4), and THSC, §382.085(b), by failing to perform stack testing within 90 days after the installation of Temporary Boiler Number 1 at the Houston Refinery; TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0000535000, Final Phase Effluent Limitations and Monitoring Requirements Number 1 for Outfall 001, by failing to comply with the permitted effluent limitations at the Houston Refinery; 30 TAC §319.7(a)(5) and §319.11(c), and TPDES Permit Number WQ0000535000, Definitions and Standard Permit Conditions Numbers 2(f) and (g), by failing to correctly calculate the effluent loadings for free cyanide at the Houston Refinery; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Permit Numbers 2937 and PSD-TX-1023M1, SC 1, by failing to prevent unauthorized emissions at the Corpus Christi Refinery East Plant; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Permit Numbers 2937 and PSD-TX-1023M1, SC 10A, by failing to comply with the 0.035 pound of nitrogen oxide per million British thermal units on an hourly averaging period for Boiler Numbers 1, 2, and 5, as reported in the semiannual deviation reports for the annual compliance certification periods of November 24, 2007 - November 23, 2008 and November 24, 2008 - November 23, 2009 at the Corpus Christi Refinery East Plant; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Air Permit Numbers 38754 and PSD-TX-324M12, SC 1, by failing to prevent unauthorized emissions at the Corpus Christi Refinery West Plant; 30 TAC §101.20(3) and §116.715(a), THSC, §382.085(b), and Flexible Air Permit Numbers 39142 and PSD-TX-822M2, SC 1, by failing to prevent unauthorized emissions at the Texas City Refinery; PENALTY: $293,611; Supplemental Environmental Project (SEP) offset amount of $25,758 applied to Bayou Land Conservancy fka Legacy Land Trust, Spring Creek Greenway Project; SEP offset amount of $34,250 applied to Texas A&M University-Corpus Christi, Texas A&M University AutoCheck Program; and SEP offset amount of $4,046 applied to Southeast Texas Regional Planning Commission-Southeast Texas Regional Air Monitoring Network Ambient Air Monitoring Section; ENFORCEMENT COORDINATOR: Trina Grieco, (210) 403-4006; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(25) COMPANY: United States Department of the Army; DOCKET NUMBER: 2010-1783-IWD-E; IDENTIFIER: RN100662840; LOCATION: Bexar County; TYPE OF FACILITY: wastewater treatment facility; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System Permit Number WQ0003849000, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; PENALTY: $361; ENFORCEMENT COORDINATOR: Steve Villatoro, (512) 239-4930; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(26) COMPANY: Weatherford Holdings, L.P.; DOCKET NUMBER: 2010-1103-PWS-E; IDENTIFIER: RN105596860 and RN105596902; LOCATION: Parker County; TYPE OF FACILITY: apartment complex with a public water supply; RULE VIOLATED: 30 TAC §290.109(c)(2)(A)(ii) and §290.122(c)(2)(A) and Texas Health and Safety Code (THSC), §341.033(d), by failing to collect routine distribution water samples for coliform analysis at Highland Court and by failing to provide notice to persons served by Highland Court regarding the failure to conduct routine coliform monitoring; 30 TAC §290.109(c)(3)(A)(ii) and §290.122(c)(2)(A), by failing to collect a set of four repeat distribution coliform samples within 24 hours of being notified of a total coliform-positive result on a routine sample at Highland Court and by failing to provide notice to persons served by Highland Court regarding the failure to collect repeat samples; 30 TAC §290.109(c)(2)(F) and §290.122(c)(2)(A), by failing to collect at least five distribution coliform samples the month following a total coliform-positive result at Highland Court and by failing to provide notice to persons served by Highland Court regarding the failure to conduct increased routine monitoring; 30 TAC §290.109(f)(3) and §290.122(b)(2)(A) and THSC, §341.0315(c), by failing to comply with the maximum contaminant level (MCL) for total coliform at Highland Court and by failing to provide notice to persons served by Highland Court regarding the exceedance of the MCL for total coliform; 30 TAC §290.109(c)(2)(A)(ii) and §290.122(c)(2)(A) and THSC, §341.033(d), by failing to collect routine distribution water samples for coliform analysis at Highland Meadows and by failing to provide notice to persons served by Highland Meadows regarding the failure to conduct routine coliform monitoring; PENALTY: $7,667; ENFORCEMENT COORDINATOR: Michaelle Sherlock, (210) 403-4076; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(27) COMPANY: WTG Gas Processing, L.P.; DOCKET NUMBER: 2011-0122-AIR-E; IDENTIFIER: RN100211473; LOCATION: Howard County; TYPE OF FACILITY: oil and gas processing; RULE VIOLATED: 30 TAC §116.115(c), Texas Health and Safety Code, §382.085(b), and New Source Review Permit Number 20137, Special Conditions Number 5, by failing to maintain a minimum 94% sulfur recovery efficiency from the Sulfur Recovery Unit; PENALTY: $8,150; ENFORCEMENT COORDINATOR: Todd Huddleston, (512) 239-2541; REGIONAL OFFICE: 3300 North A Street, Building 4, Suite 107, Midland, Texas 79705-5404, (432) 570-1359.

TRD-201102434

Kathleen C. Decker

Director, Litigation Division

Texas Commission on Environmental Quality

Filed: June 28, 2011

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Notice of a Proposed Amendment and Renewal of a General Permit Authorizing the Discharge of Wastewater

The Texas Commission on Environmental Quality (TCEQ) proposes to amend and renew a general permit, Texas Pollutant Discharge Elimination System Permit No. TXG110000, authorizing the discharge of facility wastewater and storm water associated with industrial activities from ready-mixed concrete plants, concrete products plants, and their associated facilities into or adjacent to water in the state. The proposed general permit applies to the entire state of Texas. General permits are authorized by §26.040 of the Texas Water Code.

PROPOSED GENERAL PERMIT. The executive director has prepared a draft renewal with amendments of an existing general permit that authorizes the discharge of wastes from ready-mixed concrete plants, concrete products plants, and their associated facilities. No significant degradation of high quality waters is expected and existing uses will be maintained and protected. The executive director proposes to require regulated dischargers to submit a Notice of Intent (NOI) to obtain authorization for some discharges.

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 (CCC) regulations, and has determined that the action is consistent with applicable CMP goals and policies.

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 sixteen (16) regional offices and on the TCEQ website at http://www.tceq.state.tx.us/permitting/water_quality/wastewater/general/index.html.

PUBLIC COMMENT/PUBLIC MEETING. You may submit public comments or request a public meeting about this proposed general permit. The purpose of a public meeting is to provide the opportunity to submit written or oral comment or to ask questions about the proposed general permit. Generally, the TCEQ will hold a public meeting if the executive director determines that there is a significant degree of public interest in the proposed general permit or if requested by a local legislator. A public meeting is not a contested case hearing.

Written public comments must be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087 within 30 days from the date this notice is published in the *Texas Register.*

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 10 days before the scheduled Commission meeting when the commission will consider approval of the general permit. The commission will consider all public comment 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 LISTS. In addition to submitting public comments, you may ask to be placed on a mailing list to receive future public 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 permanent mailing list for a specific applicant name and permit number; and/or (3) the permanent mailing list for a specific county. Clearly specify the mailing lists to which you wish to be added and send your request to the 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.

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 website at: http://www.tceq.state.tx.us.

Further information may also be obtained by calling the TCEQ's Water Quality Division, Industrial Permits Team, at (512) 239-4671.

Si desea información en español, puede llamar 1-800-687-4040.

TRD-201102424
Melissa Chao
Acting Chief Clerk
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Correction - Notice of Request for Preliminary Comments for Review and Revision of the Texas Surface Water Quality Standards (TSWQS) and the Procedures to Implement the TSWQS

In the June 24, 2011, issue of the *Texas Register* (36 TexReg 3989), the Texas Commission on Environmental Quality (commission) published the Notice of Request for Preliminary Comments for Review and Revision of the Texas Surface Water Quality Standards (TSWQS) and the Procedures to Implement the TSWQS.

Within this notice the close of comment deadline published incorrectly as "5:00 p.m. on Sunday, July 24, 2011." The correct close of comment deadline is 5:00 p.m. on July 25, 2011. The error is as submitted by the commission.

For questions concerning this error, please contact Mr. David Galindo, Water Quality Division, (512) 239-0951, or Mr. Bob Brush, Environmental Law Division, (512) 239-5600.

TRD-201102431
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Correction to Agreed Order Number 2

In the March 11, 2011, issue of the *Texas Register* (36 TexReg 1714), the Texas Commission on Environmental Quality (commission) published a notice of Agreed Order Number, specifically Item Number 2. The reference to City of Mathis was submitted in error by the commission as applied to Texas Association of Resource Conservation and Development Areas, Inc. (RC&D) - Water or Wastewater Treatment Assistance and instead should have been submitted as applied to City of Corpus Christi - Wetland Construction, Habitat Enhancements, and Land Acquisition at the Oso Conservation Interpretive Park.

For questions concerning this error, please contact Kari Gilbreth at (210) 239-1320.

TRD-201102439
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Correction to Agreed Order Number 21

In the April 1, 2011, issue of the *Texas Register* (36 TexReg 2165), the Texas Commission on Environmental Quality (commission) published a notice of an Agreed Order Number, specifically item Number 21. The reference to the Lubrizol Corporation has been revised. The reference to a Supplemental Environmental Project being Texas Association of Resource Conservation and Development Areas, Inc. - Clean School Buses should instead be Houston Galveston Air Emission Reduction Credit Organization Clean Cities/Clean Vehicles Program.

For questions concerning this error, please contact Debra Barber at (512) 239-0412.

TRD-201102435
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of District Petition

Notice issued June 17, 2011.

TCEQ Internal Control No. 02222011-D02; Farmersville Investors, LP (the "Petitioner") filed a petition for creation of Lakehaven Municipal Utility District of Collin County (the "District") with the Texas Commission on Environmental Quality (TCEQ). The petition was filed pursuant to Article XVI, Section 59 of the Constitution of the State of Texas; Chapters 49 and 54 of the Texas Water Code; 30 Texas Administrative Code Chapter 293; and the procedural rules of the TCEQ. The petition was filed with the county clerk in Collin County, pursuant to 30 TAC §293.11(d). The petition states the following: (1) the Petitioner is the owner of a majority in value of the land to be included in the proposed District; (2) the proposed District will contain approximately 375.9 acres located in Collin County, Texas; and (3) the proposed District is not within the corporate boundaries or extraterritorial jurisdiction of any municipality. According to the petition, the Petitioner has conducted a preliminary investigation to determine the cost of the project and from the information available at the time, the cost of the project is estimated to be approximately $28,725,000.

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.

The TCEQ may grant a contested case hearing on the petition if a written hearing request is filed within 30 days after the newspaper publication of the notice. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) the name of the Petitioner and the TCEQ Internal Control Number; (3) the statement "I/we request a contested case hearing"; (4) a brief description of how you would be affected by the petition in a way not common to the general public; and (5) the location of your property relative to the proposed District's boundaries. You may also submit your proposed adjustments to the petition. Requests for a contested case hearing must be submitted in writing to the Office of the Chief Clerk at the address provided in the information section below. The Executive Director may approve the petition unless a written request for a contested case hearing is filed within 30 days after the newspaper publication of this notice. If a hearing request is filed, the Executive Director will not approve the petition and will forward the petition and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting. If a contested case hearing is held, it will be a legal proceeding similar to a civil trial in state district court. Written hearing requests should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 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 Districts Review Team, at (512) 239-4691. Si desea información en español, puede llamar al (512) 239-0200. General information regarding TCEQ can be found at our web site at www.tceq.state.tx.us.

TRD-201102458
Melissa Chao
Acting Chief Clerk
Texas Commission on Environmental Quality
Filed: June 29, 2011

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Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

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 (TWC), §7.075. TWC, §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. TWC, §7.075 requires that notice of 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 **August 8, 2011.** TWC, §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 A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 8, 2011.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, TWC, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: Addison Enterprises Inc. dba C-Store Royal; DOCKET NUMBER: 2010-1940-PST-E; TCEQ ID NUMBER: RN102755287; LOCATION: 2903 Royal Lane, Dallas, Dallas County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §115.245(2) and Texas Health and Safety Code (THSC), §382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months; PENALTY: $3,544; STAFF ATTORNEY: Tammy Mitchell, Litigation Division, MC 175, (512) 239-0736; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: City of Scottsville; DOCKET NUMBER: 2010-1254-PWS-E; TCEQ ID NUMBER: RN101227619; LOCATION: Farm-to-Market Road 2199 off Highway 80, east of Marshall, Harrison County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and §209.122(c)(2)(A) and THSC, §341.033(d), by failing to collect routine distribution water samples for coliform analysis and by failing to provide public notification of the failure to sample for the following months: February, April, May, July - October 2008 and February 2010; 30 TAC §290.109(f)(3) and §290.122(b)(2)(A) and THSC, §341.031(a), by failing to comply with the Maximum Containment Level (MCL) for total coliform and by failing to provide public notification of the MCL exceedence for the month of March 2010; 30 TAC §290.109(c)(3)(A)(i) and §290.122(c)(2)(A), by failing to collect, within 24 hours of being notified of a total coliform-positive result for a routine distribution coliform sample, three repeat distribution coliform samples for each routine distribution coliform-positive sample, and by failing to provide public notification of the failure to collect repeat distribution samples during the month of March 2010; 30 TAC §290.109(c)(2)(F) and §290.122(c)(2)(A), by failing to collect at least five routine distribution coliform samples the month following a coliform-positive sample result, and by failing to provide public notification of the failure to sample for the month of April 2010; PENALTY: $4,372; STAFF ATTORNEY: Stephanie J. Frazee, Litigation Division, MC 175, (512) 239-3693; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(3) COMPANY: Janet Green and Jaycee's Children Center, Inc.; DOCKET NUMBER: 2010-1070-PWS-E; TCEQ ID NUMBER: RN104375852; LOCATION: 2902 Milroy Lane, Houston, Harris County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and §290.122(c)(2)(B) and THSC, §341.033(d), by failing to collect routine distribution water samples for coliform analysis for the months of June 2008 - October 2008 and December 2008 - March 2009 and by failing to provide public notification of the failure to collect routine samples for the months of June 2008 - October 2008 and December 2008 - March 2009; and 30 TAC §290.46(p)(1), by failing to provide written notice of an ownership change to the executive director within 120 days before the date of transaction; PENALTY: $3,407; STAFF ATTORNEY: Sharesa Y. Alexander, Litigation Division, MC 175, (512) 239-3503; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(4) COMPANY: Lee Stafford and Lubbock Industries, Inc.; DOCKET NUMBER: 2011-0006-MSW-E; TCEQ ID NUMBER: RN103005617; LOCATION: 602 Erskine Street, Lubbock, Lubbock County; TYPE OF FACILITY: unauthorized scrap tire storage site; RULES VIOLATED: 30 TAC §328.59(a) and §328.60(a), by failing to obtain a scrap tire storage site registration for the facility prior to storing more than 500 scrap tires on the ground; PENALTY: $5,500; STAFF ATTORNEY: Xavier Guerra, Litigation Division, MC R-13, (210) 403-4016; REGIONAL OFFICE: Lubbock Regional Office, 5012 50th Street, Suite 100, Lubbock, Texas 79414-3426, (806) 796-7613.

(5) COMPANY: Peter H. Schouten dba Golden Star Dairy, Nova D. Schouten dba Golden Star Dairy, and Pieter Bakker dba Golden Star Dairy; DOCKET NUMBER: 2010-0093-AGR-E; TCEQ ID NUMBER: RN102804879; LOCATION: State Highway 6 on County Road 2495 which is approximately 5.5 miles east of the intersection of State Highway 6 and Highway 281, Bosque County; TYPE OF FACILITY: confined animal feeding operation; RULES VIOLATED: 30 TAC §321.40(d), TWC, §26.121, and State Permit Number WQ0003656000, Section IX., Standard Permit Conditions D., by failing to prevent a discharge of wastewater from a concentrated animal feeding operation; PENALTY: $5,200; STAFF ATTORNEY: Jim Sallans, Litigation Division, MC 175, (512) 239-2053; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(6) COMPANY: Thomas L. Barnes, Jr. dba The GreenHouse Center; DOCKET NUMBER: 2011-0031-LII-E; TCEQ ID NUMBER: RN103392627; LOCATION: 1778 Farm-to-Market Road 1942, Crosby, Harris County; TYPE OF FACILITY: landscaping business; RULES VIOLATED: 30 TAC §344.71(b), by failing to include the following statement in all written estimates, proposals, bids, and invoices relating to the installation or repair of an irrigation system: Irrigation in Texas is regulated by the Texas Commission on Environmental Quality (TCEQ) (MC-178), P.O. Box 13087, Austin, Texas 78711-3087. TCEQ's website is: www.tceq.texas.gov; PENALTY: $312; STAFF ATTORNEY: Sharesa Y. Alexander, Litigation Division, MC 175, (512) 239-3503; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-201102440
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075 this notice of the proposed order and the opportunity to comment is 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 **August 8, 2011.** The commission will consider any written comments received and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO 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 DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Build-

ing A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 8, 2011.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the DOs shall be submitted to the commission in **writing.**

(1) COMPANY: Adnen Saleh dba Westcreek Service Center; DOCKET NUMBER: 2010-2060-PST-E; TCEQ ID NUMBER: RN100765541; LOCATION: 5653 Westcreek Drive, Fort Worth, Tarrant County; TYPE OF FACILITY: temporarily out-of-service underground storage tank (UST) system; RULES VIOLATED: 30 TAC §334.49(c)(2)(C) and (4)(C) and TWC, §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; and respondent failed to have the cathodic protection system inspected and tested for operability and adequacy of protection at least once every three years; PENALTY: $5,122; STAFF ATTORNEY: Sharesa Y. Alexander, Litigation Division, MC 175, (512) 239-3503; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(2) COMPANY: ATC Transport, L.L.C.; DOCKET NUMBER: 2010-1876-WQ-E; TCEQ ID NUMBER: RN105835748; LOCATION: 14710 Atlanta Drive, Laredo, Webb County; TYPE OF FACILITY: vehicle maintenance facility; RULES VIOLATED: 30 TAC §281.25(a)(4) and 40 Code of Federal Regulations §122.26(c), by failing to obtain authorization to discharge storm water associated with industrial activities under the Texas Pollutant Discharge Elimination System Multi-Sector General Permit Number TXR050000; PENALTY: $1,050; STAFF ATTORNEY: Tammy Mitchell, Litigation Division, MC 175, (512) 239-0736; REGIONAL OFFICE: Laredo Regional Office, 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

(3) COMPANY: Gregory Trevino; DOCKET NUMBER: 2011-0124-MLM-E; TCEQ ID NUMBER: RN106013899; LOCATION: 12315 33rd Street, Santa Fe, Galveston County; TYPE OF FACILITY: property; RULES VIOLATED: 30 TAC §111.201 and §111.219(6)(A) and (B) and Texas Health and Safety Code (THSC), §382.085(b), by failing to conduct authorized burning of brush; and 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste (MSW); PENALTY: $4,866; STAFF ATTORNEY: Stephanie J. Frazee, Litigation Division, MC 175, (512) 239-3693; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(4) COMPANY: Harold G. Davis; DOCKET NUMBER: 2011-0074-MLM-E; TCEQ ID NUMBER: RN105936645; LOCATION: 4977 Tall Pine Road, Navasota, Grimes County; TYPE OF FACILITY: unauthorized waste disposal site; RULES VIOLATED: 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of MSW; and THSC, §382.085(b) and 30 TAC §111.201, by failing to comply with the general prohibition on outdoor burning; PENALTY: $2,950; STAFF ATTORNEY: Phillip Goodwin, Litigation Division, MC 175, (512) 239-0675; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(5) COMPANY: Krebs Utilities, Inc. dba K Estates Water System; DOCKET NUMBER: 2011-0417-UTL-E; TCEQ ID NUMBER: RN101257806; LOCATION: Harris County Appraisal District KEY MAP 418T, near 10810 Stephens Lane and 15503 Long Road, Harris County; TYPE OF FACILITY: public water system; RULES VIOLATED: TWC, §13.1395(b)(2), 30 TAC §290.39(o)(1) and §291.162(a) and (j), by failing to adopt and submit to the executive director for approval by March 1, 2010, an emergency preparedness plan that demonstrates the facility's ability to provide emergency operations; PENALTY: $813; STAFF ATTORNEY: Peipey Tang, Litigation Division, MC 175, (512) 239-0654; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(6) COMPANY: Leon Parsons Jr.; DOCKET NUMBER: 2010-1754-MLM-E; TCEQ ID NUMBER: RN105944508; LOCATION: south side of Old Beaumont Road, west of the crossing for Pine Island Bayou, Sour Lake, Hardin County; TYPE OF FACILITY: unauthorized MSW disposal site; RULES VIOLATED: 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of MSW; and 30 TAC §111.201 and THSC, §382.085(b), by failing to prevent the burning of MSW for the purpose of disposal; PENALTY: $2,109; STAFF ATTORNEY: Gary Shiu, Litigation Division, MC R-12, (713) 422-8916; REGIONAL OFFICE: Houston Regional Office, 5424 Polk Avenue, Suite H, Houston, Texas 77023, (713) 767-3500.

(7) COMPANY: Natalin Dorette Keenan; DOCKET NUMBER: 2010-1853-PST-E; TCEQ ID NUMBER: RN101724763; LOCATION: 3957 United States Highway 287, Latexo, Houston County; TYPE OF FACILITY: inactive UST system; RULES VIOLATED: 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed upgrade implementation date, a UST system for which any applicable component of the system is not brought into timely compliance with the upgrade requirements; and 30 TAC §334.7(d)(3), by failing to notify the agency of any change or additional information regarding the USTs within 30 days of the occurrence of the change or addition; PENALTY: $3,675; STAFF ATTORNEY: Sharesa Y. Alexander, Litigation Division, MC 175, (512) 239-3503; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Avenue, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(8) COMPANY: Virginia Franklin Fuller dba Franklin Water System 1 and dba Franklin Water System 3; DOCKET NUMBER: 2009-1295-PWS-E; TCEQ ID NUMBER: RN102817038 (Facility Number 1) and RN101264372 (Facility Number 3); LOCATION: 4701 Idalou Road, Lubbock, Lubbock County (Facility Number 1) and 4813 Idalou Road, Lubbock, Lubbock County (Facility Number 3); TYPE OF FACILITY: two public water systems; RULES VIOLATED: 30 TAC §290.45(f)(1), by failing to make available a purchase water contract that authorized a maximum hourly purchase rate plus the actual service pump capacity of at least 2.0 gallons per minute (gpm) per connection, or provides at least 1,000 gpm and is able to meet the peak hourly demands, whichever is less; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of facility number 1 and its equipment in a manner so as to minimize the possibility of harboring of rodents, insects, and other disease vectors, and in such a way as to prevent other conditions that might cause the contamination of the water; 30 TAC §290.51(a)(3) and TWC, §5.702, by failing to pay all annual and late Public Health Services (PHS) fees for TCEQ Financial Administration Account Number 91520224 for Fiscal Years 2005 - 2008; 30 TAC §290.41(c)(1)(D), by failing to ensure that livestock in pastures are not allowed within 50 feet of a water supply well; 30 TAC §290.45(b)(1)(C)(ii), by failing to provide a total storage capacity of 200 gallons per connection; 30 TAC §290.45(b)(1)(C)(iii), by failing to provide two or more service pumps having a total capacity of 2.0 gpm per connection at each pump station or pressure plane; 30 TAC §290.46(u), by failing to plug an abandoned public water supply well with cement according to 16 TAC Chapter 76 (relating to Water Well Drillers and Water Well Pump Installers), or test the well every five years or as required by the ex-

ecutive director to prove that it is in a non-deteriorated condition; 30 TAC §290.46(m), by failing to initiate maintenance and housekeeping practices to ensure the good working condition and general appearance of facility number 3; 30 TAC §290.46(m)(4), by failing to initiate maintenance facilities, and all related appurtenances in a watertight condition; and 30 TAC §290.51(a)(3) and TWC, §5.702, by failing to pay all annual and late PHS fees for TCEQ Financial Administration Account Number 91520080 for Fiscal Years 2005 - 2008; PENALTY: $2,799; STAFF ATTORNEY: Rudy Calderon, Litigation Division, MC 175, (512) 239-0205; REGIONAL OFFICE: Lubbock Regional Office, 5012 50th Street, Suite 100, Lubbock, Texas 79414-3421, (806) 796-7613.

TRD-201102441
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Public Hearing on Proposed Revisions to the State Implementation Plan

The Texas Commission on Environmental Quality (TCEQ) will conduct a public hearing to receive comments concerning revisions to the state implementation plan (SIP), under the requirements of Texas Health and Safety Code, §382.012 and §382.013; and 40 Code of Federal Regulations §51.102 of the United States Environmental Protection Agency regulations concerning SIPs.

The proposed revision would incorporate a plan to address the infrastructure requirements of Federal Clean Air Act (FCAA), §110(a)(1) and (2) under the 2008 lead National Ambient Air Quality Standard (NAAQS). These revisions would document how each infrastructure element is currently addressed in the Texas SIP by outlining the requirements in FCAA, §110(a)(2)(A) - (M) and the state statutes and rules that allow Texas to meet each requirement.

A public hearing on this proposal will be held in Austin on July 25, 2011, at 10:00 a.m., at the TCEQ headquarters, 12100 Park 35 Circle, Building F, Room 2210. The hearing will be structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. There will be no open discussion during the hearing; however, TCEQ staff will be available to discuss the proposal 30 minutes prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Shelley Naik with the Air Quality Division at (512) 239-1536. Requests should be made as far in advance as possible.

Comments may be submitted to Shelley Naik, MC 206, Air Quality Division, Chief Engineer's Office, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-5687. Electronic comments may be submitted at *www5.tceq.texas.gov/rules/ecomments/*. File size restrictions may apply to comments being submitted via the eComments system. All comments pertaining to the Lead Infrastructure Plan for the 2008 Lead NAAQS SIP revision should reference Project Number 2011-016-SIP-NR. The comment period closes on July 29, 2011. Copies of the proposed SIP revision can be obtained from the TCEQ's website at *http://www.tceq.texas.gov/airquality/sip/criteria-pollutants/sip-lead*. For further information, please contact Shelley Naik, Air Quality Planning Section, (512) 239-1536.

TRD-201102429
Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Public Hearing on Proposed Revisions to the State Implementation Plan and Agreed Order Between the Texas Commission on Environmental Quality and Exide Technologies

The Texas Commission on Environmental Quality (TCEQ) will conduct a public hearing to receive comments concerning proposed revisions to the state implementation plan (SIP) under the requirements of Texas Health and Safety Code, §382.017; Texas Government Code, Chapter 2001, Subchapter B; and 40 Code of Federal Regulations §51.102 of the United States Environmental Protection Agency regulations concerning SIPs.

The proposed Collin County Attainment Demonstration SIP revision would incorporate Federal Clean Air Act required elements, including a reasonably available control technology analysis, demonstration of attainment through air dispersion modeling, a control strategy demonstration, an emissions inventory, a demonstration of reasonable further progress, and contingency measures. (Project Number 2011-001-SIP-NR)

The control measures and contingency measures identified in this proposed Collin County Attainment Demonstration SIP revision will be enforceable through an Agreed Order between the TCEQ and Exide Technologies. (Project Number 2011-024-MIS-NR).

A public hearing on these proposals will be held in Frisco, Texas, on July 28, 2011, at 6:00 p.m., at the George A. Purefoy Municipal Center, 6101 Frisco Square Boulevard, City Council Chambers. The hearing will be structured for the receipt of oral or written comments by interested persons. Individuals may present oral statements when called upon in order of registration. There will be no open discussion during the hearing; however, TCEQ staff will be available to discuss the proposal one hour prior to the hearing.

Persons who have special communication or other accommodation needs who are planning to attend the hearing should contact Holly Brightwell with the Air Quality Division at (512) 239-4905. Requests should be made as far in advance as possible.

Comments may be submitted to Holly Brightwell, MC 204, Air Quality Planning, Chief Engineer's Office, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087, or faxed to (512) 239-5687. Electronic comments may be submitted at *www5.tceq.texas.gov/rules/ecomments/*. File size restrictions may apply to comments being submitted via the eComments system.

All comments pertaining to the Collin County Attainment Demonstration for the 2008 Lead National Ambient Air Quality Standard SIP revision should reference Project Number 2011-001-SIP-NR.

All comments pertaining to the Agreed Order should reference Project Number 2011-024-MIS-NR.

The comment period closes on August 8, 2011. Copies of the proposed SIP revision can be obtained from the TCEQ's website at *http://www.tceq.texas.gov/implementation/air/sip/texas-sip/criteria-pollutants/sip-lead*. For further information, please contact Holly Brightwell, Air Quality Planning Section, (512) 239-4905.

TRD-201102430

Robert Martinez
Director, Environmental Law Division
Texas Commission on Environmental Quality
Filed: June 28, 2011

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Notice of Receipt of Application and Intent to Obtain Municipal Solid Waste Limited Scope Major Permit Amendment Permit No. 1312A

APPLICATION. CCAA, LLC, P.O. Box 5449, College Station, Brazos County, Texas 77805, a Municipal Solid Waste (MSW) Management Company, has applied to the Texas Commission on Environmental Quality (TCEQ) for a new permit to authorize the Brazos County Disposal Facility 42.24-acre property as a Type IV MSW Disposal Facility. The facility is at 8825 Stewarts Meadow, College Station, Brazos County, Texas 77845. The TCEQ received the application on June 3, 2011. The permit application is available for viewing and copying at the Bryan + College Station Public Library System, Larry J. Ringer Public Library, 1818 Harvey Mitchell Parkway South, College Station, Brazos County, Texas 77845-4297.

ADDITIONAL NOTICE. TCEQ's Executive Director has determined the application is administratively complete and will conduct a technical review of the application. After technical review of the application is complete, the Executive Director may prepare a draft permit and will issue a preliminary decision on the application. Notice of the Application and Preliminary Decision will be published and mailed to those who are on the county-wide mailing list and to those who are on the mailing list for this application. That notice will contain the deadline for submitting public comments.

PUBLIC COMMENT/PUBLIC MEETING. You may submit public comments or request a public meeting on this application. The purpose of a public meeting is to provide the opportunity to submit comments or to ask questions about the application. TCEQ will hold 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.

OPPORTUNITY FOR 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. Unless the application is directly referred for a contested case hearing, the response to comments, and the Executive Director's decision on the application, will be mailed to everyone who submitted public comments and to those persons who are on the mailing list for this application. If comments are received, the mailing will also provide instructions for requesting reconsideration of the Executive Director's decision and for requesting a contested case hearing. A person who may be affected by the facility is entitled to request a contested case hearing from the commission. A contested case hearing is a legal proceeding similar to a civil trial in state district court.

TO REQUEST A CONTESTED CASE HEARING, YOU MUST INCLUDE THE FOLLOWING ITEMS IN YOUR REQUEST: your name, address, phone number; applicant's name and permit number; the location and distance of your property/activities relative to the facility; a specific description of how you would be adversely affected by the facility in a way not common to the general public; and, the statement "[I/we] request a contested case hearing." If the request for contested case hearing is filed on behalf of a group or association, the request must designate the group's representative for receiving future correspondence; identify an individual member of the group who would be adversely affected by the facility or activity; provide the information discussed above regarding the affected member's location and distance from the facility or activity; explain how and why the member would be affected; and explain how the interests the group seeks to protect are relevant to the group's purpose.

Following the close of all applicable comment and request periods, the Executive Director will forward the application and any requests for reconsideration or for a contested case hearing to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

The Commission will only grant a contested case hearing on disputed issues of fact that are relevant and material to the Commission's decision on the application. Further, the Commission will only grant a hearing on issues that were raised in timely filed comments that were not subsequently withdrawn.

MAILING LIST. If you submit public comments, a request for a contested case hearing or a 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.

AGENCY CONTACTS AND INFORMATION. All written public comments and requests must be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, TX 78711-3087 or electronically at www.tceq.state.tx.us/about/comments.html. If you need more information about this permit application or the permitting process, please call 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 TCEQ can be found at our web site at www.tceq.state.tx.us.

Further information may also be obtained from CCAA, LLC at the address stated above or by calling Mr. Charles Mancuso, Operating Manager/President at (979) 260-0006.

Further information may also be obtained from Rancho Viejo Waste Management, LLC at the address stated above or by calling Mr. Carlos Y. Benavides, III, Manager at (956) 523-1400.

TRD-201102460
Melissa Chao
Acting Chief Clerk
Texas Commission on Environmental Quality
Filed: June 29, 2011

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Notice of Water Quality Applications

The following notices were issued on June 17, 2011 through July 5, 2011.

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

SAN ISIDRO INDEPENDENT SCHOOL DISTRICT has applied for a new permit, Proposed TCEQ Permit No. WQ0014995001, to authorize the disposal of treated domestic wastewater at a daily average

flow not to exceed 8,000 gallons per day via evaporation. The facility was previously permitted under Permit No. WQ0014701001 which expired July 1, 2010. The wastewater treatment facility and disposal site are located immediately north of Farm-to-Market Road 1017, approximately one mile west of the intersection of Farm-to-Market Road 1017 and Farm-to-Market Road 2294 in Starr County, Texas 78588.

CITY OF COOLIDGE has applied for a renewal of Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0014751001, 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 4,500 feet northeast of the intersection of Farm-to-Market Road 73 and Farm-to-Market Road 1951 in Limestone County, Texas 76635.

UPPER JASPER COUNTY WATER AUTHORITY has applied for a renewal of TPDES Permit No. WQ0014269001, which authorizes the discharge of treated filter backwash effluent from a water treatment plant at a daily average flow not to exceed 40,000 gallons per day. The facility is located 0.8 mile south of the intersection of U.S. Highway 96 and Farm-to-Market Road 1005 in Jasper County, Texas 75951.

XIU HUI LI MCCULLOCH has applied for a renewal of TPDES Permit No. WQ0013084001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 25,000 gallons per day. The facility is located approximately 1,600 feet northwest of the intersection of Aldine-Westfield Road and Hartwick Road and approximately 2,300 feet south of Halls Bayou in Harris County, Texas 77093.

SAN LEON MUNICIPAL UTILITY DISTRICT has applied for a renewal of TPDES Permit No. WQ0011546001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 950,000 gallons per day. The facility is located at 1111 27th Street, in the northeast corner of the intersection of Avenue L and 27th Street in San Leon and approximately 2,000 feet north of Salt Bayou and 5,000 feet northwest of Dickinson Bayou in Galveston County, Texas 77539.

SEIS LAGOS UTILITY DISTRICT AND NORTH TEXAS MUNICIPAL WATER DISTRICT, have applied for a renewal of TPDES Permit No. WQ0011451001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 250,000 gallons per day. The facility is located at 1007 Riva Ridge in the Seis Lagos Development approximately 0.8 mile southeast of the intersection of Farm-to-Market Road 3286 and Farm-to-Market Road 1378 in Collin County, Texas 75098.

CHESTER ALTON ANDREWS has applied for a renewal of TPDES Permit No. WQ0011032001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 8,000 gallons per day. The facility is located approximately 13 miles north-northeast of the City of Fort Worth central business district and 1.9 miles east of the Interstate Highway 35W on the north bank of Big Bear Creek, west of its crossing of Alta Vista Road and approximately 0.5 mile south of the intersection of Alta Vista Road and Keller-Hicks Road, in the City of Keller in Tarrant County, Texas 76248.

CITY OF POINT Comfort has applied for a renewal of TPDES Permit No. WQ0010599001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 200,000 gallons per day. The facility is located at 900 Pease Street, at the intersection of Murrah Street and Pease Street, approximately 2,900 feet northwest of the intersection of Farm-to-Market Road 1593 and State Highway 35 in Calhoun County, Texas 77978.

METROPLEX QUARRY'S INC., which operates a facility that quarries stone, sand, gravel, aggregate and soil and produces block stone and dimension stone within one mile of the John Graves Scenic Riverway and 100 year flood plain, has applied for a major amendment to TPDES Permit No. WQ0004820000 to authorize the discharge of wastewater and stormwater on an intermittent and variable basis via Outfalls 001, 002, 003, 004, 005, 006, and 007, and the addition of Outfall 008.

FORMOSA UTILITY VENTURE, LTD. AND FORMOSA PLASTICS CORPORATION, Texas, which operates the Point Comfort Plant, a plastics and organic and inorganic chemicals manufacturing facility, has applied for a major amendment to TPDES Permit No. WQ0002436000 to establish minimum analytical levels for oil and grease, biochemical oxygen demand (5-day), free available chlorine, and titanium; reduce Lavaca Bay monitoring from quarterly each year to quarterly triannually based on 15 years of no impacts; increase the temperature limit at Outfall 001 from 95 0F to 100 0F; authorize the discharge of non-process area storm water, hydrostatic test water, fire water, non-contact steam condensate, non-contact wash water, potable water, air conditioner unit condensate, and ash truck wash water on an intermittent and flow variable basis via Outfall 013; increase the effluent limitations for total copper at Outfall 001; authorize the discharge of fire water via Outfalls 001, 101, and 201; and authorize the discharge of potable water and air conditioner unit condensate on an intermittent and flow variable basis via Outfalls 001, 101, 201, 002, 003, 004, 005, 006, 007, 008, 009, 010, 011, and 012. The current permit authorizes the discharge of remediated groundwater and treated previously monitored effluents (via Outfalls 101 and 201) at a daily average flow not to exceed 9,700,000 gallons per day via Outfall 001; treated process wastewater, equipment/facility washdown, storm water, and utility wastewaters at a daily average flow not to exceed 4,400,000 gallons per day via Outfall 101; treated and combined Ion Exchange Membrane (IEM) wastewater streams, utility wastewaters, equipment/facility washdown, storm water, and water treatment wastewaters on a continuous and flow variable basis via Outfall 201; non-process area storm water, hydrostatic test water, fire water, non-contact steam condensate, and non-contact wash water on an intermittent and flow variable basis via Outfalls 002, 003, 004, and 005; and non-process area storm water, hydrostatic test water, fire water, non-contact steam condensate, and non-contact wash water on an intermittent and flow variable basis via Outfalls 006, 007, 008, 009, 010, 011, and 012. The facility is located at 201 Formosa Drive, one-mile north of the intersection of State Highway 35 and Farm-to-Market Road 1593, northeast of the City of Point Comfort, Calhoun County, Texas 77978. The Executive Director has reviewed this action for consistency with the goals and policies of the Texas Coastal Management Program (CMP) in accordance with the regulations of the Coastal Coordination council (CCC) and has determined that the action is consistent with the applicable CMP goals and policies.

NACOGDOCHES POWER, LLC, which proposes to operate the Nacogdoches Power Project, has applied for a major amendment to TPDES Permit No. WQ0004414000 to remove Outfalls 002 and 003, to remove Phase II requirements, and to revise the location of the proposed cooling water intake structure to be used by the facility. The current permit authorizes the discharge of cooling tower blowdown and previously monitored effluents (low volume waste and contact storm water) at a daily average flow not to exceed 1,750,000 gallons per day via Outfall 001, non-contact storm water on an intermittent and flow variable basis via Outfall 002, and contact storm water on an intermittent and flow variable basis via Outfall 003. This application was submitted to the TCEQ on November 8, 2010. The facility is located approximately 6,400 feet northeast of the intersection of Farm-to-Market Road 1648 and State Highway 204, and approxi-

mately four miles northwest of the City of Cushing, Nacogdoches County, Texas 75760.

COUNTRY VISTA WASTEWATER TREATMENT PLANT LLC has applied for a renewal of TPDES Permit No. WQ0013769001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 42,000 gallons per day. The facility is located at 329 Meadow Oaks, approximately 0.5 mile northwest of the intersection of County Road 531 and County Road 603 A in Johnson County, Texas 76028.

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-201102459
Melissa Chao
Acting Chief Clerk
Texas Commission on Environmental Quality
Filed: June 29, 2011

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Notice of Water Rights Application

Notice issued June 22, 2011.

APPLICATION NO. 18-3824C; The City of New Braunfels, P.O. Box 311747, New Braunfels, Texas 78131-1747, Applicant, seeks an amendment to its portion of Certificate of Adjudication No. 18-3824 to establish a place of use in Comal County; a diversion segment on the Old Channel of the Comal River, Guadalupe River Basin; and a diversion rate for agricultural purposes. More information on the application and how to participate in the permitting process is given below. The application and partial fees were received on December 22, 2009. Additional information and fees were received on March 16, 2010. The application was declared administratively complete and accepted for filing on April 2, 2010. The Executive Director has completed the technical review of the application and prepared a draft amendment. The draft amendment, if granted, would include special conditions. The application, technical memoranda, and Executive Director's draft amendment is available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Bldg. F., Austin, TX 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.

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 in the information section 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, TX 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-201102457
Melissa Chao
Acting Chief Clerk
Texas Commission on Environmental Quality
Filed: June 29, 2011

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Texas Facilities Commission

Request for Proposals #303-2-20287

The Texas Facilities Commission (TFC), on behalf of the Texas Department of Insurance (TDI), announces the issuance of Request for Proposals (RFP) #303-2-20287. TFC seeks a five (5) or ten (10) year lease of approximately 5,993 square feet of office space in Tyler, Texas.

The deadline for questions is July 22, 2011 and the deadline for proposals is July 29, 2011 at 3:00 p.m. The award date is September 21, 2011. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of an RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting the Regional Leasing Assistant, Jana D. Walp, at (512) 463-3160. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=95413.*

TRD-201102432
Kay Molina
General Counsel
Texas Facilities Commission
Filed: June 28, 2011

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General Land Office

Notice of Violation - Derelict Vessel

Official Notice to Vessel Owner/Operator (Pursuant to §40.254, Texas Natural Resources Code)

This preliminary report and notice of violation was issued by Greg Pollock, Deputy Commissioner, Oil Spill Prevention and Response Division (OSPR), Texas General Land Office, on 16 June 2011.

PRELIMINARY REPORT

Based upon an inspection conducted by OSPR Region 2 staff, the Deputy Commissioner of the General Land Office (GLO), Oil Spill Prevention and Response Division, has determined that an approximately 40 foot long, wooden-hulled recreational vessel (GLO Vessel Tracking Number 2-941), named "R/V African Queen" is in an abandoned, wrecked, and derelict condition without the consent of the commissioner. The recreational vessel is sunken and aground and is located at Latitude 29 degrees 00 minutes 15.34 seconds N, Longitude 95 degrees 18 minutes 45.3 seconds W, in Oyster Creek. It is due east of the city of Oyster Creek in Brazoria County, Texas. Mr. David Luker alleged to GLO staff that he was the owner of the vessel, yet did not have any evidence of ownership, and staff have not been able to locate Mr. Luker since the initial contact. His telephone has been disconnected, and there is no known mailing address. There is no way to positively identify the owner of record since there in no USCG Vessel Documentation Number or Texas Parks and Wildlife Department vessel registration number visible. Therefore, the GLO cannot determine the owner or responsible person(s) for this vessel. In addition, the Deputy Commissioner has determined, pursuant to OSPR §40.254(b)(2)(B), that the vessel has no intrinsic value. The Commissioner has further determined that, because of the vessel's condition and location, the vessel poses a navigational hazard, an unreasonable threat to public health, safety, and welfare, and is a hazard to the environment.

Violation

You are hereby given notice, pursuant to the provisions of OSPRA §40.254 that you are in violation of OSPRA §40.108(a) that prohibits a person from leaving, abandoning, or maintaining any structure or vessel in or on coastal waters, on public or private lands, or at a public or private port or dock if the structure or vessel is in a wrecked, derelict, or substantially dismantled condition, and the Commissioner determines the vessel is involved in an actual or threatened unauthorized discharge of oil, a threat to public health, safety, and welfare, or a hazard to the environment or navigation. The Commissioner is authorized by OSPRA §40.108(b) to dispose of or contract for the disposal of any vessel described in §40.108(a).

Recommendation

The Deputy Commissioner recommends that the vessel be removed from Texas coastal waters and disposed of in accordance with OSPRA §40.108.

The owner or operator of this vessel can request a hearing to contest the violation and the removal and disposal of the vessel. If the owner or operator wants to request a hearing, a request in writing must be made within twenty (20) days of this notice being posted on the vessel. The request for a hearing must be sent to: Texas General Land Office, Oil Spill Prevention and Response Division, P.O. Box 12873, Austin, TX 78711. Failure to request a hearing may result in the removal and disposal of the vessel by the TGLO. If the TGLO removes and disposes of the vessel, the TGLO has authority under TNRC §40.108(b) to recover the costs of removal and disposal from the vessel's owner or operator.

For additional information contact Wm. D. "Bill" Grimes at (512) 475-1464.

TRD-201102451
Larry L. Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Filed: June 29, 2011

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Texas Health and Human Services Commission

Public Notice

The Texas Health and Human Services Commission announces its intent to submit an amendment to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment is effective October 1, 2011.

The amendment modifies the current reimbursement methodology in the Texas Medicaid State Plan for targeted case management provided to infants and toddlers with developmental delays. The purpose of the amendment is to change the delivery of service model from a monthly unit of service to a fifteen minute unit of service methodology. The proposed amendment has no fiscal impact.

Interested parties may obtain copies of the proposed amendment by contacting Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1432; by facsimile at (512) 491-1998; or by e-mail at dan.huggins@hhsc.state.tx.us. Copies of the proposals will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-201102417
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: June 27, 2011

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Public Notice

The Texas Health and Human Services Commission announces its intent to submit an amendment to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment is effective October 1, 2011.

The purpose of the amendment is to modify the current reimbursement methodology in the Texas Medicaid State Plan for specialized skills training services provided to infants and toddlers with developmental delays to allow for the provision of specialized skills training services in a group setting.

The proposed amendment is estimated to result in additional annual aggregate expenditures of $29,481 for the federal fiscal year (FFY) 2012, with approximately $19,593 in federal revenue and $9,888 in State General Revenue (GR). For FFY 2013, the proposed amendment is estimated to result in additional annual aggregate expenditures of $31,367, with approximately $18,262 in federal revenue and $13,105 in GR.

Interested parties may obtain copies of the proposed amendment by contacting Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1432; by facsimile at (512) 491-1998; or by e-mail at dan.huggins@hhsc.state.tx.us. Copies of the proposals will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-201102418
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: June 27, 2011

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Public Notice

The Texas Health and Human Services Commission announces its intent to submit amendments to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendments are effective October 1, 2011.

The amendments will modify the reimbursement methodologies in the Texas Medicaid State Plan as a result of a Medicaid rule change for Early Periodic Screening, Diagnosis and Treatment (EPSDT) Dental Services. The purpose of the amendment is to enable public EPSDT dental providers, including mobile dental units and clinics, to receive additional federal funding through a supplemental payment program for Medicaid dental services for children.

The proposed amendments are estimated to result in an additional annual aggregate expenditure of $481,972 for federal fiscal year (FFY) 2012, with approximately $280,604 in federal funds and $201,368 in State General Revenue (GR). For FFY 2013, the estimated additional aggregate expenditure is $501,791 with approximately $287,928 in federal funds and $213,863 in GR.

Interested parties may obtain copies of the proposed amendment by contacting Dan Huggins, Director of Rate Analysis for Acute Care Services, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1432; by facsimile at (512) 491-1998; or by e-mail at dan.huggins@hhsc.state.tx.us. Copies of the proposals will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-201102419
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: June 27, 2011

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Department of State Health Services

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.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout TX	Quantum Technical Services, Inc.	L06406	Pasadena	00	06/09/11

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Addison	Flower Mound Hospital Partners, L.L.C. dba Texas Health Presbyterian Hospital Flower Mound	L06310	Addison	02	06/02/11
Austin	The University of Texas at Austin	L00485	Austin	85	06/07/11
Austin	Seton Healthcare dba Seton Medical Center Austin	L02896	Austin	120	06/10/11
Austin	Capital Cardiovascular Consultants	L05590	Austin	17	06/01/11
Austin	Austin Nuclear Pharmacy, Inc.	L05591	Austin	15	06/06/11
Beaumont	Exxonmobil Corporation dba Exxonmobil Chemical Company	L02316	Beaumont	40	05/31/11
Borger	WRB Refining, L.L.C. dba ConocoPhillips Company	L02480	Borger	57	05/31/11
Borger	Chevron Phillips Chemical Company, L.P.	L05181	Borger	20	06/06/11
Carrollton	Trinity MC, L.L.C. dba Baylor Medical Center at Carrollton	L03765	Carrollton	64	06/01/11
Conroe	Arif Abdullah, M.D., P.A.	L06276	Conroe	02	06/03/11
Cypress	North Cypress Medical Center Operating Company, L.L.C. dba North Cypress Medical Center	L06020	Cypress	20	06/08/11
Dallas	Texas Health Presbyterian Hospital Dallas	L04288	Dallas	29	06/13/11
Dallas	Texas Oncology, P.A. dba Sammons Cancer Center	L04878	Dallas	44	06/07/11
Dallas	University of Texas Southwestern Medical Center at Dallas	L05947	Dallas	17	05/31/11
Dallas	Prime Imaging Partners, L.L.C. dba Prime Diagnostic Imaging, L.L.C.	L06309	Dallas	03	05/25/11
Dumas	Moore County Hospital District dba Memorial Hospital	L03540	Dumas	27	05/27/11
Duncanville	Dallas Oncology Consultants, P.A.	L06352	Duncanville	02	06/03/11
Fort Worth	Texas Health Harris Methodist Hospital Fort Worth	L01837	Fort Worth	129	05/31/11
Houston	Memorial Hermann Hospital System dba Memorial Hospital Southwest	L00439	Houston	164	06/09/11
Houston	Memorial Hermann Hospital System dba Memorial Hospital Southwest	L00439	Houston	165	06/13/11
Houston	Halliburton Energy Services, Inc.	L00442	Houston	124	06/13/11
Houston	The University of Texas M.D. Anderson Cancer Center	L00466	Houston	129	06/07/11
Houston	Memorial Hermann Hospital System dba Memorial Hospital Memorial City	L01168	Houston	128	06/01/11
Houston	Medical Clinic of Houston, L.L.P.	L01315	Houston	37	06/09/11
Houston	University of Houston	L01886	Houston	65	05/31/11
Houston	Halliburton Energy Services, Inc.	L02113	Houston	118	06/09/11
Houston	NIS Holdings, Inc. dba Nuclear Imaging Services	L05775	Houston	73	06/03/11
Houston	Triad Isotopes, Inc.	L06327	Houston	03	05/25/11

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED):

Location	Name	License #	City	Amend-ment #	Date of Action
Humble	Humble Surgical Hospital	L06357	Humble	01	06/15/11
Laredo	Laredo Regional Medical Center, L.P. dba Doctors Hospital of Laredo	L02192	Laredo	37	06/03/11
Linden	Good Shepherd Medical Center Linden, Inc.	L02721	Linden	25	06/06/11
Longview	Good Shepherd Medical Center	L02411	Longview	87	06/06/11
Longview	Diagnostic Clinic of Longview, P.A.	L05817	Longview	11	06/09/11
Lubbock	Texas Tech University Health Sciences Center	L01869	Lubbock	91	06/01/11
Lubbock	Covenant Medical Group dba Cardiology Associates	L04468	Lubbock	24	06/07/11
Marshall	Harrison County Hospital Association dba Good Shepherd Medical Center-Marshall	L02572	Marshall	30	06/06/11
Midlothian	TXI Operations, L.P.	L01421	Midlothian	49	06/01/11
Mt. Pleasant	Titus County Memorial Hospital	L02921	Mt. Pleasant	37	06/03/11
Palestine	Techcorr USA, L.L.C. dba Aut Specialists, L.L.C.	L05972	Palestine	84	06/06/11
Plano	North Texas Regional Cancer Center	L05357	Plano	16	06/01/11
Plano	Texas Heart Hospital of the Southwest, L.L.P. dba The Heart Hospital Baylor Plano	L06004	Plano	16	06/07/11
San Angelo	San Angelo Hospital, L.P. dba San Angelo Community Medical Center	L02487	San Angelo	47	06/15/11
San Antonio	South Texas Radiology Imaging Centers	L00325	San Antonio	196	06/03/11
San Antonio	Methodist Healthcare System of San Antonio Ltd., L.L.P.	L00594	San Antonio	288	06/08/11
San Antonio	Christus Santa Rosa Health Care	L02237	San Antonio	128	06/02/11
Seguin	Structural Metals, Inc. dba CMC Steel Texas	L02188	Seguin	23	06/09/11
Temple	Scott and White Memorial Hospital and Scott Sherwood and Brindley Foundation dba Scott and White Memorial Hospital	L00331	Temple	89	06/01/11
Texas City	Marathon Petroleum Company, L.L.C.	L04431	Texas City	29	06/02/11
Throughout TX	J-W Wireline Company	L06132	Addison	16	05/26/11
Throughout TX	J-W Wireline Company	L06132	Addison	17	06/13/11
Throughout TX	Global X-Ray & Testing Corporation	L03663	Aransas Pass	115	06/08/11
Throughout TX	Frac Tech Services, L.L.C.	L06188	Cisco	08	06/08/11
Throughout TX	Wilson Inspection X-ray Services, Inc.	L04469	Corpus Christi	69	05/26/11
Throughout TX	IOS/PCI, L.L.C. dba PCI Services	L06402	Corpus Christi	01	06/07/11
Throughout TX	IRISNDT, Inc.	L04769	Deer Park	94	05/26/11
Throughout TX	Waggoner & Associates, Inc. dba Waggoner-Texas & Associates, Inc.	L06159	Flint	14	06/14/11
Throughout TX	Wood Group Logging Services, Inc.	L05262	Houston	42	05/31/11
Throughout TX	Hi-Tech Testing Service, Inc.	L05021	Longview	90	06/07/11
Throughout TX	Petrochem Inspection Services, Inc.	L04460	Pasadena	106	06/09/11
Throughout TX	Pioneer Wireline Services, L.L.C.	L06220	Rosharon	09	05/31/11
Throughout TX	Pioneer Wireline Services, L.L.C.	L06220	Rosharon	10	06/09/11
Tyler	Delek Refining, Ltd.	L02289	Tyler	23	06/10/11
Wharton	Signature Gulf Coast Hospital, L.P. dba Gulf Coast Medical Center	L01388	Wharton	45	06/03/11

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Carthage	East Texas Medical Center Carthage	L02540	Carthage	40	06/10/11
El Paso	Isomedix Operations, Inc. dba Steris Isomedix Services	L04268	El Paso	20	06/06/11
Throughout TX	Desert Industrial X-Ray, L.P.	L04590	Abilene	116	06/13/11
Throughout TX	SGS North America, Inc.	L05796	Deer Park	04	05/31/11

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, Texas 78714-9347. For information call (512) 834-6688.

TRD-201102374
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: June 24, 2011

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Texas Department of Housing and Community Affairs

Announcement of a Request for Proposals for Impact Evaluation of the American Recovery and Reinvestment Act Weatherization Assistance Program in Texas

The Texas Department of Housing and Community Affairs (TDHCA) requests proposals for Impact Evaluation of the American Recovery and Reinvestment Act (ARRA) Weatherization Assistance Program in Texas. It is estimated that TDHCA will make one vendor award under this Request for Proposal (RFP).

Proposals will be accepted from contractors with prior experience in providing project management services in the research, preparation and delivering of reports analyzing energy impact, non-energy impact, and cost effectiveness of programs similar to TDHCA's ARRA Weatherization Assistance Program.

The deadline for questions related to the RFP is July 13, 2011 at 5:00 p.m. The deadline for responses to the RFP is July 29, 2011 at 4:00 p.m.

For more information, see RFP #332-RFP11-1008 on the Electronic State Business Daily website at http://esbd.cpa.state.tx.us/.

TRD-201102461
Timothy K. Irvine
Acting Director
Texas Department of Housing and Community Affairs
Filed: June 29, 2011

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Notice of Public Hearing for Public Comment on Proposed Amendments to 10 TAC Chapter 5, Subchapter I, §§5.900 - 5.905, WAP ARRA

The Texas Department of Housing and Community Affairs (TDHCA) will hold a public hearing for public comment on proposed amendments to 10 TAC Chapter 5, Subchapter I, §§5.900 - 5.905, Weatherization Assistance Program Department of Energy American Recovery and Reinvestment Act (WAP ARRA) concerning the deobligation and reobligation of funds. The amended sections are proposed in order to alter the exceptions through which subrecipients will not receive a deobligation notice. Other amended sections modify the documentation the subrecipient must submit when notified of possible deobligation.

The proposed amendments are necessary in order to require a higher level of production and expenditures before a subrecipient is exempted from deobligation; and once deobligation has been initiated, the amendments require subrecipients to submit information that offers a more definitive indication of a subrecipient's ability to meet contractual expectations.

The public comment period will be held between July 8, 2011 to July 20, 2011 to receive input on the proposed amendments. A public hearing will be held at the following time and location:

Wednesday July 13, 2011

10:00 a.m. - 12:00 p.m.

Texas Department of Housing and Community Affairs

221 East 11th Street, Room 116

Austin, Texas 78701

Local officials and citizens are encouraged to participate in the hearing process. Public comment on the proposed amendments may be provided via email to tdhcarulecomments@tdhca.state.tx.us, in writ-

ing to: TDHCA, Energy Assistance Section, P.O. Box 13941, Austin, Texas 78711-3941, Attn: Ms. Cate Taylor, or by fax to (512) 475-3935.

Individuals who require auxiliary aids or services should contact Gina Esteves, ADA Responsible Employee, at least two days before the scheduled hearing, at (512) 475-3943, or Relay Texas at 1-800-735-2989, so that appropriate arrangements can be made.

Non-English speaking individuals who require interpreters for this meeting should contact Cathy Collingsworth, (512) 475-3858, at least three (3) days before the meeting so that appropriate arrangements can be made.

Personas que hablan español y requieren un intérprete, favor de llamar a Jorge Reyes al siguiente número (512) 475-4577 por lo menos tres (3) días antes de la junta para hacer los preparativos apropiados.

TRD-201102376
Timothy K. Irvine
Acting Director
Texas Department of Housing and Community Affairs
Filed: June 24, 2011

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Notice of Public Hearing on FFY 2012 Low-Income Home Energy Assistance Program State Plan

For the 2012 Federal Fiscal Year (FFY) beginning October 1, 2011, the Texas Department of Housing and Community Affairs (TDHCA) anticipates receiving federal funds to continue the operation of programs that assist very low-income Texans with home energy. In the process of deciding how to use Low-Income Home Energy Assistance Program (LIHEAP) funds, TDHCA solicits public input on the details of the plan.

As part of the public information, consultation, and public hearing requirements for LIHEAP, the Community Affairs Division of TDHCA has posted the proposed plan on the TDHCA website and will conduct a public hearing. Primarily, the hearing solicits comments on the proposed use and distribution of FFY 2012 funds provided under LIHEAP. LIHEAP provides funding for the Comprehensive Energy Assistance Program (CEAP) and the Weatherization Assistance Program (WAP).

The public hearing has been scheduled as follows:

Tuesday, July 19, 2011, 1:30 p.m.- 3:30 p.m.

Room 116, State Insurance Annex Building

221 East 11th Street

Austin, Texas 78701

A representative from TDHCA will explain the planning process and receive comments from stakeholders and the general public regarding the proposed plan for LIHEAP. A copy of the Draft LIHEAP Plan may be obtained after July 1, 2011, through TDHCA's website, http://www.tdhca.state.tx.us/ea.htm or by contacting the Texas Department of Housing and Community Affairs, Community Affairs Division, Energy Assistance Section, P.O. Box 13941, Austin, Texas 78711-3941, or by phone at (512) 475-1435.

Anyone may submit comments on the draft plan in written form or oral testimony at the public hearing. TDHCA must receive written comments no later than 5:00 p.m., Tuesday, July 19, 2011. Comments concerning the draft plan may be submitted via email to cate.taylor@tdhca.state.tx.us or by fax (512) 475-3935 or by mail to the Texas Department of Housing and Community Affairs, Community Affairs Division, Energy Assistance Section, Attention Cate Taylor, at TDHCA, P.O. Box 13941, Austin, Texas 78711-3941. If you have questions regarding the public hearing process or any of the programs referenced above, please contact TDHCA, Community Affairs Division, Energy Assistance Section.

Individuals who require auxiliary aids or services for this meeting should contact Ms. Gina Esteves at (512) 475-3943 or Relay Texas at 1-800-735-2989 at least two days before the meeting so that appropriate arrangements can be made.

Non-English speaking individuals who require interpreters for this meeting should contact Cate Taylor, (512) 475-1435 at least three days before the meeting so that appropriate arrangements can be made. Personas que hablan español y requieren un intérprete, favor de llamar a Jorge Reyes al siguiente número (512) 475-4577 por lo menos tres días antes de la junta para hacer los preparativos apropiados.

TRD-201102426
Timothy K. Irvine
Acting Director
Texas Department of Housing and Community Affairs
Filed: June 28, 2011

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Texas Department of Insurance

Third Party Administrator Applications

The following third party administrator (TPA) applications have been filed with the Texas Department of Insurance and are under consideration.

Application of TEXAS POLITICAL SUBDIVISIONS JOINT SELF INSURANCE FUND, a domestic third party administrator. The home office is DALLAS, TEXAS.

Application of MODERN MEDICAL, INC., a foreign third party administrator. The home office is LEWIS CENTER, OHIO.

Application of SIMPLIFI HEALTH BENEFIT MANAGEMENT, LLC, a foreign third party administrator. The home office is WILMINGTON, DELAWARE.

Application of HA PARTNERS, INC., a domestic third party administrator. The home office is FORT WORTH, TEXAS.

Any objections must be filed within 20 days after this notice is published in the *Texas Register*, addressed to the attention of David Moskowitz, MC 305-2E, 333 Guadalupe, Austin, Texas 78701.

TRD-201102448
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance
Filed: June 29, 2011

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Texas Lottery Commission

Instant Game Number 1334 "$50,000 Player's Club"

1.0 Name and Style of Game.

A. The name of Instant Game No. 1334 is "$50,000 PLAYER'S CLUB". The play style is "multiple games".

1.1 Price of Instant Ticket.

A. Tickets for Instant Game No. 1334 shall be $5.00 per ticket.

1.2 Definitions in Instant Game No. 1334.

A. Display Printing - That area of the instant game ticket outside of the area where the Overprint and Play Symbols appear.

B. Latex Overprint - The removable scratch-off covering over the Play Symbols on the front of the ticket.

C. Play Symbol - The printed data under the latex on the front of the ticket that is used to determine eligibility for a prize. Each Play Symbol is printed in Symbol font in black ink in positive except for dual-image games. The possible black play symbols are: 2 CARD SYMBOL, 3 CARD SYMBOL, 4 CARD SYMBOL, 5 CARD SYMBOL, 6 CARD SYMBOL, 7 CARD SYMBOL, 8 CARD SYMBOL, 9 CARD SYMBOL, 10 CARD SYMBOL, J CARD SYMBOL, Q CARD SYMBOL, K CARD SYMBOL, A CARD SYMBOL, JOKER CARD SYMBOL, $5.00, $10.00, $15.00, $20.00, $40.00, $50.00, $100, $500, $2,000, $50,000, FISTFUL OF MONEY SYMBOL, NECKLACE SYMBOL, DIAMOND SYMBOL, DOLLAR BILL SYMBOL, PIGGY BANK SYMBOL, GOLD BAR SYMBOL, STACK OF COINS SYMBOL, CLOVER SYMBOL, BOW SYMBOL, MINK SYMBOL, RING SYMBOL, STAR SYMBOL, X SYMBOL, O SYMBOL, GRAPES SYMBOL, CENTS SYMBOL, POT OF GOLD SYMBOL, HORSESHOE SYMBOL, BELL SYMBOL, LEMON SYMBOL, EMERALD SYMBOL, MELON SYMBOL, APPLE SYMBOL, CHEST SYMBOL, CROWN SYMBOL, WALLET SYMBOL, SAFE SYMBOL, MONEY BAG SYMBOL, 3 SYMBOL and 5 SYMBOL.

D. Play Symbol Caption - The printed material appearing below each Play Symbol which explains the Play Symbol. One caption appears under each Play Symbol and is printed in caption font in black ink in positive. The Play Symbol Caption which corresponds with and verifies each Play Symbol is as follows:

Figure 1: GAME NO. 1334 - 1.2D

PLAY SYMBOL	CAPTION
2 CARD SYMBOL	TWO
3 CARD SYMBOL	THR
4 CARD SYMBOL	FOR
5 CARD SYMBOL	FIV
6 CARD SYMBOL	SIX
7 CARD SYMBOL	SVN
8 CARD SYMBOL	EGT
9 CARD SYMBOL	NIN
10 CARD SYMBOL	TEN
J CARD SYMBOL	JCK
Q CARD SYMBOL	QUN
K CARD SYMBOL	KNG
A CARD SYMBOL	ACE
JOKER CARD SYMBOL	JKR
$5.00	FIVE$
$10.00	TEN$
$15.00	FIFTN
$20.00	TWENTY
$40.00	FORTY
$50.00	FIFTY
$100	ONE HUND
$500	FIV HUND
$2,000	TWO THOU
$50,000	50 THOU
FISTFUL OF MONEY SYMBOL	FISTFUL
NECKLACE SYMBOL	NKLACE
DIAMOND SYMBOL	DMND
DOLLAR BILL SYMBOL	BILL
PIGGY BANK SYMBOL	PIGBNK
GOLD BAR SYMBOL	BAR
STACK OF COINS SYMBOL	STACK
CLOVER SYMBOL	CLOVER
BOW SYMBOL	BOW
MINK SYMBOL	MINK
RING SYMBOL	RING
STAR SYMBOL	STAR
X SYMBOL	
O SYMBOL	
GRAPES SYMBOL	GRAPES
CENTS SYMBOL	CENTS
POT OF GOLD SYMBOL	POT
HORSESHOE SYMBOL	SHOE
BELL SYMBOL	BELL
LEMON SYMBOL	LEMON
EMERALD SYMBOL	EMRLD
MELON SYMBOL	MELON

APPLE SYMBOL	APPLE
CHEST SYMBOL	CHEST
CROWN SYMBOL	CROWN
WALLET SYMBOL	WALLET
SAFE SYMBOL	SAFE
MONEY BAG SYMBOL	$BAG
3 SYMBOL	WINX3
5 SYMBOL	WINX5

E. Serial Number - A unique 14 (fourteen) digit number appearing under the latex scratch-off covering on the front of the ticket. There is a boxed four (4) digit Security Number placed randomly within the Serial Number. The remaining ten (10) digits of the Serial Number are the Validation Number. The Serial Number is positioned beneath the bottom row of play data in the scratched-off play area. The Serial Number is for validation purposes and cannot be used to play the game. The format will be: 00000000000000.

F. Low-Tier Prize - A prize of $5.00, $10.00, $15.00 or $20.00.

G. Mid-Tier Prize - A prize of $50.00, $100 or $500.

H. High-Tier Prize - A prize of $2,000 or $50,000.

I. Bar Code - A 24 (twenty-four) character interleaved two (2) of five (5) bar code which will include a four (4) digit game ID, the seven (7) digit pack number, the three (3) digit ticket number and the ten (10) digit Validation Number. The bar code appears on the back of the ticket.

J. Pack-Ticket Number - A 14 (fourteen) digit number consisting of the four (4) digit game number (1334), a seven (7) digit pack number, and a three (3) digit ticket number. Ticket numbers start with 001 and end with 075 within each pack. The format will be: 1334 -0000001-001.

K. Pack - A pack of "$50,000 PLAYER'S CLUB" Instant Game tickets contains 075 tickets, packed in plastic shrink-wrapping and fanfolded in pages of one (1). The packs will alternate. One will show the front of ticket 001 and back of 075 while the other fold will show the back of ticket 001 and front of 075.

L. Non-Winning Ticket - A ticket which is not programmed to be a winning ticket or a ticket that does not meet all of the requirements of these Game Procedures, the State Lottery Act (Texas Government Code, Chapter 466), and applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401.

M. Ticket or Instant Game Ticket, or Instant Ticket - A Texas Lottery "$50,000 PLAYER'S CLUB" Instant Game No. 1334 ticket.

2.0 Determination of Prize Winners. The determination of prize winners is subject to the general ticket validation requirements set forth in Texas Lottery §401.302, Instant Game Rules, these Game Procedures, and the requirements set out on the back of each instant ticket. A prize winner in the "$50,000 PLAYER'S CLUB" Instant Game is determined once the latex on the ticket is scratched off to expose 43 (forty-three) play symbols. GAME 1: If a player's YOUR CARD play symbol beats the DEALER'S CARD play symbol within a GAME, the player wins the PRIZE for that game. If a player reveals a "joker" play symbol, the player wins DOUBLE the PRIZE for that game! Aces are high. GAME 2: If a player matches any of YOUR SYMBOLS to the WINNING SYMBOL, the player wins the PRIZE for that symbol. If a player reveals a "star" play symbol, the player wins the PRIZE for that symbol instantly! GAME 3: If a player reveals 3 X's or 3 O's play symbols in any one row, column or diagonal, the player wins the PRIZE in the prize box. GAME 4: If a player reveals a "money bag" play symbol, the player wins the PRIZE for that symbol. If a player reveals a "3" play symbol, the player wins TRIPLE the PRIZE for that symbol. If a player reveals a "5" play symbol, the player wins 5 TIMES the PRIZE for that symbol! No portion of the display printing nor any extraneous matter whatsoever shall be usable or playable as a part of the Instant Game.

2.1 Instant Ticket Validation Requirements.

A. To be a valid Instant Game ticket, all of the following requirements must be met:

1. Exactly 43 (forty-three) Play Symbols must appear under the latex overprint on the front portion of the ticket;

2. Each of the Play Symbols must have a Play Symbol Caption underneath, unless specified, and each Play Symbol must agree with its Play Symbol Caption;

3. Each of the Play Symbols must be present in its entirety and be fully legible;

4. Each of the Play Symbols must be printed in black ink except for dual image games;

5. The ticket shall be intact;

6. The Serial Number, Retailer Validation Code and Pack-Ticket Number must be present in their entirety and be fully legible;

7. The Serial Number must correspond, using the Texas Lottery's codes, to the Play Symbols on the ticket;

8. The ticket must not have a hole punched through it, be mutilated, altered, unreadable, reconstituted or tampered with in any manner;

9. The ticket must not be counterfeit in whole or in part;

10. The ticket must have been issued by the Texas Lottery in an authorized manner;

11. The ticket must not have been stolen, nor appear on any list of omitted tickets or non-activated tickets on file at the Texas Lottery;

12. The Play Symbols, Serial Number, Retailer Validation Code and Pack-Ticket Number must be right side up and not reversed in any manner;

13. The ticket must be complete and not miscut, and have exactly 43 (forty-three) Play Symbols under the latex overprint on the front portion of the ticket, exactly one Serial Number, exactly one Retailer Validation Code, and exactly one Pack-Ticket Number on the ticket;

14. The Serial Number of an apparent winning ticket shall correspond with the Texas Lottery's Serial Numbers for winning tickets, and a ticket with that Serial Number shall not have been paid previously;

15. The ticket must not be blank or partially blank, misregistered, defective or printed or produced in error;

16. Each of the 43 (forty-three) Play Symbols must be exactly one of those described in Section 1.2.C of these Game Procedures;

17. Each of the 43 (forty-three) Play Symbols on the ticket must be printed in the Symbol font and must correspond precisely to the artwork on file at the Texas Lottery; the ticket Serial Numbers must be printed in the Serial font and must correspond precisely to the artwork on file at the Texas Lottery; and the Pack-Ticket Number must be printed in the Pack-Ticket Number font and must correspond precisely to the artwork on file at the Texas Lottery;

18. The display printing on the ticket must be regular in every respect and correspond precisely to the artwork on file at the Texas Lottery; and

19. The ticket must have been received by the Texas Lottery by applicable deadlines.

B. The ticket must pass all additional validation tests provided for in these Game Procedures, the Texas Lottery's Rules governing the award of prizes of the amount to be validated, and any confidential validation and security tests of the Texas Lottery.

C. Any Instant Game ticket not passing all of the validation requirements is void and ineligible for any prize and shall not be paid. However, the Executive Director may, solely at the Executive Director's discretion, refund the retail sales price of the ticket. In the event a defective ticket is purchased, the only responsibility or liability of the Texas Lottery shall be to replace the defective ticket with another unplayed ticket in that Instant Game (or a ticket of equivalent sales price from any other current Instant Lottery game) or refund the retail sales price of the ticket, solely at the Executive Director's discretion.

2.2 Programmed Game Parameters.

A. Consecutive non-winning tickets in a pack will not have identical play data, spot for spot.

B. The top prize symbol will appear on every ticket unless otherwise restricted.

C. No three or more duplicate non-winning prize symbols on a ticket.

D. GAME 1: No duplicate non-winning prize symbols in this game.

E. GAME 1: Non-winning prize symbols will never be the same as the winning prize symbol(s) in this game.

F. GAME 1: No duplicate non-winning YOUR CARD play symbols in this game.

G. GAME 1: No ties between the DEALER'S CARD and YOUR CARD play symbols within a GAME.

H. GAME 1: No duplicate DEALER'S CARD play symbols in this game.

I. GAME 2: No duplicate non-winning prize symbols in this game.

J. GAME 2: Non-winning prize symbols will never be the same as the winning prize symbol(s) in this game.

K. GAME 2: No duplicate non-winning YOUR SYMBOLS play symbols on a ticket.

L. GAME 3: There will be only one (1) occurrence of three (3) matching symbols appearing in a row, column or diagonal on winning games.

M. GAME 3: Every game will contain either four (4) X's and five (5) O's or four (4) O's and five (5) X's.

N. GAME 4: No duplicate non-winning prize symbols in this game.

O. GAME 4: Non-winning prize symbols will never be the same as the winning prize symbol(s) in this game.

P. GAME 4: No duplicate non-winning play symbols in this game.

Q. GAME 4: The "3" (win x 3) and "5" (win x 5) play symbols will only appear on intended winning tickets as dictated by the prize structure.

2.3 Procedure for Claiming Prizes.

A. To claim a "$50,000 PLAYER'S CLUB" Instant Game prize of $5.00, $10.00, $15.00, $20.00, $50.00, $100 or $500, a claimant shall sign the back of the ticket in the space designated on the ticket and present the winning ticket to any Texas Lottery Retailer. The Texas Lottery Retailer shall verify the claim and, if valid, and upon presentation of proper identification, if appropriate, make payment of the amount due the claimant and physically void the ticket; provided that the Texas Lottery Retailer may, but is not required, to pay a $50.00, $100 or $500 ticket. In the event the Texas Lottery Retailer cannot verify the claim, the Texas Lottery Retailer shall provide the claimant with a claim form and instruct the claimant on how to file a claim with the Texas Lottery. If the claim is validated by the Texas Lottery, a check shall be forwarded to the claimant in the amount due. In the event the claim is not validated, the claim shall be denied and the claimant shall be notified promptly. A claimant may also claim any of the above prizes under the procedure described in Section 2.3.B and 2.3.C of these Game Procedures.

B. To claim a "$50,000 PLAYER'S CLUB" Instant Game prize of $2,000 or $50,000, the claimant must sign the winning ticket and present it at one of the Texas Lottery's Claim Centers. If the claim is validated by the Texas Lottery, payment will be made to the bearer of the validated winning ticket for that prize upon presentation of proper identification. When paying a prize of $600 or more, the Texas Lottery shall file the appropriate income reporting form with the Internal Revenue Service (IRS) and shall withhold federal income tax at a rate set by the IRS if required. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

C. As an alternative method of claiming a "$50,000 PLAYER'S CLUB" Instant Game prize, the claimant must sign the winning ticket, thoroughly complete a claim form, and mail both to: Texas Lottery Commission, Post Office Box 16600, Austin, Texas 78761-6600. The Texas Lottery is not responsible for tickets lost in the mail. In the event that the claim is not validated by the Texas Lottery, the claim shall be denied and the claimant shall be notified promptly.

D. Prior to payment by the Texas Lottery of any prize, the Texas Lottery shall deduct:

1. a sufficient amount from the winnings of a prize winner who has been finally determined to be:

a. delinquent in the payment of a tax or other money to a state agency and that delinquency is reported to the Comptroller under Government Code §403.055;

b. in default on a loan made under Chapter 52, Education Code; or

c. in default on a loan guaranteed under Chapter 57, Education Code; and

2. delinquent child support payments from the winnings of a prize winner in the amount of the delinquency as determined by a court or a Title IV-D agency under Chapter 231, Family Code.

E. If a person is indebted or owes delinquent taxes to the State, other than those specified in the preceding paragraph, the winnings of a person shall be withheld until the debt or taxes are paid.

2.4 Allowance for Delay of Payment. The Texas Lottery may delay payment of the prize pending a final determination by the Executive Director, under any of the following circumstances:

A. if a dispute occurs, or it appears likely that a dispute may occur, regarding the prize;

B. if there is any question regarding the identity of the claimant;

C. if there is any question regarding the validity of the ticket presented for payment; or

D. if the claim is subject to any deduction from the payment otherwise due, as described in Section 2.3.D of these Game Procedures. No liability for interest for any delay shall accrue to the benefit of the claimant pending payment of the claim.

2.5 Payment of Prizes to Persons Under 18. If a person under the age of 18 years is entitled to a cash prize of less than $600 from the "$50,000 PLAYER'S CLUB" Instant Game, the Texas Lottery shall deliver to an adult member of the minor's family or the minor's guardian a check or warrant in the amount of the prize payable to the order of the minor.

2.6 If a person under the age of 18 years is entitled to a cash prize of $600 or more from the "$50,000 PLAYER'S CLUB" Instant Game, the Texas Lottery shall deposit the amount of the prize in a custodial bank account, with an adult member of the minor's family or the minor's guardian serving as custodian for the minor.

2.7 Instant Ticket Claim Period. All Instant Game prizes must be claimed within 180 days following the end of the Instant Game or within the applicable time period for certain eligible military personnel as set forth in Texas Government Code §466.408. Any rights to a prize that is not claimed within that period, and in the manner specified in these Game Procedures and on the back of each ticket, shall be forfeited.

2.8 Disclaimer. The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed. An Instant Game ticket may continue to be sold even when all the top prizes have been claimed.

3.0 Instant Ticket Ownership.

A. Until such time as a signature is placed upon the back portion of an Instant Game ticket in the space designated, a ticket shall be owned by the physical possessor of said ticket. When a signature is placed on the back of the ticket in the space designated, the player whose signature appears in that area shall be the owner of the ticket and shall be entitled to any prize attributable thereto. Notwithstanding any name or names submitted on a claim form, the Executive Director shall make payment to the player whose signature appears on the back of the ticket in the space designated. If more than one name appears on the back of the ticket, the Executive Director will require that one of those players whose name appears thereon be designated by such players to receive payment.

B. The Texas Lottery shall not be responsible for lost or stolen Instant Game tickets and shall not be required to pay on a lost or stolen Instant Game ticket.

4.0 Number and Value of Instant Prizes. There will be approximately 6,000,000 tickets in the Instant Game No. 1334. The approximate number and value of prizes in the game are as follows:

Figure 2: GAME NO. 1334 - 4.0

Prize Amount	Approximate Number of Winners*	Approximate Odds are 1 in**
$5	560,000	10.71
$10	720,000	8.33
$15	160,000	37.50
$20	80,000	75.00
$50	45,000	133.33
$100	20,500	292.68
$500	3,300	1,818.18
$2,000	75	80,000.00
$50,000	6	1,000,000.00

*The number of prizes in a game is approximate based on the number of tickets ordered. The number of actual prizes available in a game may vary based on number of tickets manufactured, testing, distribution, sales and number of prizes claimed.

**The overall odds of winning a prize are 1 in 3.78. The individual odds of winning for a particular prize level may vary based on sales, distribution, testing, and number of prizes claimed.

A. The actual number of tickets in the game may be increased or decreased at the sole discretion of the Texas Lottery.

5.0 End of the Instant Game. The Executive Director may, at any time, announce a closing date (end date) for the Instant Game No. 1334 without advance notice, at which point no further tickets in that game may be sold. The determination of the closing date and reasons for closing the game will be made in accordance with the instant ticket game closing procedures and the Instant Game Rules. See 16 TAC §401.302(j).

6.0 Governing Law. In purchasing an Instant Game ticket, the player agrees to comply with, and abide by, these Game Procedures for Instant Game No. 1334, the State Lottery Act (Texas Government Code, Chapter 466), applicable rules adopted by the Texas Lottery pursuant to the State Lottery Act and referenced in 16 TAC Chapter 401, and all final decisions of the Executive Director.

TRD-201102399
Kimberly L. Kiplin
General Counsel
Texas Lottery Commission
Filed: June 27, 2011

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Public Utility Commission of Texas

Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on June 23, 2011, to amend 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 Cebridge Acquisition, L.P. d/b/a Suddenlink Communications for Amendment to a State-Issued Certificate of Franchise Authority, Project Number 39530.

The requested amendment is to expand the service area footprint to include the municipality of Hudson, Texas.

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 39530.

TRD-201102391
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 24, 2011

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Notice of Application for Designation as an Eligible Telecommunications Carrier

Notice is given to the public of an application filed with the Public Utility Commission of Texas on June 22, 2011, for designation as an eligible telecommunications carrier (ETC) pursuant to P.U.C. Substantive Rule §26.418.

Docket Title and Number: Application of TAG Mobile, LLC for Designation as an Eligible Telecommunications Carrier Pursuant to 47 U.S.C. §214(e) and P.U.C. Substantive Rule §26.418 on a Wireless Basis (Low Income Only). Docket Number 39525.

The Application: The company seeks ETC designation throughout the State of Texas for the purpose of receiving federal universal service support for wireless services. It will not seek access to funds from the federal Universal Service Fund for the purpose of providing service to high cost areas. TAG Mobile seeks only Lifeline and Link-Up support from the low-income program and does not seek any high-cost support. Pursuant to 47 U.S.C. §214(e), the commission, either upon its own motion or upon request, shall designate qualifying common carriers as ETCs for service areas set forth by the commission. The company requested an effective date no earlier than 30 days after publication in the *Texas Register,* which in this instance is Monday, August 8, 2011.

Persons who wish to comment on this application should notify the Public Utility Commission by Thursday, July 28, 2011. Requests for further information should be mailed to the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326, or you may call the Public Utility Commission's Customer Protection Division 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 comments should reference Docket Number 39525.

TRD-201102390
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: June 24, 2011

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Texas Council on Purchasing from People with Disabilities

Request for Comment Regarding the Management Fee Rate Charged by TIBH Industries Inc. (Central Nonprofit Agency)

Notice is hereby given that the Texas Council on Purchasing from People with Disabilities (Council) will review and make a decision on the management fee rate charged by the central nonprofit agency, TIBH Industries Inc., for its services to the community rehabilitation programs and operation of the State Use Program for Fiscal Year 2012 as required by §122.019(e) of the Texas Human Resources Code. This review will be conducted at the Council's meeting on Friday, September 16, 2011. The Council's meeting will be held at the Capitol Extension, 1400 North Congress Avenue, Hearing Room E2.026 Austin, Texas. TIBH Industries Inc. has requested that the Council set the Fiscal Year 2012 management fee rate at 6% of the sales price for products, 6% of the contract price for services and 5% of the contract price for temporary services. The Council seeks public comment on TIBH Industries Inc. management fee rate request as required by §122.030(a) - (b) of the Texas Human Resources Code and 40 Texas Administrative Code §189.7(b) - (d).

Comments should be submitted in writing on or before Friday, September 2, 2011 to Kelvin Moore of the Texas Council on Purchasing from People with Disabilities, 111 E. 17th Street, Austin, Texas 78711, or via email to: kelvin.moore@tcppd.state.tx.us.

For all other questions or comments, contact the Texas Council on Purchasing from People with Disabilities at (512) 463-3244. In addition, hearing and speech impaired individuals with text telephones (TTY) may contact the Council on Purchasing from People with Disabilities at (800) 531-5441, or may use the relay option of their choice to call the TCPPD at (512) 463-3244.

TRD-201102422
David Duncan
Deputy General Counsel
Texas Council on Purchasing from People with Disabilities
Filed: June 27, 2011

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Request for Comment Regarding the Services Performed by TIBH Industries Inc.

Notice is hereby given that the Texas Council on Purchasing from People with Disabilities (Council) intends to review the services provided by the central nonprofit agency (agency), TIBH Industries Inc., and the revenues required to accomplish the program for Fiscal Year 2011 as required by §122.019(c) of the Texas Human Resources Code. As required by that section, the Council will review the performance of TIBH to determine whether that agency's performance complies with the Council's contractual specifications. This review will be consid-

ered at the next Council meeting on Friday, September 16, 2011. The Council's meeting will be held at the Capitol Extension, 1400 North Congress Avenue, Hearing Room E2.026, Austin, Texas. The Council requests that interested parties submit comments regarding the services provided by TIBH Industries Inc. in its operation of the State Use Program, under §122.019(a) - (b) of the Texas Human Resources Code and the revenues required to accomplish the program.

Comments should be submitted in writing on or before Friday, September 2, 2011 to Kelvin Moore of the Texas Council on Purchasing from People with Disabilities, 111 E. 17th Street, Austin, Texas 78711, or via email to: kelvin.moore@tcppd.state.tx.us.

For all other questions or comments, contact the Texas Council on Purchasing from People with Disabilities at (512) 463-3244. In addition, hearing and speech impaired individuals with text telephones (TTY) may contact the Council on Purchasing from People with Disabilities at (800) 531-5441, or may use the relay option of their choice to call the TCPPD at (512) 463-3244.

TRD-201102423
David Duncan
Deputy General Counsel
Texas Council on Purchasing from People with Disabilities
Filed: June 27, 2011

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Supreme Court of Texas

Final Approval of Amendments to the Texas Rules of Appellate Procedure and Templates for Local Rules Governing Electronic Copies and Electronic Filings in the Courts of Appeals

Misc. Docket No. 11-9118

ORDERED that:

1. Pursuant to Section 22.004 of the Texas Government Code, the Supreme Court of Texas amends Rules 9.2 and 9.3 of the Texas Rules of Appellate Procedure, as follows.

9.2. Filing

(c) *Electronic Filing.* Documents may be permitted or required to be filed, signed, or verified by electronic means by order of the Supreme Court or the Court of Criminal Appeals, or by local rule of a court of appeals. A technical failure that precludes a party's compliance with electronic-filing procedures cannot be a basis for disposing of any case.

9.3. Number of Copies; Electronic Copies

(a) *Courts of Appeals.*

(1) Paper Copies in General. A party must file:

(A) the original and three copies of all documents in an original proceeding;

(B) the original and two copies of all motions in an appellate proceeding; and

(C) the original and five copies of all other documents.

(2) Local Rules. A court of appeals may by local rule require:

(A) the filing of more or fewer paper copies of any document other than a petition for discretionary review; and

(B) an electronic copy of a document filed in paper form.

(b) *Supreme Court and Court of Criminal Appeals.*

(1) Paper Copies of Document Filed in Paper Form. A party must file the original and 11 copies of any document addressed to either the Supreme Court or the Court of Criminal Appeals, except that in the Supreme Court, only an original and one copy must be filed of any motion, response to the motion, and reply in support of the motion, and in the Court of Criminal Appeals, only the original must be filed of a motion for extension of time or a response to the motion, or a pleading under Code of Criminal Procedure article 11.07.

(2) Electronic Copies of Document Filed in Paper Form. An electronic copy of a document filed in paper form may be required by order of the Supreme Court or the Court of Criminal Appeals.

(3) Paper Copies of Electronically Filed Document. Copies of each document that is electronically filed with the Supreme Court or the Court of Criminal Appeals must be mailed or hand-delivered to the Supreme Court or the Court of Criminal Appeals, as appropriate, within one business day after the document is electronically filed. The number of paper copies required shall be determined, respectively, by order of the Supreme Court or the Court of Criminal Appeals.

(c) *Exception for Record.* Only the original record need be filed in any proceeding.

2. The Supreme Court also promulgates the attached templates for local rules governing electronic copies and electronic filings in the courts of appeals.

a. A court of appeals' local rule requiring electronic copies of documents must be in the form of Appendix A with modifications only as permitted by the Supreme Court. The local rule must be approved by Order of the Supreme Court.

b. A court of appeals' local rule permitting the electronic filing of documents must be in the form of Appendix B with modifications only as permitted by the Supreme Court. The local rule must be approved by Order of the Supreme Court.

c. The procedures prescribed by the local rules apply in lieu of those prescribed by the Texas Rules of Appellate Procedure to the extent there are differences between the procedures; otherwise, the Rules of Appellate Procedure continue to apply with full force and effect.

3. By Order dated February 28, 2011, in Misc. Docket No. 11-9032, the Court proposed amendments to Rules 9.2 and 9.3 of the Texas Rules of Appellate Procedure and invited public comment. This Order contains the final version of amended Rules 9.2 and 9.3 of the Texas Rules of Appellate Procedure that take effect June 30, 2011.

4. The Clerk of the Supreme Court is directed to:

a. file a copy of this Order with the Secretary of State;

b. cause a copy of this Order to be mailed to each registered member of the State Bar of Texas by publication in the Texas Bar Journal;

c. send a copy of this Order to each elected member of the Legislature; and

d. submit a copy of the Order for publication in the *Texas Register.*

Dated: June 27, 2011.

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Wallace B. Jefferson, Chief Justice

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Nathan L. Hecht, Justice

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Dale Wainwright, Justice

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David M. Medina, Justice

_____

Paul W. Green, Justice

_____

Phil Johnson, Justice

_____

Don R. Willett, Justice

_____

Eva M. Guzman, Justice

_____

Debra H. Lehrmann, Justice

APPENDIX A

Local Rule ___. Electronic Copies of Documents Filed in Paper Form.

(a) Electronic copies of documents required. For the convenience of the court, attorneys, parties, and the public, an attorney for a party must email to the court an electronic copy of every document filed with the court, except a document under seal or subject to a motion to seal. A party who is not represented by an attorney is encouraged to email to the court an electronic copy of every document filed with the court, except a document under seal or subject to a motion to seal. [Courts may add exceptions for attorneys and unrepresented parties.]

(b) Filing required. An electronic copy does not constitute a filing. Documents must continue to be filed as provided by the Texas Rules of Appellate Procedure[, except that only the original and [insert number] copies must be filed of any document other than a petition for discretionary review. A party must file the original and 11 copies of a petition for discretionary review].

(c) Time to email electronic copy. The electronic copy must be emailed to the court at [insert applicable email address] on the same day the original document is filed. Also on that day, the electronic copy must be emailed to each other party's lead counsel for whom the filing attorney has an email address.

(d) Identification of document. The email subject line must identify the document by case number and by name. The electronic copy must be named as follows: [insert court's desired naming conventions here].

(e) Redaction of electronic copies. An electronic copy must be substantively identical to the original document filed with the court, except it must not contain a social security number; a birth date; a home address; the name of any person who was a minor when the underlying suit was filed; a driver's license number, passport number, tax identification number, or similar government-issued personal identification number; or a bank account number, credit card number, or other financial account number. The attorney emailing the electronic copy must redact all such information in accordance with the redaction guidelines posted by the Supreme Court's Clerk on the Supreme Court's website; however, the electronic copy may contain a reference to this information as long as the reference does not include any part of the actual information (e.g., "passport number"). For good cause, the court may order redaction of additional information.

(f) Certification of counsel. The submission of an electronic copy constitutes a certification by all attorneys of record for the party filing the document that the electronic copy complies with paragraph (e).

(g) Posting of electronic copies. The clerk may post electronic copies of documents in a case on the court's website. By letter to the clerk, a party to the case may request that electronic copies posted on the court's website be redacted further or removed altogether. The request must identify with particularity the document(s) to be removed or the information to be redacted and state specific reasons for the request. If the request is for further redaction, the party must email a copy of the requested version of the document.

(h) Format of electronic copies. An electronic copy must be formatted as follows:

(1) An electronic copy must be in text-searchable portable document format (PDF) compatible with the latest version of Adobe Reader.

(2) Except as otherwise provided by this rule, an electronic copy of a document created by a word processing program must not be a scan of the original but must instead be converted from the original directly into a PDF file using Adobe Acrobat, a word processing program's PDF conversion utility, or another software program.

(3) Records filed in original proceedings and appendix materials may be scanned if necessary, but scanning creates larger file sizes with images of lesser quality and should be avoided when possible. An appendix must be combined into one computer file with the document it is associated with, unless the resulting computer file would exceed the size limits in paragraph (i). If a record filed in an original proceeding or an appendix contains more than one item, it should include a table of contents and either bookmarks to assist in locating each item or separator pages with the title of the item immediately following and any number or letter associated with the item in the table of contents.

(4) A scanned document must be made searchable using optical-character-recognition software, such as Adobe Acrobat, and have a resolution of 300 dots per inch (dpi).

(5) An electronic copy may contain hyperlinks to another part of the same document, an external source cited in the document, an appendix item associated with the document, an embedded case, or a record cite. Hyperlinks within an appendix item are also permitted.

(6) An electronic copy must not contain a virus or malware. The submission of an electronic copy constitutes a certification by all attorneys of record for the party filing the document that the electronic copy has been checked for viruses and malware.

(7) An electronic copy need not be signed.

(i) Size of electronic copies. A electronic copy must not exceed 20 megabytes. Electronic copies larger than 20 megabytes must be divided into smaller files.

(j) Communications with the clerk. An attorney who emails an electronic copy of a document must supply the clerk with an email address to which the clerk may send notices or other communications about the case in lieu of mailing paper documents. If the attorney's email address changes, the attorney must provide the clerk with the new email address within one business day of the change. Lead counsel must register for Casemail and follow the instructions for receiving notices for cases in which they represent a party.

APPENDIX B

Local Rule ___. Electronic Filings of Documents.

(a) Electronic filing permitted. A party may electronically file (e-file) any document that may be filed with the court in paper form, except a document under seal or subject to a motion to seal.

(b) E-filing mechanism. E-filing must be done through Texas.gov, the portal established by the Texas Legislature. Directions for its use may be found on its website. This is a summary. A person must first register with an Electronic Filing Service Provider (EFSP). A list of approved

EFSPs is on the Texas.gov website. The EFSP will provide the registrant with a confidential, secure username and password to use when e-filing a document. This username and password will also function as a signature on each e-filed document, and will authorize payment of all filing fees and service fees. A document to be e-filed must be transmitted to the EFSP, which will send the document to Texas.gov, which in turn will send the document to the clerk. The e-filer will receive by email an immediate acknowledgment of the e-filing, a confirmation of the clerk's acceptance of the filing, and a file-stamped copy of the document. Fees charged by Texas.gov for the e-filing of a document are in addition to any filing fees and are costs of court.

(c) Electronic service. A party who has registered to e-file documents through an EFSP may electronically serve (e-serve) documents through that EFSP on any other party who has consented to e-service by registering for the e-service option with an EFSP or by setting up a complimentary account with Texas.gov. Directions may be found on the Texas.gov website.

(1) Service through an EFSP is complete on transmission to the e-served person's EFSP or complimentary Texas.gov account. The e-filer's EFSP will send proof of service to the e-filer. Fees that an EFSP charges for e-service are not costs of court.

(2) If an e-filer must serve a copy of a document on a party who has not consented to e-service, the e-filer must comply with the service requirements in Texas Rule of Appellate Procedure 9.5 and, on the same day the document is e-filed, must send the document to:

(A) the party's lead counsel by email if the e-filer has an email address for the lead counsel; or

(B) if the party is not represented by counsel, to the party by email if the e-filer has the party's email address.

(d) Redaction of information in e-filed document.

(1) Unless the court orders otherwise, an e-filed document must not contain a social security number; a birth date; a home address; the name of any person who was a minor when the underlying suit was filed; a driver's license number, passport number, tax identification number, or similar government-issued personal identification number; or a bank account number, credit card number, or other financial account number. The e-filer must redact all of this information in accordance with the redaction guidelines posted by the Supreme Court's Clerk on the Supreme Court's website; however, the e-filed document may contain a reference to this information as long as the reference does not include any part of the actual information (e.g., "passport number"). For good cause, the court may order redaction of additional information.

(2) The e-filing of a document constitutes a certification by all attorneys of record for the party filing the document that the document complies with paragraph (1) of this rule.

(3) If an e-filer believes any information described in paragraph (1) of this rule is essential to an e-filed document or that the e-filed document would be confusing without the information, the e-filer may submit the information to the court in a reference list that is in paper form and under seal. The reference list must specify an appropriate identifier that corresponds uniquely to each item listed. Any reference in the e-filed document to a listed identifier will be construed to refer to the corresponding item of information. If the e-filer provides a reference list pursuant to this rule, the front page of the e-filed document must indicate that the reference list has been, or will be, provided.

(4) On its own initiative, the court may order a sealed reference list in any case. The court may also order that a document be filed under seal in paper form, without redaction. The court may later unseal the document or order the filer to provide a redacted version of the document for the public record.

(e) Format of e-filed document. An e-filed document must be formatted as follows:

(1) An e-filed document must be formatted in accordance with Texas Rule of Appellate Procedure 9.4(b)-(e). The "paper" requirements in Rule 9.4(b)-(c) apply equally to a "page" of the e-filed document.

(2) An e-filed document must be in text-searchable portable document format (PDF) compatible with the latest version of Adobe Reader. An EFSP will convert each e-filed document from its original form into a PDF file that complies with this rule.

(3) Records filed in original proceedings and appendix materials may be scanned if necessary, but scanning creates larger file sizes with images of lesser quality and should be avoided when possible. An appendix must be combined into one computer file with the document it is associated with, unless the resulting computer file would exceed Texas.gov's size limits for the document. If a record filed in an original proceeding or an appendix contains more than one item, it should include a table of contents and either bookmarks to assist in locating each item or separator pages with the title of the item immediately following and any number or letter associated with the item in the table of contents.

(4) A scanned document must be made searchable using optical-character-recognition software, such as Adobe Acrobat, and have a resolution of 300 dots per inch (dpi).

(5) An e-filed document may contain hyperlinks to another part of the same document, an external source cited in the document, an appendix item associated with the document, an embedded case, or a record cite. Hyperlinks within an appendix item are also permitted.

(6) An e-filed document must not contain a virus or malware. The e-filing of a document constitutes a certification by the e-filer that the document has been checked for viruses and malware.

(7) The court may strike an e-filed document for nonconformance with this rule.

(f) Signatures on e-filed documents.

(1) Except as otherwise provided by this rule, the confidential, secure username and password that the e-filer must use to e-file a document constitute the e-filer's signature on the document, in compliance with signature requirements in the Texas Rules of Appellate Procedure. When a signature is provided in this manner, the e-filer must also include either an "/s/" and the e-filer's name typed in the space where the e-filer's signature would otherwise appear or an electronic image of the e-filer's signature, which may take the form of a public key-based digital signature or a scanned image of the e-filer's signature. The e-filer must not allow the e-filer's username or password to be used by anyone other than an agent who is authorized by the e-filer.

(2) If a document must be notarized, sworn to, or made under oath, the e-filer must e-file the document as a scanned image containing the necessary signature(s).

(3) If a document requires the signature of an opposing party, the e-filer must e-file the document as a scanned image containing the opposing party's signature.

(4) When an e-filer e-files a scanned image of a document pursuant to paragraph (2) or (3) of this rule, the e-filer must retain the original document from which the scanned image was made until the case in which the document was filed is resolved. If the original document is in another party's possession, that party must retain the original document until the case in which the document was filed is resolved.

(5) If an e-served document was also e-filed and the person who completes a certificate of service under Texas Rule of Appellate Procedure 9.5(e) is different from the person who e-filed the document, the person who completes the certificate of service must sign the certificate by including either an "/s/" and his or her name typed in the space where his or her signature would otherwise appear or an electronic image of his or her signature.

(g) Time of e-filing. A document will be considered filed timely if it is e-filed at any time before midnight (in the court's time zone) on the date on which the document is due.

(1) An e-filed document is deemed filed when the e-filer transmits the document to the e-filer's EFSP, unless the document is transmitted on a Saturday, Sunday, or legal holiday or requires a motion and an order allowing its filing.

(2) If a document is transmitted on a Saturday, Sunday, or legal holiday, it will be deemed filed on the next day that is not a Saturday, Sunday, or legal holiday.

(3) If a document requires a motion and an order allowing its filing, it will be deemed filed on the date the motion is granted.

(4) If an e-filed document is untimely due to a technical failure or a system outage, the e-filer may seek appropriate relief from the court.

(h) Paper copies.

OPTION 1: An e-filer is not required to file any paper copies of an e-filed document, except that paper copies of a petition for discretionary review must still be filed in accordance with Rule 9 of the Texas Rules of Appellate Procedure within one business day after the petition is e-filed.

OPTION 2: An e-filer must file 11 paper copies of an e-filed petition for discretionary review and [insert number] paper copies of any other e-filed document in accordance with Rule 9 of the Texas Rules of Appellate Procedure within one business day after the document is e-filed.

(i) Email address requirements and communications with the clerk. An e-filed document must include the e-filer's email address, in addition to any other information required by the Texas Rules of Appellate Procedure. If the e-filer's email address changes, the e-filer must provide the clerk and the e-filer's EFSP with the new email address within one business day of the change. If there is a change in the email address of a party who has consented to receive e-service, the party must provide Texas.gov or, if applicable, the party's EFSP with the new email address within one business day of the change. The clerk may send notices or other communications about a case to an attorney's email address in lieu of mailing paper documents.

(j) Casemail registration. Lead counsel must register for Casemail and follow the instructions for receiving notices for cases in which they represent a party.

(k) Construction of rules. This rule must be liberally construed so as to avoid undue prejudice to any person who makes a good-faith effort to comply with requirements in this rule.

TRD-201102438
Marisa Secco
Rules Attorney
Supreme Court of Texas
Filed: June 28, 2011

♦ ♦ ♦

Texas Department of Transportation

Aviation Division - Request for Proposal for Professional Engineering Services

The City of DeSoto, 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 DeSoto. TxDOT CSJ No. 1118DESOT. Scope: Provide engineering/design services for a new heliport.

The HUB goal is set at 6%. TxDOT Project Manager is Clayton Bridwell.

To assist in your proposal preparation the criteria and the project diagram are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "DeSoto Heliport."

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 website 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 August 2, 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 Aviation Division staff 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.

If there are any procedural questions, please contact Edie Stimach, Grant Manager at 1-800-68-PILOT at extension 4518. For technical questions, please contact Clayton Bridwell, at 1-800-68-PILOT at extension 4531.

TRD-201102387

Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: June 24, 2011

♦ ♦ ♦

Aviation Division - Request for Proposal for Professional Engineering Services

The City of Cotulla and La Salle County, through their agent the Texas Department of Transportation (TxDOT), intend 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 Cotulla-La Salle County Airport during the course of the next five years through multiple grants.

Current Project: City of Cotulla and La Salle County. TxDOT CSJ No.: 1122COTLA. Provide engineering/design services to extend, rehabilitate and mark Runway 13-31; expand and rehabilitate apron; rehabilitate taxiway; construct parallel taxiway to Runway 13; extend medium intensity runway lights; relocate precision approach path indicators-2; relocate Automated Surface Observing System; modify distance to go signs; partial building demolition and replacement and install deer proof fence.

The DBE goal for the current project is 7%. The 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 parallel taxiway to Runway 31

The City of Cotulla and La Salle County reserve 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, project diagram, and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Cotulla-La Salle 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 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 website 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:

Six (6) 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 **August 16, 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 **Beverly Longfellow, TxDOT Aviation Grant Manager.**

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 Beverly Longfellow, Grant Manager. For technical questions, please contact Harry Lorton, Project Manager.

TRD-201102436
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: June 28, 2011

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Notice of Intent - US 181 Harbor Bridge Replacement/SH 286 (Crosstown Expressway) Improvement Project, Nueces County, Texas

Pursuant to 43 TAC §2.5(e)(2), the Texas Department of Transportation (department), in cooperation with the Federal Highway Administration, is issuing this notice to advise the public that an Environmental Impact Statement (EIS) will be prepared for a proposed transportation project. The proposed project is US 181 Harbor Bridge replacement/SH 286 (Crosstown Expressway) improvement project in Nueces County, Texas. The project and study limits include the US 181 and Beach Avenue interchange on the north and the SH 286 and Morgan Avenue interchange on the south.

Two previous NOIs have been published for this project. The original NOI, published on May 27, 2005, reported that the project would replace the existing Harbor Bridge and approaches where US 181 crosses the Corpus Christi Ship Channel for a roadway distance of approximately 2.25 miles. Subsequent to the publication of the 2005 NOI, the project and study limits were expanded to accommodate added capacity that might have included managed lanes or various tolling strategies. A second NOI was published on April 6, 2007, to report this change in project limits and scope. On October 22, 2010, the revised NOI published in 2007 was rescinded, via a notice in the Texas Register, because of changes in the scope (managed toll lanes) and limits. The project limits have now been revised to eliminate the added capacity that would have included managed lanes and various tolling strategies, and have been reduced at the southern limit back to the SH 286 and Morgan Avenue interchange. The new project limits are as follows: the northern limit is the US 181 and Beach Avenue interchange located north of the Corpus Christi Ship Channel but south of the Nueces Bay

Causeway; the southern limit is SH 286 between Morgan Avenue and Baldwin Boulevard; the eastern limit is the I-37/US 181 intersection with Shoreline Boulevard in the Corpus Christi central business district; and the western limit is the I-37 and Nueces Bay Boulevard interchange. The new project limits total approximately 4.5 miles in length from north to south along US 181 and SH 286, and approximately 2.1 miles in length from east to west along I-37.

The EIS will evaluate potential impacts from construction and operation of the project, including, but not limited to, the following: impacts or potential displacements to residences and businesses; detours; air and noise impacts from construction equipment, and operation of the project; water quality impacts from the construction area and from roadway storm water runoff; impacts to waters of the United States, including wetlands; impacts to historic and archeological resources; impacts to public parkland; impacts to communities, including low-income and minority communities; indirect impacts; cumulative impacts; land use; vegetation; wildlife; and aesthetic and visual resources.

The department will consider several alternatives intended to satisfy the identified need and purpose. The alternatives will include the no-build alternative, Transportation System Management/Transportation Demand Management, and roadway build alternatives. The roadway build alternatives will include replacing the existing US 181 Harbor Bridge and approach roads with a facility that meets current highway design standards.

The project may require the following approvals by the federal government: Clean Water Act Section 404/401 (U.S. Army Corps of Engineers); Clean Water Act Section 402 National Pollutant Discharge Elimination System (U.S. Environmental Protection Agency); Endangered Species Act (U.S. Fish & Wildlife Service); Magnuson-Stevens Fishery Conservation and Management Act, Essential Fish Habitat (National Marine Fisheries Service); 1946 General Bridge Act, Joint Aquatic Resource (Navigable Waterway) Permit (U.S. Coast Guard); National Historic Preservation Act Section 106 (State Historic Preservation Officer); and Department of Transportation Act Section 4(f) (Federal Highway Administration). The actual approvals required may change after the department completes field surveys, conducts public involvement activities, and selects the alignment for the project.

A scoping meeting is an opportunity for participating agencies, cooperating agencies, and the public to be involved in defining the need and purpose for the proposed project, to assist in determining the range of alternatives for consideration in the draft EIS, and to comment on methodologies to evaluate alternatives. Public and agency scoping meetings will be held at the department's Corpus Christi District Office - Training Center, 1701 S. Padre Island Drive, Corpus Christi, Texas 78416, on August 9, 2011. The department will publish notices of the meetings, including the times, in general circulation newspapers in the project area.

The department will complete the procedures for public participation and coordination with other agencies as described in one or both the National Environmental Policy Act and state law. In addition to any scoping meetings, the department will hold a series of meetings to solicit public comment during the environmental review process. They will be held during appropriate phases of the project development process. Public notices will be given stating the date, time, and location of the meeting or hearing and will be published in English as well as Spanish. Provision will be made for those with special communication needs, including translation if requested. The department will also send correspondence to federal, state, and local agencies, and to organizations and individuals who have previously expressed or are known to have an interest in the project, which will describe the proposed project and solicit comments. The department invites comments and suggestions from all interested parties to ensure that the full range of issues related to the proposed project are identified and addressed. Comments or questions should be directed to the department at the address set forth below.

A proposed schedule for completion of the environmental review process is not available.

Agency Contact: Comments or questions concerning this proposed action and the EIS should be sent to Ms. Dianna Noble, P.E., Director, Environmental Affairs Division, Texas Department of Transportation, 125 E. 11th Street, Austin, Texas 78701-2483, (512) 416-3001.

TRD-201102388
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: June 24, 2011

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Public Hearing Notice - Statewide Transportation Improvement Program

The Texas Department of Transportation will hold a public hearing on Monday, July 25, 2011 at 10:00 a.m. at the Texas Department of Transportation, 200 East Riverside Drive, Room 1A-1, in Austin, Texas to receive public comments on the July 2011 Out of Cycle Revisions to the Statewide Transportation Improvement Program (STIP) for FY 2011-2014. The STIP reflects the federally funded transportation projects in the FY 2011-2014 Transportation Improvement Programs (TIPs) for each Metropolitan Planning Organization (MPO) in the state. The STIP includes both state and federally funded projects for the nonattainment areas of Beaumont, Dallas-Fort Worth, El Paso, and Houston. The STIP also contains information on federally funded projects in rural areas that are not included in any MPO area, and other statewide programs as listed.

Title 23, United States Code, §134 and §135 require each designated MPO and the state, respectively, to develop a TIP and STIP as a condition to securing federal funds for transportation projects under Title 23 or the Federal Transit Act (49 USC §5301, et seq.).

Section 134(j) requires an MPO to develop its TIP in cooperation with the state and affected public transit operators and to provide an opportunity for interested parties to participate in the development of the program. Section 135(g) requires the state to develop a STIP for all areas of the state in cooperation with the designated MPOs and, with respect to non-metropolitan areas, in consultation with affected local officials, and further requires an opportunity for participation by interested parties as well as approval by the Governor or the Governor's designee.

A copy of the proposed July 2011 Out of Cycle Revisions to the FY 2011-2014 STIP 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 website at:

www.txdot.gov

Persons wishing to review the July 2011 Out of Cycle Revisions to the FY 2011-2014 STIP 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 Friday, July 22, 2011, or they may register at the hearing location beginning at 9:00 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 FY 2011-2014 STIP 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, August 8, 2011 at 4:00 p.m.

TRD-201102401
Joanne Wright
Deputy General Counsel
Texas Department of Transportation
Filed: June 27, 2011

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University of North Texas System

Notice of Cancellation of Invitation to Provide Consulting Services

University of North Texas at Dallas

Notice of cancellation of invitation for consultants to provide offers of consulting services to assist with visioning and planning efforts to implement the strategic plan of the University of North Texas at Dallas. The University of North Texas at Dallas has decided to cancel the Request for Proposal (RFP773-12-684CS). The University would like to take this time to thank you for your interest in the proposal process.

TRD-201102359
Carrie Stoeckert
Assistant Director of PPS
University of North Texas System
Filed: June 23, 2011

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Texas Water Development Board

Request for Applications for Grants Under the FEMA Severe Repetitive Loss Program for Federal Fiscal Year 2012

The Texas Water Development Board (TWDB), as administrator of the Severe Repetitive Loss (SRL) Program on behalf of the Federal Emergency Management Agency (FEMA), requests the submission of applications leading to the possible award of SRL Program grants from communities within the State with the legal authority to mitigate the impacts of flooding, and which participate in the National Flood Insurance Program (NFIP), in accordance with FEMA policy and regulations set forth in Title 44 of Code of Federal Regulations (CFR) Part 79 (44 CFR 79). A "community" is defined as (a) a political subdivision, including any Indian tribe or authorized native organization, that has zoning and building code jurisdiction over a particular area having special flood hazards, and which is participating in the NFIP; or (b) a political subdivision or other authority that is designated a political subdivision to develop and administer a mitigation plan. Eligible applicants for SRL Program grants must have a FEMA approved Multi-Hazard Mitigation Plan.

Description of the SRL Program Purpose and Objectives: The purpose of the SRL Program is to reduce or eliminate the risk of flood damage to severe repetitive loss residential structures insured under the NFIP. An SRL property is defined by FEMA as a residential property that is covered under an NFIP flood policy and: a) has at least four NFIP claims payments (including building and contents) of over $5,000 each, and the cumulative amount of such claims exceeds $20,000; or b) has at least two separate claims (building only, excluding contents losses) with cumulative claims exceeding the market value of the structure. For both a) and b), at least two of the referenced claims must have occurred within any ten-year period, and must be greater than ten days apart. The long-term goal of the SRL Program is to reduce or eliminate claims under the NFIP. The SRL Program will provide funding assistance for eligible flood mitigation projects which will result in the greatest savings to the National Flood Insurance Fund in the shortest period of time, based on a Benefit-Cost Ratio using FEMA approved Benefit Cost Analysis (BCA) software to conduct the BCA. Types of projects that could be funded under the SRL grant program are acquisitions, demolitions or relocation; elevation of existing structures; mitigation reconstruction, dry flood proofing; and minor localized flood reduction projects.

Description of Funding Considerations: FEMA has recently notified the TWDB that Federal Fiscal Year 2012 was opened starting June 1, 2011. There are considerable funds available. Applications will be reviewed and forwarded to FEMA in order to take advantage of these funds. This grant requires a 10-percent local match. There are no award limits associated with grant requests for the SRL program.

Consultation with the Property Owner: The consultation process is a required notification and information gathering process which is conducted by the applicant prior to the submittal of the application. The applicant will consult with the property owner on project activity types, estimated cost, and potential insurance implications. The applicant should be clear to the property owner that the consultation does not represent a formal offer of mitigation assistance. In addition, as part of the consultation process, each interested property owner should sign documentation of the Notice of Voluntary Participation which will be provided by the applicant as part of the application submittal.

Deadline, Review Criteria and Contact Person for Additional Information: Following the consultation process, the applicant is required to submit applications electronically through FEMA's web-based Electronic Grant Management System (eGrants). Applicants must request access into the eGrants system. Access requests should be directed to Kathy Hopkins at (512) 463-6198 or by e-mail to kathy.hopkins@twdb.state.tx.us. Deadline for submitting applications to the TWDB for SRL program grant funds is 5:00 p.m. Wednesday, October 12, 2011. Applications will be evaluated according to the federal rules and guidance. For additional information concerning the SRL program, current program guidance, and links to federal rules, go to http://www.twdb.state.tx.us/wrpi/flood/srl.asp and http://www.fema.gov/government/grant/srl/index.shtm. For additional information on FEMA's eGrant system, go to http://www.fema.gov/government/grant/hma/egrants.shtm. Final awards for grant funding will be approved by FEMA.

TRD-201102357

Kenneth Petersen
General Counsel
Texas Water Development Board
Filed: June 22, 2011

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Request for Applications for Planning and Project Grants Under the FEMA Flood Mitigation Assistance Program for Federal Fiscal Year 2012

The Texas Water Development Board (TWDB), as administrator of the Flood Mitigation Assistance (FMA) Program on behalf of the Federal Emergency Management Agency (FEMA), requests the submission of applications leading to the possible award of FMA Planning and Project grants from communities within the State with the legal authority to plan for and mitigate the impacts of flooding, and which participate in the National Flood Insurance Program (NFIP), in accordance with FEMA policy and regulation set forth in Title 44 of the Code of Federal Regulations (Part 79). A "community" is defined as (a) political subdivision, including any Indian tribe or authorized native organization, that has zoning and building code jurisdiction over a particular area having special flood hazards, and which is participating in the NFIP; or (b) a political subdivision or other authority that is designated by a political subdivision to develop and administer a mitigation plan. Eligible applicants from any area of the State may submit applications for FMA Program Planning and Project grants. Eligible applicants for FMA Project grants must have a FEMA approved Multi-Hazard Mitigation Plan.

Description of FMA Program Purpose and Objectives: The purpose of the FMA Program is to provide Planning and Project grants to communities. The overall goal of the program is to fund cost-effective measures that reduce or eliminate the long-term risk of flood damage to buildings, manufactured homes, and other NFIP-insurable structures. Specific goals include reducing the number of repetitively or substantially damaged structures and associated claims under the NFIP and encouraging long-term comprehensive mitigation planning. FMA Planning grants are used to develop or update the flood hazard component of the jurisdiction's Multi-Hazard Mitigation Plan, which must meet the planning requirements under the Code of Federal Regulations Title 44 §201.6. Types of FMA Projects grants are acquisitions, demolition or relocation; elevation of existing structures; dry flood proofing; and minor localized flood reduction projects. FMA Project grants will provide funding assistance for eligible flood mitigation projects based on a Benefit-Cost Ratio using FEMA approved Benefit Cost Analysis (BCA) software to conduct the BCA.

Description of Funding Considerations: The anticipated funding for Federal Fiscal Year 2012 will be approximately $250,000.00 for Planning grants and $3,200,000.00 for Project grants. These grants all require a 25 percent local match of which not more the one-half (12.5 percent) may be in the form of third party in-kind services. No award for a Planning grant may exceed $50,000, and no single community may receive more than one Planning grant per five-year period. In addition, there is a $3,300,000 limit for the total amounts of Project grant funds to any single community over a five year period, unless a waiver is approved by FEMA.

Deadline, Review Criteria and Contact Person for Additional Information: Applications must be submitted electronically through FEMA's web-based Electronic Grants Management System (eGrants). Applicant must request access into the eGrants system. Access request should be directed to Ivan Ortiz at (512) 463-8184, or by e-mail to ivan.ortiz@twdb.state.tx.us. Deadline for submitting application to the TWDB for FMA Planning and/or Project grant funds is 5:00 p.m., Wednesday, October 12, 2011. Applications will be evaluated according to the federal rules and guidance. For additional information on the FMA Program: http://www.twdb.state.tx.us/wrpi/flood/fma.asp or http://www.fema.gov/government/grant/fma/index.shtm. For additional information on the FEMA's eGrant system: http://www.fema.gov/government/grant/hma/egrants.shtm. Final awards for grant funding will be as approved by FEMA.

TRD-201102358
Kenneth Petersen
General Counsel
Texas Water Development Board
Filed: June 22, 2011

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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 36 (2011) is cited as follows: 36 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 "36 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 36 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)*