TEXAS REGISTER

IN THIS ISSUE

Volume 20, Number 71 September 19, 1995 *Page 7423-7541*

Correction

The *In This Issue* table of contents for the September 15, 1995, issue (Vol. 20, No. 70, Part II) was printed with the second and third pages out of order. The table of contents on the front cover is continued on the page which begins with "Small Employer Health Insurance Regulations".

Contents Continued Inside

Texas Register

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How to Use the Texas Register

Information Available: The 11 sections of the ***Texas Register*** represent various facets of state government Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

Attorney General - summaries of requests for opinions, opinions, and open records decisions.

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions

Emergency Rules- sections adopted by state agencies on an emergency basis.

Proposed Rules - sections proposed for adoption.

Withdrawn Rules - sections withdrawn by state agencies from consideration for adoption, or automatically withdrawn by the Texas Register six months after the proposal publication date.

Adopted Rules - sections adopted following a 30-day public comment period.

Tables and Graphics - graphic material from the proposed, emergency and adopted sections.

Open Meetings - notices of open meetings.

In Addition - miscellaneous information required to be published by statute or provided as a public service.

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 20 (1995) is cited as follows: 20 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 "20 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 20 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.

Texas Administrative Code

The ***Texas Administrative Code*** (***TAC***) is the official 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***. West Publishing Company, the official publisher of the ***TAC***, publishes on an annual basis.

The ***TAC*** volumes are arranged into Titles (using Arabic numerals) and Parts (using Roman numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency. The ***Official TAC*** also is available on WESTLAW, West's computerized legal research service, in the TX-ADC database.

To purchase printed volumes of the ***TAC*** or to inquire about WESTLAW access to the ***TAC*** call West: **1-800-328-9352.**

The Titles of the ***TAC***, and their respective Title numbers are:

1. Administration
4. Agriculture
7. Banking and Securities
10. Community Development
13. Cultural Resources
16. Economic Regulation
19. Education
22. Examining Boards
25. Health Services
28. Insurance
30. Environmental Quality
31. Natural Resources and Conservation
34. Public Finance
37. Public Safety and Corrections
40. Social Services and Assistance
43. Transportation

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15:

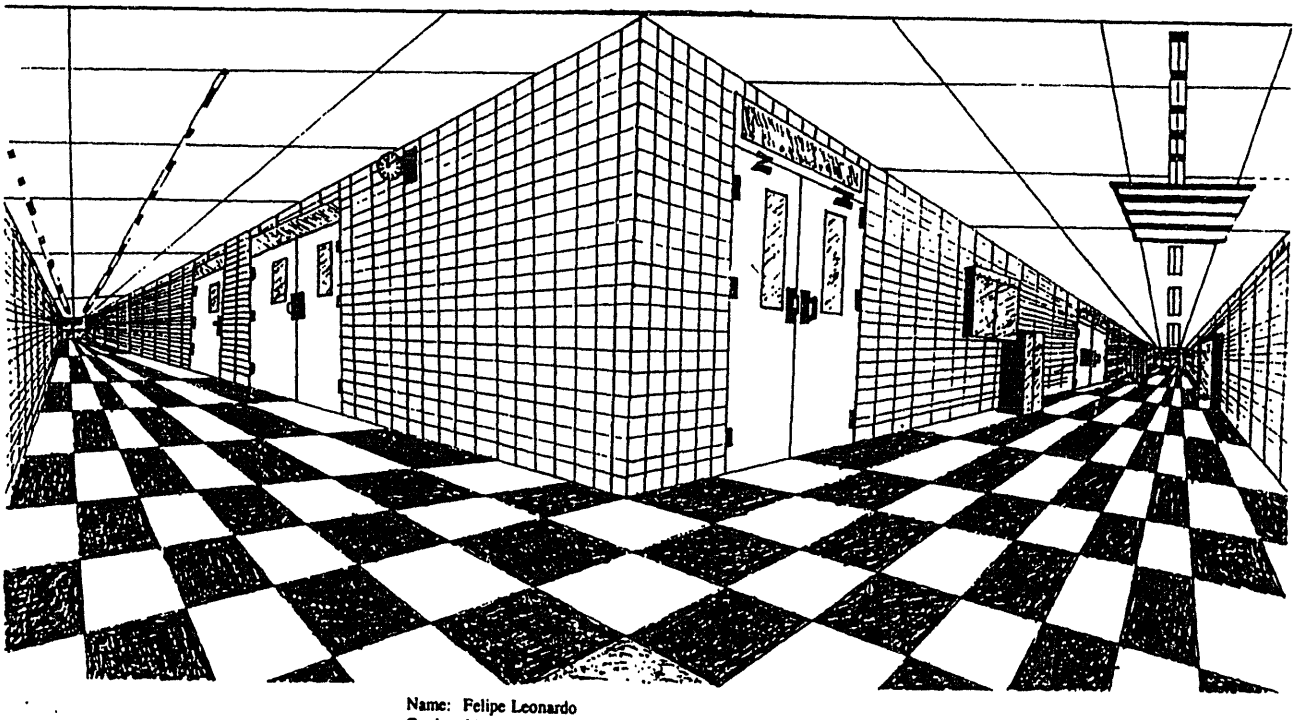
1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 21, April 15, July 12, and October 11, 1994). In its second issue each month the ***Texas Register*** contains a cumulative ***Table of TAC Titles Affected*** for the preceding month. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

TITLE 40. SOCIAL SERVICES AND ASSISTANCE
Part I. Texas Department of Human Services
40 TAC §3.704.....950, 1820

The ***Table of TAC Titles Affected*** is cumulative for each volume of the ***Texas Register*** (calendar year).

Update by FAX: An up-to-date ***Table of TAC Titles Affected*** is available by FAX upon request. Please specify the state agency and the TAC number(s) you wish to update. This service is free to ***Texas Register*** subscribers. Please have your subscription number ready when you make your request. For non-subscribers there will be a fee of $2.00 per page (VISA, MasterCard). (512) 463-5561.



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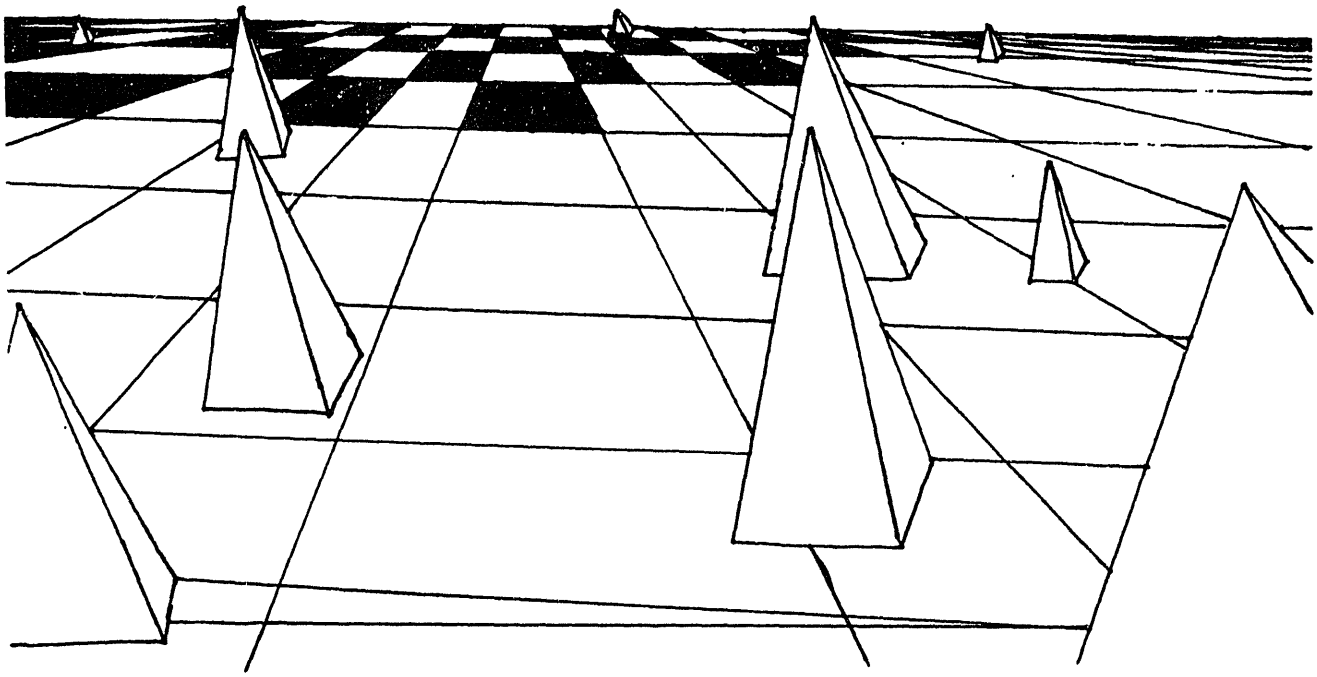

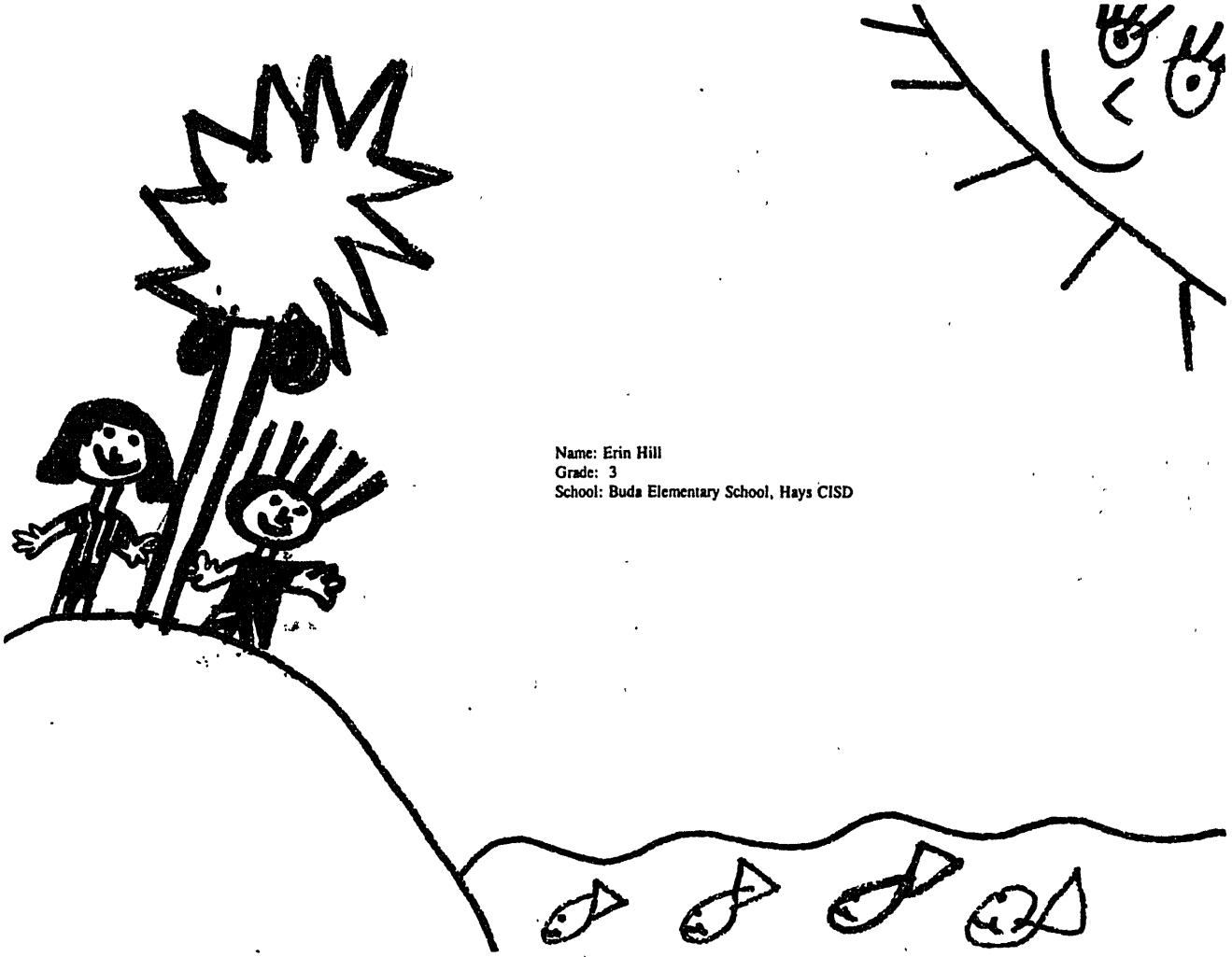

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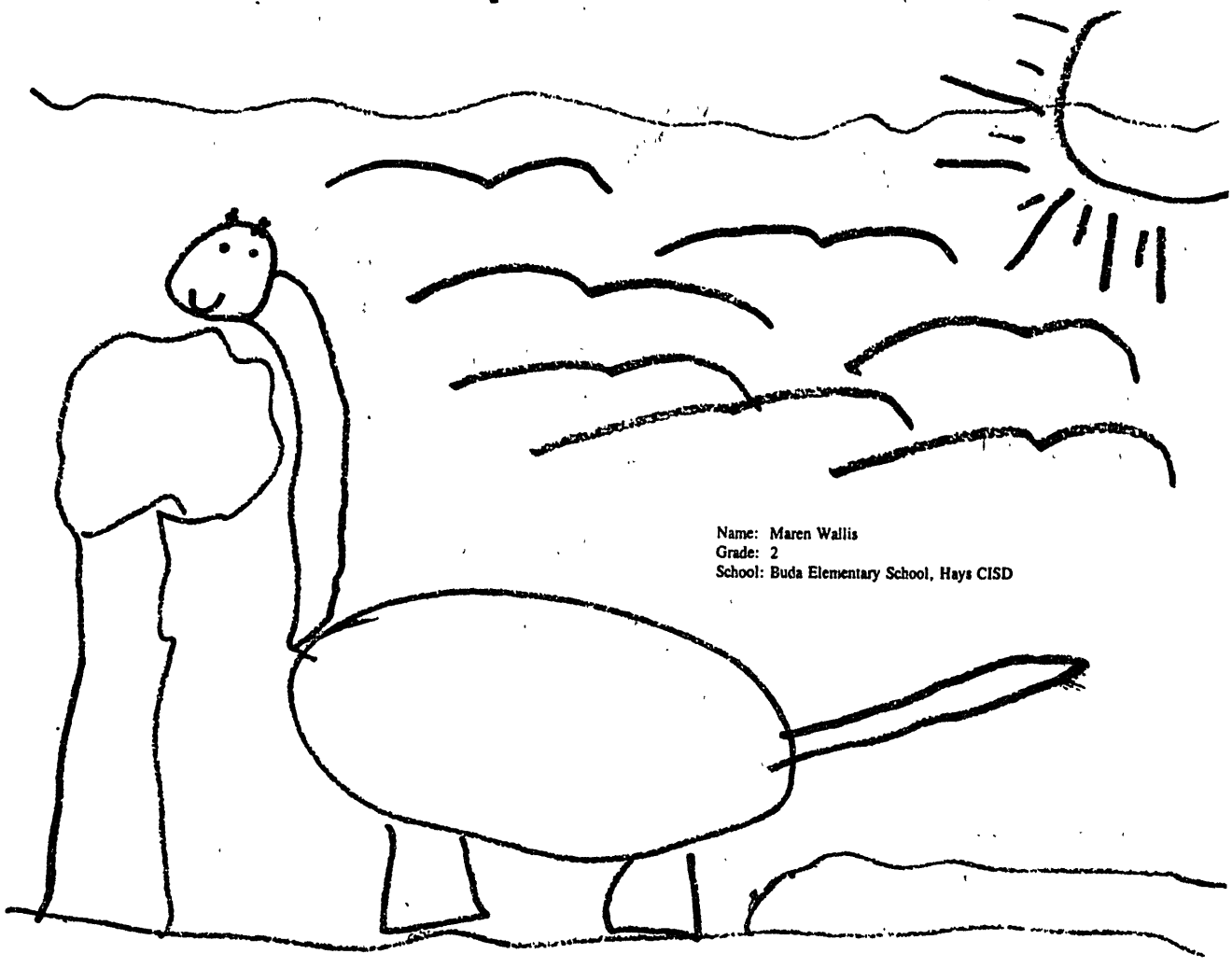

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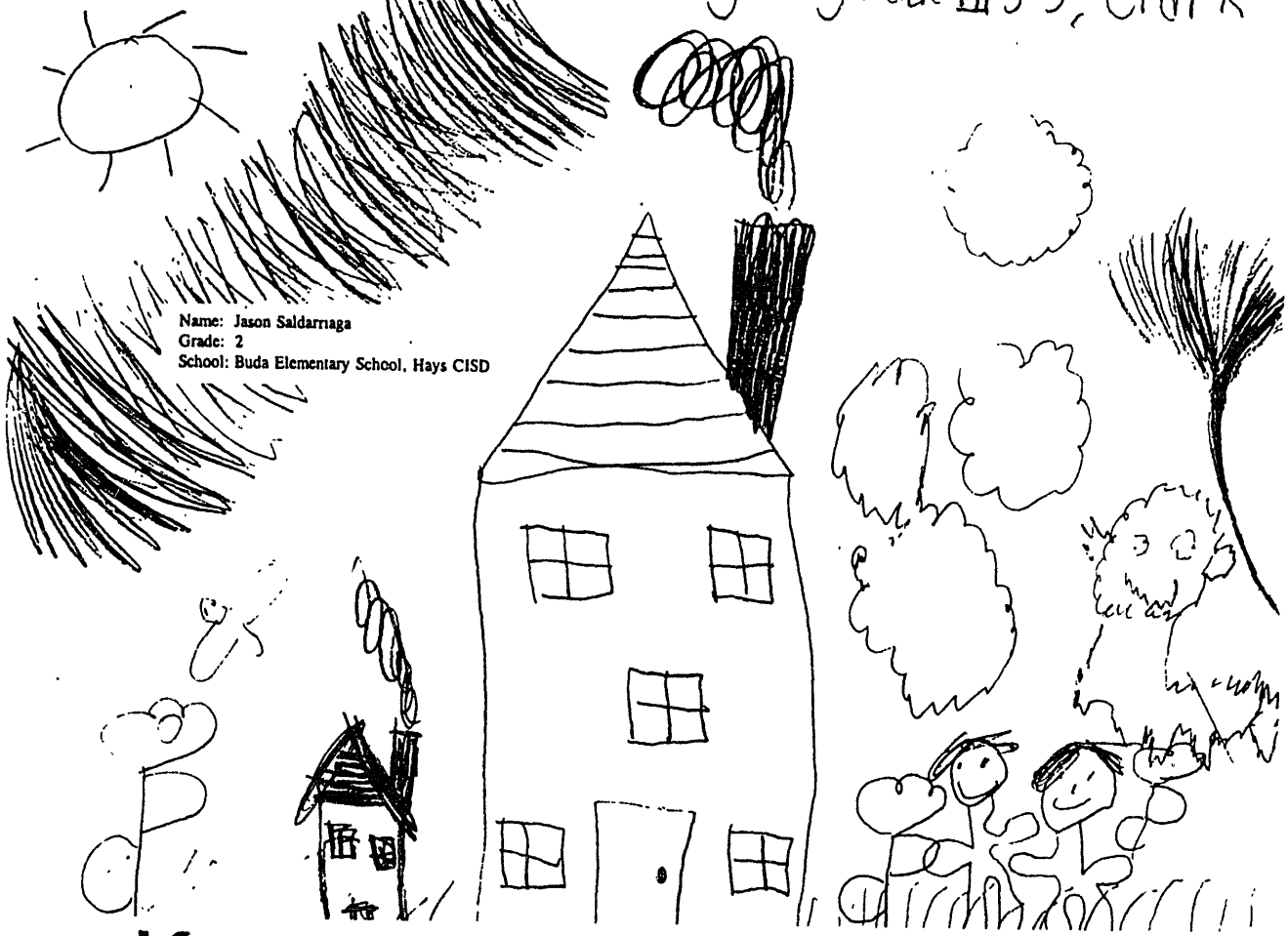

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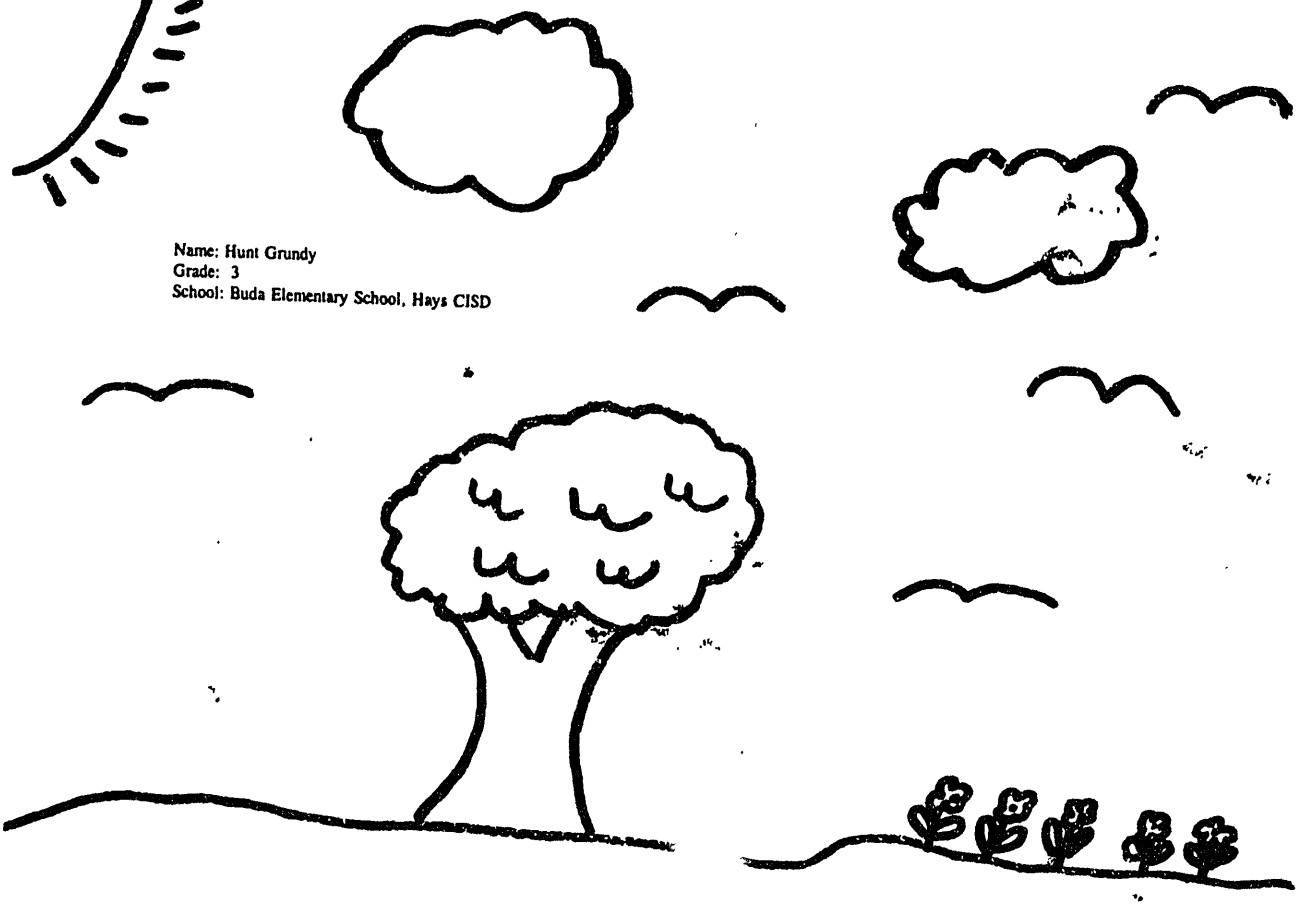

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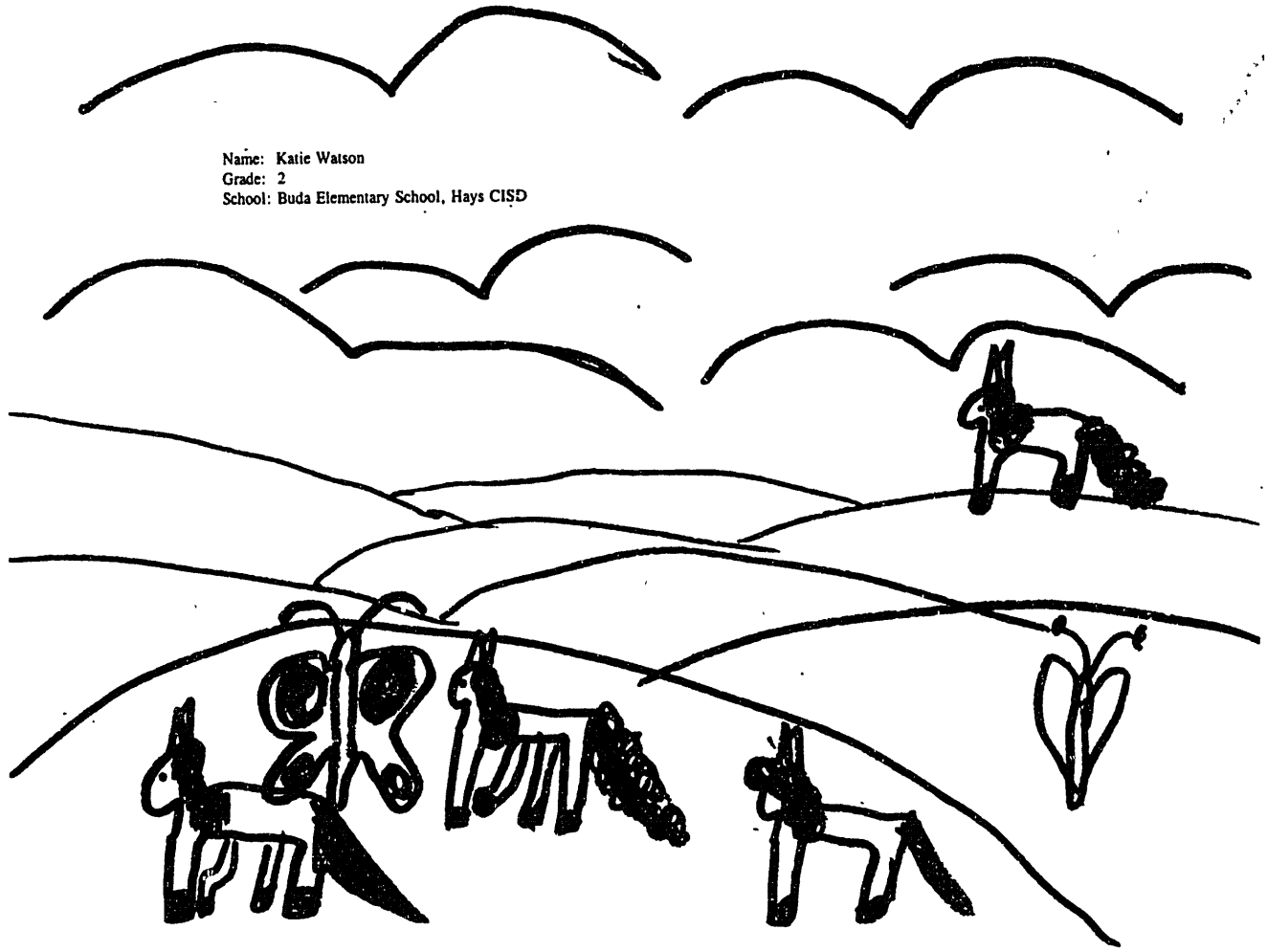

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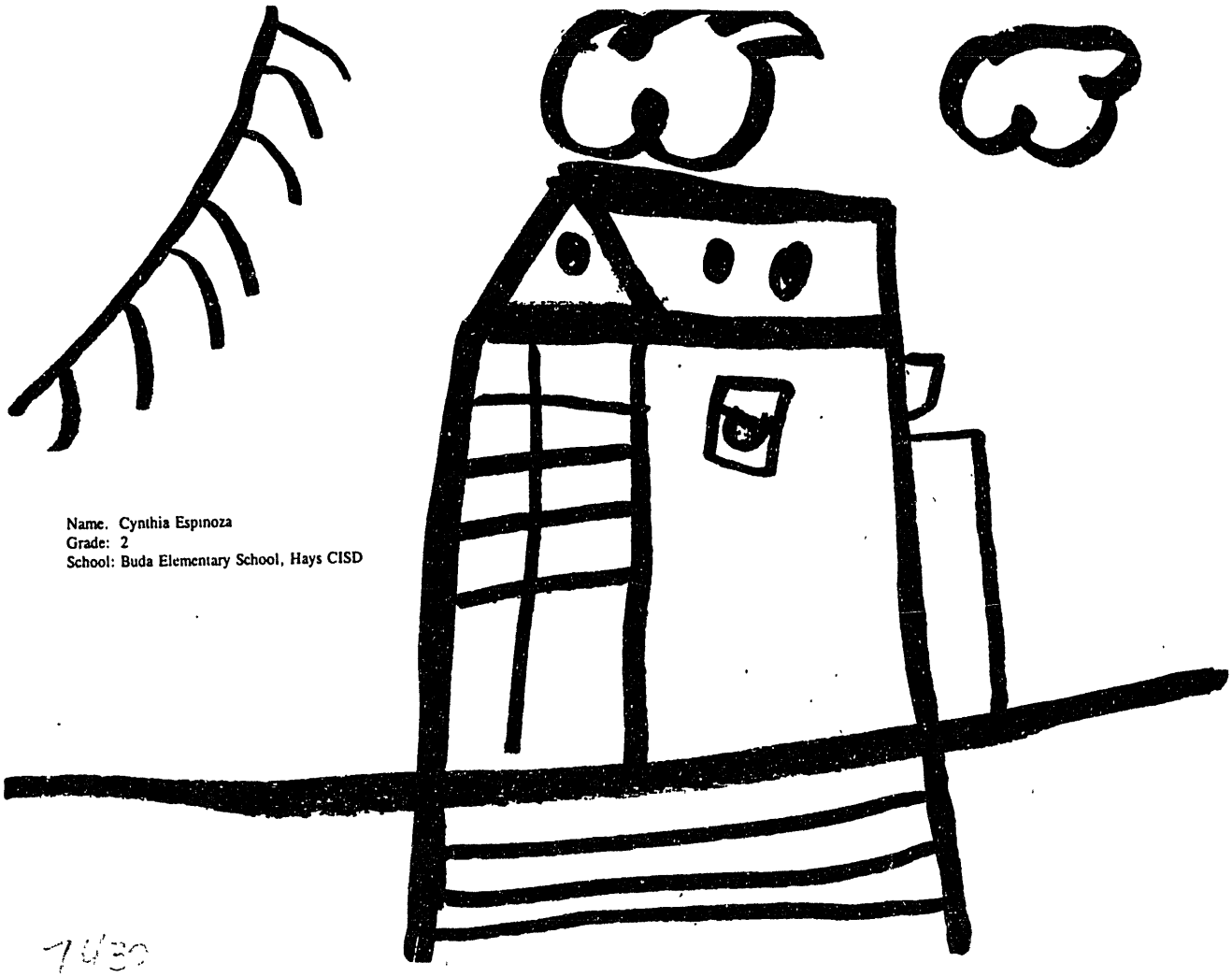

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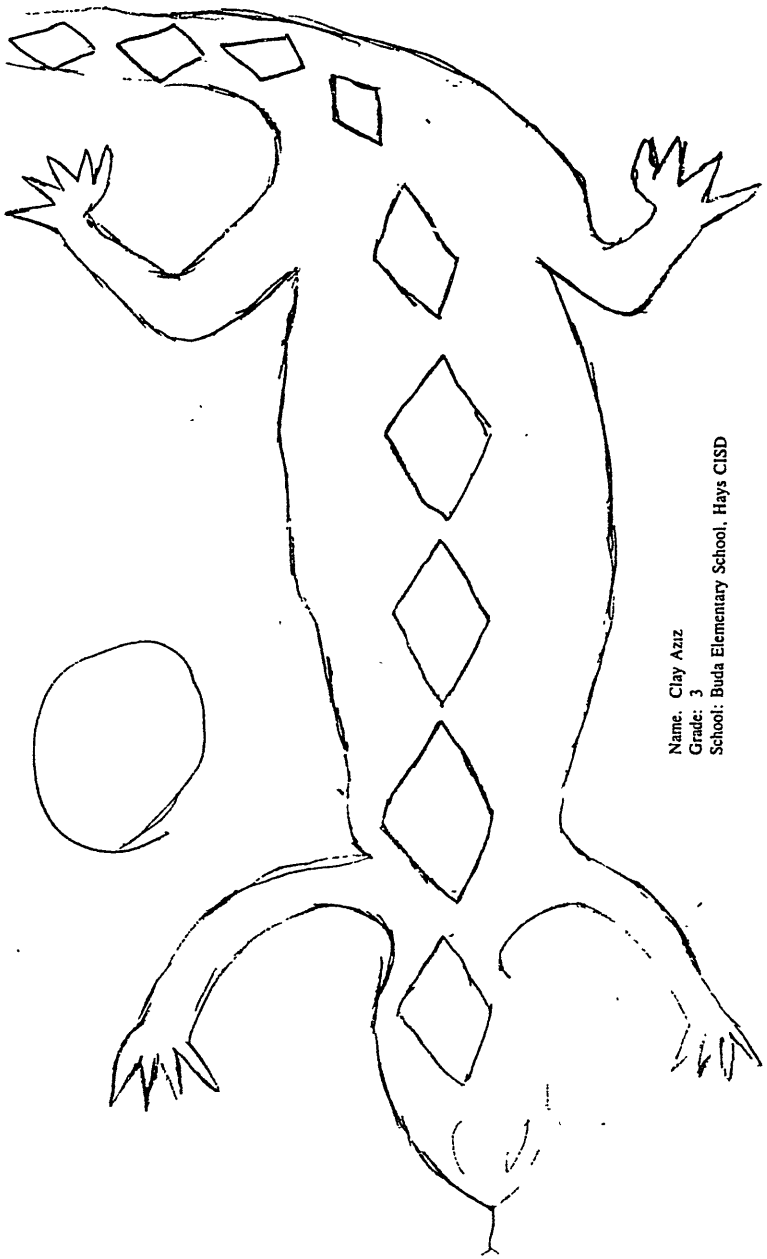

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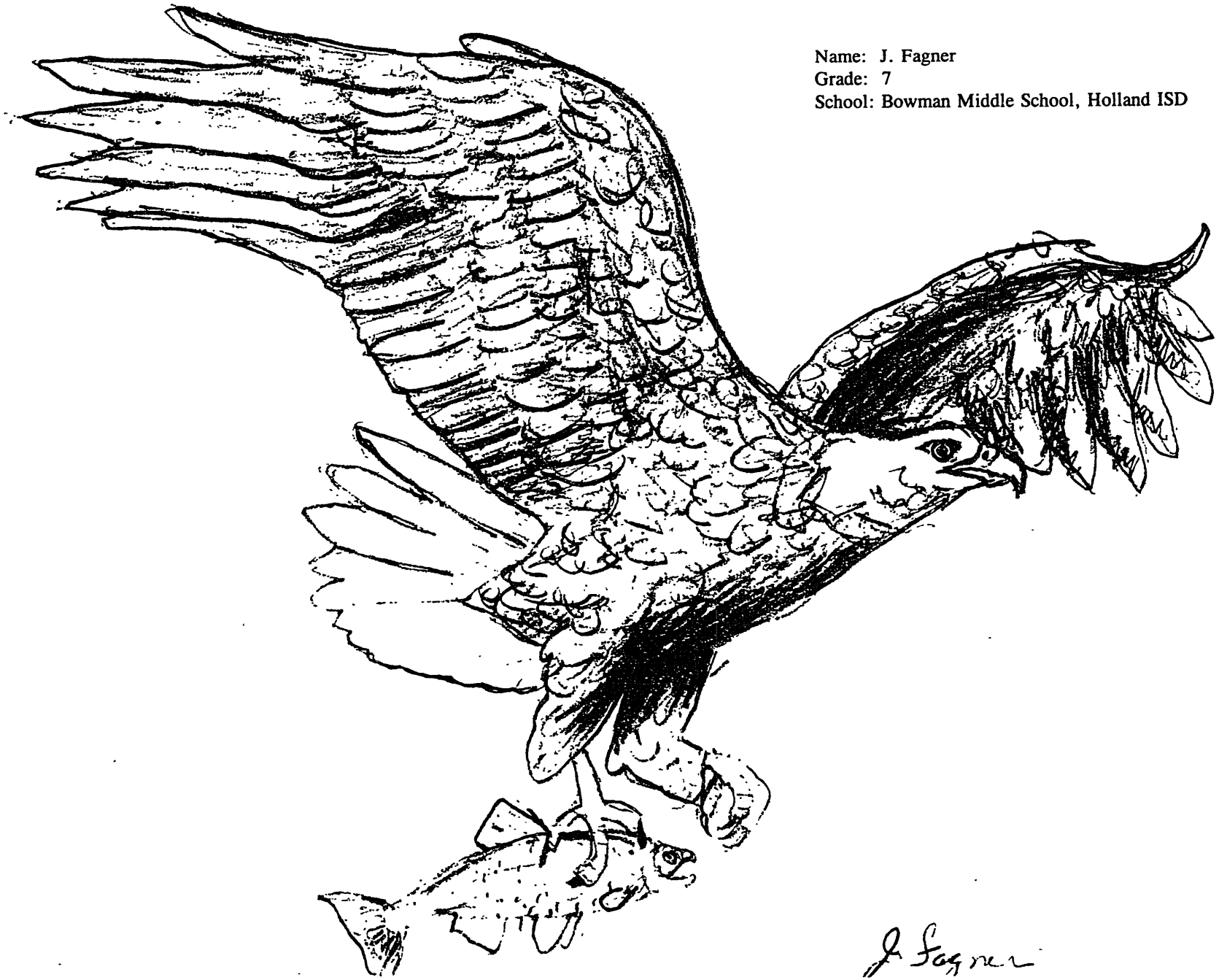

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EMERGENCY RULES

An agency may adopt a new or amended section or repeal an existing section on an emergency basis if it determines that such action is necessary for the public health, safety, or welfare of this state. The section may become effective immediately upon filing with the ***Texas Register***, or on a stated date less than 20 days after filing and remaining in effect no more than 120 days. The emergency action is renewable once for no more than 60 additional days.

Symbology in amended emergency sections. New language added to an existing section is indicated by the use of **bold text.** [Brackets] indicate deletion of existing material within a section.

TITLE 22. EXAMINING BOARDS

Part IX. Texas State Board of Medical Examiners

Chapter 193. Standing Delegation Orders

• 22 TAC §§193.2-193.4, 193.8

The Texas State Board of Medical Examiners adopts on an emergency basis amendments to §§193.2-193.4 and 193.8, concerning standing delegation orders. These amendments will comply with changes made during the 74th Legislature through Senate Bill 1302 and Senate Bill 673.

The amendments are adopted on an emergency basis under the Medical Practice Act, Texas Civil Statutes, Article 4495b, §2.09(a), which provide the Texas State Board of Medical Examiners with the authority to make rules, regulations and bylaws not inconsistent with this Act as may be necessary for the governing of its own proceedings, the performance of its duties, the regulation of the practice of medicine in this state, and the enforcement of this Act. In addition, this emergency rule is authorized by the Administrative Procedure Act, Texas Government Code, §2001.034.

Reason for emergency-Since the changes made through Senate Bill 1302 and Senate Bill 673 regarding the delegation of prescriptive privileges were effective in June, 1995, and because these changes will have a profound effect on healthcare in Texas, it was felt necessary that these amendments should be adopted on an emergency basis to provide guidance to physicians in this area.

Article 4495b, §3.06, is affected by this amendment.

§193.2. Definitions. The following words and terms, when used in this chapter, shall have the following meanings, unless the contents clearly indicate otherwise.

Advanced practice nurse-A registered nurse approved by the Texas State Board of Nurse Examiners to practice as an advanced practice nurse on the basis of completion of an advanced educational program. The term includes a nurse practitioner, a nurse midwife, nurse anesthetist, and clinical nurse specialist.

Authorizing physician-A physician or physicians licensed by the board who execute a standing delegation order.

Carrying out or **signing** a prescription drug order-To complete a prescription drug order presigned by the delegating physician, **or the signing of a prescription by an advanced practice nurse or physician assistant after the person has been designated with the board by the delegating physician as a person delegated to sign a prescription. The following information shall be provided on each prescription:** [by providing the following information:] the patient's name and address; the drug to be dispensed; directions to the patient for taking the drug; dosage; **the intended use of the drug, if appropriate;** the name, address, and telephone number of the physician; the name, address, telephone number, identification number, and signature of the physician assistant or **advanced practice** [registered] nurse completing or **signing** the prescription drug order; the date; and the number of refills permitted. **This also includes the ability of a physician assistant or advanced practice nurse to telephone prescriptions in to a pharmacy under their prescriptive authority.**

Dangerous drug-A device or a drug that is unsafe for self medication and that is not included in the Texas Health and Safety Code, Schedules I-V or Penalty Groups I-IV of Chapter 481 (Texas Controlled Substances Act). The term includes a device or a drug that bears or is required to bear the legend: "Caution: federal law prohibits dispensing without prescription".

Health **professional** [manpower] shortage area **(HPSA)** [(HMSA)]-

(A) An area in an urban or rural area of Texas (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the secretary of health and human services determines has a health manpower shortage and which is not reasonably accessible to an adequately served area;

(B) a population group which the secretary determines to have such a shortage; or

(C) a public or nonprofit private medical facility or other facility which the secretary determines has such a shortage as delineated in 42 U.S.C. §254(e)(a)(1). [An area, population group, or facility designated by the United States Department of health and Human Services (USDHHS) as having a shortage of primary care physicians.]

Medically underserved area (MUA)-An area or population group designated by the USDHHS as an area with a shortage of personal health services. **Also includes an area defined by rule adopted by the Texas Board of Health that is based on demographics specific to this state, geographic factors that affect access to health care, and environmental health factors.**

Physician Assistant-A person who has graduated from a physician assistant or surgeon assistant training program accredited by the American Medical Association's Commission on Accreditation of Allied Health Education Programs and who has passed the certifying examination administered by the National Commission on Certification of Physician Assistants and who is licensed as a physician assistant by the Texas State Board of Physician Assistant Examiners.

Physician's orders-The instructions of a physician for the care of an individual patient.

Protocols-Standing delegation orders or standing medical orders authorizing a physician assistant or **advanced practice** [registered] nurse to carry out prescription drug orders pursuant to the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) and (6) and §193.8 of this title **relating to the Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician assistants and Advanced Practice Nurses)** [(relating to Delegation of the Carrying Out of Prescription Drug Orders to Physician Assistants

and Registered Nurses)] agreed upon and signed by the physician, the physician assistant and/or **advanced practice** [registered] nurse which are reviewed and signed at least annually, are maintained at the site serving a medically underserved population, and contain a list of **the types or categories** of dangerous drugs available for prescription, limitations on the number of dosage units and refills permitted, and instructions to be given the patient for follow-up monitoring or **contain a list of dangerous drugs that may not be prescribed. Protocols shall be defined to promote the exercise of professional judgment by the advanced practice nurse and physician assistant commensurate with the ireducation and experience. The protocols used by a reasonable and prudent physician exercising sound medical judgment need not describe the exact steps that an advanced practice nurse or a physician assistant must take with respect to each specific condition, disease, or symptom.**

Site serving a medically underserved population–A site located in a medically underserved area; a site located in a health manpower shortage area; a rural health clinic designated under Public Law 95-210, the Rural Health Clinic Services Act of 1977; a public health clinic or a family planning clinic operating under contract with the Texas Department of Human Services or the Texas Department of Health; a site located in an area in which there exists an insufficient number of physicians providing services to eligible clients of federal, state, or locally funded health care programs, as determined by the Texas Department of Health; or a site that serves a disproportionate number of clients eligible to participate in federal, state, or locally funded health care programs, as determined by the Texas Department of Health.

Standing delegation order–Written instructions, orders, rules, regulations, or procedures prepared by a physician and designed for a patient population with specific diseases, disorders, health problems, or sets of symptoms. Such written instructions, orders, rules, regulations or procedures shall delineate under what set of conditions and circumstances action should be instituted. These instructions, orders, rules, regulations or procedures are to provide authority for and a plan for use with patients presenting themselves prior to being examined or evaluated by a physician to assure that such acts are carried out correctly and are distinct from specific orders written for a particular patient, and shall be limited in scope of authority to be delegated as provided in §193.4 of this title (relating to Scope of Standing Delegation Orders). As used in this chapter, standing delegation orders do not refer to treatment programs ordered by a physician following examination or evaluation by a physician, nor to established procedures for providing of care by personnel under direct, personal supervision of a physician who is directly supervising or overseeing the delivery of medical or health care. Such standing delegation orders should be developed and approved by the physician who is responsible for the delivery of medical care covered by the orders. Such standing delegation orders, at a minimum, should:

(A) include a written description of the method used in developing and approving them and any revision thereof;

(B) be in writing, dated, and signed by the physician;

(C) specify which acts require a particular level of training or licensure and under what circumstances they are to be performed;

(D) state specific requirements which are to be followed by persons acting under same in performing particular functions;

(E) specify any experience, training, and/or education requirements for those persons who shall perform such orders;

(F) establish a method for initial and continuing evaluation of the competence of those authorized to perform same;

(G) provide for a method of maintaining a written record of those persons authorized to perform same;

(H) specify the scope of supervision required for performance of same, for example, immediate supervision of a physician;

(I) set forth any specialized circumstances under which a person performing same is to immediately communicate with the patient's physician concerning the patient's condition;

(J) state limitations on setting, if any, in which the plan is to be performed;

(K) specify patient record-keeping requirements which shall, at a minimum, provide for accurate and detailed information regarding each patient visit; personnel involved in treatment and evaluation on each visit; drugs, or medications administered, prescribed or provided; and such other information which is routinely noted on patient charts and files by physicians in their offices; and

(L) provide for a method of periodic review, which shall beat least annually, of such plan including the effective date of initiation and the date of termination of the plan after which date the physician shall issue a new plan.

Standing medical orders–Orders, rules, regulations or procedures prepared by a physician or approved by a physician or the medical staff of an institution for patients which have been examined or evaluated by a physician and which are used as a guide in preparation for and carrying out medical or surgical procedures or both. These orders, rules, regulations or procedures are authority and direction for the performance for certain prescribed acts for patients by authorized persons as distinguished from specific orders written for a particular patient.

§193.3. Exclusion from the Provisions of this Chapter. The provisions of this chapter shall not be applicable, nor shall they restrict the use of pre-established programs of health care, nor shall they restrict physicians from authorizing the provision of patient care by use of pre-established programs under the following circumstances:

(1)-(7) (No change.)

(8) Where care is to be delivered as authorized by the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) or (6) except as provided in §193.8 of this title **(relating to the Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses)** [(relating to Delegation of the Carrying Out of Prescription Drug Orders to Physician Assistants and Registered Nurses)].

§193.4. Scope of Standing Delegation Orders. Providing the authorizing physician is satisfied as to the ability and competence of those for whom the physician is assuming responsibility, and with due regard for the safety of the patient and in keeping with sound medical practice, standing delegation orders may be authorized for the performance of acts and duties which do not require the exercise of independent medical judgment. Limitations on the physician's use of standing delegation orders which are stated in this section shall not apply to patient care delivered as authorized by the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) **or (6)**, or §193.8 of this title **(relating to Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and**

Advanced Practice Nurses [(relating to Delegated Delivery of Health Care)]. When care is delivered under other circumstances, standing delegation orders may include authority to undertake the following:

(1) (No change.)

(2) The performance of **an** appropriate physical examination and the recording of physical findings.

(3)-(8) (No change.)

§193.8. Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice [Registered] Nurses.

(a) **Purpose. The purpose of this section is to provide guidelines for implementation of the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) and (6)** , which provide[s] for the use by physicians of standing delegation orders, standing medical orders, physician's order, or other orders or protocols in delegating authority to physician assistants or **advanced practice** [registered] nurses at sites serving medically underserved populations, **at a physician's primary practice site, or at a site described in subsection (j) of this section.** For purposes of this section, the term **"advanced practice"** [registered] nurse means a licensee of the Texas Board of Nurse Examiners who is approved to carry out a prescription drug order by that board. **For purposes of this section, the term "physician assistant" means a licensee of the Texas State Board of Physician Assistants Examiners.** In accord with Texas Civil Statutes, Article 4495b, §3.06(d)(5) **and (6)** , this section establishes minimum standards for supervision by physicians of physician assistants and **advanced practice** [registered] nurses for provision of services at such sites. This section also provides for **the signing of a prescription by an advanced practice nurse or a physician assistant after the person has been designated by the delegating physician and for** the use of prescriptions presigned by the supervising physician which may be carried out by a physician assistant or **advanced practice** [registered] nurse according to protocols. [At sites serving medically underserved populations, such] **Such** protocols may authorize diagnosis of the patient's condition and treatment, including prescription of dangerous drugs. Proper use of protocols requires integration of clinical data gathered by the physician assistant or **advanced practice** [registered] nurse by means of the supervising physician's pre-existing written plan for determining a diagnosis and appropriate treatment. Neither the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) **or (6)**, nor these rules authorize the exercise of independent medical judgment by physician assistants or **advanced practice** [registered] nurses, and the supervising physician remains responsible to the board and to his or her patients for acts performed under the physician's delegated authority. **Advanced practice nurses** [Registered nurses] **and physician assistants** remain professionally responsible for acts performed under the scope and authority of their own licenses.

(b) **Physician Supervision at Site Serving Medically Underserved Populations.** Physician supervision of a physician assistant or **advanced practice** [registered] nurse at a site serving a medically underserved population will be adequate if a delegating physician:

(1) receives a daily status report to be conveyed in person, by telephone, or by radio from the **advanced practice** [registered] nurse or physician assistant on any complications or problems encountered that are not covered by a protocol;

(2) visits the clinic in person at least once a week during regular business hours to observe and to provide medical direction and consultation to include, but not be limited to:

(A) reviewing with the physician assistant or **advanced practice** [registered] nurse case histories of patients with problems or complications **encountered** [not covered by a protocol];

(B)-(C) (No change.)

(3) is available by telephone or direct telecommunication for consultation, assistance with medical emergencies, or patient referrals [at all times the clinic is open].

(4) is responsible for the formulation of approval of such physician's orders, standing medical orders, standing delegation orders, or other orders or protocols and periodically reviews such orders and the services provided patients under such orders.

(c) **Documentation of Supervision.** Physician supervision shall be documented through a log kept at the clinic that includes the names or identification numbers of patients discussed during the daily status reports, the times when the physician is on site, and a summary of what the physician did while on site. Said summary shall include a description of the quality assurance activities conducted and the names of any patients seen or whose case histories were reviewed with the physician assistant or **advanced practice** [registered] nurse. The supervising physician shall sign each log at the conclusion of each site visit.

(d) **Alternate Physicians.** If a delegating physician will be unavailable to supervise the physician assistant or **advanced practice** [registered] nurse as required by this section, arrangements shall be made for another physician to provide that supervision. The physician providing that supervision shall affirm in writing that he or she is familiar with the protocols or standing delegation orders in use at the clinic and is accountable for adequately supervising care provided pursuant to those protocols or standing delegation orders **by fulfilling the requirements for registration as an alternate supervising physician as detailed in rules of the Texas State Board of Physician Examiners, 22 Texas Administrative Code, §185.**

(e) **Supervision of Clinics.** A physician may not supervise more than three clinics without approval of the board. A physician may not supervise any number of clinics with combined regular business hours exceeding **150** [80] hours per week without approval of the board **and with no supervision of a single clinic exceeding 50 hours per week.**

(f) **Exceptions to Patient Chart Review.** Exceptions to the percentage of patient chart reviews required by subsection (b)(2)(C) of this section and the provisions of subsection (e) of this section relating to the number of clinics or clinic hours supervised may be made by the board upon special request by a delegating physician. Such a request shall state the special circumstances and needs prompting the exception, the names and locations of the clinics and/or hours to be supervised, and a plan of supervision. In granting an exception, the board shall state the percentage of charts that must be reviewed and/or the number of clinics or the combined clinic hours that can be supervised.

(g) **Delegation of Prescriptive Authority.** A physician may **designate to** [authorize] a physician assistant or **advanced practice nurse** [registered nurse to complete and issue prescriptions presigned] **the act or acts of administering, providing, or carrying out or signing a prescription drug order as authorized** by the physician **through physician's orders, standing medical orders, standing delegation orders, or other orders or protocols as defined by the board** in treating patients at a site serving a medically underserved population. The prescription form itself shall comply with applicable rules adopted by the Texas State Board of Pharmacy. **Prescriptions** [Presigned Prescriptions] issued pursuant to this section may only be written for dangerous drugs. No prescriptions for controlled substances may be authorized or issued. **An appropriate** [A physician's] signature on one of the two signature lines on the prescription shall convey [his or her] instructions to a pharmacist regarding the pharmacist's authority to dispense a generically equivalent drug, if available. **If the physician assistant or ad-**

vanced practice nurse [a physician proposes to] authorizes generic substitution, the protocol shall provide direction to the physician assistant or advanced practice [registered] nurse as to whether and under what circumstances product selection will be permitted by a pharmacist. A delegating physician is responsible for devising and enforcing a system to account for and monitor the issuance of prescriptions under his supervision [use of presigned prescriptions].

(h) Violations. Violation of this section by the supervising physician may result in a refusal to approve supervision or cancellation of the physician's authority to supervise a physician assistant or advanced practice [registered] nurse under this section. Violation of this section may also subject the physician to disciplinary action as provided by the Medical Practice Act, Texas Civil Statutes, Article 4495b, §4.12 for violation of that Act, §3.08. If an advanced practice nurse [a registered nurse] violates this section or the Medical Practice Act, Texas Civil Statutes, Article 4495b,§3.06(d)(5) or (6) , the board shall promptly notify the Texas Board of Nurse Examiners of the alleged violation. **If a physician assistant violates this section or the Medical Practice Act, Texas Civil Statutes, Article 4495b, §3.06(d)(5) or (6), the board shall promptly notify the Texas State Board of Physician Assistant Examiners. [The board may refuse to approve or may revoke its approval for a physician to supervise a physician assistant who has violated this section.]**

(i) Delegation at Primary Practice Site. At a physician's primary practice site or a location as described by subsection (j) of this section, a physician licensed by the board may delegate to a physician assistant or an advanced practice nurse acting under adequate physician supervision the act or acts of administering, providing, carrying out or signing a prescription drug order as authorized through physician's orders, standing medical orders, standing delegation orders, or others or protocols as defined by the board. Providing and carrying out or signing a prescription drug order under this subdivision is limited to dangerous drugs and shall comply with other applicable laws. Physician supervision of the carrying out and signing of prescription drug orders shall conform to what a reasonable, prudent physician would find consistent with sound medical judgment but may vary with the education and experience of the advanced practice nurse or physician assistant. A physician shall provide continuous supervision, but the constant physical presence of the physician is not required.

(1) A physician's authority to delegate the carrying out or signing of a prescription drug order at his primary practice site under this section is limited to:

(A) three physician assistants or advanced practice nurses or their full-time equivalents practicing at the physician's primary practice site; and

(B) the patients with whom the physician has established or will establish a physician-patient relationship, but this shall not be construed as requiring the physician to see the patient within a specific period of time.

(2) "Primary practice site" means:

(A) the practice location where the physician spends the majority of the physician's time;

(B) a licensed hospital, a licensed long-term care facility, and a licensed adult care center where both the physician and the physician assistant or advanced practice nurse are authorized to practice, or an established patient's residence; or

(C) where the physician is physically present with the physician assistant or advanced practice nurse.

(j) Delegation at Facility-Based Practice. A physician licensed by the board shall be authorized to delegate, to one or more physician assistants or advanced practice nurses acting under adequate physician supervision whose practice is facility based at a licensed hospital or licensed long-term care facility, the carrying out or signing of prescription drug orders if the physician is the medical director or chief of medical staff of the facility in which the physician assistant or advanced practice nurse practices, the chair of the facility's credentialing committee, a department chair of a facility department in which the physician assistant or advanced practice nurse practices, or a physician who consents to the request of the medical director or chief of medical staff to delegate the carrying out or signing of prescription drug orders at the facility in which the physician assistant or advanced practice nurse practices. A physician's authority to delegate under this paragraph is limited as follows:

(1) the delegation is pursuant to a physician's order, standing medical order, standing delegation order, or other order or protocol developed in accordance with policies approved by the facility's medical staff or a committee thereof as provided in facility bylaws;

(2) the delegation occurs in the facility in which the physician is the medical director, the chief of medical staff, the chair of the credentialing committee, or a department chair;

(3) the delegation does not permit the carrying out or signing of prescription drug orders for the care or treatment of the patients of any other physician without the prior consent of that physician;

(4) delegation in a long-term care facility must be by the medical director and the medical director is limited to delegating the carrying out and signing of prescription drug orders to no more than three advanced practice nurses or physician assistants or their full-time equivalents; and

(5) under this section, a physician may not delegate at more than one licensed hospital or more than two long-term care facilities unless approved by the board.

(k) Delegation to Certified Registered Nurse Anesthetists.

(1) In a licensed hospital or ambulatory surgical center a physician may delegate to a certified registered nurse anesthetist the ordering of drugs and devices necessary for a certified registered nurse anesthetist to administer an anesthetic or an anesthesia-related service ordered by the physician. The physician's order for anesthesia or anesthesia-related services does not have to be drug-specific, dose-specific, or administration-technique-specific. Pursuant to the order and in accordance with facility policies or medical staff bylaws, the nurse anesthetist may select, obtain, and administer those drugs and apply the appropriate medical devices necessary to accomplish the order and maintain the patient within a sound physiological status.

(2) This paragraph shall be liberally construed to permit the full use of safe and effective medication orders to utilize the skills and services of certified registered nurse anesthetists.

(l) Delegation Related to Obstetrical Services.

(1) A physician may delegate to a physician assistant offering obstetrical services and certified by the board as specializing in obstetrics or an advanced practice nurse recognized by the Texas State Board of Nurse Examiners as a nurse midwife the act or acts of administering or providing controlled substances to the nurse midwife's or physician assistant's clients during intrapartum and immediate post-partum care. The physician shall not delegate the use or issuance of a triplicate prescription form under the triplicate prescription program, §481.075, Health and Safety Code.

(2) The delegation of authority to administer or provide controlled substances under this paragraph must be under a physician's order, medical order, standing delegation order, or protocol which shall

require adequate and documented availability for access to medical care.

(3) The physician's orders, medical orders, standing delegation orders, or protocols shall provide for reporting or monitoring of client's progress including complications of pregnancy and delivery and the administration and provision of controlled substances by the nurse midwife or physician assistant to the clients of the nurse midwife or physician assistant.

(4) The authority of a physician to delegate under this paragraph is limited to:

(A) three nurse midwives or physician assistants or their full-time equivalents; and

(B) the designated facility at which the nurse midwife or physician assistant provides care.

(5) The administering or providing of controlled substances under this paragraph shall comply with other applicable laws.

(6) In this paragraph, "provide" means to supply one or more unit doses of a controlled substance for the immediate needs of a patient not to exceed 48 hours.

(7) The controlled substance shall be supplied in a suitable container that has been labeled in compliance with the applicable drug laws and shall include the patient's name and address; the drug to be provided; the name, address, and telephone number of the physician; the name, address, and telephone number of the nurse midwife or physician assistant; and the date.

(8) This paragraph does not permit the physician or nurse midwife or physician assistant to operate a retail pharmacy as defined under the Texas Pharmacy Act (Texas Civil Statutes, Article 4542a-1).

(9) This paragraph shall be construed to provide a physician the authority to delegate the act or acts of administering or providing controlled substances to a nurse midwife or physician assistant but not as requiring physician delegation of further acts to a nurse midwife or as requiring physician delegation of the administration of medications to registered nurses or physician assistants other than as provided in this paragraph.

(m) Liability. A physician shall not be liable for the actor acts of a physician assistant or advanced practice nurse solely on the basis of having signed an order, a standing medical order, a standing delegation order, or other order or protocols authorizing a physician assistant or advanced practice nurse to perform the act or acts of administering, providing, carrying out, or signing a prescription drug order unless the physician has reason to believe the physician assistant or advanced practice nurse lacked the competency to perform the act or acts.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511719

Bruce A. Levy, M.D., J D.
Executive Director
Texas State Board of
Medical Examiners

Effective date: September 13, 1995

Expiration date: January 11, 1995

For further information, please call: (512) 834-7728

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PROPOSED RULES

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

Symbology in proposed amendments. New language added to an existing section is indicated by the use of **bold text.** [Brackets] indicate deletion of existing material within a section.

TITLE 4. AGRICULTURE

Part II. Texas Animal Health Commission

Chapter 43. Tuberculosis

Subchapter A. Cattle

• 30 TAC §43.2

The Texas Animal Health Commission proposes an amendment to Chapter 43, Tuberculosis, by amending section, §43.2, interstate movement requirements.

The proposed amendment is necessary to provide a method by which steers and spayed heifers from Mexican states that have not implemented the initial phase of the Tuberculosis Eradication Program can move into Texas. These cattle may: (1) move to an approved Mexican state within 12 months of a whole herd test and be retested there no earlier than 60 days after the previous test; or (2) move to an approved Mexican state with a negative tuberculosis test within 60 days of movement, and be tested no earlier than 120 days after entering the approved state. This requirement will allow the importation of steers and spayed heifers from unapproved Mexican states while offering protection against tuberculosis.

Victor Gonzalez, Assistant Executive Director for Support Services, has determined that for the first five-year period the section is in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Robert L. Daniel, Director of Program Records, has determined that the public benefit anticipated is to provide a method for allowing the importation of steers and spayed heifers from unapproved Mexican states but still protect against tuberculosis. There will be no effect on small businesses.

Comments on the proposal may be submitted to Melissa Nitsche, Executive Secretary, Texas Animal Health Commission, Post Office Box 12966, Austin, Texas 78711-2966.

The amendment is proposed under the Texas Agriculture Code, Texas Civil Statutes, Chapters 161 and 162, which provides the Commission with the authority to protect livestock against communicable diseases, including tuberculosis.

The amendment implements the Agriculture Code, §161.081 and §162.033, which authorize the Commission to adopt necessary rules to regulate the movement of livestock into the state and to prescribe the manner, method, and system of tuberculosis testing.

No other code or article is affected by this amended rule.

§43.2. Interstate Movement Requirements.

(a)-(c) (No change.)

(d) Steers and spayed heifers from Mexico may enter as follows:

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

(4) From states that have not been determined by the Commission, acting on the recommendation of the Bi-National Committee, to have fully implemented the Control/Preparatory Phase of the Mexican Tuberculosis Eradication Program by September 1, 1995-steers and spayed heifers may enter Texas without further restriction if they:

(A) move from an unapproved Mexican state to an approved Mexican state:

(i) **after a verifiable negative tuberculosis test of the entire herd of origin within 12 months of movement; and**

(ii) **are retested negative for tuberculosis in the approved state no earlier than 60 days after the last test; or**

(B) move from an unapproved Mexican state to an approved Mexican state with a negative tuberculosis test within 60 days of movement, and are tested negative for tuberculosis no less than 120 days after entering the approved state.

(5)[(4)] Holstein and Holstein cross steers, and Holstein and Holstein cross spayed heifers from Mexico are prohibited from entering Texas regardless of test history.

(e)-(g) (No change.)

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

Issued in Austin, Texas, on September 11, 1995.

TRD-9511615 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 719-0714

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TITLE 16. ECONOMIC REGULATION

Part II. Public Utility Commission of Texas

Chapter 23. Substantive Rules

The Public Utility Commission of Texas proposes an amendment to: §23.11, concerning general reports; §23.12, concerning financial records and reports; §23.21, concerning cost of service; §23.26, concerning new and experimental services; §23.28, concerning promotional rates for LEC services; and §23.43, concerning applicant and customer deposits. The amendments are required to comply with the Public Utility Regulatory Act of 1995 (PURA '95), §3.213(j); which directs the commission to examine its policies, reporting requirements, and procedural and substantive rules as they relate to rural and small incumbent local exchange companies and cooperatives to eliminate or revise those policies and rules that place unnecessary burdens and expenses on those companies.

Following the initial review of commission substantive rules and a workshop held on July 13, 1995, the commission staff recommends that some of the changes needed for Small Local Exchange Carriers (SLECs) should be made for all dominant certificated telecommunications utilities and/or all other utilities. A SLEC is defined in proposed §23.94 as any incumbent certificated telecommunications utility as of September 1,

1995, that has fewer that 31,000 access lines in service in this state, including the access lines of all affiliated incumbent local exchange companies within the state, or a telephone cooperative organized pursuant to Texas Civil Statutes, Article 1528c. Some of the amendments pertaining to all utilities regulated by the commission are included in this rulemaking as a matter of administrative efficiency.

The proposed change to §23.11(g), concerning general reports, will eliminate the requirement that SLECs file an annual report regarding payments, compensation, and other expenditures. The proposed change to §23.12(e), concerning financial records and reports, will allow a SLEC to file annual revision sheets containing all changes made to its Cost Allocation Manual. The proposed change to §23.21, concerning cost of service, will add a Subsection (e) entitled Policies for SLECs. One policy states that a SLEC's future construction plans and operational changes may be considered in evaluating the overall reasonableness of the SLEC's current rates. A second policy states that the Commission may not initiate an inquiry under PURA '95, §3.210 into the overall reasonableness of the current rates of a SLEC more frequently than every three years from the date of a Commission order setting reasonable rates under PURA '95, §3.210 or §3.211. The proposed change to §23.26, concerning new and experimental services, will add a Subsection (m), entitled Provisions for SLECs. This provision will allow, a SLEC to adopt for its new and experimental services the rates for the same or substantially similar services offered by a larger incumbent local exchange company (LEC). The proposed change to §23.28, concerning promotional rates for LEC services will add a Subsection (p), entitled Provisions for SLECs. This provision will allow a SLEC to adopt as its promotional rates for its services the rates for the same or substantially similar services offered by a larger incumbent LEC. The proposed change to §23.43, concerning applicant and customer deposits, will allow a utility to provide the Your Rights as a Customer publication, as contemplated by Substantive Rule §23.41(a)(5), at the time a deposit is required rather than a separate deposit publication. A utility may provide the Your Rights as a Customer publication only if it contains the information regarding customer deposits as required by commission substantive rule §23.43.

The commission specifically invites comments on whether there is a public interest in mere disclosure of the information now required by §23.11(g).

Acting General Counsel Martin Wilson has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of the enforcing or administering the sections.

Mr. Wilson also has determined that for each year of the first five years the sections are in effect, the public benefit and the benefit to small businesses anticipated as a result of administering the rules is the reduction in labor costs and consulting fees paid by utilities for preparation of reports. Additionally, the changes will allow the Commission to better prioritize resources. Furthermore, the proposed changes result in no anticipated economic cost to persons who are required to comply with the rules.

Mr. Wilson has further determined that for the first five years the proposed amendments are in effect there will be no impact on the opportunities for employment in the geographic areas of Texas affected by implementing the requirements of the rules.

Comments on the proposed rule (13 copies) may be submitted to Paula Mueller, Secretary of the Commission, 7800 Shoal Creek Boulevard, Austin, Texas 78757, within 30 days after publication. All comments should refer to Project Number 14359. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the amendments. The commission will consider the costs and benefits in deciding whether to adopt the amendments.

The commission staff will conduct a public hearing on this rulemaking under Government Code, §2002.029 at the Commission's offices on November 9, 1995, at 10:00 a.m.

Records and Reports

• 16 TAC §23.11, §23.12

The amendments are proposed under PURA '95, §1.101, which provides the Public Utility Commission of Texas with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction, and PURA 95, §3.213(j), which directs the commission to examine its policies, reporting requirements, and procedural and substantive rules as they relate to rural and small incumbent local exchange companies and cooperatives to eliminate or revise those policies and rules that place unnecessary burdens and expenses those companies.

The following statute is affected by this rule: the Public Utility Regulatory Act of 1995, §1.101 and §3.213.

§23.11. General Reports.

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

(g) Payments, compensation and, other expenditures. An annual report shall be filed with the commission **by all electric utilities and dominant carriers, other than Small Local Exchange Carriers (SLECs) as defined in §23.94 of this title (relating to Small Local Exchange Carrier Flexibility)**, providing information for each of the following classes of payments, compensation (other than salary or wages subject to the withholding of federal income tax) and expenditures made relating to matters in Texas, and detailing (by payee) each expenditure (and for the purposes of this rule any series of expenditures) made to a single payee exceeding $250 for:

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

(h)-(p) (No change.)

§23.12. Financial Records and Reports.

(a)-(d) (No change.)

(e) Cost allocation manual.

(1) Cost allocation manual requirement. Each **dominant certificated telecommunications utility** [local exchange company (LEC)] that provides regulated intrastate utility service and also provides nonregulated utility service or sells other services or products shall maintain and file with the commission annually a cost allocation manual (CAM) describing the methodology used for allocating its costs between its regulated activities and its other activities in accordance with this subsection.

(2) Allocation of costs. Notwithstanding any provision of this subsection to the contrary, each **dominant certificated telecommunications utility** [LEC] shall maintain its accounts and subaccounts consistently with the content and titles prescribed in the Uniform System of Accounts for Telecommunications Companies as adopted and amended by the Federal Communications Commission (FCC) for Class A utilities. Each **dominant certificated telecommunications utility** [LEC] subject to the FCC Class A cost allocation manual (CAM) filing requirements shall apportion its total costs in each of the Part 32 accounts into regulated, nonregulated and other cost pools, as required by the FCC rules governing this allocation (FCC Rule 64.901-Allocation of Costs) and as filed in that **dominant certificated telecommunications utility's** [LEC's] CAM on file with the FCC. For such **dominant certificated telecommunications utilities** [LECs], the Part 32 accounts, appropriate cost pools, and approved apportionment methods are set forth in the FCC-approved CAM filed by the Class A **dominant certificated telecommunications utilities. Each dominant certificated telecommunications utility** [LECs. Each LEC] not subject to the FCC Class A CAM filing requirements shall describe the methodology used to apportion its total costs in each of the Part 32 accounts into regulated, nonregulated and other cost pools. After initial assignment, costs included in the common cost pool shall be apportioned to the regulated and nonregulated cost pools utilizing the apportionment methods approved by the commission. The Part 32 accounts, appropriate cost pools, and approved apportionment methods are set forth in the commission-approved cost allocation matrix, which is available from the commission's central records office.

(3) Contents of CAM. The CAM filed with the commission by a [an] **dominant certificated telecommunications utility** [LEC] shall contain at least the following sections and information:

(A) (No change.)

(B) Nonregulated Activities-identifying each nonregulated product or service provided by the **dominant certificated telecommunications utility** [LEC] and the accounts associated with each such nonregulated product or service;

(C) Incidental Activities-identifying all incidental activities of the **dominant certificated telecommunications utility** [LEC]. Incidental activities shall be defined using the following four criteria:

(i)-(iv) (No change.)

(D) Costs Apportionment Table-identifying the **dominant certificated telecommunications utility's** [LEC's] specific methodologies, taken from the commission-approved cost allocation matrix, applied to each Part 32 account to apportion costs between regulated activities and nonregulated activities. For Class A **dominant certificated telecommunications utilities** [LECs], the appropriate cost pools and apportionment methods approved by the FCC shall be used; and

(E) Time Reporting Procedures-describing the time reporting system used by the **dominant certificated telecommunications utility's** [LEC's] regulated telephone operating units, how frequently the reporting system is updated, the methods used to train employees to report time accurately, and the methods used to implement, monitor, and reinforce accurate time reporting by employees.

(4) Filing requirements. **Each dominant certificated telecommunications utility** [The initial filing of information required in subparagraphs (A)-(E) of this paragraph shall be filed no later than August 15, 1995. For periods after the initial filing, each LEC] shall file annually, by June 1st, with the commission the following information for the preceding calendar year:

(A) its CAM;

(B) estimates of the monetary costs or savings associated with any annual revisions by the **dominant certificated telecommunications utility** [LEC] to its CAM, broken down with reference to particular affected Part 32 accounts;

(C) a statement signed by an officer of the **dominant certificated telecommunications utility** [LEC] attesting to the fact that the CAM was followed throughout the year for regulatory reporting purposes;

(D) (No change.)

(E) a copy of any audits, interpretive letters, reviews, or orders pertaining to the **dominant certificated telecommunications utility's** [LEC's] CAM or its application to transactions with affiliates or nonregulated lines of business which have been issued by the FCC.

(5) Alternative filings. Notwithstanding any provision of this subsection to the contrary:

(A) If the FCC requires a [an] **dominant certificated telecommunications utility** [LEC] to file a CAM regarding its interstate activities, and that **dominant certificated telecommunications utility** [LEC] uses the same allocation basis for its intrastate costs as it does for its interstate costs, then the **dominant certificated telecommunications utility** [LEC] shall meet the requirements of subsection (e)(3) of this section by filing with the commission annually by June 1st a complete copy of the CAM it filed most recently with the FCC, and, for purposes of developing and maintaining a CAM for its intrastate costs, shall follow the procedures set forth by the FCC for interstate cost allocation.

(B) If a [an] **dominant certificated telecommunications utility** [LEC] allocates its intrastate costs on the same basis on which an affiliate of the **dominant certificated telecommunications utility** [LEC] allocates its interstate costs, and the affiliate files a CAM with the FCC, then the **dominant certificated telecommunications utility** [LEC] shall meet the requirements of subsection (e)(3) of this section by filing with the commission annually by June 1st a complete copy of the CAM its affiliate filed most recently with the FCC, and, for purposes of developing and maintaining a CAM for its intrastate costs, shall follow the procedures set forth by the FCC for interstate cost allocation.

(6) Exceptions to CAM filing requirements:

(A) A [An] **dominant certificated telecommunications utility** [LEC] is not required to file the information specified in paragraph (4)(B) of this subsection if the only nonregulated activities in which the **dominant certificated telecommunications utility** [LEC] engages are the sale or installation, and/or repair of customer premises equipment and/or inside wire.

(B) A [An] **dominant certificated telecommunications utility** [LEC] shall not be required to file the information specified in paragraph (4)(B) of this subsection solely on the basis of its ownership of less than 5.0% of the voting securities of a nonregulated entity (which entity would be an affiliate of the **dominant certificated telecommunications utility if the dominant certificated telecommunications utility** [LEC if the LEC] owned 5.0% or more of its voting securities).

(C) A [An] **dominant certificated telecommunications utility** [LEC] exclusively engaged in regulated activities is not required to file a CAM with the commission. Annually by June 1st, each such **dominant certificated telecommunications utility** [LEC] shall file with the commission a statement signed by an officer of the **dominant certificated telecommunications utility** [LEC] attesting to the fact that the **dominant certificated telecommunications utility** [LEC] was engaged in only regulated activities throughout the preceding calendar year.

(D) A [An] **dominant certificated telecommunications utility** [LEC] is not required to file a CAM with the commission if the **dominant certificated telecommunications utility's** [LEC's] rates have been approved on a reciprocal basis, as provided for in §22.263 of this title (relating to Final Orders).

(E) A [An] **dominant certificated telecommunications utility** [LEC] is not required to file the information specified in subsection (e) of this section if the **dominant certificated telecommunications utility** [LEC] is considered an average schedule company for determining interstate revenue requirements.

(F) A Small Local Exchange Carrier(SLEC) as defined in §23.94 of this title (relating to Small Local Exchange Carrier Flexibility) is not required to file the information specified in paragraph (4) (A) of this subsection. Each SLEC shall file annually, by June 1st, with the commission, revision sheets containing all changes made to its CAM for the preceding calendar year.

(7) **Dominant certificated telecommunications utility flexibility. If a dominant certificated telecommunications utility** [LEC flexibility. If a LEC] subject to this subsection believes that certain Part 32 accounts, cost pools, or apportionment methods are not applicable to its activities, and further believes that its use of alternative accounts, cost pools, or apportionment methods would be in the public

interest, then that **dominant certificated telecommunications utility** [LEC] may apply to the commission for permission to use specifically identified alternative accounts, cost pools, or apportionment methods described in its application. If the commission finds that such alternative accounts, cost pools, or apportionment methods are in the public interest, then the commission may grant the application. Such an application by a [an] **dominant certificated telecommunications utility** [LEC] may be reviewed administratively.

(8) Costs of affiliate transactions. Nothing in this subsection, nor the commission-approved cost allocation matrix, shall relieve the **dominant certificated telecommunications utility** [LEC] of its burden of proving in a proceeding pursuant to the Public Utility Regulatory Act **of 1995 §3. 210** [§42] or **§3.211** [§43] that affiliate transactions meet the requirements of **§3.208(b)** [§41(c)(1)] of the Act. The ability of a **dominant certificated telecommunications utility** [an LEC] to recover its affiliate transactions through the intrastate cost of service remains subject to **§3.208(b)** [§41(c)(1)] of the Act.

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

Issued in Austin, Texas, on September 13, 1995.

TRD-9511716 Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 458-0100

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Rates

• 16 TAC §§23.21, 23.26, 23.28

The amendments are proposed under PURA '95, §1.101, which provides the Public Utility Commission of Texas with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction, and PURA '95, §3.213(j), which directs the commission to examine its policies, reporting requirements, and procedural and substantive rules as they relate to rural and small incumbent local exchange companies and cooperatives to eliminate or revise those policies and rules that place unnecessary burdens and expenses those companies.

The following statute is affected by this rule: the Public Utility Regulatory Act of 1995, §1.101 and §3.213.

§23.21. Cost of Service.

(a)-(d) (No change.)

(e) Policies for SLECS. This subsection applies to Small Local Exchange Carriers (SLECs) as defined in §23.94 of this title (relating to Small Local Exchange Carrier Flexibility):

(1) Notwithstanding subsections (a), (b), and (c) of this section, a SLEC's future construction plans and operational changes may be considered in evaluating the overall reasonableness of the SLEC's current rates.

(2) The commission may not initiate an inquiry under the Act, §3.210, into the overall reasonableness of the current rates of a SLEC more frequently than every three years from the date of a commission order setting reasonable rates under the Act, §3.210 or §3. 211.

§23.26. New and Experimental Services.

(a)-(l) (No change.)

(m) Provisions for SLECs. Notwithstanding subsections (c), (d), (f) , and (g) of this section, the provisions of this subsection apply to a Small Local Exchange Carrier (SLEC) as defined in §23.94 of this title (relating to Small Local Exchange Carrier Flexibility). If the presiding examiner determines that the SLEC is seeking to adopt as its rates for its new or experimental services the rates for the same or substantially similar services offered by a larger incumbent local exchange company (LEC):

(1) the SLEC's proposed rates and terms of the service will be deemed not to be unreasonably preferential, prejudicial, or discriminatory, subsidized directly or indirectly by regulated monopoly services, or predatory or anticompetitive; and

(2) a waiver of the incremental cost standard shall be granted.

§23.28. Promotional Rates for LEC Services.

(a)-(o) (No change.)

(p) Provisions for SLECs. Notwithstanding subsections (d), (e), (g) and (h) of this section, the provisions of this subsection apply to a Small Local Exchange Carrier (SLEC) as defined in §23.94 of this title (relating to Small Local Exchange Carrier Flexibility). If the presiding examiner determines that the SLEC is seeking to adopt as its promotional rates for its services the rates for the same or similar services offered by a larger incumbent local exchange company (LEC):

(1) the SLEC's proposed rates and terms of the service will be deemed not to be unreasonably preferential, prejudicial, or discriminatory, subsidized directly or indirectly by regulated monopoly services, or predatory or anticompetitive; and

(2) a waiver of the incremental cost standard shall be granted.

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

Issued in Austin, Texas, on September 13, 1995.

TRD-9511717 Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 458-0100

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Customer Service and Protection

• 16 TAC §23.43

The amendment is proposed under PURA '95, §1.101, which provides the Public Utility Commission of Texas with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction, and PURA '95, §3.213(j), which directs the commission to examine its policies, reporting requirements, and procedural and substantive rules as they relate to rural and small incumbent local exchange companies and cooperatives to eliminate or revise those policies and rules that place unnecessary burdens and expenses those companies.

The following statute is affected by this rule: the Public Utility Regulatory Act of 1995, §1.101 and §3.213.

§23.43. Applicant and Customer Deposit.

(a) Definition. Unless the context clearly indicates otherwise, in this section the term utility, insofar as it relates to telephone utilities, shall refer to dominant certificated telecommunications utilities.

(b) [(a)] Establishment of credit for permanent residential applicants.

(1) Each utility may require a residential applicant for service to satisfactorily establish credit, but such establishment of credit shall not relieve the customer from complying with rules for prompt payment of bills. Credit history shall be applied equally for a reasonable period of time to a spouse or former spouse who shared the service. Credit history maintained by one must be applied equally to the other without modification and without additional qualifications not required of the other.

(2) For purposes of this section, applicant is to be defined as a person who applied for service for the first time or reapplies at a new or existing location after discontinuance of service. Customer is defined as someone who is currently receiving service.

(3) Subject to these rules, a residential applicant shall not be required to pay a deposit:

(A) if the residential applicant has been a customer of any utility for the same kind of service within the last two years and is not delinquent in payment of any such utility service account, and during the last 12 consecutive months of service did not have more than one occasion in which a bill for such utility service was paid after becoming delinquent and never had service disconnected for nonpayment; applicants are encouraged to obtain a letter of credit history from their previous utility, and utilities are encouraged to provide such information with final bills.

(B) if the residential applicant demonstrates a satisfactory credit rating by appropriate means, including, but not limited to, the production of generally acceptable credit cards, letters of credit reference, the names of credit references which may be quickly and inexpensively contacted by the utility, or ownership of substantial equity; or

(C) if the residential applicant furnishes in writing a satisfactory guarantee to secure payment of bills for the service required;

(i) unless otherwise agreed to by the guarantor, the guarantee shall be for the amount of deposit the utility would normally seek on the applicant's account. The amount of guarantee shall be clearly indicated on any documents or letters of guarantee signed by the guarantor;

(ii) when the customer has paid bills for service for 12 consecutive residential billings without having service disconnected for nonpayment of bills and without having more than two occasions in which a bill was delinquent, and when the customer is not delinquent in the payment of current bills, the utility shall void and return any documents or letters of guarantee placed with the utility to the guarantor.

(4) An initial deposit may not be required from residential customers unless the customer has more than one occasion during the last 12 consecutive months of service in which a bill for utility service was paid after becoming delinquent or if the customer's service was disconnected for nonpayment. A deposit required pursuant to this section shall not exceed an amount equivalent to one-sixth of annual billings including the carriage charges of interexchange carriers only where a local exchange carrier's tariffs provide for billing for the interexchange carrier. Such deposit may be required to be made within ten days after issuance of written termination notice and requested deposit. In lieu of initial deposit, the customer may elect to pay the current bill by the due date of the bill, provided the customer has not exercised this option in the previous 12 months. The customer may furnish in writing a satisfactory guarantee to secure payment of bills in lieu of cash deposit. In the event the appropriate federal authority prohibits inclusion of interstate charges for an interexchange carrier in the determination of the deposit amount, or prohibits payment of interexchange carriage charges as a condition for local exchange service or reason for disconnection of local exchange service, intrastate carriage charges of an interexchange carrier shall not be included in the determination of the deposit amount.

(5) At the time a deposit is required, every electric and telephone utility shall provide applicants for, and customers of, commercial, industrial, or residential service written information about deposits [separate from the information on deposits required in §23.41(a)(5) of this title (relating to Customer Relations)]. This information shall contain:

(A) the circumstances under which a utility may require a deposit or an additional deposit;

(B) how a deposit is calculated;

(C) the amount of interest paid on a deposit and how this interest is calculated; and

(D) the time frame and requirement for return of the deposit to the customer.

(c)[(b)] Commercial and industrial service. In the case of commercial or industrial service, if the credit of an applicant for service has not been established satisfactorily to the utility, the applicant may be required to make a deposit.

(d)[(c)] Amount of deposit and interest for permanent residential, commercial, and industrial service and exemption from deposit.

(1) The required deposit shall not exceed an amount equivalent to one-sixth of the estimated annual billing. For local exchange telephone carriers the estimated annual billings shall include, in addition to the charges of the local exchange carrier, the carriage charges of interexchange carriers only where the local exchange carrier's tariff provides for billing for the interexchange carrier. In the event the appropriate federal authority prohibits inclusion of interstate charges in the determination of the deposit amount, or prohibits payment of interexchange carriage charges as a condition for local exchange service or as a reason for disconnection of local exchange service, intrastate carriage charges of an interexchange carrier shall not be included in the determination of the deposit amount.

(A) During the first 12 months of service, an additional deposit may be requested prior to the issuance of a bill;

(i) To require such deposit, the customer's actual usage must be three times estimated usage (or three times average usage of most recent three bills), and the customer's current usage must exceed $150, and the customer's current usage must exceed 150% of the security held;

(ii) The request for such additional deposit must be issued in writing and must indicate that the customer may elect to pay the current usage in lieu of the additional deposit;

(iii) The utility may disconnect service if the additional deposit or the current usage payment is not made within ten days of request provided a written disconnect notice has been issued to the customer. Such disconnect notice may be issued concurrently with the written request for the additional deposit or current usage payment.

(B) If actual billings of a commercial customer are at least twice the amount of the estimated billings, and a suspension notice has been issued on a bill within the previous 12-month period, a new deposit may be required to be made within 15 days after issuance of written notice of termination and requested additional deposit. If actual billings of a residential customer are at least twice the amount of the estimated billings after two billing periods, and a suspension notice has been issued on a bill within the previous 12-month period, a new deposit may be required to be made within 15 days after issuance of written notice of termination and requested additional deposit. In lieu of additional deposit, the customer may elect to pay the current bill by the due date of the bill, provided the customer has not exercised this option in the previous 12 months.

(2) All applicants for permanent residential service who are 65 years of age or older will be considered as having estab-

lished credit if such applicant does not have an outstanding account balance within the utility or another utility for the same utility service which accrued within the last two years. No cash deposit shall be required of such applicant under these conditions.

(3) Each utility which requires deposits to be made by its customers shall pay a minimum interest on such deposits at an annual rate at least equal to 6.0% compounded annually. If a refund of deposit is made within 30 days of receipt of deposit, no interest payment is required. If the utility retains the deposit more than 30 days, payment of interest shall be made retroactive to the date of deposit.

(A) Payment of the interest to the customer shall be annually if requested by the customer, or at the time the deposit is returned or credited to the customer's account.

(B) The deposit shall cease to draw interest on the date it is returned or credited to the customer's account.

(4) Determining amount of deposit. In determining the amount of any deposit permitted by these rules, no revenue from estimated telephone directory advertising may be used.

(5) In determining the amount of any deposit permitted by this section, charges for calls placed from combat or war zones, as designated by the federal government, by American military personnel that are billed to a telephone number in Texas may not be used.

(6) An electric utility shall not charge an additional deposit for residential electric utility service if the customer, a spouse, or the head of the household is serving military duty in a combat or war zone, as designated by the Federal government, or is a member of the reserve component who is serving military duty that is directly related to such hostilities, or if the customer is a party to a deferred payment plan with the utility under §23.46(m)(2) of this title (relating to Discontinuance of Service).

(e)[(d)] Deposits for temporary or seasonal service and for weekend residences. The utility may require a deposit sufficient to reasonably protect it against the assumed risk for temporary or seasonal service, provided such policy is applied in a uniform and nondiscriminatory manner. The utility may require a deposit for weekend residences sufficient to reasonably protect it against the assumed risk, provided such policy is applied in a uniform and nondiscriminatory manner. These deposits shall be returned according to guidelines set out in subsection (h) of this section.

(f)[(e)] Complaint by applicant or customer. Each utility shall direct its personnel engaged in initial contact with an applicant or customer for service, seeking to establish or reestablish credit under the provisions of these sections, to inform the customer, if dissatisfaction is expressed with the utility's decision, of the customer's right to file a complaint with the commission thereon.

(g)[(f)] Reestablishment of credit. Every applicant who previously has been a customer of the utility and whose service has been discontinued for nonpayment of bills or meter tampering or bypassing of meter shall be required, before service is rendered, to pay all amounts due the utility or execute a deferred payment agreement, if offered, and reestablished credit as provided in subsection (a) of this section. The burden shall be on the utility to prove the amount of utility service received but not paid for and the reasonableness of any charges for such unpaid service, as well as all other elements of any bill required to be paid as a condition of service restoration.

(h)[(g)] Records of deposits.

(1) The utility shall keep records to show:

(A) the name and address of each depositor;

(B) the amount and date of the deposit; and

(C) each transaction concerning the deposit.

(2) The utility shall issue a receipt of deposit to each applicant from whom a deposit is received and shall provide means whereby a depositor may establish claim if the receipt is lost.

(3) A record of each unclaimed deposit must be maintained for at least four years, during which time the utility shall make a reasonable effort to return the deposit.

(i)[(h)] Refund of deposit.

(1) If service is not connected, or after disconnection of service, the utility shall promptly and automatically refund the customer's deposit plus accrued interest or the balance, if any, in excess of the unpaid bills for service furnished. A transfer of service from one premise to another within the service area of the utility shall not be deemed a disconnection within the meaning of these sections, and no additional deposit may be demanded unless permitted by these sections.

(2) When the customer has paid bills for service for 12 consecutive residential billings or for 24 consecutive commercial or industrial billings without having service disconnected for nonpayment of bill and without having more than two occasions in which a bill was delinquent, and when the customer is not delinquent in the payment of the current bills, the utility shall promptly and automatically refund the deposit plus accrued interest to the customer in the form of cash or credit to a customer's bill, or void the guarantee. If the customer does not meet these refund criteria, the deposit and interest may be retained in accordance with subsection (c) of this section.

(j)[(i)] Upon sale or transfer of utility or company. Upon the sale or transfer of any [public] utility or operating units thereof, the seller shall file with the commission, under oath, in addition to other information, a list showing the names and addresses of all customers served by such utility or unit who have to their credit a deposit, the date such deposit was made, the amount thereof, and the unpaid interest thereon.

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

Issued in Austin, Texas, on September 13, 1995.

TRD-9511718 Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 458-0100

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Customer Service and Protection

• 16 TAC §23.54

The Public Utility Commission of Texas proposes an amendment to §23.54, relating to Private Pay Telephone Providers, to conform the existing rule to the mandates of the Public Utility Regulatory Act of 1995 (PURA), §3.2625. The amendment is also proposed in compliance with PURA, §3.213, concerning Small Incumbent Local Exchange Companies, which requires the Commission to review its rules affecting rural and small incumbent local exchange companies.

The proposed changes broaden the applicability of the rule by incorporating the statute's expansive definition of "provider of pay telephone service." The proposed changes also require providers of pay telephone service who do not possess a certificate of convenience and necessity to register with the Commission, and they make informational posting requirements directly applicable to all providers of pay telephone service rather than such requirements being applicable through dominant certificated telecommunica-

tions utility tariffs for customer-owned pay telephone service. Similarly, the proposed changes now make certain requirements of a dominant certificated telecommunications utility's tariffed customer-owned pay telephone service applicable to the dominant certificated telecommunications utility's provisioning of its own pay telephone service.

Additionally, changes are proposed to establish limits on the charges for local pay telephone calls which are either coin-paid or involve operator assistance or the use of a credit or calling card. The proposed amendment also restates various statutory provisions, including the requirements for a provider of pay telephone service to impose a set use fee for "1-800" type calls, a prohibition on charges for local directory assistance from a pay telephone, and a limit on the amount that may be charged by a provider of pay telephone service (other than an incumbent local exchange company) for credit or calling card or operator assisted intrastate long distance calls. In addition, references to "local exchange carrier" are changed to "dominant certificated telecommunications utility" to better reflect the Commission's jurisdiction. Finally, the proposed changes also respond to the concerns of rural and small incumbent local exchange companies by eliminating for all dominant certificated telecommunications utilities the rule's cost studies requirement, and by increasing to ten the number of special assembly arrangements authorized before a dominant certificated telecommunications utility must tariff its provision of pay telephone service.

Kevin K. Zarling, Assistant General Counsel, has determined that for each year of the first five-year period the section is in effect there may be additional costs of approximately $41,000 to state government as a result of enforcing or administering the section. The Commission will determine in its budgeting process the appropriate amount of resources to devote to enforcement of this section. There will be no fiscal implications for local government.

Mr. Zarling also has determined that for each year of the first five years that the proposed section is in effect the public benefit anticipated as a result of enforcing the section will be that users of pay telephones will be better informed about the use of pay telephones, including various charges and how to access long distance carriers, operator services, and emergency services. There will be no effect on small businesses as a result of enforcing this section. There may be minimal economic costs to persons who are required to comply with the section as proposed.

Mr. Zarling also has determined that for each year of the first five years the proposed section is in effect there will be no impact on employment in the geographical areas affected by implementing the requirements of the sections.

Comments on the proposed amendment (13 copies) may be submitted within 30 days to Paula Mueller, Secretary of the Commission, 7800 Shoal Creek Boulevard, Austin, Texas 78757. Comments should refer to Project Number 14559. The commission invites specific comments regarding the costs associated with, and benefits that will be gained by, implementation of the specific requirements imposed by the Commission in the proposed amendment, that are not in fact imposed by PURA, §3.2625. The commission will consider the costs and benefits in deciding whether to adopt the amendment.

General Counsel will conduct a public hearing on this rulemaking under Texas Government Code, §2001.029 at the Commission's offices on October 5, 1995 at 10:00 a.m.

The amendment is proposed under PURA, §1.101, which provides the Public Utility Commission of Texas with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and PURA, §3.2625, which authorizes the Commission to promulgate rules requiring registration of providers of pay telephone service that do not possess a certificate of convenience and necessity and to establish limits on the charges for various pay telephone calls. The rule is also proposed under PURA, §3.213, which authorizes the Commission to amend its rules affecting rural and small incumbent local exchange companies.

The following statute is affected by this amendment: Public Utility Regulatory Act of 1995, §3.213 and §3.2625.

§23.54. [Private] Pay Telephone Service.

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

(1) "0-" call-A call made by the caller dialing the digit "0" and no other digits within five seconds. A "0-" call may be made after a digit (or digits) to access the local network is (are) dialed.

(2) "0+" call-A call made by the caller dialing the digit "0" followed by the terminating telephone number. On some automated call equipment, a digit or digits may be dialed between the "0" and the terminating telephone number.

(3) Automatic Number Identification (ANI)-The automatic transmission by the local switching system of the originating telephone number to an interexchange or other communications carrier or to the operator of a 911 system.

(4) Call Aggregator-Any person or entity that owns or otherwise controls telephones intended to be utilized by the public. For the purposes of this definition, a person or entity controls a telephone if that person or entity has the authority to post notices and/or unblock access.

(5) Customer-owned pay telephone service-A service offered by a dominant certificated telecommunications utility which provides a two-way, or optionally, a one way originating only business access line composed of the serving central office line equipment, all outside plant facilities needed to connect the serving central office with the customer premises, and the network interface.

(6)[(1)] End User Choice-A system that allows the automatic routing of interexchange, operator-assisted calls to the billed party's chosen carrier without the use of access codes. [Private Pay Telephone-Any coin, coinless, credit card reader, or cordless instrument that is accessible by members of the general public, or business patrons, employees, and/or visitors of the premises owner or lessee where private pay telephone service is installed, provided that the end user pays for local or toll calls from such instrument on a per call basis. For purposes of this section, coinless telephones provided in guest rooms by a hotel/motel are not private pay telephones. A telephone that is primarily used by business patrons, employees, and/or visitors of the local exchange carrier customer is not a private pay telephone if:

[(A) the primary use of such telephone is for local calls or toll-free "1-800" calls;

[(B) all local calls and "1-800" calls from such telephone are free to the end user; and

[(C) the telephone is not accessible by members of the general public.]

(7)[(2)] Operator Service-Any service using live operator or automated operator functions for the handling of telephone service, such as toll calling via collect, third number billing, and calling card services. The transmission of 800 numbers, where the called party has arranged to be billed, is not operator service.

(8)[(3)] Operator Service Provider (OSP)-Any person or entity that provides operator services by using either live or automated operator functions. When more than one entity is involved in processing an operator service call, the party setting the rates shall be considered to be the OSP. However, subscribers to customer-owned pay telephone service shall not be deemed to be OSPs.

(9) Originating Line Screening (OLS)-A two digit code passed by the local switching system with the ANI at the beginning of a call that provides information about the originating line.

(10) Pay Telephone Service-A service utilizing any coin, coinless, credit card reader, or cordless instrument that is accessible by members of the general puolic, or business patrons, employees, and/or visitors of the premises owner or lessee where pay telephone service is in-

stalled, provided that the end user pays for local or toll calls from such instrument on a per call basis. For purposes of this section, coinless telephones provided in guest rooms by a hotel/motel are not pay telephones. A telephone that is primarily used by business patrons, employees, and/or visitors of the premise's owner is not a pay telephone if:

(A) the primary use of such telephone is for local calls or toll-free "1-800" calls;

(B) all local calls and "1-800" calls from such telephone are free to the end user; and

(C) the telephone is not accessible by members of the general public.

(11) Provider of Pay Telephone Service-A subscriber to customer-owned pay telephone service, an incumbent local exchange company providing pay telephone service, and any other entity providing pay telephone service.

(12)[(4)] Rate Information-All charges ultimately charged to the end user by the **provider of** [private] pay telephone **service** [provider], including any surcharges, fees, and any other form of compensation charged by the **provider of** [private] pay telephone **service** [provider] on behalf of the call aggregator.

[(5) "0+" call-A call made by the caller dialing the digit "0" followed by the terminating telephone number. On some automated call equipment, a digit or digits may be dialed between the "0" and the terminating telephone number.

[(6) "0-" call-A call made by the caller dialing the digit "0" and no other digits within five seconds. A "0-" call may be made after a digit (or digits) to access the local network is (are) dialed.

[(7) Automatic Number Identification (ANI)-The automatic transmission by the local switching system of the originating telephone number to an interexchange or other communications carrier or to the operator of a 911 system.

[(8) Originating Line Screening (OLS)-A two digit code passed by the local switching system with the ANI at the beginning of a call that provides information about the originating line.

[(9) End User Choice-A system that allows the automatic routing of interexchange, operator-assisted calls to the billed party's chosen carrier without the use of access codes.

[(10) Call Aggregator-Any person or entity that owns or otherwise controls telephones intended to be utilized by the public. For the purposes of this definition, a person or entity controls a telephone if that person or entity has the authority to post notices and/or unblock access.]

(b) Registration.

(1) All providers of pay telephone service not holding a certificate of convenience and necessity must register with the commission, using commission prescribed forms, in order to do business in the state of Texas. Registration requires disclosure of the physical location of each of the registrant's pay telephones, and such location information must be updated by the registrant each calendar quarter. The commission shall provide each registrant with proof of registration.

(2) A dominant certificated telecommunications utility shall not provide customer-owned pay telephone service to a person required to be registered under this subsection, unless that person provides a commission-supplied proof of registration to the dominant certificated telecommunications utility.

(c)[(b)] Available upon request. Upon formal request for service by any prospective **provider of customer-owned** [private] pay telephone **service, a dominant certificated telecommunications utility** [provider, a local exchange carrier] is required to file a tariff providing for interconnection of **customer-owned** [private] pay telephones, except as otherwise provided in subsection **(p)** [(l)] of this section.

(d)[(c)] Initial filing requirements. Unless otherwise provided in this section, when a **dominant certificated telecommunications utility** [local exchange carrier] makes its initial filing to offer **customer-owned** [private] pay telephone service the application must include the proposed tariff, a surrogate cost study based on the traffic sensitive and nontraffic sensitive costs of providing interconnection to the **dominant** [local exchange] carrier network, and supporting explanation.

(e)[(d)] **Tariff requirements for** [Requirements for connection of private pay telephone by local exchange carriers. A tariff filed by a local exchange carrier to offer private] pay telephone service. **The** [must include the] requirements set forth in this subsection **must be included in any tariff filed by a dominant certificated telecommunications utility for the dominant certificated telecommunications utility to offer pay telephone service, and in any tariff filed by such utility to offer customer-owned pay telephone service.**

[(1) Information to be provided at the private pay telephone set.

[(A) The private pay telephone provider must attach to each instrument a card that provides:

[(i) instructions in English and Spanish for accessing emergency service subject to the conditions contained in subclauses (I) and (II) of this clause:

[(I) where 911 emergency service is available, the caller must be instructed to dial 911 and the private pay telephone provider must allow 911 calls to be outpulsed directly to the Public Service Answering Point at no charge and without requiring a coin or credit card; or

[(II) where 911 is not available, the caller must be instructed to dial "0" and dialing "0" must, at no charge and without requiring a coin or credit card, directly connect the caller either with the local exchange carrier operator serving the exchange from which the call is made or with an OSP that is in compliance with the requirements of §23.55(g)(2)(A)-(F) of this title (relating to Operator Services);

[(ii) instructions for use, including specifically instructions for: completion of local and toll calls, access to operator services, access to directory assistance, obtaining refunds, obtaining repair service, registering complaints at a designated toll-free telephone number, reporting out-of-service conditions, and using one-way calling (if the instrument is so equipped); and

[(iii) notice identifying the set as a private pay telephone, stating the name, address, and 10 digit telephone number for the private pay telephone owner or agent providing the set, and providing the name and toll-free telephone number of the owner or agent responsible for refunds and repairs.

[(B) If the private pay telephone provider uses automated call completion technology to complete operator service calls, the private pay telephone provider must also attach to each instrument a card that provides:

[(i) the name of the private pay telephone provider, indicating that the private pay telephone provider is the provider of operator services;

[(ii) a statement that rate information is available, 24 hours a day, seven days a week at no charge;

[(iii) instructions for obtaining rate information;

[(iv) instructions for accessing the "local exchange carrier operator"; and

[(v) a notice that states, "You may use another long distance carrier if that carrier serves this area. Follow your carrier's instructions, or contact the local exchange carrier operator for assistance."

[(C) If the private pay telephone provider uses automated call completion technology to complete operator service calls, and if the private pay telephone provider's average intrastate charge (which includes all charges ultimately charged to the end user, including surcharges, fees and any other form of compensation charged by the private pay telephone provider on behalf of the call aggregator) exceeds 115% of the average intrastate charge of a dominant carrier, the private pay telephone provider must also attach to the telephone set a notice that legibly and conspicuously states in capital letters: CHARGES FOR (insert private pay telephone provider's name)'s OPERATOR SERVICES ARE NOT REGULATED. For the purposes of this subparagraph, the private pay telephone provider's average intrastate charge exceeds 115% of the average intrastate charge of a dominant carrier if the requirements of §23.55(d)(2) (A)-(D) are not met. The private pay telephone provider is considered to be the OSP for the purpose of determining if the requirements of §23.55(d)(2)(A) -(D) are met.

[(D) If the private pay telephone provider subscribes to the services of an OSP that is required to comply with §23.55, the private pay telephone provider remains liable for compliance with this paragraph, but may coordinate with the OSP so that information to be provided at the private pay telephone set is not duplicated. If the private pay telephone provider uses automated call completion technology to complete some operator service calls and subscribes to the services of an OSP that is required to comply with §23.55, the private pay telephone provider must ensure that the information provided at the private pay telephone set clearly informs the caller regarding which information applies to which operator service calls.

[(E) The requirements of this paragraph do not apply to private pay telephones accessible to inmates of confinement facilities.

[(F) If a private pay telephone cannot receive incoming calls, the private pay telephone provider shall place in a conspicuous location on the pay telephone a notice, in letters one-quarter inch high, stating, "THIS TELEPHONE CANNOT RECEIVE TELEPHONE CALLS." Furthermore, the private pay telephone provider shall not display on the set the number of the private pay telephone set not able to receive incoming calls.

[(i) Subparagraph (F) of this paragraph takes effect for all newly installed private pay telephones on September 1, 1993.

[(ii) For all private pay telephones in service prior to September 1, 1993, subparagraph (F) of this paragraph takes effect on January 1, 1994.]

(1)[(2)] Requirements before call is completed. If the **provider of** [private] pay telephone **service** [provider] uses automated call completion technology to complete operator service calls, the **provider of** [private] pay telephone **service** [provider] must:

(A) audibly and distinctly identify itself to the caller upon answering;

(B) audibly and distinctly identify itself to the billed party, if the billed party is different from the caller;

(C) provide a mechanism for the caller to obtain rate information, without charge, 24 hours a day, seven days a week; and

(D) permit the caller or billed party to terminate the call at no charge prior to completion of the call by the **provider of** [private] pay telephone **service.** [provider.]

(2)[(3)] 911 calls, "0-" calls, and end user choice.

(A) The **provider of** [private] pay telephone **service** [provider] must allow 911 calls to be outpulsed directly to the public service answering point at no charge and without requiring a coin or credit card.

(B) Where end user choice, as **defined in subsection (a)(9) of this section** [herein defined], is not available, the **provider of** [private] pay telephone **service** [provider] must allow "0-" calls, and must directly route, without charge to the calling party, all "0-" calls [either to the local exchange carrier operator serving the exchange from which the call is made or] to an OSP that provides access to emergency **services** [service providers and] that **meet** [meets] the **technical standards** [requirements] set forth in §23.55(g)(2)(A)-(F) of this title (relating to Operator Services).

(C) When and where available, use of End User Choice, as **defined in subsection (a)(9) of this section** [herein defined], is required.

(D) The requirements of this paragraph do not apply to [private] pay telephones accessible to inmates of confinement facilities.

(3)[(4)] Access.

(A) The **provider of** [private] pay telephone **service** [provider] must:

(i) provide access to operator services, which access must be available 24 hours a day, seven days a week, at no charge and without requiring a coin or credit card;

(ii) provide access to directory assistance, **which access must be available 24 hours a day, seven days a week, at no charge and without requiring a coin or credit card** [to the same extent as access to directory assistance is provided by the local exchange carrier from public pay telephones]; and

(iii) provide access to the **operator of a local exchange company that meets the requirements enumerated in §23.55(k)(3) and that serves the area** [local exchange carrier operator serving the exchange] from which the call is made, at no charge and without requiring a coin or credit card, either:

(I) by directly routing all "0-" calls to **such** [the] local exchange **company** [carrier] operator, without charge to the caller; or

(II) by transfer or redirection of the call by an OSP in accordance with the provisions of §23.55(i)(1)(A)(ii)(I)-(III).

(B) The **provider of** [private] pay telephone **service** [provider] must also allow access to other telecommunications utilities unless otherwise provided in clause (ii) of this subparagraph.

(i) The access required by this subparagraph must be provided subject to the conditions contained in subclauses (I) and (II) of this clause.

(I) Access to interexchange carriers by "950-XXXX" and "1-800" numbers must not be blocked.

(II) Access to interexchange carriers by "10XXX+0" (whether "10XXX+0+" or "10XXX+0-") dialing must not be blocked if the end office serving the originating line has originating line screening capability.

(ii) The following generic waivers of the access requirement are required to prevent fraudulent use. An application under subsection **(i)** [(e)] of this section is not required for any generic

waiver granted by subclauses (I) or (II) of this clause.

(I) Access to interexchange carriers by "10XXX+0" (whether "10XXX+0+" or "10XXX+0-") dialing may be blocked if the end office serving the originating line does not have originating line screening capability.

(II) Access to interexchange carriers by "10XXX+1" dialing may be blocked.

(C) The requirements of this paragraph do not apply to [private] pay telephones accessible to inmates of confinement facilities.

[(5) Charges.

[(A) The private pay telephone provider must:

[(i) charge for directory assistance calls that are handled by the local exchange carrier at the same price as the local exchange carrier charges end users at its public pay telephones;

[(ii) not impose a total charge for a local call that is an amount greater than the rate charged for a local call placed from a public or semi-public pay telephone in the same exchange, except this clause does not apply to local operator service calls, as defined in subsection (a)(2) of this section; and

[(iii) not impose a charge for "950-XXXX" calls, "1-800" calls, or "10XXX+0" calls.

[(B) The requirements of this paragraph do not apply to private pay telephones accessible to inmates of confinement facilities.]

(4)[(6)] Other.

(A) The **provider of pay telephone service** [private pay telephone provider] must:

(i) ensure that end users can place all local and toll calls, except direct dialed international calls, from the [private] pay telephone–including, but not limited to, operator-assisted international calls, collect calls, third number billed calls, and calling card calls;

(ii) be responsible for the payment of charges for all local and toll messages, including, but not limited to, non-local [exchange carrier-handled] directory assistance charges [originating from or accepted at this type of service], except as provided in subsection (j) [(f)] of this section;

(iii) comply with all applicable federal, state and local laws and regulations including those concerning the use of [private] pay telephones by disabled and/or hearing- or speech-impaired persons;

(iv) not attach extension telephones to [private] pay telephones; and

(v) not impose a time limit on local calls.

(B) If the **provider of** [private] pay telephone **service** [provider] uses automated call completion technology to complete operator service calls, and if validation information is available for calls that the **provider of** [private] pay telephone service [provider] (or a third-party billing and collection agent operating on behalf of the **provider of** [private] pay telephone service [provider]) will bill through a **certificated telecommunications utility, the provider of** [the local exchange carrier, the private] pay telephone **service** [provider] is required to validate the call and is allowed to submit the call for billing only if the call was validated.

(C) [Private] Pay telephone service cannot be connected to, from, or through any customer-provided telecommunications switching system, or **dominant certificated telecommunications utility** [local exchange carrier] provided central office based PBX-type switching system.

(D) The requirements of subparagraph (A)(i) and (v) of this paragraph do not apply to [private] pay telephones accessible to inmates of confinement facilities.

(f) Posting requirements for pay telephones.

(1) The provider of pay telephone service must attach to each instrument a card that provides:

(A) instructions in English and Spanish for accessing emergency service subject to the conditions contained in clauses (i) and (ii) of this subparagraph:

(i) **where 911 emergency service is available, the caller must be instructed to dial 911 and the provider of pay telephone service must allow 911 calls to be outpulsed directly to the Public Service Answering Point at no charge and without requiring a coin or credit card; or**

(ii) **where 911 is not available, the caller must be instructed to dial "0" and dialing "0" must, at no charge and without requiring a coin or credit card, directly connect the caller with an OSP that is in compliance with the technical standards set forth of §23.55(g)(2)(A) -(F);**

(B) instructions for use, including specifically instructions for completion of local and toll calls, access to operator services, access to directory assistance, obtaining refunds, obtaining repair service, registering complaints at a designated toll-free telephone number, reporting out-of-service conditions, and using one-way calling (if the instrument is so equipped); and

(C) notice stating the name, address, and 10 digit telephone number for the pay telephone owner or agent providing the set, and providing the name and toll-free telephone number of the owner or agent responsible for refunds and repairs; and

(D) notice that legibly and conspicuously states in capital letters: "THIS PAY TELEPHONE PROVIDER CHARGES $.25 FOR "1-800" CALLS, EXCEPT FOR "1-800" ACCESS CALLS TO LONG DISTANCE CARRIERS", as provided in subsection (h)(1)(E) of this section.

(2) If the provider of pay telephone service uses automated call completion technology to complete operator service calls, the provider of pay telephone service must also attach to each instrument a card that provides:

(A) the name of the provider of pay telephone service, indicating that the provider of pay telephone service is the provider of operator services;

(B) a statement that rate information is available, 24 hours a day, seven days a week at no charge;

(C) instructions for obtaining rate information;

(D) instructions for accessing a dominant certificated telecommunications utility operator; and

(E) a notice that states, "You may use another long distance carrier if that carrier serves this area. Follow your carrier's instructions, or contact the (insert name of dominant certificated telecommunications utility) operator for assistance."

(3) If the provider of pay telephone service subscribes to the services

of an OSP that is required to comply with §23.55, the provider of pay telephone service remains liable for compliance with this paragraph, but may coordinate with the OSP so that information to be provided at the pay telephone set is not duplicated. If the provider of pay telephone service uses automated call completion technology to complete some operator service calls and subscribes to the services of an OSP that is required to comply with §23. 55, the provider of pay telephone service must ensure that the information provided at the pay telephone set clearly informs the caller regarding which information applies to which operator service calls.

(4) The requirements of this subsection do not apply to pay telephones accessible to inmates of confinement facilities. (5) If a pay telephone cannot receive incoming calls, the provider of pay telephone service shall place in a conspicuous location on the pay telephone a notice, in letters one-quarter inch high, stating, "THIS TELEPHONE CANNOT RECEIVE TELEPHONE CALLS." Furthermore, the provider of pay telephone service shall not display on the set the number of the pay telephone set not able to receive incoming calls.

(g) Charges.

(1) A provider of pay telephone service must:

(A) not impose on pay phone end users any charge for local directory assistance calls or calls made under Chapter 771 or 772 of the Texas Health and Safety Code;

(B) not impose a rate or charge for a coin sent-paid call within the local exchange company's toll-free calling area that is an amount greater than 25 cents, including those calls which are made toll-free through an Extended Area Service or Extended Local Calling proceeding, except this subparagraph does not apply to local operator service calls, as defined in subsection (a)(2) of this section;

(C) not impose a charge for "950-XXXX" calls, "10XXX+0", or "1-800" type calls to nonpresubscribed interexchange carriers, for example; "1-800-COLLECT" , "1-800-CALLATT", or "1-800-877-8000";

(D) not impose a charge for local calls which are collect or operator-assisted or paid by credit card or calling card, which is greater than the highest applicable rate for such calls of any of the four largest interexchange carriers operating in this state; and

(E) not charge for credit card, calling card, or live or automated operator-handled toll calls a rate or charge that is an amount greater than the authorized rates and charges published, in the eight newspapers having the largest circulation in this state, on March 18, 1995. The requirements of this subparagraph do not apply to incumbent local exchange companies offering pay telephone service.

(2) A rate or charge specified by a subparagraph of paragraph (1) of this subsection is the maximum total charge (including surcharges, fees and any other form of compensation charged by the provider of pay telephone service on behalf of itself or a call aggregator) which may be ultimately charged to the end user.

(3) The requirements of this subsection do not apply to pay telephones accessible to inmates of confinement facilities.

(h) Use fee for "1-800" type calls.

(1) A provider of pay telephone service may impose a set use fee not exceeding 25 cents at the point at which the call is initiated for each "1-800" type call made from a pay telephone, provided that:

(A) except for pay telephones of local exchange companies holding a certificate of convenience and necessity, the pay telephone is registered with the commission and the provider of pay telephone service certifies that the pay telephone is in compliance with commission rules regarding the provision of pay telephone service. A provider of pay telephone service shall register its pay telephones and certify their compliance through the registration process referenced in subsection (b) of this section;

(B) the imposition of the use fee is not inconsistent with federal law;

(C) the fee is not imposed for any local call, 911 call, or local directory assistance call;

(D) the fee is not imposed for a call that is covered by the Telephone Operator Consumer Services Improvement Act of 1990 (47 United States Code, §226) (for example, a call placed to the end user's long distance carrier of choice); and

(E) the pay telephone service provider causes to be posted on each pay telephone instrument, in plain sight of the user and in a manner consistent with existing commission requirements for posting information, the fact that the surcharge will apply to those calls, as required by subsection (f)(1)(D) of this section.

(i)[(e)] Applications for modification of information to be provided at the [private] pay telephone set and for waivers of the requirement for access.

(1) The commission may approve applications for modification of the requirements contained in subsection (f)(2) [(d)(1)(B)] and (3) [(C)] of this section upon showing of good cause. Applications for modification may be filed by the provider of [private] pay telephone service [provider]. The commission shall process applications for modification using the criteria and procedures set forth in §23.55(d)(4).

(2) The commission may approve waivers to the access requirements of subsection (e)(3)(B) [(d)(4)(B)] of this section to prevent fraudulent use of telephone services or for other good cause. Applications for waiver may be filed by the provider of [private] pay telephone service [provider]. The commission shall process such applications for waiver using the criteria and procedures set forth in §23.55(i)(3)(B).

(j)[(f)] Fraud protection.

(1) Notwithstanding the provision of §23.55(i)(1)(C)(ii) that would otherwise require notice to interexchange carriers, an OSP must not bill the provider of [private] pay telephone service [provider] for charges for calls billed to a [private] pay telephone line where the call(s) originated at that [private] pay telephone by use of "10XXX+0", "10XXX+01", "950-XXXX", or "1-800" access codes, or where the call(s) originated at that [private] pay telephone and otherwise reached an operator position, if the originating telephone line was subscribed to outgoing call screening, and the call was placed after the effective due date of the outgoing call screening service order.

(2) An OSP or provider of [private] pay telephone service [provider] that uses automated call completion technology to complete operator service calls must not bill charges for any collect or third number billed call to a provider of[the private] pay telephone service [provider] if the [private] pay telephone line to which the call was billed was subscribed to incoming call screening and the call was placed after the effective due date of the incoming call screening service order.

(3) Any calls billed through a **dominant certificated telecommunications utility** [the local exchange carrier] in violation of paragraphs (1) and (2) of this subsection must be removed from the **provider of** [private] pay telephone **service's** [provider's] bill by the **dominant** [local exchange] carrier upon identification. Upon investigation by the **dominant certificated telecommunications utility** [local exchange carrier] serving the **pay telephone to which** [exchange where] the call was billed, if it is determined that the appropriate incoming or outgoing call screening was available to the OSP or **provider of** [private] pay telephone **service** provider that uses automated call completion technology to complete operator service calls at the time of the call, the **dominant certificated telecommunications utility** [local exchange carrier] may return the charges for the call billed in violation of paragraph (1) or (2) of this subsection to the OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls as unbillable.

(4) Any calls billed directly by an OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls in violation of paragraph (1) or (2) of this subsection must be removed from the **provider of** [private] pay telephone **service's** [provider's] bill by the OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls upon identification. The OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls may request an investigation of such a call by the **dominant certificated telecommunications utility** [local exchange carrier] serving the **pay telephone to which** [exchange where] the call was billed. Upon investigation by the **dominant certificated telecommunications utility** [local exchange carrier], if it is determined that the appropriate incoming or outgoing call screening was not available to the OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls at the time of the call, the OSP or **provider of** [private] pay telephone **service** [provider] that uses automated call completion technology to complete operator service calls may bill the charges for the call billed in violation of paragraph (1) or (2) of this subsection to the **dominant certificated telecommunications utility** [local exchange carrier] serving the **pay telephone to which** [exchange where] such a call was billed.

(k)[(g)] Dominant certificated telecommunications utility [Local exchange carrier] responsibilities.

(1) A listing in the local telephone directory must be provided to **any provider of** [the private] pay telephone service [provider] on request.

(2) Access for **a subscriber of customer-owned** [private] pay telephone **services** [providers] must be available in all exchanges.

(3) Incoming and outgoing call screening must be provided where facilities are available.

(4) Regardless of whether call screening is available, the **dominant certificated telecommunications utility** [local exchange carrier] will not bill any call, including, but not limited to, third number billed, collect, "0+" or "0-" calls, to a number which has been clearly identified to the **dominant certificated telecommunications utility** [local exchange carrier] operator at the time of the call attempt as a [private] pay telephone. The **dominant certificated telecommunications utility** [local exchange carrier] will not be responsible for refunds or adjustments of charges for calls placed through non-**dominant** [local exchange] carrier operators, except as provided in subsection **(j)** [(f)] of this section.

(5) The **dominant certificated telecommunications utility** [local exchange carrier] shall not initiate a maintenance service call or take any other action in response to a trouble report on a **customer-owned** [private] pay telephone until such time as requested by the [private] pay telephone owner or its agent. The [private] pay telephone owner must keep the **dominant certificated telecommunications utility** [local exchange carrier] advised of the identity of the [private] pay telephone owner or agent authorized to request a maintenance service call.

(6) **Dominant certificated telecommunications utility** [Local exchange carrier] provided directory assistance service must be provided **at no charge to all providers of pay telephone service. However, a dominant certificated telecommunications utility is not** [to private pay telephone providers on the same prices, terms and conditions that the local exchange carrier provides such service to the end user of its public pay telephones, except the local exchange carrier will not be] required to provide such service to [private] pay telephones accessible to inmates of confinement facilities.

(7) The **dominant certificated telecommunications utility** [local exchange carrier] must provide to **a provider of** [private] pay telephone **services** [providers] who use automated call completion technology to complete operator service calls the same services and information that the **dominant certificated telecommunications utility** [local exchange carrier] provides to interexchange carriers in §23.55(j)(1) and (2), on the same prices, terms, and conditions that the **dominant certificated telecommunications utility** [local exchange carrier] provides such services and information to any interexchange carrier.

(8) **Dominant certificated telecommunications utilities** [By June 1, 1991, local exchange carriers] must file tariffs to offer direct dialed international call blocking ("011+" and "10XXX+011+") **as facilities become available.** [where facilities are available.]

[(9) Each local exchange carrier with more than 100,000 access lines in Texas must file a report with the commission by June 1, 1991 that describes in detail how the local exchange carrier can provide two additional central office blocking options: all direct dialed calls ("1+", "011+", "10XXX+1+", and "10XXX+011+"); and direct dialed calls using "10XXX" ("10XXX+1+" and "10XXX+011+"). The report must detail the incremental costs (including recurring and nonrecurring) of providing the service. The report must describe how the service will be technically provided. The report must be filed in the Central Records Office of the commission, and a copy must be delivered to the Director of the Telephone Utility Analysis Division.]

(l)[(h)] Enforcement of tariff requirements. [Violation of regulations.] **If a subscriber to customer-owned pay telephone service** [If a private pay telephone provider] is in violation of a tariff provision, the **dominant certificated telecommunications utility** [local exchange carrier] must notify the **subscriber to customer-owned** [private] pay telephone **service** [provider] of the violation in writing. Such notice must refer to the specific tariff provisions being violated. The notice must state that the **subscriber to customer-owned** [private] pay telephone **service** [provider] is subject to disconnection by the **dominant certificated telecommunications utility** [local exchange carrier] of the instrument(s) in violation of the tariff unless the **subscriber to customer-owned** [private] pay telephone **service** [provider] corrects the violation and notifies the **dominant certificated telecommunications utility** [local exchange carrier] in writing, within 20 days of receipt of the notice of the violation, that the violation has been corrected. The **dominant certificated telecommunications utility** [local exchange carrier] may disconnect the instrument(s) that are in violation of the tariff on or after the 20th day after receipt of the notice by the **subscriber to customer-owned** [pri-

vate] pay telephone service, [provider,] if the **subscriber to customer-owned** [private] pay telephone **service** [provider] did not notify the **dominant certificated telecommunications utility** [local exchange carrier] in writing within 20 days of receipt of the notice that the violation was corrected. However, if the **subscriber to customer-owned** [private] pay telephone **service** [provider] has filed a complaint with the commission regarding the disconnection and has provided the **dominant certificated telecommunications utility** [local exchange carrier] with a copy of the complaint that indicates that the complaint has been filed with the commission's complaint office, within 20 days of receipt of the notice of a violation from the **dominant certificated telecommunications utility, the dominant certificated telecommunications utility** [local exchange carrier, the local exchange carrier] may not disconnect the instrument(s) pending resolution of the complaint by the commission.

(m) Violation of regulations. The commission may order disconnection of service for up to one year for repeat violations of commission rules. A provider of pay telephone service who violates commission rules is also subject to administrative penalties, civil penalties, and injunctive relief under Subtitle I of the Public Utility Regulatory Act of 1995.

(n)[(i)] Rate structure. **Dominant certificated telecommunications utility rates for customer-owned pay telephone service** [Local exchange carrier rates] must be designed on a flat access line and a local message usage rate basis. Multi-element measured rates are prohibited. In areas without measuring capabilities, the **dominant certificated telecommunications utility** [local exchange carrier] may use a flat rate usage surrogate instead of a per call message rate. Measurement capabilities are defined as the capability in place to measure and bill [private] pay telephone usage without incurring unreasonable expense.

(o)[(j)] **Average schedule dominant certificated telecommunications utilities.** [Cost studies.] Rates for **customer-owned** [private] pay telephone service provided by **an average schedule dominant certificated telecommunications utility** [a local exchange carrier that performs cost separations studies] must be based on the **average customer-owned.** [cost of providing the service, plus contribution.]

[(1) In the absence of actual cost data, the initial application for approval of a private pay telephone service must include a surrogate cost calculation based on the local exchange carrier's nontraffic sensitive and traffic sensitive costs of providing the service.

[(2) A local exchange carrier must commence tracking actual costs of providing private pay telephone service and local exchange carrier-provided public pay telephone service after the 50th private pay telephone access line has received service, unless otherwise provided in this subsection. Cooperatives are exempt from filing private pay telephone and local exchange carrier-provided public pay telephone tracking reports. The local exchange carrier must report actual costs to the commission on a quarterly basis. This report must be filed in the Central Records Office of the commission, and a copy must be delivered to the Director of the Telephone Utility Analysis Division. This report must include the following:

[(A) revenues and expenses associated with the provision of each element of private pay telephone service, including, but not limited to, access line, per message charge, and local exchange carrier-provided incoming or outgoing call screening, and revenues and expenses associated with the provision of each element of local exchange carrier-provided public pay telephone service;

[(B) the number of private pay telephones and the number of local exchange carrier-provided public pay telephones installed;

[(C) the number of local exchange carrier-provided public pay telephones displaced; and

[(D) the average number of calls placed from private pay telephones in areas with measuring capabilities and the average number of calls placed from local exchange carrier-provided public pay telephones in areas with measuring capabilities.

[(3) Cost studies based on its tracking reports must be included in any general rate case filed by a local exchange carrier after its obligation to commence tracking begins. These cost studies must include cost and revenue information necessary to design rates based on actual costs plus contribution.

[(k) Average schedule local exchange carriers. Rates for private pay telephone service provided by an average schedule local exchange carrier must be based on the average private] pay telephone rates of four similarly-situated **dominant certificated telecommunications utilities.** [local exchange carriers.]

(p)[(l)] Special assembly tariffs. A **dominant certificated telecommunications utility** [local exchange carrier] with less than 50 [private] pay telephone lines may provide **customer-owned** [private] pay telephone service pursuant to existing special assembly tariffs; however, in no event may a **dominant certificated telecommunications utility provide customer-owned** [local exchange carrier provide private] pay telephone service to more than **ten** [three] special assembly arrangements. Special assembly rates must be computed in accordance with this section. **Dominant certificated telecommunications utilities** [Local exchange carriers] that provide **customer-owned** [private] pay telephone service pursuant to special assembly tariffs must enter into a written agreement with the **subscriber to customer-owned** [private] pay telephone **service** [provider] that requires the **subscriber** [private pay telephone provider's private pay telephones] to perform all functions and obligations specified in subsection (e) [(d)] of this section.

(q)[(m)] Compliance. All **dominant certificated telecommunications utilities** [local exchange carriers] must file revised tariffs in compliance with this section within 45 days of the effective date of this section, or of any amendments thereto. [The compliance tariffs will be reviewed by the Telephone Utility Analysis Division. Within 35 days of the date of filing of the report, the Hearings Division shall either approve the tariff or suspend the effective date of the tariff for further review.]

(r)[(n)] Severability. If any provision of this section or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of this section that can be given effect without the invalid provision or application. It is the intent of the commission that the provisions of this section are severable.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511658

Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 458-0100

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TITLE 22. EXAMINING BOARDS

Part IX. Texas State Board of Medical Examiners

Chapter 193. Standing Delegation Orders

• 22 TAC §§193.2-193.4, 193.8

(Editor's Note: The Texas State Board of Medical Examiners proposes for permanent adoption the amended sections it adopts on

an emergency basis in this issue. The text of the amended sections is in the Emergency Rules section of this issue.)

The Texas State Board of Medical Examiners proposes amendments to §§193. 2-193.4 and 193.8 concerning standing delegation orders. These amendments will comply with changes made during the 74th Legislature through Senate Bill 1302 and Senate Bill 673 related to the delegation of prescriptive authority to physician assistants and advanced practice nurses.

Tim Weitz, general counsel, has determined that for the first five-year period the section is in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the section.

Mr. Weitz also has determined that for each year of the first five years the section is in effect the public benefit anticipated as a result of enforcing the section will be to make better use of the training and skills of physician assistants and advanced practice nurses through physician delegation.

Comments on the proposal may be submitted to Pat Wood, P.O. Box 149134, Austin, Texas 78714-9134. A public hearing will beheld at a later date.

The amendments are proposed under the Medical Practice Act, Texas Civil Statutes, Article 4495b, §2.09(a), which provide the Texas State Board of Medical Examiners with the authority to make rules, regulations and bylaws not inconsistent with this Act as may be necessary for the governing of its own proceedings, the performance of its duties, the regulation of the practice of medicine in this state, and the enforcement of this Act.

Article 4495b, §3.06, is affected by this amendment.

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

Issued in Austin, Texas, on September 13, 1995.

TRD-9511722 Bruce A. Levy, M.D., J.D
Executive Director
Texas State Board of
Medical Examiners

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 834-7728

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TITLE 25. HEALTH SERVICES

Part I. Texas Department of Health

Chapter 313. Athletic Trainers

General Requirements and Guidelines

• 25 TAC §313.3, §313.19

The Advisory Board of Athletic Trainers (board) proposes an amendment to §313.3 and new §313.19, concerning the regulation of licensed athletic trainers. Specifically, the sections cover fees and procedures for suspension of a license for failure to pay child support. The amendment adds a new fee for reinstatement of a license suspended for failure to pay child support. The new section sets out procedures for suspension and reinstatement of a license for failure to pay child support under the Family Code, Chapter 232, as added by Acts 1995, 74th Legislature, Chapter 751, §85 (House Bill 433).

Becky Berryhill, Program Director, has determined that for the first five-year period the sections are in effect there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Ms. Berryhill also has determined that for each year of the first five years the sections are in effect the public benefit anticipated as a result of enforcing the sections will be to assure the regulation of athletic trainers continues to identify competent practitioners. There will be no effect on small businesses. There is an anticipated economic cost of $40 to persons for reinstatement of a license suspended for failure to pay child support. There is no impact on local employment.

Comments on the proposal may be submitted to Becky Berryhill, Program Director, Advisory Board of Athletic Trainers, 1100 West 49th Street, Austin, Texas 78756-3183, (512) 834-6615. Comments will be accepted for 30 days from the date of publication of this proposal in the *Texas Register.*

The amendment and new section are proposed under Texas Civil Statutes, Article 4512d, §5, which provide the Advisory Board of Athletic Trainers with the authority to adopt rules concerning the regulation and licensure of athletic trainers.

The amendment and new section affect Texas Civil Statutes, Article 4512d.

§313.3. Fees.

(a) The schedule of fees of the board is as follows:

(1)-(4) (No change.)

(5) late renewal fee:

(A)-(B) (No change.)

(C) $130 when renewed at least one year but less than two years after expiration plus $10 if license certificate must be reissued; **and** [.]

(6) child support reinstatement fee-$50.

(b)-(f) (No change.)

§313.19. Suspension of License for Failure to Pay Child Support.

(a) On receipt of a final court or attorney general's order suspending a license due to failure to pay child support, the executive secretary shall immediately determine if the board has issued a license to the obligator named on the order, and, if a license has been issued:

(1) record the suspension of the license in the board's records;

(2) report the suspension as appropriate; and

(3) demand surrender of the suspended license.

(b) The board shall implement the terms of a final court or attorney general's order suspending a license without additional review or hearing. The board will provide notice as appropriate to the licensee or to others concerned with the license.

(c) The board may not modify, remand, reverse, vacate, or stay a court or attorney general's order suspending a license issued under the Family Code, Chapter 232 as added by Acts 1995, 74th Legislature, Chapter 751, §85 (House Bill 433) and may not review, vacate, or reconsider the terms of an order.

(d) A licensee who is the subject of a final court or attorney general's order suspending his or her license is not entitled to a refund for any fee paid to the board.

(e) If a suspension overlaps a license renewal period, an individual with a license suspended under this section shall comply with the normal renewal procedures in the Act and this chapter; however, the license will not be renewed until subsections (g) and (h) of this section are met.

(f) An individual who continues to use the title "athletic trainer" or practice athletic training after the issuance of a court or attorney general's order suspending the license is liable for the same civil and criminal penalties provided for engaging in the prohibited activity without a license or while a license is suspended as any other license holder of the board.

(g) On receipt of a court or attorney general's order vacating or staying an order suspending a license, the executive secretary shall promptly issue the affected license to the individual if the individual is otherwise qualified for the license.

(h) The individual must pay a reinstatement fee set out at §313.5 (relating to Fees) prior to issuance of the license under subsection (g) of this section.

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

Issued in Austin, Texas, on September 11, 1995.

TRD-9511654 Michael Saly
Chairman, Advisory Board of Athletic Trainers
Texas Department of Health

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 458-7236

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TITLE 28. INSURANCE

Part II. Texas Workers' Compensation Commission

Chapter 114. Self-Insurance

• 28 TAC §114.15

The Texas Workers' Compensation Commission proposes an amendment to §114.15, concerning revocation of certificate of authority to self-insure.

Recent legislation (House Bill 1089, 74th Legislature, 1995) amended the Texas Labor Code, §407.046 to require that hearings to determine whether a certificate of self-insurance should be revoked be conducted by the State Office of Administrative Hearings (SOAH) rather than Commission staff. House Bill 1089, §1.57 provides that transfer of a hearing to SOAH takes effect January 1, 1996 and a hearing held before or pending on December 31, 1995 is governed by the law in effect immediately before September 1, 1995. Procedures for requesting and conducting hearings transferred to SOAH are contained in Commission rules currently proposed as Chapter 148 of this title (relating to Hearings Conducted by the State Office of Administrative Hearings). Hearings convened prior to December 31, 1995 will continue to be conducted in accordance with Chapter 145 of this title (relating to Hearings Under the Administrative Procedure Act). The amendment to §114.15 is proposed to implement this requirement and clarify that the commission may request the hearing.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the section. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the Commission pursuant to an interagency contract. Costs for the hearings held under Chapter 145 of this title will decrease since no new hearings will be convened by the Commission hearing officers after December 31, 1995.

Ms. Chamness also has determined that for each year of the first five years the section as proposed is in effect the public benefit anticipated as a result of enforcing the section will be implementation of the changes made to the self-insurance program as adopted by the Legislature in House Bill 1089 and establishment of procedures for an impartial hearing process to determine if a certificate of authority to self-insure should be revoked.

The costs of the hearing process to participants other than the Commission should be no different than they are now, with the exception of the requirement that hearing documents be filed with the State Office of Administrative Hearings and in addition, with the Commission. This requirement could add minimal costs to the hearing process.

There will be no differences in the costs of compliance for small businesses as compared to large businesses. An entity must meet certain minimum premium requirements to apply for a certificate of authority to self-insure.

Comments on the proposal or requests for a public hearing must be received by 4:00 p.m. on October 20, 1995 and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The amendment is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; and the Texas Labor Code, §407.046, as amended by House Bill 1089, 74th Legislature, 1995, which provides the procedure for revocation of certificates of authority to self insure for those employers that fail to comply with requirements of the Workers' Compensation Act or Commission rules and mandates that the Commission refer all recommendations for revocation of authority to self-insure to the State Office of Administrative Hearings for a hearing on the matter.

The amendment to §114.15 affects the following statutes: the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §402.073, which requires the Texas Workers' Compensation Commission and the State Office of Administrative Hearings to cooperate in establishing procedures for holding hearings; the Texas Labor Code, §407.046, as amended by House Bill 1089, 74th Legislature, 1995, which provides the procedure for revocation of certificates of authority to self insure for those employers that fail to comply with requirements of the Workers' Compensation Act or Commission rules and mandates that the Commission refer all revocation of authority to self-insure recommendations to the State Office of Administrative Hearings for a hearing on the matter; the Texas Labor Code, §407.047, which sets out the effect of revocation of a certificate of authority to self-insure; and the Texas Government Code, §2003.021(c), which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

§114.15. Revocation of Certificate of Authority to Self-Insure.

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

(c) Pursuant to the Texas Labor Code, §§407.046, 407.047, and 407.082, [Articles 8308-3.61 and 3.68] the director shall continue to audit the claims of any self-insurer whose certificate has been revoked or withdrawn.

(d) The commission may exercise its right to request a hearing pursuant to §145.24 of this title (relating to Special Provisions for Imposing Sanctions Pursuant to the Act, §2.09(f)) or pursuant to §148. 3 of this title (relating to Requesting a Hearing) as applicable.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511731 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 133. General Medical Provisions

Subchapter C. Second Opinions for Spinal Surgery

• 28 TAC §133.206

The Texas Workers' Compensation Commission (the commission) proposes an amendment to §133.206, concerning the spinal surgery second opinion process.

Section 133.206 describes the process by which a carrier becomes liable for the costs of spinal surgery. The rule sets out procedures and liability for costs of a second-opinion examination and sets the fee for second opinions. The rule also sets qualifications for doctors to perform second opinions on spinal surgery and requires the commission to maintain a list of spinal surgeons and to provide sublists of five qualified doctors from which a second opinion doctor may be chosen by the injured employee and the carrier. A doctor must be on the spinal surgery list to be reimbursed by the carrier for spinal surgery. The commission's Medical Review division is given the authority to issue orders requiring timely submission of doctor's reports, to refer for administrative violation a doctor who fails to comply with the rule or an order, and to refer a doctor to the commissioners for removal from the Approved Doctor List. The rule sets out actions which may result in division action to suspend or commission action to remove a doctor from the

spinal surgeon list. In addition, the rule sets out the procedure for a doctor who has been suspended to request a hearing to contest the suspension.

Recent legislation (House Bill 1089, 74th Legislature, 1995) amended Texas Labor Code §415.034 to require that hearings on administrative violations be held by the State Office of Administrative Hearings. In addition, House Bill 1089 added Texas Labor Code §402.073 which requires the commission and the State Office of Administrative Hearings (SOAH) to cooperate in setting procedures for hearings transferred to SOAH and established when the administrative law judge would make a recommendation to the commission and when a final decision would be issued by the SOAH administrative law judge. House Bill 1089, §1.57 provides that transfer of jurisdiction of a hearing to SOAH takes effect January 1, 1996 and a hearing held before or pending on December 31, 1995 is governed by the law in effect immediately before September 1, 1995. Procedures for requesting and conducting hearings transferred to SOAH are contained in commission rules currently proposed as Chapter 148 of this title. Hearings convened prior to December 31, 1995 will continue to be conducted in accordance with Chapter 145 of this title.

The amendment to §133.206(c)(9) is proposed to make the hearing provisions of the rule consistent with the changes to Texas Labor Code, §402. 073 which transfers jurisdiction to hold hearings on deletions from the spinal surgeon list to the State Office of Administrative Hearings. To accomplish this, language has been added to subsection (c)(9) of §133.206 to clarify that when a hearing is requested under this rule it will be held by SOAH rather than commission staff for all hearings which convene after January 1, 1996. In addition, subsection (m) has been amended to change the expiration date of the rule from January 1, 1996 to January 1, 1997. This change of the expiration date is proposed because the rule has proved to be an effective tool in maintaining cost effective, quality care for spinal injuries and without this amendment, the rule will automatically expire on January 1, 1996. By changing the expiration date to January 1, 1997, the commission will be required to review and reevaluate the rule for it to continue in effect.

Subsection (d)(5) has been added to allow the commission Medical Review division to consider circumstances where an alternate second opinion doctor may be selected without penalty to the refusing second opinion doctor. The breadth and depth of knowledge needed to address spinal pathologies varies greatly. This amendment has been proposed to address the situation where a chosen second opinion doctor does not feel qualified to assess a certain case and wishes to decline the selection. Under the current rule the declining doctor would be subject to penalty for a refusal to accept the assignment. This amendment allows the Medical Review division to consider these circumstances, release a second opinion doctor, and select an alternate second opinion doctor without penalty to the originally selected doctor.

The current process for spinal surgery second opinion does not allow timely and effective case management by the Medical Review division. Injured employees who receive a nonconcurring opinion on spinal surgery from carrier selected second opinion doctors often do not schedule employee selected second opinion examinations because they do not wish to proceed with the recommendation for surgery. This causes the cases to stall indefinitely. The proposed amendment would address the issue by deleting current subsection (h) (1)(E) and (4) and adding subsection (h)(7) and (8). Subsection (h)(7) requires the Medical Review division to notify the employee, treating doctor, and surgeon that there is a nonconcurring second opinion, that for the carrier to become liable for the costs of surgery the employee must receive a concurrence from a doctor on the employee's sublist, and that failure to inform the division of the employee's selected doctor within 14 days will result in the withdrawal of the recommendation for spinal surgery. Subsection (h)(8) allows the treating doctor or surgeon to resubmit a withdrawn recommendation. In addition, subsection (h)(3) has been revised to clarify the selection process for an employee-selected second opinion doctor.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the proposed section. The dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held pursuant to these sections of the rules. Costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the commission pursuant to an interagency contract. There will be savings realized as a result of elimination of this hearing function from the commission's responsibility. The changes to subsection (h)(9) should result in a fiscal savings to state government, as the Medical Review Division will not have to allocate resources to continue processing and tracking spinal surgery requests which have in effect been abandoned by the requestor. The other changes to subsection (h) will not have a fiscal impact on the division but will allow the staff resources to be better utilized in a more efficient process which achieves concrete results. State and local entities required to comply with the section will be impacted the same as other entities, discussed later in this preamble.

Ms. Chamness also has determined that for each year of the first five years the section as proposed is in effect the public benefits anticipated as a result of enforcing the section will be to provide fair and efficient procedures for the resolution of workers' compensation disputes. The benefit to an individual who needs spinal surgery is speedier resolution, decreasing the time before surgery and recovery. While the anticipated economic costs to persons who are required to comply with the rule as proposed cannot be accurately estimated, there may be economic costs to persons who are required to comply with the rule as proposed due to filing of contested case documents with SOAH as well as with the commission Chief Clerk. There may be a reduction in costs to persons involved in medical disputes referred to SOAH since the evidence in most cases will be limited to what was introduced in the division review and may shorten hearings. In addition, there may be a savings to employers and carriers and to the workers' compensation system as a whole. No-shows at commission-scheduled second opinion appointments are currently reimbursed at $100 each, and the amendment to the rule should significantly reduce the number of no-shows. Quicker resolution of the process should decrease the time required for a worker to achieve maximum medical improvement, at which point temporary income benefits cease.

There will be no difference in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal or requests for public hearing must be received by 4:00 p.m. on October 20, 1995, and may be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The amendment is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §408.026, which establishes when a carrier is liable for costs relating to spinal surgery and mandates that the commission adopt rules necessary effectuate the statute; the Texas Labor Code, §415.034, as amended by House Bill 1089, 74th Legislature, 1995, which allows a party charged with an administrative violation or the Executive Director of the commission to request a hearing with the State Office of Administrative Hearings; and the Texas Government Code, §2003.021(c), which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

The amendment to §133.206 affects the following statutes: the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §402.072, which mandates that only the commission can impose sanctions which deprive a person of the right to practice before the commission, receive remuneration in the workers' compensation system, or revoke a license, certification or permit required for practice in the system; the Texas Labor Code, §402.073, as amended by House Bill 1089, 74th Legislature, 1995, which requires the Texas Workers' Compensation Commission and the State Office of Administrative Hearings to cooperate in establishing procedures for holding hearings; the Texas Labor Code, §408.022, which requires an employee receiving treatment under the workers' compensation system to choose a doctor from a list of doctors approved by the commission and establishes the extent of an employee's option to select an alternate doctor; the Texas Labor Code, §408.023, as amended by House Bill 1089, 74th Legislature, 1995, which establishes which doctors are placed on the approved list

of doctors and mandates that the commission establish rules for deleting and reinstating doctors to the list, the Texas Labor Code, §408 026, which establishes when a carrier is liable for costs relating to spinal surgery and mandates that the commission adopt rules necessary effectuate the statute; the Texas Labor Code, §413.007, which prescribes certain statewide data which must be maintained by the Medical Review division; the Texas Labor Code, §413.011, which mandates that the commission by rules establish medical policies and guidelines; the Texas Labor Code, §415.003, as amended by House Bill 1089, 74th Legislature, 1995, which lists actions or inactions which constitute an administrative violation by a health care provider; the Texas Labor Code, §415.034, as amended by House Bill 1089, 74th Legislature, 1995, which allows a party charged with an administrative violation or the Executive Director of the commission to request a hearing with the State Office of Administrative Hearings, the Texas Government Code, §2003.021(c), which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

§133.206. Spinal Surgery Second Opinion Process.

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

(c) Commission List and Sublist.

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

(3) If requested by an injured employee, a treating doctor or surgeon on behalf of the injured employee, or a carrier, the division will provide a sublist of five qualified doctors from which a second opinion doctor may be chosen. The sublist will be composed of qualified doctors located within 75 miles of the injured employee's residence, and will be selected from the List by the division on a rotating basis. If the List does not include five qualified doctors located within 75 miles of the injured employee's residence, the division will include on the sublist the qualified doctors who are located at a greater distance. **The treating doctor or surgeon must, within seven days of receiving the sublist from Medical Review, notify Medical Review of the employee's selection of second opinion doctor, and the date and time of the employee-selected second opinion appointment.**

(4)-(8) (No change.)

(9) The division will notify the doctor by delivery, return receipt requested, of the division's intent to recommend to the commissioners that the doctor be suspended from the List. Within 20 days after receiving the notice, a doctor may request a hearing to be held as provided by §145.3 of this title (relating to Requesting a Hearing) or **as provided by §148.3 of this title (relating to Requesting a Hearing) as applicable.** The request must be in writing to the division and actually received in the commission's central office in Austin, Texas, within 20 days after the doctor's receipt of the notice of intent to suspend the doctor from the List. If a request for hearing is timely received, the commission will hold a hearing as provided in Chapter 145 of this title (relating to Dispute Resolution–Hearings Under the Administrative Procedure Act) **or the State Office of Administrative Hearings will hold a hearing as provided in Chapter 148 of this title (relating to Hearings Conducted by the State Office of Administrative Hearings.) At the conclusion of a hearing conducted under the provisions of Chapter 145 of Chapter 148 of this title, the hearing officer shall propose a decision to the commission for final consideration and decision by the commission.** If no request for a hearing is timely filed, the division's recommendation will be reviewed by the commissioners at a public meeting and a decision made to either suspend or maintain the doctor on the List.

(10)-(11) (No change.)

(d) Second Opinion Doctor's Qualifications.

(1)-(4) (No change.)

(5) A second opinion doctor is responsible for performing an exam if requested by the insurance carrier, the injured worker or the Commission unless the division releases the doctor from assessing a particular employee. To consider releasing a proposed second opinion from the requirement to render an opinion on a specific case, Medical Review must agree that the selected second opinion doctor is not qualified due to unique or complex pathology or because the doctor's expertise excludes the involved body area.

(e)-(g) (No change.)

(h) Division Notification to Employee of Option to Obtain a Second Opinion From an Employee-Selected Doctor.

(1) If the carrier elects to have a second opinion and the employee has not already scheduled a second opinion from an employee-selected doctor, the division shall notify the employee of the following:

(A)-(B) (No change.)

(C) the sublist from which the employee may select an employee-selected doctor; **and**

(D) the procedures and the time deadlines, for obtaining a second opinion from an employee-selected doctor[; and]

[(E) if the carrier-selected second opinion is a nonconcurrence, that failure to select an employee-selected doctor pursuant to paragraph (2) of this subsection will result in a requirement to attend a medical examination scheduled by the commission unless the employee withdraws the request for spinal surgery.]

(2) (No change.)

(3) If the injured employee [selects] **elects to have an** [the] employee-selected second opinion [doctor], the injured employee [with assistance from the treating doctor or surgeon] shall select a qualified second opinion doctor from the sublist. **The injured employee may seek assistance from the treating doctor or surgeon in selecting a doctor from the sublist. The appointment must be** [and schedule] **scheduled** [the appointment date] prior to **the treating doctor's or surgeon's submission of** [submitting] an amended TWCC-63 which contains the information required by subsection (e) of this section. The amended TWCC-63 must be filed with the division no later than ten days after the treating [doctor] **doctor's** or surgeon's receipt of notification from the division.

[(4) If the commission does not receive the notice within five days, the commission shall set the appointment with a doctor on the employee's sublist and notify the injured employee, treating doctor, surgeon, and carrier of the appointment information. The carrier will be notified via the carrier representative's box.]

(4)[(5)] The second opinion exams scheduled in this subsection shall be set for a date later than the carrier-selected doctor second opinion appointment.

(5)[(6)] If the second opinion of the carrier-selected doctor is a concurrence the appointment scheduled in this subsection may be canceled.

(6)[(7)] Decisions, reports, records, and payments for second opinions obtained pursuant to this subsection shall be governed by the same provisions applicable to second opinions pursuant to subsections (i) and (j) of this section.

(7) If the carrier selected second opinion exam results in a nonconcurrence and the division has not received notice of the employee's choice of second opinion doctor, the division will notify the employee, treating doctor and surgeon of the following:

(A) that the carrier selected second opinion exam resulted in a nonconcurrence;

(B) that in order for the carrier to become liable for the costs of surgery, the employee must receive a concurrence from one of the doctors on the employee sublist; and

(C) that failure to inform the division of the employee's selection of a second opinion doctor, within 14 days of nonconcurrence notification from the division, will result in withdrawal of the recommendation for spinal surgery.

(8) If a recommendation is withdrawn, the treating doctor or surgeon may resubmit in accordance with subsection (l)(1) of this section.

(i)-(l) (No change.)

(m) This section will become effective [November 1, 1994] and affects all [for initial] Form TWCC-63's filed with the commission on or after November 1, 1994 [that date] and remain effective until January 1, [1996] 1997.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511730 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 145. Dispute Resolution–Hearings Under the Administrative Procedure Act

• 28 TAC §145.1

The Texas Workers' Compensation Commission proposes an amendment to §145.1, concerning the scope of the commission's dispute resolution procedure rules for hearings held under the Administrative Procedure Act. The amendment is proposed in order to limit the scope of the chapter 145 rules to those hearings conducted by the commission's hearings officers. Separately, the commission will propose new rules under new Chapter 148 to specify procedures for hearings to be held by administrative law judges of the State Office of Administrative Hearings, pursuant to recent legislation (House Bill 1089, 74th Legislature, 1995).

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the section. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in the future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the commission pursuant to an interagency contract. Costs for the hearings held under chapter 145 of the commission's rules will decrease since no new hearings will be convened by commission hearing officers after December 31, 1995.

Ms. Chamness also has determined that for each year of the first five years the section as proposed is in effect the public benefits anticipated as a result of enforcing the section will be to clarify that the procedure rules in chapter 145 are applicable only to those Administrative Procedure Act hearings held by the commission's hearings officers. There will be no anticipated economic costs to persons who are required to comply with the section as proposed.

There will be no differences in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal must be received by 4:00 p.m. on October 20, 1995 and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491. The commission has scheduled a public hearing on these proposed new rules for 11:00 a.m., on October 11, 1995, in Room 910 at the commission's central office at the address listed previously in this request for comments. If a quorum of the Commission is not present, a public hearing will still be held.

The amendment is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Texas Workers' Compensation Act, as amended by recent legislation (House Bill 1089, 74th Legislature, 1995); and the Texas Labor Code, §§402.073, 407.046(b) and (c), 411.049(b), 413.031(d), and 415.034(a), as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings, and House Bill 1089, 74th Legislature, 1995, which provides that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995.

The proposed amendment affects the following statutes: Texas Labor Code, §§402.061, 402.073, 407.046(b) and (c), 411.049(b), 413.031(d), and 415. 034(a), as amended by House Bill 1089, 74th Legislature, 1995.

§145.1. Scope and Applicability.

(a) Scope of these rules. Except for benefit disputes, governed by chapters 140, 142, and 143 of this title (relating to Dispute Resolution-General Provisions; Dispute Resolution-Benefit Contested Case Hearing; and Dispute Resolution-Review by the Appeals Panel), these rules govern all hearings provided by the commission to adjudicate disputes arising under the Texas Workers' Compensation Act (the Act), **where the first day of a hearing in which evidence is admitted occurs prior to January 1, 1996 or where pre-evidentiary-hearing procedures occur prior to January 1, 1996.**

(b) Applicability of the Administrative Procedure [and Texas Register] Act. The sections of the Administrative [Procedures and Texas Register] **Procedure** Act [(APTRA)] **(APA)** enumerated in **the Texas Labor Code, §401.021(1)** [§1.02(a)(1)], apply to the hearings governed by this chapter. In hearings involving those sanctions defined by the **Texas Labor Code, §§402.072, 407.046, and 408.023** [Act, §2.09(f)], the commissioners render the final decision and the provisions of **the APA, §2001.062** [APTRA, §15], will be followed.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511724 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 148. Hearings Under the State Office of Administrative Hearings

• 28 TAC §§148.1-148.28

The Texas Workers' Compensation Commission proposes new §§148.1-148.28 in a new Chapter 148, concerning procedures governing all hearings, conducted by the State Office of Administrative Hearings, to adjudicate disputes arising under the Texas Workers' Compensation Act (the Act). These procedures are not applicable to benefit disputes, governed by Chapters 140, 142, and 143 of this title (related to Dispute Resolution-General Provisions; Benefit Contested Case Hearing; and Review by the Appeals Panel, respectively) and other hearings where the original hearing day for the introduction of evidence is called to order prior to January 1, 1996 as specified by chapter 145 of this title (related to Dispute Resolution–Hearings Under The Administrative Procedure Act). The new rules are proposed in order to establish procedures for commission hearings to be conducted by the State Office of Administrative Hearings in compliance with recent legislation (House Bill 1089, 74th Legislature, 1995). The existing rules in Chapter 145 of

this title (relating to Hearings Under the Administrative Procedure Act) will remain in effect after January 1, 1996 only for those hearings described in that chapter.

These new rules are based on the text of the rules in Chapter 145, with modifications made either to clarify existing procedures of the commission or to ensure efficiency in hearings by administrative law judges involving specialized procedures unique to the Texas Workers' Compensation Act and the implementing rules. New §148.4(a) is designed to allow sufficient time for pre-hearing discovery and settlement negotiations. However, the subsection requires that hearings for preauthorization requests under Texas Labor Code, §413.014, be held within 30 days because of the need for an expedited decision in cases involving a proposed medical procedure for an injured worker. Due to increasing costs of travel and agency budgetary constraints, the new §148.6 eliminates the possibility of holding hearings outside of Austin, Texas but allows for receipt of testimony of witnesses by telephone. New §148.7 clarifies that a party to a hearing is entitled to the assistance of his or her counsel, if present at the hearing. New §148.8(b) should result in reduced expenses for all parties (since the decision-maker will be able to withdraw or amend the small percentage of decisions containing an obvious error, when identified in requests for hearing), without necessitating formal hearings. New §148.18(a) promotes the consideration of all relevant evidence at the first review of the dispute by the commission's dispute resolution officer and the integrity of that review. If an APA hearing is requested after the decision of the dispute resolution officer, the offeror of new evidence could demonstrate "good cause" for admissibility of such evidence if it was not available and was not reasonably obtainable by the deadline for submission of evidence to be considered by the commission's dispute resolution officer. The offeror of new evidence will be required to make an advance filing with the other parties of what new evidence will be offered and the facts purporting to be "good cause" for the admissibility of the new evidence so that other parties can be adequately prepared to argue the issue of "good cause" and to present any rebuttal evidence. New §148.18(b) will allow the commission's dispute resolution officer to be called as a witness only when served with a timely subpoena. The procedural limitations, established for the appearance and testimony of a dispute resolution officer of the commission, are based upon the irrelevancy of the thought processes of an administrative decision-maker in a subsequent review of any decision (as indicated in *Smith v. Houston Chemical Services, Inc.*, 872 S.W. 2d 252, 266-267, Tex. App.-Austin, 1994, no writ) and the "mental processes" rule (as indicated in *Thomas v. Walker*, 860 S.W. 2d 579, 582, Tex. App.-Waco, 1993, no writ). New §148.21(h) is based, in part, upon the burden of proof being placed upon the parties other than the commission by the Texas Workers' Compensation Act and the implementing rules. Examples are specified in the rule. The procedural requirements established in new §148.21(j) should result in more efficient hearings since the parties will have advance knowledge of objections to any portion of the record considered or the decision rendered by the commission's dispute resolution officer. New §148.25 does not contain language similar to the Texas Labor Code, §415.035(c), because of the ruling in *Tex. Ass'n of Business v. Air Control Bd.*, 852 S.W. 2d 440 (Tex. 1993).

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed sections are in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the new sections. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in the future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the commission pursuant to an interagency contract.

Ms. Chamness also has determined that for each year of the first five years the new sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be to provide fair and efficient procedures for the conduct of those commission contested case hearings which will be conducted by State Office of Administrative Hearings administrative law judges. The anticipated economic costs to individuals who are required to comply with the rule as proposed cannot be accurately estimated. There may be economic costs to persons who are required to comply with the sections as proposed due to filings of contested case documents being made at SOAH as well as with the TWCC Chief Clerk. The amount of any additional costs to individuals due to the filing requirements cannot be accurately estimated because the number of filings in a case varies depending on many factors. In addition, the cost of mailing a filing is generally dependent on the weight of the mailed documents. There may, also, be reduced costs in hearings for many parties in hearings involving issues of medical fees and services because a party either objecting to prior evidence considered or requesting the appearance of the dispute resolution officer will be required to provide prior notice to the other parties in such a hearing. Such prior notice should allow disputes in these areas to be solved more economically prior to the hearing. There will be no difference in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal must be received by 4:00 p.m. on October 20, 1995 and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491. The commission has scheduled a public hearing on these proposed new sections for 11:00 a.m., on October 11, 1995, in Room 910 at the commission's central office at the address listed previously in this request for comments. If a quorum of the Commission is not present, a public hearing will still be held.

The new rules are proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Texas Workers' Compensation Act, as amended by recent legislation (House Bill 1089, 74th Legislature, 1995); and the Texas Labor Code, §§402.073, 407.046(b) and (c), 411.049(b), 413.031(d), and 415.034(a), as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings, and House Bill 1089, 74th Legislature, 1995, which provides that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995.

The new sections affect the following statutes: Texas Labor Code, §§402. 061, 402.073, 407.046(b) and (c), 411.049(b), 413.031(d), and 415.034(a), as amended by House Bill 1089, 74th Legislature, 1995.

§148.1. Scope and Applicability.

(a) Scope of these rules. Except for benefit disputes, governed by chapters 140, 142, and 143 of this title (relating to Dispute Resolution-General Provisions; Dispute Resolution-Benefit Contested Case Hearing; and Dispute Resolution-Review by the Appeals Panel), these rules govern all hearings to adjudicate disputes arising under the Texas Workers' Compensation Act (the Act), where the first day of a hearing in which evidence is admitted occurs on or after January 1, 1996.

(b) Applicability of the Administrative Procedure Act. The sections of the Administrative Procedure Act (APA) enumerated in the Texas Labor Code, §401.021(1), apply to the hearings governed by this chapter. In hearings involving those sanctions defined by the Act, §§402.072, 407.046, and 408.023, the commissioners render the final decision and the provisions of the APA, §2001.062 will be followed.

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

Act-The Texas Workers' Compensation Act, as specified in the Act, §§401.001 et seq.

APA-The Administrative Procedure Act, as specified in the Government Code, Chapter 2001.

Commission-The Texas Workers' Compensation Commission.

Commission Representative-The attorney or representative designated by the executive director of the commission to represent the commission.

Hearing Officer-The administrative law judge (ALJ) designated by the State Office of Administrative Hearings (SOAH) to preside over the hearing.

Party-A person including the commission entitled to take part in a proceeding

because of a direct legal interest in the outcome.

Petitioner–The person who has filed a written request for a hearing in accordance with these procedures.

Respondent–The person responding to the petitioner's request for a hearing.

SOAH–The State Office of Administrative Hearings.

§148.3. Requesting a Hearing.

(a) The person requesting a hearing must file a written request with the Chief Clerk of Proceedings, Hearings Division of the commission not later than 20 days after receipt of the official notice of adverse action from the commission, receipt of the decision from the medical review division on a review of a medical service or a medical fee under the Act, §413.031, or receipt of a notice of the intent of the commission to determine the legal rights, duties, or privileges of a party within the scope of §148.1 of this title (relating to Scope and Applicability)

(b) The commission shall deliver the request for a hearing to SOAH within five working days of receipt.

(c) If the notice of adverse action is a notice of alleged violation, the person charged must file an answer not later than the 20th day after the date of receipt of the notice. The answer must either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing.

(d) Notwithstanding the provisions of subsection (a) of this section, the commission may request a hearing as permitted by the Act and the implementing rules to the Act, including, but not limited to the Act, §407.046(b) and §411.0415(c).

§148.4. Notice of Hearing.

(a) General scheduling of hearings. Except as provided in subsection (c) of this section, SOAH shall schedule the date, time, and location of the hearing, and will notify the commission's Chief Clerk of Proceedings, Hearings Division, of such scheduling no later than ten days after receiving a request for hearing. Unless good cause is shown, SOAH will set a hearing to consider a proposed penalty under the Texas Labor Code, Chapter 415, Subchapter B for a date no earlier than 60 days after SOAH has received the request for a hearing. Unless good cause is shown, SOAH will set hearings involving issues of preauthorization under the Act, §413.014, for a date no more than 30 days after SOAH has received the request for a hearing. In all other cases under the Act, §413.031, SOAH will set such cases for a date within the 90-day period specified in §413.031(d).

(b) Notice of hearing. Except as provided in subsection (c) of this section, and no later than ten days before the hearings date, the commission's Chief Clerk of Proceedings, Hearings Division, shall notify the parties in writing of the date, time, place and nature of the hearing; the legal authority and jurisdiction under which the hearing will be held; a reference to the particular sections of the statutes and any rules involved; and a short, plain statement of the matters asserted. The reference to the statutes and rules and the short, plain statement may be provided by the commission's representative, and, if so, would not be provided by the Chief Clerk of Proceedings, Hearings Division.

(c) Notice of hearing under the Act, §407.046(b). No later than 30 days before the hearing date, SOAH shall notify, in writing, a certified self-insurer and the commission's Chief Clerk of Proceedings, Hearings Division of the date, time, place, and nature of a hearing concerning the intent of the commission to revoke a certificate of self-insurance under the Act, §407.046. The notice shall contain a reference to the particular sections of the statute and any rules involved; and a short, plain statement of the matters asserted, including the grounds for the proposed revocation action.

(d) Expediting the hearing. The hearing officer may expedite any or all parts of the hearing if any party requesting it provides a verified statement of good cause, the opposing party has the opportunity to respond, and the hearing officer makes a determination of good cause. In this event, the hearings officer shall notify the commission's Chief Clerk of Proceedings of the Hearings Division who shall send all parties notice of the hearing officer's decision to expedite any or all parts of the hearing. The written notice shall be sent to all parties no later than ten days prior to the expedited hearing date and shall include:

(1) a statement of the date, time, place, and nature of the hearing;

(2) a statement of the legal authority and jurisdiction under which the hearing will be held; and

(3) a reference to the particular sections of the statutes and rules involved and a short, plain statement of the matters asserted.

§148.5. Statement of Matters Asserted. Except for expedited hearings or when already completed within the notice of hearing under §148.4 of this title (relating to Notice of Hearing), the commission's representative must deliver to the parties and file with the hearing officer no later than ten days prior to the hearing date.

(1) a reference to the particular sections of the statutes and rules involved; and

(2) a short, plain statement of the matters asserted.

§148.6. Venue. Hearings are held in Austin, Travis County. A party may appear in person or, if approved in advance of the hearing by the hearing officer, may participate by telephone conference.

§148.7. Appearance and Representation. A party may represent himself or herself or be represented by a designated person. A party may be represented by an attorney who is licensed to practice law in Texas. A party is entitled to the assistance of his or her counsel, if present, during the hearing.

§148.8. Withdrawal of Hearing Request.

(a) The petitioner may, at any time before the decision and order is signed, submit a written request to withdraw the request for a hearing. Unless good cause is demonstrated by the petitioner, subsequent requests for a hearing on the same issues will not be considered and the contested action will be final and effective as specified in the notice letter to the petitioner.

(b) Notwithstanding the provisions of subsection (a) of this section, if a decision of the commission's medical review division in a review of a medical service or medical fee under the Act, §413.031 has been set for a contested case hearing before SOAH and if the decision of the division is withdrawn or an amended decision is issued by the division within ten working days after the commission received the request for hearing before SOAH, then the commission shall file a request to withdraw the case from the SOAH docket. SOAH shall then issue an order dismissing the case without prejudice from the SOAH docket.

§148.9. Informal Disposition. At any time prior to the signing of the decision by the Hearing Officer or the commission, informal disposition of any case may be made by a written stipulation, an agreed settlement or consent order, or default.

§148.10. Filing Instruments; Furnishing Copies.

(a) Filing instruments. All instruments relating to a pending proceeding, including pleadings, requests, motions, and responses, shall:

(1) be in writing;

(2) specify the desired relief and grounds for relief; and

(3) be filed with SOAH and the commission's Chief Clerk of Proceedings in the Hearings Division.

(b) Motions. If based upon matters that do not appear of record, a motion must be supported by affidavit.

(c) Furnishing copies. A copy of every instrument shall be provided by the party offering it to every other party or attorney. A certification of this fact shall accompany the instruments filed with SOAH and the commission. Failure to provide copies may be grounds for refusal to consider the instrument.

(d) Certificate of service. A certificate by the party, or attorney who files a pleading stating that it has been served on the other parties will be considered prima facie evidence of service. The following form of certificate is sufficient: "I hereby certify that I have on this day of, 19, served a copy of the attached instrument on [state the name of the other parties on whom a copy was served in addition to service upon SOAH and the commission's Chief Clerk of Proceedings, Hearings Division] by [state the manner of service.]" Signature

§148.11. APA Prehearing Conference.

(a) On the motion of any party, or on his or her own motion, the hearing officer may direct the parties and their representatives to appear at a specified time and place for a conference before the hearing, for the purpose of:

(1) formulating issues;

(2) simplifying issues;

(3) discussing matters to be officially noticed;

(4) discussing the possibility of making admissions of fact or stipulations concerning the use by any party of matters of public record, such as the official records of the commission, for the purpose of avoiding the unnecessary introduction of proof;

(5) ruling on previously filed motions;

(6) discussing the procedure to be followed at the hearing;

(7) discussing the limitation, where possible, of the number of witnesses; and

(8) discussing any other matters that may assist in the simplification of the proceedings and the disposition of the case, including settlement of issues in dispute.

(b) Action taken at the conference shall be recorded in any appropriate order or written communication to the parties by the hearing officer.

§148.12. Request for Alternative Dispute Resolution. A party may request alternative dispute resolution. If the request is granted, the hearing officer will notify the Senior ALJ of SOAH who will appoint another hearing officer to assist in the dispute resolution process. If the dispute resolution process is successful, then the settlement will be reduced to writing, signed by the parties and submitted to the assisting hearing officer for entry of orders. If the dispute resolution process is unsuccessful, the case shall be reset as quickly as possible for hearing by the original hearing officer.

§148.13. Discovery and Production of Documents and Tangible Things for Inspection, Copying or Photographing.

(a) Inspection, copying and photographing tangible things and entry upon land. Upon timely motion of any party and upon notice to all other parties, and subject to such limitations of the kind provided for discovery under the Texas Rules of Civil Procedure, the hearing officer may order any party to:

(1) produce and permit the inspection and copying or photographing by or on behalf of the moving party of any of the following that are in his possession, custody or control: designated documents, papers, books, accounts, letters, videotapes, photographs, objects, or tangible things, not privileged, that constitute or contain, or are reasonably calculated to lead to the discovery of, evidence that is material to any matter involved in the action; and

(2) permit entry upon designated land or other property in that party's possession or control for the purpose of inspecting, measuring, surveying, or photographing the property or any designated objects or operation on the property that may be material to any matter involved in the action.

(b) Order permitting discovery. The order must specify the time, place and manner of making the inspection, measurement, or survey and taking the copies and photographs and may prescribe terms and conditions that are just.

(c) Reports and statements. The identity and location of any potential party or witness may be obtained from any communication or other paper in the possession, custody, or control of a party, and any party may be required to produce and permit the inspection and copying of the reports, including factual observations and opinions, of an expert who will be called as a witness. However, this provision does not apply to other written statements of witnesses or other written communications passing between agents or representatives or the employees of any party to the hearing or to other communications between any party and his agents, representatives, or their employees, where made subsequent to the occurrence or transaction upon which the hearing is based, and made in connection with the prosecution, investigation, or defense of issues before the hearing officer.

(d) Statement previously made. Any person, whether or not a party, is entitled to obtain, upon request, a copy of any statement he has previously made concerning the action or its subject matter. If his request is refused, he may move for an order according to this section. For the purpose of this section, a statement previously made is either:

(1) a written statement signed or otherwise adopted or approved by the person making it; or

(2) a videotape, or a stenographic, mechanical, electrical, or other recording, or a transcription thereof, which is a substantially verbatim recital of an oral statement by the person making it and contemporaneously recorded.

(e) Nonparty discovery. The hearing officer may order a person not a party to the hearing to appear and produce relevant documents or tangible things according to this section. The hearing officer may make this order only after a motion has been filed specifically stating the request and necessity therefore. All parties and those who are not parties must have the opportunity to object in writing to the motion. The hearing officer may hold a hearing on the motion at the hearing officer's discretion.

(f) Admissions of facts and genuineness of documents. Any time after the request for a hearing, a party may deliver or have delivered to any other party a written request for admissions of facts and genuineness of documents. The provisions of the Rules of Civil Procedure, Rule 168 apply, except that filing and enforcing are controlled by the hearing officer and that the time limit to respond is 25 (not 30) days.

(g) Interrogatories to parties. Any time after the hearing has been docketed, any party may serve interrogatories upon any other party. The provisions of the Rules of Civil Procedure, Rule 169 apply, except that filing and enforcing are controlled by the hearing officer and the number of questions is limited so as not to require more than 25 answers.

§148.14. Subpoenas; Depositions.

(a) Request for subpoena. On the hearing officer's own motion or on the written request of any party, and a showing of good cause, and on the deposit of sums that reasonably ensure payment of the amounts estimated to accrue under this section, the hearing officer may issue a subpoena addressed to the sheriff or any constable to require the attendance of a witness and production of books, records, paper or other objects that may be necessary and proper for the purpose of the proceedings.

(b) Request for deposition. On the hearing officer's own motion or on any party's written request and on deposits of sums that reasonably ensure payment of the amounts estimated to accrue under this section, the hearing officer may issue a commission addressed to the several officers authorized by statute to take depositions, to require that the deposition of a witness be taken. The hearing officer authorizes the issuance of any subpoena necessary to require that the witness appear and produce, at the time the deposition is taken, books, records, papers, or other objects that may be necessary and proper for the purpose of the proceeding. The deposition of a member of an agency, board or commission may not be taken after a hearing date has been set. The deposition is taken according to the requirements of the APA, Chapter 2001.

(c) Filing request for deposition. Requests for commissions are addressed to the hearing officer.

(d) Objections during deposition. The officer taking the oral depositions may not sustain objections to any of the testimony taken, or exclude any of it, and any of the parties or attorneys engaged in taking testimony may have their objections reserved for the action of the hearing officer. The hearing officer is not confined to objections made at the taking of the testimony.

(e) Returning completed deposition to SOAH. A deposition may be returned to SOAH either by mail, by a party interested in taking the deposition, or by any other person. If returned by mail, SOAH must endorse the deposition to show it was received from the post office. The SOAH employee receiving the deposition must sign it. If it is not sent by mail, the person delivering it to SOAH must make an affidavit before a SOAH representative that:

(1) he received it from the hands of the officer before whom it was taken;

(2) it has not been out of his possession since; and

(3) it has undergone no alteration.

(f) Opening deposition at SOAH. After the deposition is filed with SOAH, any SOAH employee may open the deposition at the request of either a party or the party's counsel. The employee must endorse the deposition by entering the date and name of the person who asked that it be opened. The employee must then sign the deposition. The deposition must remain on file with SOAH and may be inspected by any party.

(g) Failure to comply with subpoena or commission. If a person fails to comply with a subpoena or commission, SOAH, acting through the attorney general, or the party requesting the subpoena or commission, may bring suit to enforce the subpoena or commission in a district court in Travis County.

§148.15. Ex Parte Communications. The Administrative Procedure Act, §2001.061 applies to commissioners and employees of the commission and to the hearings officers of SOAH. It provides that:

(1) unless required for the disposition of ex parte matters authorized by law, members or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law in a contested case may not communicate, directly or indirectly, in connection with any issue of fact or law with any agency, person, party, or their representatives, except on notice and opportunity for all parties to participate; and

(2) under the APA, §2001.090, a member of an agency or employees of an agency assigned to render a decision or to make findings of fact and conclusions of law in a contested case, including SOAH, may communicate ex parte with employees of the commission, who have not participated in any hearing in the case for the purpose of utilizing the special skills or knowledge of the commission and its staff in evaluating the evidence.

§148.16. Conduct and Decorum.

(a) The hearing officer may, at the beginning of any proceeding and during the course of that proceeding, establish rules of decorum to be followed during the proceeding. The hearing officer may also establish times for beginning the proceeding, for recesses, and for ending the proceeding.

(b) Parties and participants in a proceeding shall conduct themselves with dignity, shall show courtesy and respect for one another and for the hearing officer, shall follow the decorum prescribed by the hearing officer at the proceeding, and shall adhere to the beginning times of the proceeding, and to the times established for each recess and for ending the proceeding.

(c) To maintain and enforce proper conduct and decorum at a proceeding, and to enforce promptness at a proceeding, the hearing officer may take appropriate action, including but not limited to:

(1) issuing a warning;

(2) excluding any person from the proceeding; and

(3) recessing the proceeding.

§148.17. Hearing Officer's Authority.

(a) The hearing officer is in charge of the proceedings.

(b) The hearing officer has the authority to:

(1) administer oaths;

(2) examine witnesses;

(3) issue subpoenas and commissions; and

(4) rule on the admissibility of evidence and amendments to pleadings.

(c) The hearing officer may also:

(1) establish reasonable time limits for conducting hearings;

(2) establish reasonable time limits for accepting requests for additional information; and

(3) issue any intermediate orders.

(d) The hearing officer has the authority to issue any orders necessary to enforce rulings, including, but not limited to:

(1) limiting evidence or witnesses;

(2) limiting oral argument;

(3) entering appropriate orders or default decisions on any issue; or

(4) postponing, recessing or dismissing the hearing, with or without prejudice, except as limited by §148.8 of this title (relating to withdrawal of Hearing Request).

(e) Upon a finding of good cause as determined by the hearing officer, the hearing officer may postpone, continue, or recess the hearing.

(f) Before or during a hearing, the hearing officer may call any witness or witnesses or request any party to call a witness or witnesses that the hearing officer believes are necessary.

§148.18. Parties' Rights in Hearings.

(a) Subject to the hearing officer's ruling and orders, opportunity must be given to all parties to present and respond to evidence and argument on each issue involved. If a decision of the commission's medical review division in a review of a medical service or medical fee dispute has been set for a contested case hearing, new evidence, not considered at the review, will not be admitted unless the offeror demonstrates good cause and submits a summary of the new evidence and the facts purporting to be good cause at least seven days prior to the hearing, unless the offeror demonstrated good cause why such a summary and facts cannot be provided.

(b) The parties to a hearing shall be permitted to call any witness desired, within the limits set by the hearing officer. The

medical dispute resolution officer rendering a decision shall not be required to appear at the hearing or at a deposition except if a subpoena is timely issued after the requestor has demonstrated good cause why the commission's dispute resolution officer should appear.

(c) The parties to a hearing may conduct cross-examination of witnesses.

§148.19. Failure to Appear. If a party seeking relief does not appear for the hearing, after presentation of a prima facie case by the opposing party, a default decision will be entered, absent good cause that prevented the party's appearance.

§148.20. Recording the Hearing.

(a) Recording by the hearing officer. Except as otherwise provided, the hearing will be recorded by the hearing officer on audio cassette tape.

(b) Recording by a party. A party may, with prior notice to the hearing officer, furnish a certified hearings reporter to make a verbatim record, or a transcript, of the hearing. The party is responsible for all associated costs. If a verbatim record is made, the party shall provide the commission and SOAH with a copy of the audiotape, free of charge. If a transcript is made, the party shall provide the commission with the original of the transcript free of charge.

§148.21. Evidence.

(a) Rules of evidence in general. Except as provided in §148.18(a) of this title (relating to Parties' Rights in Hearings), the rules of evidence as applied in non jury civil cases in the district courts of this state shall be followed. Irrelevant, immaterial or unduly repetitious evidence is excluded. When necessary to determine facts not reasonably susceptible of proof under those rules, evidence not admissible under those rules may be admitted. This is true except when precluded by statute, if the evidence is of a type commonly relied upon by reasonably prudent individuals in the conduct of their affairs.

(b) Rules of privilege. The rules of privilege recognized by law are in effect.

(c) Objections to evidentiary offers. Objection to evidentiary offers may be made and must be noted in the record.

(d) Written evidence. Subject to these requirements, any part of the evidence may be received in written form if a hearing is to be expedited and if the parties' interests will not be substantially prejudiced.

(e) Prepared testimony. The prepared testimony of a witness upon direct examination, either in narrative or in question and answer form, may be incorporated in the record if read or received as an exhibit after the witness has been sworn and has identified that the prepared testimony is as true and accurate as his oral testimony would be. The witness is subject to clarifying questions and to cross-examination. The prepared testimony is subject to a motion to strike either in whole or part.

(f) Documentary evidence. Documentary evidence may be received in the form of copies or excerpts if the original is not readily available.

(g) Official notice may be taken of all facts judicially cognizable. In addition, notice may be taken of generally recognized facts within the area of the commission's specialized knowledge. Parties shall be notified either before or during the hearing, or by reference in preliminary reports or otherwise, of the material officially noticed, including any staff memoranda or data. Parties must be given an opportunity to contest the material so noticed. The special skills and knowledge of the commission and the commission staff may be used in evaluating the evidence.

(h) Burden of proof. The burden of proof rests with the commission except where the controlling statute or rule specifies otherwise. Exceptions include, but are not limited to, hearings conducted pursuant to the Act, §413.031, when the burden of proof rests with the party seeking relief; hearings conducted pursuant to the Act, §407.046, when the burden of proof rests with the certified self-insurer; and issues concerning whether an employer has timely filed a report of injury with an insurance carrier, pursuant to §120.2 of this title (relating to Employer's Report of Injury) when the burden of proof of showing timely filing or good cause when a timely filing has not been made rests with the employer.

(i) Proof. Proof required to prevail at a contested case hearing shall be by a preponderance of the evidence.

(j) Record of commission's Medical Review Division in a review of a medical fee or a medical service. If a decision of the commission's medical review division in a review of a medical fee or a medical service under the Act, §413.031 has been set for a contested case hearing before SOAH, then the commission's representative will file a copy of the certified record of the medical fee or service review by the division with all other parties and with SOAH, no later than 15 days before the hearing date unless a different time period is specified by the hearing officer. A certified copy of the record of the medical service review by the division, including the decision of the division, shall be admitted as evidence in the contested case, if offered, unless any objecting party ensures that all other parties and SOAH receives a written notice, at least five working days prior to the hearing date, of the objection and the legal basis for such objection. If a written notice of objection is filed, the hearing officer shall consider any request for a prehearing conference to rule on admissibility issues and any request for a continuance of the hearing, if properly filed in accordance with SOAH procedures.

§148.22. Decision of the Hearing Officer.

(a) Decision. In contested cases held under the Act, §§411.049, 413.031, and 415.034, and after all evidence has been heard, the hearing officer shall adjourn the hearing. The hearing officer shall make a final decision no later than 60 days after the date of the hearing, except that, for preauthorization cases under the Act, §413.031(d), the hearings officer will make a good faith effort to expedite the issuance of the final order and to issue the final order no later than 30 days after the hearing is concluded.

(b) Description of final decision. The final decision shall be based solely upon the record of the individual case. It shall be in writing and include separate findings of fact, conclusions of law, and a decision and order.

(c) Findings of fact. Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the underlying facts supporting the findings.

(d) Basis for findings of fact. Findings of fact must be based exclusively on the evidence and on matters officially noticed.

(e) Entry of orders. The hearing officer shall enter orders that are necessary to implement the decision. If it is determined an administrative penalty violation has occurred, the decision shall set forth the amount of the penalty assessed and shall order payment within a period of time not to exceed 30 days from the date that the order is served.

(f) Orders Assessing Administrative Penalties. Any penalty assessed by the hearing officer for an administrative violation shall be in accordance with the Act, §415.021(c).

(g) Furnishing decision. The decision shall be sent immediately to the parties or their representatives by certified mail, return receipt requested, or personally delivered. A receipt verifying personal delivery shall be made by the person who makes the personal delivery and shall be file-stamped and placed in the hearing file.

(h) Finality of decision. The hearing officer's decision is final on the date

when the party is notified of the decision. If the hearing officer's decision is mailed, a party or the party's representative is presumed to have been notified on the date on which the notice is mailed.

(i) Exhaustion of administrative remedies. The notification to a party of the hearing officer's final decision constitutes exhaustion of all administrative remedies. No motion for rehearing will be entertained. A party dissatisfied with a decision of the hearing officer may seek judicial review as provided by the Act. If judicial review is authorized by the Act, such review will be in accordance with the Administrative Procedure Act, §§2001.171, 2001.172, and 2001.174.

§148.23. Proposal For Decision by the Hearing Officer.

(a) Proposal For Decision. In contested cases held under the Act, §§402.072, 407.046, and 408.023, and after all evidence has been heard, the hearing officer shall adjourn the hearing. No later than 60 days after the date of the hearing, the hearing officer shall issue a proposal for decision.

(b) Description of Proposal For Decision. The proposal for decision shall be based solely upon the record of the individual case. It shall be in writing and include information specified in §149.8 of this title (relating to Proposals for Decision in Accordance with the Act, §§402.072, 407.046, and 408.023).

(c) Findings of fact. Findings of fact, if set forth in statutory language, must be accompanied by a concise and explicit statement of the underlying facts supporting the findings.

(d) Basis for findings of fact. Findings of fact must be based exclusively on the evidence and on matters officially noticed.

(e) Furnishing decision. SOAH shall furnish the proposal for decision to the commission's Chief Clerk of Proceedings and to the parties to the hearing

(f) Filing of briefs and exceptions. Any party may file briefs and exceptions to the proposal for decision, with SOAH, no later than 15 days after receiving the proposal for decision. Any brief and exceptions filed by any party shall be served by that party on all other parties as provided in §148.10 of this title (relating to Filing Instruments and Furnishing Copies) except that service upon SOAH is not required.

(g) Filing replies. Any party may file a reply to a brief and exceptions filed under subsection (f) of this section, with SOAH, no later than ten days after the filing of the brief and exceptions. Any reply filed by any party shall be served by that party on all other parties as provided in §148.10 of this title (relating to Filing Instruments and Furnishing Copies).

(h) Decision by the Commission. The commission shall consider the case at a posted meeting of the commission, no later than 120 days after SOAH provides the commission with the proposal for decision, the date of the last filing of any exceptions or briefs and any replies to such exceptions or briefs. Parties to a contested case will be notified of the final decision of the commissioners by certified mail, return receipt requested, or by personal delivery. A party or attorney of record notified by mail is presumed to have been notified on the date on which the notice is mailed.

(i) Exhaustion of administrative remedies. The notification to a party of the commission's final decision constitutes exhaustion of all administrative remedies. No motion for rehearing will be entertained. A party dissatisfied with a decision of the commission may seek judicial review as provided in the Act. If judicial review is authorized by the Act, such review will be in accordance with the Administrative Procedure Act, §§2001.171, 2001.172, and 2001.174.

§148.24. Special Provisions for Administrative Penalties. Required response to assessment of administrative penalty. Not later than the 30th day after a party receives notification of the hearing officer's decision assessing an administrative penalty, under §148.23(g) of this title (relating to Final Decisions), the charged party shall file with the executive director:

(1) the full amount of the penalty, in the form of a cashier's check, a certified check, or a certified draft; or

(2) a bond for the full amount of the penalty. The bond must be:

(A) executed by a licensed surety company authorized to do business in Texas;

(B) approved by the commission;

(C) made payable to the Texas Workers' Compensation Commission; and

(D) must be effective until all judicial review is final.

§148.25. Record of the Hearing. The record of the hearing includes:

(1) all pleadings, motions, and intermediate rulings;

(2) evidence received or considered;

(3) a statement of matters officially noticed;

(4) questions and offers of proof, objections, and rulings of them;

(5) proposed findings and exceptions;

(6) any decision, opinion, report or proposal for decision by the officer presiding at the hearing and any decision by the commission; and

(7) all staff memoranda or data submitted to or considered by the hearing officer or members of the agency who are involved in making the decision.

§148.26. Transcript or Duplicate of the Hearing Audiotape.

(a) A party may submit a request to the commission for a transcript of the hearing audiotape. The requestor shall pay the cost of the transcript, as established by the commission.

(b) A party may submit a request to the commission for a duplicate of the hearing audiotape. The requestor shall pay the cost of the duplication, as established by the commission.

§148.27. Reimbursement, Travel Expenses, and Fees for Witnesses and Deponents.

(a) Reimbursement of witness or deponent. A witness or deponent who is not a party and who is served with a subpoena or otherwise compelled to attend any hearing or proceeding to give a deposition or to produce books, records, papers, or other objects that are necessary for the proceeding is entitled to receive:

(1) reimbursement for travel in an amount generally applicable to state employees for traveling to and from the place of the hearing or the place where the deposition is taken, if the place is more than 25 miles from the person's residence; and

(2) either a fee in the amount equal to the rate of per diem generally applicable to state employees, or $30 a day, whichever is greater, for each day or part of a day the person must be present as a witness or deponent.

(b) Responsibility for costs. The party who calls the witness is responsible.

§148.28. Expenses To Be Paid By Party Seeking Judicial Review.

(a) Upon receiving a copy of a petition filed in district court which seeks judicial review of a final decision in a contested case decided under this chapter, the com-

mission shall prepare a certified copy of the entire record of the proceeding under review, including a transcript of the hearing audiotape, and transmit it to the reviewing court.

(b) The commission shall assess to the party seeking judicial review, expenses incurred by the commission in preparing this copy, including transcription costs. Upon request, the commission shall consider the financial ability of the party to pay the costs or any other factor which is relevant to a just and reasonable assessment of costs. If the party seeking judicial review is an injured employee, the commission shall not charge for duplicating the record.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511725 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 149. Memorandum of Understanding with SOAH

• 28 TAC §§149.1-149.10

The Texas Workers' Compensation Commission proposes new §§149.1-149.10 in a new Chapter 149, concerning an interagency agreement between the commission and the State Office of Administrative Hearings (SOAH) for administrative law judges of SOAH to conduct certain contested case hearings under the Workers' Compensation Act. The procedural rules for such hearings have simultaneously been proposed under a new Chapter 148 of this title. The new rules are proposed in order to establish, by rule, the provisions of the interagency agreement as required by recent legislation (House Bill 1089, 74th Legislature, 1995). The existing rules in Chapter 145 of this title (relating to Hearings Under the Administrative Procedure Act) will remain in effect after January 1, 1996 only for those hearings described in that chapter.

New §149.3 contemplates that any request for a contested case hearing before a SOAH administrative law judge will be sent to the commission's Chief Clerk of Proceedings. The Chief Clerk will then forward the request to SOAH in the manner described in the new rule. New §149.6 contains provisions for the maintenance of the confidentiality for information deemed confidential by law under the Texas Workers' Compensation Act. New §149.10 provides a procedure which has been designed to promote an efficient transition from commission hearings officers to administrative law judges of SOAH.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed sections are in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the new sections. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in the future and the time and expense involved in each hearing, the costs for the hearing held by SOAH will be reimbursed by the commission pursuant to an interagency contract.

Ms. Chamness also has determined that for each year of the first five years the sections as proposed are in effect the public benefit anticipated as a result of enforcing the sections will be to provide fair and efficient procedures for both the commission and SOAH to handle requests for certain contested case hearings under the Texas Workers' Compensation Act. While the anticipated economic costs to individuals, who are required to comply with the new sections as proposed, cannot be accurately estimated, because the complexity, duration and number of future hearings is unknown, the new sections are not anticipated to increase the average, procedural costs of a contested case hearing. There may be economic costs to persons who are required to comply with the sections as proposed due to filings of contested case documents being made at SOAH as well as with the TWCC Chief Clerk. There may, also, be reduced costs in hearings for many parties in hearings involving issues of medical fees and services because a party either objecting to prior evidence considered or requesting the appearance of the dispute resolution officer will be required to provide prior notice to the other parties in such a hearing. Several provisions have been added to reduce or eliminate certain tactics by a party which could result in longer and more-costly hearings for other parties to such hearings. There will be no difference in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal must be received by 4:00 p.m. on October 20, 1995 and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491. The commission has scheduled a public hearing on these proposed new sections for 11.00 a.m., on October 11, 1995, in Room 910 at the commission's central office at the address listed previously in this request for comments. If a quorum of the Commission is not present, a public hearing will still be held.

The new sections are proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Texas Workers' Compensation Act, as amended by recent legislation (House Bill 1089, 74th Legislature, 1995); and the Texas Labor Code, §§402.073, 407.046(b) and (c), 411.049(b), 413 031(d), and 415.034(a), as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings, and House Bill 1089, 74th Legislature, 1995, which provides that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995.

These proposed new sections affect the following statutes: Texas Labor Code, §§402.061, 402.073, 407.046(b) and (c), 411.049(b), 413.031(d), and 415. 034(a), as amended by House Bill 1089, 74th Legislature, 1995.

§149.1. General Statement.

(a) The Act, §402.073, mandates the Texas Workers' Compensation Commission (the commission) and the chief administrative law judge of the State Office of Administrative Hearings (SOAH) to adopt by rule a memorandum of understanding (MOU) governing contested case hearings held by SOAH under the Texas Workers' Compensation Act (the Act).

(b) The MOU is necessary to accomplish the efficient and expeditious hearing of matters to be heard by SOAH under the Act, §402.073 by establishing the procedures to be used by each agency and clearly delineating each agency's responsibilities. Additionally, the MOU is necessary to inform the public of each agency's responsibilities and the procedures for the institution, conduct and determination of proceedings before SOAH on behalf of the commission.

(c) The MOU provides procedures for referring a case to SOAH, the notice of hearing, filing requirements, hearings, final orders, and custody of the hearing record, and related matters.

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

Act-The Texas Workers' Compensation Act, Texas Labor Code, §§401.001 et seq.

ALJ-The Administrative Law Judge assigned by the State Office of Administrative Hearings.

Commission-The Texas Workers' Compensation Commission.

Contested Case-A proceeding in which the legal rights, duties, or privileges of a party are to be determined by an agency after an opportunity for adjudicative hearing as defined in the Government Code, §2001.003, subject, however, to the provisions of the Act as codified in the Texas Labor Code, Title 5, Subtitle A, including §§401.021(1), 411.049, 413. 031, 415.034, 402.072, 407.046, and 408.023; and the

rules adopted by the commission, in particular Chapter 145 of this title (relating to Hearings Under the Administrative Procedure Act).

MOU-The Memorandum of Understanding executed by the commission in accordance with this chapter.

SOAH-The State Office of Administrative Hearings.

TWCC Chief Clerk-The Chief Clerk of Proceedings within the Hearings Division of the commission.

§149.3. Referral of Contested Case to SOAH.

(a) Referral of a contested case to SOAH may be made only by the commission The referral is initiated by filing with SOAH either a Request For Setting of Hearing Form or a Request For Assignment of ALJ Form. The Request For Setting of Hearing Form shall be filed when the commission seeks to have the case set for hearing and no request for a prehearing is pending. If prehearing matters arise after the Request For Setting of Hearing Form is filed, SOAH shall assign an ALJ to resolve the matter. The Request For Assignment of ALJ Form shall be filed when a request for a prehearing conference is pending or a request for an ALJ's ruling on various matters is made prior to commencement of the hearing. In addition to filing the appropriate form, a referral also consists of the following items:

(1) all pleadings in the case, including but not limited to complaints, petitions, applications, motions, or such other documents describing agency action relating to the contested case;

(2) a current service list; and

(3) notification of any statutory deadlines imposed by statute or rule involving the contested case.

(b) Not later than ten days after receiving either the Request For Setting of Hearing Form or the Request For Assignment of ALJ Form, SOAH shall assign the case a docket number and provide the docket number and a confirmation of the date, time, and place of hearing to the commission within the limitations specified in §148.4 of this title (relating to Notice of Hearing). The SOAH docket clerk will coordinate the assignment of hearing dates with the TWCC Chief Clerk so that hearings are scheduled both for the efficient use of ALJs and commission representatives in such cases. Following receipt of a Request For Assignment of ALJ Form, SOAH shall assign an ALJ and shall notify all parties and the commission in writing of the ALJ assigned to the case.

§149.4. Notice of Hearing.

(a) Except as provided in subsection (c) of this section and upon receipt of the docket number, location and setting date from SOAH, the commission shall issue the notice of hearing as required by the Act and the Government Code, and will serve the notice of hearing by certified mail, return receipt requested, first class mail, or by personal delivery to all parties to the docketed matter. After the initial notice is sent by the commission, the administrative law judge may issue additional notices of the time, date, and place of the hearing as needed.

(b) Notice is governed by the Government Code, §2001.051 and §2001. 052, and other applicable laws. The notice shall include the date, time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing is to be held; a reference to the particular sections of the statutes and any corresponding regulations to which the hearing relates; a short, plain statement of the matters asserted; the docket number; and a certificate of service.

(c) No later than 30 days before the scheduled hearing date for a hearing conducted under the Act, §407.046(b), SOAH will issue a notice of hearing to the certified self-insurer and to the TWCC Chief Clerk according to the procedures specified in §148.4(c) of this title (relating to Notice of Hearing).

§149.5. Filing Requirements. Filing of documents shall be made in accordance with the following requirements.

(1) Any party filing notices of hearing, pleadings (including discovery), motions, and other filings shall address the document to SOAH and shall file the original with SOAH and a true and correct copy with the TWCC Chief Clerk. Such documents shall be delivered to TWCC and SOAH by the same method or by personal delivery and on the same date.

(2) Any SOAH ruling or prehearing order concerning a delay, continuance, or future filing shall be forwarded to the TWCC Chief Clerk on the same date and by the same method as SOAH shall forward the document to other parties except that such rulings or orders may be personally delivered to the TWCC Chief Clerk.

§149.6. Hearings.

(a) Hearings, including prehearing proceedings, on contested cases shall be conducted in accordance with the Government Code, Chapter 2001, subject to the provisions of the Act, the commission's rules of procedure, the SOAH rules of procedure and any other applicable law and accompanying regulations.

(b) In the event of any conflict between the SOAH rules of procedure and the commission's rules of procedure, the rules of the commission control, unless such rules conflict with other controlling law.

(c) SOAH shall ensure that the confidentiality provisions of the Act, §§402.082 through 402.091 and §411. 034 will be followed, including requests for release of documents or information made confidential under the Act or other applicable law. In addition, SOAH will conduct all hearings pursuant to the Act, §401.021, including the requirements in contested case hearings that only the parties, the parties' designated representatives and counsel, witnesses, designated court reporters and other persons as authorized by the ALJ may attend and that such hearings will be closed to the public. While SOAH will have temporary custody of the hearing records, the Executive Director of the commission retains statutory authority as custodian of records and is ultimately responsible, as the originating agency, for the release or nonrelease of the information. Therefore, should any information, which may be confidential under the Act, commission rules, or other law, be requested from SOAH by any person or entity, SOAH shall follow all legal requirements necessary to ensure that the confidential information or document is not released, unless specifically required by law, and shall provide such request to the commission's executive communication division immediately upon receipt.

(d) The ALJ shall establish reasonable deadlines and procedures for the filing of affidavits, the designation of witnesses, and such other matters as are necessary or appropriate.

(e) The respondent in any proceeding may file an answer with the ALJ in accordance with the SOAH rules of procedure and §148.10 of this title (relating to Filing Instruments; Furnishing Copies) .

(f) If a decision of the commission's medical review division in a review of a medical service under the Act, §413.031 has been set for a contested case hearing before SOAH and if the decision of the division is withdrawn or an amended decision is issued by the division within ten working days after the commission received the request for hearing before SOAH, then the commission shall file a request to withdraw the case from the SOAH docket. SOAH shall then issue an order dismissing the case without prejudice from the SOAH docket.

(g) If a decision of the commission's medical review division in a review of a medical service under the Act, §413.031 has been set for a contested case

hearing before SOAH, then the commission's attorney, representing the commission's medical review division as a party in the contested case hearing, will file a copy of the certified record of the medical service review by the division with all other parties and with SOAH no later than 15 days before the hearing date, unless a different time period is specified by the ALJ. A certified copy of the record of the medical service review by the division, including the decision of the division, shall be admitted as evidence in the contested case, if offered, unless any objecting party ensures that all other parties and SOAH receive a written notice, at least five working days prior to the hearing date, of the objection and the legal basis for such objection. If a written notice of objection is filed, the hearing officer shall consider any request for a prehearing conference to rule on admissibility issues and any request for a continuance of the hearing, if properly filed in accordance with SOAH procedures.

(h) SOAH shall tape all hearings for which neither the commission nor a party provides court reporting services. Payment for any court reporting services shall be made in accordance with §148.20 and §148.28 of this title (relating to Recording the Hearing; and Expenses to be Paid by Party Seeking Judicial Review, respectively).

(i) SOAH shall notify the TWCC Chief Clerk of the date, time, and location of the hearing within ten days after receiving from the TWCC Chief Clerk a Request For Setting of Hearing form. Unless good cause is shown, SOAH will set a hearing to consider a proposed penalty under the Act, Chapter 415, Subchapter B no earlier than 60 days after SOAH has received the Request For Setting of Hearing Form. Unless good cause is shown, SOAH will set hearings involving issues of preauthorization under the Act, §413.014 for a date no more than 30 days after SOAH has received the Request For Setting of Hearing Form. In all other cases under the Act, §413.031, SOAH will set such cases for a date within the 90-day period specified in the Act, §413.031(d).

§149.7. Final Orders in Accordance with the Act, §§411.049, 413. 031 and 415.034.

(a) The ALJ shall prepare and issue the decision and order for contested cases under the Act, §§411.049, 413.031 and 415.034. Legal citations in the proposed order shall be made in accordance with the *Texas Rules of Form*. The decision shall include findings of fact, conclusions of law, and the order(s) of the ALJ. The Government Code, §2001. 058(d) does not permit the commission to attempt to influence the ALJ's findings of fact, conclusions of law, or the ALJ's application of the law to the facts in any proceedings except by proper evidence and legal argument. Unless otherwise provided by statute or rule, the ALJ shall issue a decision and order no later than the 60th day after the date the record is finally closed. In cases involving issues of preauthorization under the Act, §413. 014, the ALJ will make a good faith effort to expedite the issuance of the final order and to issue the final order no later than 30 days after the hearing is concluded.

(b) The ALJ shall serve true and correct copies of the transmitted letter and the decision and order by certified mail, return receipt requested, upon the parties and shall provide a copy of such documents to the TWCC Chief Clerk.

(c) SOAH shall place a confidentiality stamp on each page of the final order.

§149.8. Proposals for Decision in Accordance with the Act, §§402. 072, 407.046, and 408.023.

(a) After holding a hearing pursuant to the Act, §§402.072, 407.046, and 408.023, the hearing officer shall prepare a proposal for decision not later than 60 days after the date of the hearing.

(b) The proposal for decision shall contain:

(1) a statement of the reasons upon which the decision is based;

(2) findings of fact based on the evidence presented and matters officially noticed;

(3) conclusions of law based upon the findings of fact and other legal requirements of the law; and

(4) the sanction or other order recommended by the hearing officer.

(c) The proposal for decision may also contain:

(1) a summary of the evidence presented by each party; and

(2) a list of all mitigating circumstances and a list of all aggravating circumstances, separately stated, which are necessary for the commissioners to have a complete understanding of the case.

(d) SOAH shall serve a copy of the transmitted letter and the proposal for decision by personal delivery or certified mail, return receipt requested, to each party or attorney of record.

(e) Any party may file briefs and exceptions with SOAH, no later than 15 days after receipt of the proposal for decision. All briefs and exceptions shall be served on all parties as provided in §148. 10 of this title (relating to Filing Instruments: Furnishing Copies).

(f) Replies to the exceptions and briefs shall be filed with SOAH no later than ten days after the filing of the exceptions and be served on all parties as provided in subsection (e) of this section.

(g) SOAH shall forward the proposal for decision or any amended proposal for decision, exceptions or briefs, and any replies to exceptions or briefs to the TWCC Chief Clerk no later than ten days after either the last document in this subsection has been issued or received or the deadline for issuance or receipt of such document has passed; whichever is later.

(h) The commissioners shall consider the case at a posted meeting, no later than 120 days after the date SOAH provides to the TWCC Chief Clerk the proposal for decision or amended proposal for decision, if any exceptions or briefs and any replies to exceptions or briefs. Parties shall be notified of the final decision of the commissioners by certified mail, return receipt requested, or by personal delivery.

(i) SOAH shall place a confidentiality stamp on each page of the proposal for decision.

§149.9. Custody of the Hearing Record.

(a) SOAH shall maintain the official record in a contested case from the time the commission refers the case to SOAH until the conclusion of the administrative hearing process. The commission shall also maintain a copy of the record. The conclusion of the administrative hearing process occurs when:

(1) there is the entry of a final order by an ALJ:

(2) the ALJ enters an order to withdraw or dismiss a case from the SOAH docket either by the granting of a party's motion or on the ALJ's own motion; or

(3) the ALJ sends the proposal for decision to the commission.

(b) Prior to the conclusion of the administrative hearing process, any request for a copy of the record may be directed either to SOAH or the commission. Requests for official copies shall be directed to SOAH as the official custodian authorized to certify as to the completeness of the record before the conclusion of the administrative hearing process. SOAH shall consider the confidentiality provisions of the Act, §§402.081-402.091 and other applicable laws before denying release or releasing the requested information within the procedures specified in §149.6(c) of this title (relating to Hearings).

(c) After the conclusion of the administrative hearing process, the official custodian of the record shall be the commission. SOAH shall deliver the official record, including the hearing audiotape, to the TWCC Chief Clerk along with a certified statement that the documents delivered con-

stitute the complete record in the case. Any request for a copy or transcript of the record shall then be directed to the commission. The commission shall have the authority to certify as to the completeness of the record.

§149.10. Transition of Hearings from the Commission to SOAH.

(a) During 1995, the TWCC Chief Clerk shall provide SOAH with lists of hearings to be set after December 31, 1995. SOAH will provide the TWCC Chief Clerk with times, dates, and locations for such hearings and the TWCC Chief Clerk will send notices of hearing. The SOAH docket clerk will coordinate the assignment of hearing dates with the TWCC Chief Clerk so that hearings are scheduled both for the efficient use of ALJs and commission representatives in such cases.

(b) No hearings will be set to begin before a TWCC hearing officer after December 1, 1995 unless the circumstances require an expedited hearing including a hearing involving an issue of preauthorization under the Act, §413.014.

(c) The following hearings will be completed by a commission hearing officer:

(1) hearings where evidence was introduced on or before December 31, 1995; and

(2) hearings involving a prehearing conference which occurred on or before December 31, 1995 and which involve matters under the Act, Chapter 411.

(d) Except for hearings included in subsection (c)(2) of this section, hearings where evidence was introduced on or after January 1, 1996 will be heard by an ALJ even if prehearing or other matters were considered by a commission hearings officer prior to January 1, 1996.

(e) If SOAH desires that its administrative law judges have temporary offices within the offices of the commission, or if SOAH desires that the contested case hearings under this MOU be temporarily held in the offices of the commission, the contracted rate of payment between the commission and SOAH will be reduced by an appropriate amount to reflect the use of such offices of the commission for the applicable time periods.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511726 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 164. Extra-Hazardous Employer Program

• 28 TAC §164.2, §164.10

The Texas Workers' Compensation Commission proposes amendments to §164. 2, concerning notice to extra-hazardous employers and §164.10 concerning removal from the list of approved professional sources. The amendments are proposed to clarify the procedure for requesting a hearing under these rules.

Recent legislation (House Bill 1089, 74th Legislature, 1995) amended the Texas Labor Code, §411.049 to provide that hearings to contest identification of an employer as extra-hazardous shall be held by the State Office of Administrative Hearings (SOAH) rather than Commission staff. Texas Labor Code §402.073 was added by House Bill 1089 and provides, among other things, that hearings under the Administrative Procedure Act shall be held by the State Office of Administrative Hearings rather that commission staff. House Bill 1089, §1.57 provides that transfer of jurisdiction of hearings to SOAH takes effect January 1, 1996 and a hearing held before or pending on December 31, 1995 is governed by the law in effect immediately before September 1, 1995. Procedures for requesting and conducting hearings transferred to SOAH are contained in Commission rules currently proposed as Chapter 148 of this title. Hearings convened prior to December 31, 1995 will continue to be conducted in accordance with Chapter 145 of this title. The amendments to rules 164.2 and 164.10 are proposed to implement this transfer of jurisdiction by referencing the Chapter 148 as well as the Chapter 145 rules.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed sections are in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the sections. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in the future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the commission pursuant to an interagency contract.

Ms. Chamness also has determined that for each year of the first five years the sections as proposed is in effect the public benefits anticipated as a result of enforcing the sections will be to provide fair and efficient procedures for the conduct of those commission hearings which will be conducted by State Office of Administrative Hearings administrative law judges. The anticipated economic costs to persons who are required to comply with the sections as proposed cannot be accurately estimated. There may be economic costs to persons who are required to comply with the sections as proposed due to filings of hearing documents being made at SOAH as well as with the TWCC Chief Clerk. The amount of any additional costs to individuals due to the filing requirements cannot be accurately estimated because the number of filings in a case varies depending on many factors. In addition, the cost of mailing a filing is generally dependent on the weight of the mailed documents. There may, also, be reduced costs in hearings for many parties in hearings involving issues of medical fees and services because a party either objecting to prior evidence considered or requesting the appearance of the dispute resolution officer will be required to provide prior notice to the other parties in such a hearing. Such prior notice should allow disputes in these areas to be solved more economically prior to the hearing. There will be no difference in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal or requests for a public hearing must be received by 4:00 p.m. on October 20, 1995, and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The amendments are proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §402.072, which provides that only the commission may impose certain sanctions; and the Texas Labor Code, §402.073 and §411.049, as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings; House Bill 1089, 74th Legislature, 1995, §1.57, which provides that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995; the Texas Government Code, §2003.021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

The proposed amendments affect the following statutes: Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §402.072, which provides that only the commission may impose certain sanctions; and the Texas Labor Code, §402. 073 and §411.049, as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings; House Bill 1089, 74th Legislature, 1995, Section 1.57, which provides that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995; the Texas Government Code, §2003.021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative

Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

§164.2. Notice to "Extra-Hazardous Employers".

(a) (No change.)

(b) The notice shall be in writing and shall inform the employer of the following requirements:

(1)-(4) (No change.)

(5) the information that the employer has the right to contest "extra-hazardous employer" status by requesting a hearing within 20 days of notification of identification or failure to resolve the matter administratively, as provided by Chapter 145 of this title (relating to Dispute Resolution Hearings Under the Administrative Procedure Act) **or as provided by Chapter 148 of this title (relating to Hearings Conducted by the State Office of Administrative Hearings) as applicable**. The Workers' Health and Safety Division will offer the employer the opportunity to refer to a hearing requests for an administrative review that are not resolved through the administrative process. A request for a hearing will suspend identification as an "extra-hazardous employer" pending the outcome of the hearing;

(6)-(7) (No change.)

§164.10. Removal From the List of Approved Professional Sources.

(a) (No change.)

(b) The division shall notify a consultant by certified mail, return receipt requested, of the division's intent to recommend to the commissioners that the consultant be removed from the list. Within 20 days after receiving the notice, a consultant may request a hearing as provided by §145.3 of this title (relating to Requesting a Hearing) **or as provided by §148.3 of this title (relating to Requesting a Hearing) as applicable**. If a request for hearing is received, the commission shall hold a hearing as provided in Chapter 145 of this title (relating to Dispute Resolution-Hearings Under the Administrative Procedure Act) **or as provided in Chapter 148 of this title (relating to Hearings Conducted by the State Office of Administrative Hearings) as applicable**. If no request for hearing is filed within the time allowed, the division's recommendation will be reviewed by the commissioners at a public meeting and a decision made to either delete or maintain the consultant on the list.

(c) As described in the Texas Labor Code, §402. 072, [and] §145.24 of this title (relating to Special Provisions for Imposing Sanctions Pursuant to the Act, §2.09(f)), **and §148.23 of this title (relating to Proposal for Decision by the Hearing Officer)**, only the commissioners may delete a consultant from the list. The commission shall notify the consultant by issuing an order of deletion. This order will be delivered to the consultant by certified mail, return receipt requested, with a copy maintained in the consultant's file until the consultant meets reinstatement criteria as outlined in subsections (d), (e), (f), or (g) of this section.

(d)-(i) (No change.)

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511727 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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• 28 TAC §164.5

The Texas Workers' Compensation Commission proposes an amendment to §164.5, concerning Follow-Up Inspection by the Division.

The amendment is proposed in order to be consistent with the recent statutory amendment to Texas Labor Code §411.045(a). Section 411.045 requires the Workers' Health and Safety Division of the commission to conduct a follow-up inspection of an extra-hazardous employer following formulation and implementation of an accident prevention plan. The statute initially required the inspection to be conducted six months after formulation of the plan House Bill 1089, passed by the 74th Legislature in 1995, amended §411. 045(a) to provide that the follow-up inspection shall be conducted not earlier than six months or later than nine months after formulation of the plan. This proposed amendment makes the same change to §164.5.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be no fiscal implications for state or local governments as a result of enforcing or administering the section.

Ms. Chamness also has determined that for each year of the first five years the section as proposed is in effect the public benefit anticipated as a result of enforcing the section will be implementation of the statutory requirement in the Texas Labor Code §411.045 and allow more efficient scheduling of inspections. There is no anticipated increase in costs to employers or insurance companies and there is a possible decrease in costs to employers as a result of efficient scheduling of inspections in the same geographic area, which will allow employers to share of travel expenses. There will be no anticipated economic costs to persons who are required to comply with the section as proposed.

There will be no greater costs of compliance for small businesses as compared with large businesses.

Comments on the proposal or requests for a public hearing must be received by 4:00 p.m. on October 20, 1995, and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The amendment is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act, and the Texas Labor Code, §411.045, which requires the Workers' Health and Safety Division of the commission to conduct a follow-up inspection of an extra-hazardous employer following formulation and implementation of an accident prevention plan.

The proposed amendment affects the following statutes: Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §§411.041-411.049, which require the commission to identify extra-hazardous employers, notify the employer and carrier of identification, provide safety consultations to identified employers, assist in formulating accident prevention plans, investigate accidents occurring on the worksite, conduct follow-up inspections, enforce accident prevention plans, and monitor safety conditions. These sections also provide the method for an employer to request a hearing to contest the commission's findings and require the commission to charge the employer for services provided.

§164.5. Follow-up Inspection by the Division.

(a) [Six] **Not earlier than six months or later than nine** months after the formulation of the employer's accident prevention plan, or earlier when requested by the employer and with the concurrence of the professional source, the division shall conduct a follow-up inspection to ensure compliance with, and effectiveness of, the accident prevention plan at the employer's premises.

(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 authority to adopt.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511728 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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• 28 TAC §164.15

The Texas Workers' Compensation Commission proposes new §164.15, concerning administrative reviews and hearings regarding identification as an extra-hazardous employer.

Recent legislation (House Bill 1089, 74th Legislature, 1995) added new §411.0415 to the Texas Labor Code to provide an exemption for certain employers from identification as an extra-hazardous employer. This new statutory provision addresses the situation where an employer has been identified as an extra-hazardous employer based on injury frequencies which result from a fatality. If the employer can establish that the fatality occurred because of factors beyond the employer's control or was outside the course and scope of the deceased employee's job, the executive director may exclude the employer from the extra-hazardous designation. This new statute also mandates that the Commission analyze and list fatalities that may not be related to the work environment and authorizes the Commission to request a hearing to determine proximate cause of a fatality pursuant to the Texas Labor Code, §411.049. House Bill 1089 amended §411.049 to require that hearings under that section be held by the State Office of Administrative Hearings rather than by Commission staff.

The new rule is proposed to implement these new statutory provisions by providing the procedure for the Commission to request a hearing to determine proximate cause of a fatality, and for the employer to contest the identification as extra-hazardous by requesting an administrative review or by requesting a hearing. The issues which may be addressed at a hearing or administrative review are set out in the rule.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the section. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the Commission pursuant to an interagency contract. Costs for the hearings held under Chapter 145 of this title (relating to Hearings Held Under the Administrative Procedure Act) will decrease since no new hearings will be convened by the Commission hearing officers after December 31, 1995.

Ms. Chamness also has determined that for each year of the first five years the rule as proposed is in effect the public benefit anticipated as a result of enforcing the section will be implementation of the legislative changes to the Texas Labor Code.

There will be no anticipated economic costs to persons who are required to comply with the section as proposed and there will be a savings to employers who are allowed exemption from identification as extra-hazardous employers through avoidance of consultation and inspection fees. The costs of the hearing process to participants other than the Commission should be no different than they are now, with the exception of the requirement that hearing documents be filed with the State Office of Administrative Hearings and in addition, with the Commission. This requirement could add minimal costs to the hearing process.

There will be no greater cost of compliance for small businesses as compared to large businesses.

Comments on the proposal or requests for a public hearing must be received by 4:00 p.m. on October 20, 1995, and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The new section is proposed under the Texas Labor Code, §402.061, as amended by House Bill 1089, 74th Legislature, 1995, which authorizes the commission to adopt rules necessary to administer the Act, the Texas Labor Code, §402.073, which requires the Texas Workers' Compensation Commission and the State Office of Administrative Hearings to cooperate in establishing procedures for holding hearings; the Texas Labor Code, §411.0415, as added by House Bill 1089, 74th Legislature, 1995, which provides exemption from identification as extra-hazardous for certain employers and provides for hearings to determine proximate cause of a fatality if it was the basis of the designation as an extra-hazardous employer; the Texas Labor Code, §411.049(b) , as amended by House Bill 1089, 74th Legislature, 1995, which mandates that hearings to contest an extra-hazardous determination be held by the State Office of Administrative Hearings; and the Texas Government Code, §2003. 021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

This proposed new section affects the following statutes: the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code, §411.0415, as added by House Bill 1089, 74th Legislature, 1995, which provides exemption from identification as extra-hazardous for certain employers and provides for hearings to determine proximate cause of a fatality if it was the basis of the designation as an extra-hazardous employer, the Texas Labor Code, §411.049(b), as amended by House Bill 1089, 74th Legislature, 1995, which mandates that hearings to contest an extra-hazardous determination be held by the State Office of Administrative Hearings; and the Texas Government Code, §2003.021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

§164.15. Administrative Reviews and Hearings Regarding Identification as an Extra-Hazardous Employer.

(a) After a screening under §164.14 of this title (relating to Values Assigned for Computation of Extra-Hazardous Employer Identification), if the commission decides to go forward with the identification of an employer as extra-hazardous, based on the inclusion of a fatality, the Commission shall request a hearing to determine whether the employer or the work environment was a proximate cause(s) of the fatality. Proximate cause shall have the meaning given to it by the Texas courts in negligence cases.

(b) The Commission shall notify the employer of the request for a hearing and notify the employer that it may waive the right to have the hearing on the inclusion of the fatality prior to identification.

(c) After an employer has been identified as extra hazardous, the employer may contest the identification by requesting an administrative review within ten days of notification of identification.

(d) An employer may also contest the identification by requesting a hearing within 20 days of notification of the identification or within 20 days of notification of the results of an administrative review.

(e) At a hearing or at administrative review, an employer may contest the proximate cause of an injury only when the injury was a fatality and the issue was not adjudicated under subsection (a) of this section prior to identification.

(f) At a hearing after an administrative review, an employer may raise any subject raised at the administrative review.

(g) Requests for hearings under this rule must be made in compliance with §145.3 of this title (relating to Requesting a Hearing) or §148.3 of this title (relating to Requesting a Hearing) as applicable.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511775

Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 170. Risk Management

The Texas Workers' Compensation Commission proposes new §170.2, concerning state risk management guidelines and simultaneous repeal of the current §170 2, concerning applications by state agencies for exemption under the Texas Workers' Compensation Act. In addition, the commission proposes an amendment to §170 3, concerning reports required from state agencies.

Current §170.2 provides a procedure by which an agency may claim an exemption from the requirement in the Texas Labor Code §412.002 to implement a comprehensive risk management program. This exemption required the agency to file an application for exemption prior to August 31, 1991 No further exemptions will be granted based on the Texas Labor Code §412.002 and as a result current rule §170.2 is no longer needed and therefore proposed to be repealed

House Bill 1089, 74th Legislature, 1995, added new §412.0025 to the Texas Labor Code. New §412.0025 requires each state agency subject to Chapter 412 of the Texas Labor Code to actively manage the risks of that agency by developing, implementing, and maintaining health and safety programs and programs designed to assist employees who sustain compensable injuries to return to work. House Bill 1089 also amended the Texas Labor Code, §412.003 by adding a requirement that the commission's Risk Management division review, verify, monitor, and approve risk management programs adopted by state agencies and by adding to §412.007 the requirement that the commission include in its report to the legislature identification of each state agency that has not complied with the commission's risk management guidelines. New §170.2 is proposed to implement the new statutory requirements. New §170. 2(a) requires each state agency and major facility covered by Chapter 412 of the Texas Labor Code to develop and implement an agency risk management program which includes a safety and health program and a return to work program. The programs must comply with the guidelines contained in *Risk Management for Texas State Agencies*, published by the Risk Management Division of the Texas Workers' Compensation Commission. New §170.2(b) and (c) provide that if a risk exposure is not covered by the guidelines then nationally recognized standards shall be followed and if the applicable guideline or standard cannot be complied with, the agency file a statement with the Risk Management division explaining the noncompliance and alternative actions to be taken. New §170.2(d) requires the Risk Management division to review, verify, monitor, and approve state agency risk management programs and subsection (e) states the new statutory requirement that non-compliant agencies be identified in the commission's report to the legislature

Section 170.3 details the requirements of the reports that state agencies covered by the Act are required to file with the commission's division of Risk Management each year and requires other agencies to allow the commission access to data bases relating to state property and liability losses and exposures. The amendment to this rule updates statutory references and revises reporting requirements. The amount of information required from state agencies is reduced by the amendment. The ability to obtain the needed information electronically from other sources allows for more efficient and accurate information retrieval.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed new rule, amendment and repeal are in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the new rule, amendment, and repeal. If it becomes necessary for an agency to increase staff to comply with the statutorily mandated requirements of the proposed rules, an increase in costs will be experienced The proposed rules formalize the commission's current risk management philosophy and many agencies are already meeting the criteria set out in proposed new §170 2. For those agencies there will be no additional costs No increase in costs to TWCC is expected. The amendment to §170.3 reduces the information required to be reported to the commission by state agencies and will result in a cost savings to agencies through reduction in paper work and staff time In addition, TWCC will be obtaining the necessary information in a more efficient manner from other sources reducing the number of forms required to be reviewed, thereby freeing staff resources for other functions

Ms. Chamness also has determined that for each year of the first five years the new rule, amended rule and repeal as proposed are in effect the public benefit anticipated as a result of enforcing the new rule, amended rule, and repeal will be implementation of the Workers' Compensation Act as amended by recent legislation, to clarify requirements for risk management programs, to clarify report filings and to provide a definite standard for state agency risk management programs. The result should be a safer workplace for state government workers in Texas. A reduction in employee injuries will result in a cost savings to taxpayers.

There will be no anticipated economic costs to persons who are required to comply with the new rule as proposed. There will be no costs of compliance for small businesses because the proposed rules only apply to state government

Comments on the proposal or requests for public hearing must be received by 4:00 p.m. on October 20, 1995, and may be submitted to Elaine Crease, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

• 28 TAC §170.2, §170.3

The amendment and new section are proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act, and the Texas Labor Code, §§412.001 through 412.008, as amended by House Bill 1089, 74th Legislature, 1995, which set out requirements for management of job related risks in state agencies, the duties of state agencies and the commission's division of risk management,duties of the state risk manager, annual reports of state agencies, the commission's rulemaking authority, the commission's report to the legislature and interagency contracts for payment of risk management costs.

The proposed amendment and new section affect the following statutes: the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act, and the Texas Labor Code, §§412.001-412.008, as amended by House Bill 1089, 74th Legislature, 1995, which set out requirements for management of job related risks in state agencies, the duties of state agencies and the commission's division of risk management, duties of the state risk manager, annual reports of state agencies, the commission's rulemaking authority, the commission's report to the legislature and interagency contracts for payment of risk management costs.

§170.2. State Risk Management Guidelines.

(a) Each state agency covered by Texas Labor Code, Chapter 412 shall develop and implement an agency risk management program which shall include a safety and health program and a return to work program. State agency risk management programs shall comply with the risk managements guidelines for risk control and risk financing contained in *Risk Management for Texas State Agencies*, published by the Risk Management Division of the commission.

(b) When a risk exposure is not covered by the guidelines referenced in subsection (a) of this section, appropriate nationally recognized standards shall be followed.

(c) A state agency which cannot comply with any applicable guideline or nationally recognized standard shall file a statement with the Risk Management division which.

(1) clearly identifies the factors preventing the agency's compliance with the appropriate guideline or nationally recognized standard; and

(2) states the action the agency will take in lieu of complying with the guideline or nationally recognized standard.

(d) The division shall review, verify, monitor, and approve state agency risk management programs based on compliance with subsections (a), (b), and (c) of this section.

(e) State agencies covered by Chapter 412 of the Act which do not comply with subsections (a), (b), and (c) of this section will be identified as not in compliance with this subchapter in the biennial report to the Legislature.

§170.3. Reports.

(a) A state agency subject to the Act, [§7.21,] **Chapter 412,** shall file the following with the Commission no later than October 30 of each year:

[(1) annual exposure reports, on TWCC form 125 with appropriate detail supplements; and]

(1) [(2)] annual Loss Summary Report on TWCC form[s] **126.** [126A, TWCC 126B, TWCC 126C, with:]

[(A) supporting loss information for liability and property losses on forms TWCC forms 122, 123, and 124; and

[(B) supporting analysis of workers' compensation losses on AGS-10-91/TWCC Form 121.]

(2) a list of any loss exposures unique to the agency that have not been reported and placed in a statewide database accessible to the Division.

(b) Where state controlled databases containing information relating to state property and liability losses and exposures already exist, **the controlling agency shall provide** the Risk Management Division [shall be provided] **with** access to the database [by the controlling agency].

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511733 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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• 28 TAC §170.2

(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 Workers' Compensation Commission or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin.)

The repeal is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act, and the Texas Labor Code, §§412.001-412.008, as amended by House Bill 1089, 74th Legislature, 1995, which set out requirements for management of job related risks in state agencies, the duties of state agencies and the commission's division of risk management,duties of the state risk manager, annual reports of state agencies, the commission's rulemaking authority, the commission's report to the legislature and interagency contracts for payment of risk management costs.

§170.2. Applications for Exemptions.

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

Issued in Austin, Texas, on September 12, 1995.

TRD-9511732 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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Chapter 180. Compliance and Practices

• 28 TAC §180.8

The Texas Workers' Compensation Commission proposes an amendment to §180.8, concerning notice of administrative violation and penalty. The amendment is proposed to clarify the procedure for requesting a hearing on a proposed sanction.

Recent legislation (House Bill 1089, 74th Legislature, 1995) amended the Texas Labor Code, §415.034 to provide that hearings related to an administrative penalty assessed by the commission be held by the State Office of Administrative Hearings (SOAH) rather than Commission staff. House Bill 1089, §1.57 provides that transfer of jurisdiction of hearings to SOAH takes effect January 1, 1996 and a hearing held before or pending on December 31, 1995 is governed by the law in effect immediately before September 1, 1995. Procedures for requesting and conducting hearings transferred to SOAH are contained in Commission rules currently proposed as Chapter 148 of this title. Hearings convened prior to December 31, 1995 will continue to be conducted in accordance with Chapter 145 of this title. The amendment to §180.8 is proposed to implement this transfer of jurisdiction by referencing the Chapter 148 rules as well as the Chapter 145 rules.

Janet Chamness, Chief of Budget, has determined that for the first five-year period the proposed section is in effect there will be fiscal implications for state or local governments as a result of enforcing or administering the section. While the dollar amounts of the fiscal implications cannot be determined because of the uncertainty of the number of hearings to be held in the future, costs for the hearings held by the State Office of Administrative Hearings will be reimbursed by the commission pursuant to an interagency contract.

Ms. Chamness also has determined that for each year of the first five years the amended section as proposed is in effect the public benefit anticipated as a result of enforcing the section will be to provide fair and efficient procedures for the conduct of those commission contested case hearings which will be conducted by State Office of Administrative Hearings administrative law judges. The anticipated economic costs to persons who are required to comply with the section as proposed cannot be accurately estimated. There may be economic costs to persons who are required to comply with the section as proposed due to filings of contested case documents being made at SOAH as well as with the TWCC Chief Clerk. The amount of any additional costs to individuals due to the filing requirements cannot be accurately estimated because the number of filings in a case varies depending on many factors. In addition, the cost of mailing a filing is generally dependent on the weight of the mailed documents. There will be no difference in anticipated costs of compliance for small businesses as compared to large businesses.

Comments on the proposal or requests for public hearing must be received by 4:00 p.m. on October 20, 1995, and should be submitted to Elaine Crease, Office of the General Counsel, Mailstop #4-D, Texas Workers' Compensation Commission, Southfield Building, 4000 South IH-35, Austin, Texas 78704-7491.

The amendment is proposed under the Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §402.073, as amended by House Bill 1089, 74th Legislature, 1995, which transfers specific hearing functions to the State Office of Administrative Hearings; the Texas Labor Code §415.034, as amended by House Bill 1089, 74th Legislature, 1995, which allows a party charged with an administrative violation or the Executive Director or the Commission to request a hearing with the State Office of Administrative Hearings; §1.57, and §4.01, which provide that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pending on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995; the Texas Government Code, §2003.021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

The proposed amendment affects the following statutes: Texas Labor Code, §402.061, which authorizes the commission to adopt rules necessary to administer the Act; the Texas Labor Code §402.072, which provides that only the commission may impose certain sanctions; and the Texas Labor Code, §402.073 and §415.034, as amended by House Bill 1089, 74th Legislature, 1995, which transfer the specified hearing functions to the State Office of Administrative Hearings; House Bill 1089, 74th Legislature, 1995, §1.57 and §4.01, which provide that the State Office of Administrative Hearings has jurisdiction over the transferred hearings effective January 1, 1996, but that hearings held before or pend-

ing on December 31, 1995 will be governed by the law in effect immediately before September 1, 1995; the Texas Government Code, §2003.021(c), as amended by House Bill 1089, 74th Legislature, 1995, which requires the State Office of Administrative Hearings to conduct hearings under the Texas Labor Code, Title 5, in accordance with the applicable substantive rules and policies of the Texas Workers' Compensation Commission.

§180.8. Notice of Administrative Violation and Penalty.

(a) (No change.)

(b) The notice will provide the charged person with:

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

(4) any other information required by rules under Chapter 145 of this title (relating to Dispute Resolutions-Hearings Under the Administrative Procedure and Texas Register Act) **or under Chapter 148 of this title (relating to Hearings Conducted by the State Office of Administrative Hearings) as applicable**; and,

(5) information of the rights, obligations, and procedures for the charged person to file a written answer or request a hearing.

(c) The charged person must file a written answer not later than the twentieth day after the day the notice is received. The answer must either consent to the proposed sanction, and remit the amount of the penalty, if any, or request a hearing as provided by **either** §145.3 of this title (relating to Requesting a Hearing) **or §148.3 of this title (relating to Requesting a Hearing) as applicable.**

(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 authority to adopt.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511729 Susan Cory
General Counsel
Texas Workers' Compensation Commission

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 440-3700

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

Part IV. Texas Commission for the Blind

Chapter 171. Cooperative Activities

• 40 TAC §171.3

The Texas Commission for the Blind proposes an amendment to §171.3, concerning memoranda of understanding between agencies. The Commission proposes the amendment of §171.3(3), concerning coordinated services for children and youths. The purpose of the amendment is to add the Texas Department of Human Services and the Texas Interagency Council on Early Childhood Intervention to the agencies participating in the MOU; to replace the term "multiproblem children and youth" with the term "children and youths with multi-agency needs"; to generally improve the clarity and directness of the MOU; and to require participating agencies to work with the Texas Health and Human Services Commission to ensure that the commission's strategic plan includes appropriate plans for delivering coordinated services to children and youths with multi-agency needs. The chief executive officers of the agencies participating in the MOU have all signed the amended MOU.

Jim Fowler, Deputy Director, Administration and Finance, 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 or administering the proposed amendment.

Pat D. Westbrook, Executive Director, has determined that for each year of the the first five years the rule as proposed is in effect the public benefit anticipated as a result of enforcing the proposed amendment will be a process for ensuring that children and youths with multi-agency needs receive effective coordinated services. There will be no effect on small businesses. There is no anticipated economic cost to persons who are required to comply with the proposed section.

Written comments on the proposal may be submitted to Jean Wakefield, Policy and Rules Coordinator, P.O. Box 12866, Austin, Texas 78711. Comments should be received within 30 days of the publication of this proposal.

The amendment is proposed under the Human Resources Code, Title 5, Chapter 91, which authorizes the commission to adopt rules prescribing the policies and procedures followed by the commission in the administration of its programs and to negotiate interagency agreements with other state agencies to extend and improve the regular services provided by the agencies.

The amendment affects Human Resources Code, Title 5, Chapter 91, §91.021, concerning Responsibility for Visually Handicapped Persons, §91.023, concerning Rehabilitation Services, §91.052, concerning the Vocational Rehabilitation Program for the Blind, and §91.056, concerning Eligibility for Vocational Rehabilitation Services.

§171.3. Memoranda of Understanding Between Agencies. In the spirit of cooperation and coordination, and to facilitate the delivery of statewide services to disabled persons in Texas, the commission has entered into various memoranda of agreements which delineate the responsibilities and agreements between the various parties. A copy of each memorandum of understanding enumerated in this section is available for review at the commission's central office located at 4800 North Lamar Boulevard, Austin, Texas, or a copy can be obtained by writing to the commission at P.O. Box 12866, Austin, Texas 78711, or by calling (512) 459-2600.

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

(3) Coordinated services for [multiproblem] children and **youths** [youth]. The commission adopts by reference a memorandum of agreement between the **Texas Department of Human Services, the Texas Interagency Council on Early Childhood Intervention, the Texas Department of Health, the** Texas Department of Mental Health and Mental Retardation, the Texas Commission for the Blind, the Texas Department of Protective and Regulatory Services, the Texas Education Agency, the Texas Juvenile Probation Commission, the Texas Rehabilitation Commission, and the Texas Youth Commission. The memorandum provides for the implementation of a system of community resource coordination groups to coordinate services for [all multiproblem] children and **youths** [youth] and was published in the **January 27, 1995** [April 20, 1993], issue of the *Texas Register* **(20 TexReg 430)** [(18 TexReg 2551)] by the Texas Department of Protective and Regulatory Services under §736.701 of this title (relating to Memorandum of Understanding for Services to [Multiproblem] Children and **Youths** [Youth]) and subsequently adopted without changes effective April 1, 1995.

(4)-(5) (No change.)

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

Issued in Austin, Texas, on September 11, 1995.

TRD-9511737 Pat D. Westbrook
Executive Director
Texas Commission for the Blind

Earliest possible date of adoption: October 20, 1995

For further information, please call: (512) 459-2611

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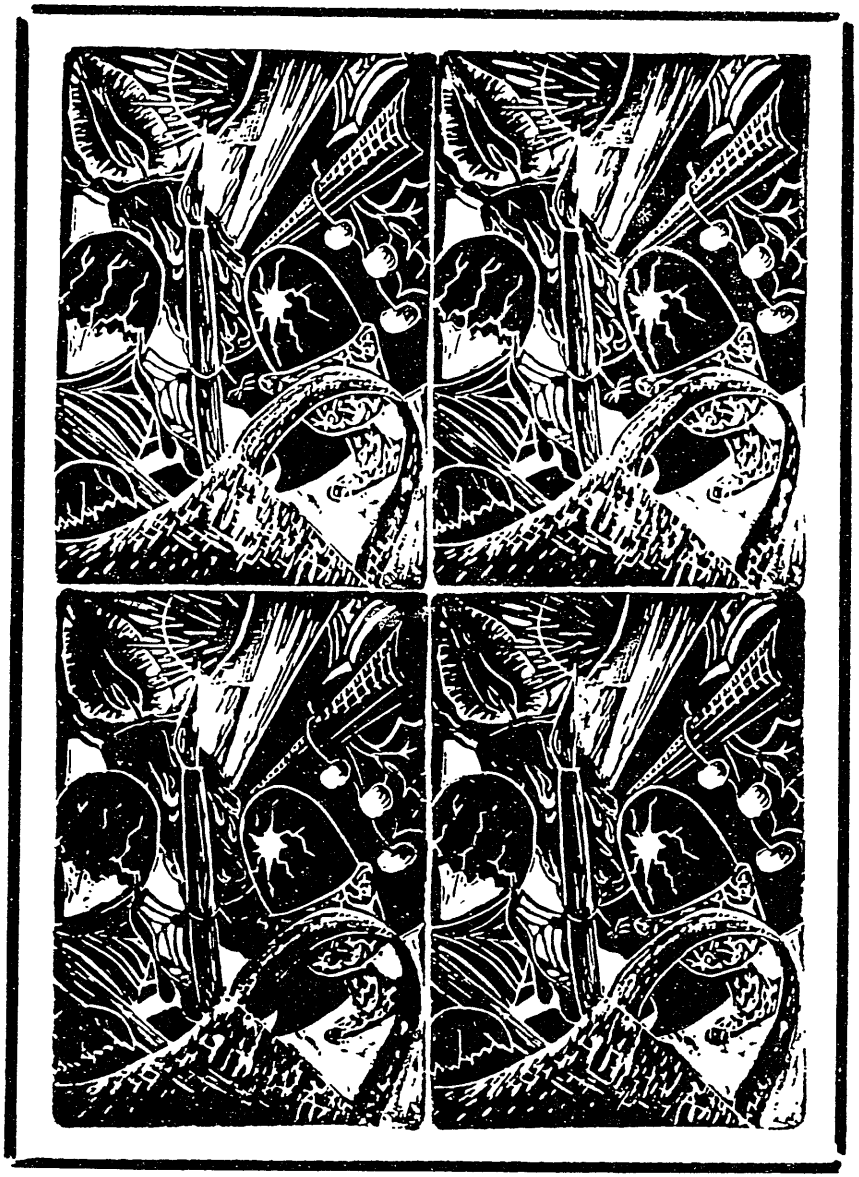
Name Linda Levpold
Grade 11
School Corrigan/Camden High School, Corrigan/Camden ISD



Name Linda Levpold
Grade. 11
School Corrigan/Camden High School, Corrigan/Camden ISD

ADOPTED RULES

An agency may take final action on a section 30 days after a proposal has been published in the ***Texas Register***. The section becomes effective 20 days after the agency files the correct document with the ***Texas Register***, unless a later date is specified or unless a federal statute or regulation requires implementation of the action on shorter notice.

If an agency adopts the section without any changes to the proposed text, only the preamble of the notice and statement of legal authority will be published. If an agency adopts the section with changes to the proposed text, the proposal will be republished with the changes.

TITLE 1. ADMINISTRATION

Part V. General Services Commission

Chapter 111. Executive Administration Division

Historically Underutilized Business Certification Program

• 1 TAC §§111.11-111.19

The General Services Commission adopts the repeal of §§111.11-111.19, concerning the Historically Underutilized Business Certification Program, without changes to the proposed repeal as published in the March 14, 1995, issue of the *Texas Register* (20 TexReg 1805).

The sections are repealed to be replaced with new §§111.11 to 111.23.

The repealed sections are replaced by new sections 111.11 to 111.23 which reorganize and clarify the rules and allow for improved recordkeeping with the Disparity Study.

No comments were received regarding adoption of the repeals.

The repeals are adopted under the authority of Texas Civil Statutes, Article 601b, which provide the General Services Commission with the authority to promulgate rules necessary to accomplish the purpose of the Article.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511711 David Ross Brown
Assistant General Counsel
General Services Commission

Effective date: October 4, 1995

Proposal publication date: March 14, 1995

For further information, please call: (512) 463-3960

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• 1 TAC §§111.11-111.23

The General Services Commission adopts new §§111.11-111.23, concerning utilization of historically underutilized businesses ("HUBs"), based upon the results of the Texas Disparity Study. The Commission also repeals current §§111.11-111.19. Sections 111.12-111.16, 111.22, and 111.23 are adopted with changes to the proposed text as published in the March 14, 1995, issue of the *Texas Register* (20 TexReg 1805). Sections 111.17-111.21 are adopted without changes and will not be republished.

The new sections establish guidelines that may be used by governmental bodies in managing their contracting goals for historically underutilized businesses (HUBs).

In §111.11, Policy and Purpose, the first sentence has been revised to read as follows: "It is the policy of the commission to encourage the use of historically underutilized businesses by state agencies and to assist agencies to achieve these goals through race, ethnic, and gender neutral means." The change deletes language concerning the use of race and gender conscious remedial actions and clarifies the scope of the policy.

The definition of "Historically Underutilized Business." in §111.12, Definitions, has been amended to reorganize the subsections. The first sentence now reads: "A business outlined in subparagraph (C), (D), (E), (F), (G) and (H) in which the owner(s):". New subparagraph (A) was the second half of the sentence in former subparagraph (C). The first sentence in new subparagraph (B) was the second half of the sentence in former subparagraph (A) . New clauses (i)-(v) were part of former subparagraph (A). The definition of "American women" that appears in subparagraph (B)(iii) has been amended to add the words, "except those specified in clauses (i), (ii) (iv) and (v)." New subparagraph (C) now reads: "a corporation formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons described by subparagraphs (A) and (B); or." New subparagraph (D) was formerly subparagraph (B) and has been modified to insert the words "and (B)" between the words "(A) " and "of this section," and to add the word "or" following the semicolon. New subparagraph (E) was formerly subparagraph (C) which was amended to replace the word "subparagraph" with the word "subparagraphs," to insert the word "and (B)" between the words "(A)" and "of this section," and to strike the words following the semicolon which have been moved to new subparagraph (A). New subparagraph (F) was formerly subparagraph (D) and new subparagraph (G) was formerly subparagraph (E). New subparagraph (H) is added and reads as follows: "a business other than described in subparagraphs (D), (F), and (G) of this section, which formed for the purpose of making a profit and is otherwise a legally recognized business organization under the laws of the State of Texas, provided that at least 51% of the assets and interest and 51% of any classes of stock and equitable securities are owned by one or more persons described by subparagraphs (A) and (B) of this section." The amendment reorganizes the text of the former rule, adds new subparagraph (H) in order to clarify the factors used in defining HUBs and excludes minorities from the description of "American women-owned businesses." These changes clarify the subsection and allow for improved recordkeeping consistent with the Disparity Study. Also in §111.12, the definition of "term contract" has been amended to add the words, "as defined in §113.2 of this title." The change reconciles this definition with agency practices.

In the first sentence of §111.13, subsection (a), the words, "increasing the level of HUB participation" have been replaced with the words, "encouraging the use of HUBs." A final sentence is added which reads: "Each agency may achieve the annual program goals by contracting directly with HUBs or indirectly through subcontracting opportunities." The amendments are made to clarify the subsection and to emphasize that contracting with a HUB at either the prime or subcontractor levels is permissive.

Section 111.13, subsection (b) is amended to read: "Each state agency shall make a good faith effort to assist HUBs in receiving a portion of the total contract value of all contracts that the agency expect to award in a fiscal year in accordance with the following percentages: (1) 11.9% for heavy construction other than building contracts; (2) 26.1% for all other building construction, including general contractors and operative builders contracts; (3) 57.2% for all special trade construction contracts; (4) 20% for professional services contracts; (5) 33% for all other services contracts; and (6) 12.6% for commodities contracts." The amendments substitute the

term "good faith effort" for the term "best efforts" and delete the words "not less than" from the stated overall contracting goals for each category of contract, thus clearly denoting the stated percentages as goals rather than "set-asides". The category construction has been subdivided into three construction (sub) categories consistent with the relevant Standard Industrial Code(s) (SIC) reported in the Disparity Study. The numerical goal for each category or (sub) category has been amended to reflect total actual availability of HUBs as a percent of dollars as reported in Table 3.12 or Appendix H of the Disparity Study. The revisions also emphasize that the goals are applicable to the sum total of an agency's contracts on an annual basis.

Former §111.13, subsection (c), has been deleted and replaced with former subsections (d) and (e) as amended The subsection as amended reads: " Each agency shall make a good faith effort to meet or exceed the goals outlined in §111.13(b). The percentage goals established in subsection (b) are overall annual program goals for each state agency applicable to the total annual dollar amount of an agency's contracts for each of the specific types of contracts. It may not be practicable to apply these goals to each contract. For each contract, state agencies may set higher or lower program goals than those outlined in subsection (b). Agencies may consider HUB availability, HUB utilization, geographical location of the project, the contractual scope of work or other relevant factors. By implementing the following procedures, an agency shall be presumed to have made a good faith effort: (1) prepare and distribute information on procurement procedures in a manner that encourages participation in state contracts by all businesses; (2) divide proposed requisitions into reasonable lots in keeping with industry standards and competitive bid requirements; (3) assess bond and insurance requirements and design such requirements to reasonably permit more than one business to perform the work; (4) specify reasonable, realistic delivery schedules consistent with an agency's actual requirements; (5) ensure that specifications, terms, and conditions reflect an agency's actual requirements, are clearly stated and do not impose unreasonable or unnecessary contract requirements; (6) provide contractors with referenced list of certified HUBs for subcontracting; (7) determine whether specific agency-wide goals are appropriate under the Disparity Study because some HUB groups have not been underutilized within applicable contracting categories and should not be included in the HUB goals for that category." These amendments delete references to former subsection (c) which identified specific racial and gender goals for each contract category, consolidate related provisions and clarify the subsection. Paragraph (7), in particular, clarifies the responsibilities of state agencies to review and revise agency-wide racial and gender goals for each contracting category to conform with the Disparity Study.

Former §111.13, subsection (f), now subsection (d), is amended to read: "A state agency may also demonstrate good faith under this section by including a supplemental letter with documentation as prescribed by the commission: (1) identifying the percentage of contracts awarded to women and/or minority-owned businesses that are not certified as HUBs; (2) demonstrating that a different goal from that identified in §111.13(b) was appropriate given the agency's mix of purchases; (3) demonstrating that a different goal was appropriate given the particular qualifications required by an agency for its contracts; or (4) demonstrating that a different goal was appropriate given that graduated HUBs cannot be counted toward the goal." The changes affirm state agency flexibility in satisfying the good faith standard.

Section 111.14, subsection (a) has been amended to add the following language as the first sentence: "Each agency's bid and contract documents for construction, professional services, other services and commodities exceeding $100,000 shall include HUB subcontracting good faith effort guidelines and goals as established in §111.13." The amendment establishes a $100,000 threshold for the application of the good faith effort guidelines specified in §111.14 to subcontracts. The former second and now third sentence of subsection (a) has been revised to replace the words "in house" with the words, "with its employees as defined by the Internal Revenue Service. A new fourth sentence has been added which reads: "The HUB prime contractor may subcontract the remaining 75% of the contract with HUB or non-HUB subcontractors." The fifth and sixth sentences of subsection (a) as revised replace the words "in house" with the words "with its employees." The latter amendments clarify current restrictions on pass-through and brokering contracting arrangements so that a HUB may not assign more than 75% of the contract work to non-employees and be credited as a prime contractor. The section also clarifies that a HUB prime has the option of subcontracting up to 75% of the contract work to HUB or non-HUB subcontractors.

In §111.14, subsection (b), the second sentence has been replaced with the following language: "The contractor shall submit a copy of the notice described in subsection (c)(2) below with its offer, and shall submit a statement within seven working days following its offer that specifies the expected percentage of work, if any, to be subcontracted." The change streamlines the language of the proposed rule, indicates a timeframe for contractor outreach efforts and clarifies that subcontracting is permissive.

In §111.14, the first sentence of subsection (c) and subsection (c), paragraphs (2) and (4) have been modified. The first sentence of subsection (c) now reads: "By implementing the following procedures, a contractor shall be presumed to have made a good faith effort:" In subsection (c), paragraph (1), the words "the smallest feasible parts" have been replaced with the words, "reasonable lots." The second sentence in paragraph (2) of subsection (c) has been amended to read: "The notice shall include a description of the subcontracting opportunities and identify the location to review contract specifications." The third sentence in paragraph (2) of subsection (c) has been amended to read: "The notice shall be provided to potential subcontractors prior to submission of the contractor's bid." In paragraph (3) of subsection (c), the words "in the area in which the work will be performed" have been added to the first sentence and the second and third sentences have been deleted. In paragraph (4) of subsection (c), the words "but not selected" have been inserted between the words "bid," and "the contractor" and the words "explain not hiring a HUB subcontractor" have been replaced with the words "document the selection process." In paragraph (5), the words "at the times (and) reporting" have been replaced with the word "report." The changes streamline and clarify the language. The change in paragraph (2) deletes the requirement that primes transmit a complete copy of all specifications as this could be unduly burdensome.

Revised §111.14, subsection (d) now reads: "If the commission's directory does not include at least five businesses, the contractor shall send the notice to HUBs on lists of minority and women-owned businesses maintained by other government agencies or organizations. If a contractor uses a source other than the commission's directory, the selected HUB subcontractor must become certified by the commission in accordance with the procedures set forth in §111.17 of this title." The new language encourages contractors to look outside of the commission's HUB directory when the directory does not include at least five HUB businesses within the applicable profession or trade, but also requires that any HUB contractor selected from outside the commission's directory become certified before the agency may receive good faith credit.

Section 111.14, subsection (e) contains the language of former subsection (d) as amended. Subsection (e) now reads: "An agency shall ensure that a contractor has complied with this §111.14 as a condition of awarding any contract." The modifications clarify that it is the responsibility of the state agency to confirm that a contractor has conducted the outreach efforts described in §111.14 before making a formal contract award.

Section 111.14, subsection (f) contains the language of former subsection (e) as amended. In the first sentence in subsection (f) as revised the word "minimum" has been deleted and the words, "after the award date of the contract" have been replaced with the words "following selection, but prior to the award of the contract." The second sentence of former subsection (e) has been deleted. Subsection (f) includes revisions to paragraphs (1), (2),(3),(4), (5), (6), and (7) of former subsection (e). Former paragraph (8) has been deleted and former paragraph (9) has become subsection (g). Former paragraphs (1) and (2) have been combined as revised paragraph (1). Paragraph (1) now reads: "Whether the contractor provided written notices to at least five qualified HUBs or the contractor advertised in general circulation, trade association, and/or minority/women focus media concerning subcontracting opportunities." Paragraph (2) contains the language of former paragraph (3) as amended. Specifically, the words, "a reasonable number of" were replaced with the words "at least five qualified HUBs" in paragraph (2) as amended. In paragraph (3), the language of former paragraph (4) has

been inserted, the words "smallest feasible" have been replaced with the word "reasonable" and the words "in order to increase HUB participation" have been replaced with the words "in accordance with standard industry practices." Revised paragraph (4) contains the language of former paragraph (5), revised to add the words "or met with the rejected HUB to discuss the rejection" to the end of the first sentence and to delete the second sentence. Revised paragraph (5) contains the language of former paragraph (6) as amended and reads; "Whether the contractor provided qualified HUBs with adequate information about bonding, insurance, the plans, the specifications, scope of work and requirements of the contract. " Revised paragraph (6) contains the language of former paragraph (7) as amended and reads: "Whether the contractor negotiated in good faith with qualified HUBs, not rejecting qualified HUBs who are also the lowest responsive bidder." The revisions streamline and clarify contractor obligations with regard to subcontracting and remove provisions deemed unduly burdensome.

Revised §111.14, subsection (g) contains the amended language of former subsection (f), paragraph (9). Subsection (g) now reads: "Contractors are encouraged to use the services of available minority and women community organizations, contractor groups, local, state and federal business assistance offices, and other organizations that provide support services to HUBs."

Revised §111.14, subsection (h) contains the language of former subsection (f) as amended. In the second sentence of revised subsection (h), the words "include but not limited to the following:" have been replaced with the words, "state the reasons for the deficiency," and paragraphs (1) and (2) have been deleted. The revisions clarify the responsibilities of state agencies to notify contractors regarding the sufficiency of the contractor's asserted good faith effort(s).

Section 111.15, subsection (a) has been replaced with the following language: "Agencies are required to prepare a written plan for the use of HUBs in purchasing and in public works contracts in accordance with Texas Government Code, Chapter 2056 and Article 601b, §1.03(l)." The revisions clarify the responsibility of state agencies to prepare written plans for the use of HUBs in accordance with law.

In §111.16, subsection (c), the words "and suppliers" have been deleted from the first sentence. The words "and equipment" and have been added to the end of the second sentence. The words, "On a quarterly basis," have been added at the beginning of the third sentence. The words "or suppliers" have been deleted from the third sentence and in the fourth sentence, the words "or suppliers" have been deleted between the words "contractor" and "should". The changes conform the terminology used in this section with that used elsewhere in the title and clarify that contractors are subject to quarterly reporting requirements.

In §111.16, subsection (f), the text of subparagraphs (A)-(E) of paragraph (3) have been added to paragraph (2) and former paragraph (3) has been deleted. Paragraph (2) now reads: " the total number of HUBs receiving payments from each state agency and actually paid by each state agency to the following groups as defined in §111.12 of this title and certified by the commission: (A) Black Americans; (B) Hispanic Americans: (C) American Women; (D) Asian Pacific Americans and (E) Native Americans." The change clarifies the language in a manner consistent with §111.12.

In §111.22, subsection (a), the second sentence has been revised to read: "The commission shall update the directory semiannually and make the directory available to state agencies, local governments and the public on a cost recovery basis." The changes better reflect the groups to which the Commission makes the directory available. The third sentence in subsection (a) has been amended to substitute the words " in hard copy, on floppy diskette, or on magnetic tape" for the words "or in another format." The change specifies the alternative formats of the directory which the Commission shall make available. Subsection (b) of §111.22 has been deleted because the substance has been incorporated in subsection (a).

In §111.23, subsection (a), the first sentence has been revised to read: "A HUB shall be graduated from being used to fulfill HUB procurement utilization goals when it has maintained gross receipts or total employment levels for four consecutive years which exceed 75% of the following schedule which is extracted from the U.S. Small Business Administration's size standard for firms within similar primary four-digit Standard Industrial Classification codes, as stated in 13 Code of Federal Regulations, 121.601:" In addition, new paragraphs (1)-(8) were added to establish graduation ceilings for each contract category referenced in §111.12 and §111.13. New paragraphs (1)-(8) read: "(1) for heavy construction other than is building construction, $17, 0000,000; (2) for building construction, including general contractors and operative builders, $17,000,000; (3) for special trade construction, $7,000, 000; (4) for medical, financial and accounting services, $3,500,000; (5) for architectural/engineering and surveying services, $3,500,000; (6) for other services including legal services, $3,500,000; (7) for commodities wholesale, 100 full-time equivalent employees; (8) for commodities manufacturers, 500 full-time equivalent employees."

The new sections describe the basic components of the State's HUB contracting program consistent with the provisions of House Bill 2626, Acts, 73rd Legislature and Chapter, 1051, Article V, §101, and Chapter 684, §65(c), Acts, 73rd Legislature, Regular Session (1993) and the State of Texas Disparity Study. Proposed §111.11 states the commission's adopted policy; (2) §111.12 defines terms; (3) §111.13 establishes statewide remedial HUB utilization goals based upon the disparities identified in the study for potential availability of HUBs overall in each contract category and for separate HUB groups in each contract category; (4) §111.14 prescribes requirements for the application of the utilization goals to subcontracts; (5) §111.15 states agencies' strategic planing responsibilities; (6) §§111. 17-111.22 restate the commission's current HUB certification program requirements, including audits, revocations, and protest procedures, and race, ethnic, and gender neutral assistance efforts for HUBs; (7) §111.23 provides a graduation requirement for HUBs which maintain certain levels of gross receipts or employment for two consecutive years.

Forty-four written comments were received from individuals, groups, associations, and governmental bodies in response to the proposed sections. Oral comments were received from 21 individuals, groups, associations, and governmental bodies during a public hearing held on April 24, 1995. The transcripts of that hearing are available upon request. The comments fell within ten general subject categories, as follows:

A. Definitions (§111.12) A number of commenters questioned the use of the term "American Women" as falling outside the statute. Some commenters suggested that the definition of and criteria for women-owned businesses should include all women of any ethnicity. The alternative view is that the definition of women and women-owned businesses should exclude women or businesses that would also qualify for minority-based HUB status. Others noted an inconsistency in the definitions of women used in §111.12 and §111.13. At least one commenter suggested that the definition of "term contract" be amended to correspond with the GSC's general usage. One commenter recommended that the definition of "professional services" be expanded to include the services available under Chapter 12, Health and Safety Code.

B. Proposed HUB Contracting and Procurement Goals (§111.13 and §111. 14) Most of the comments concerned the proposed HUB contracting goals at the prime (111.13) and subcontracting (111.14) levels. A number of commenters described the proposed rules as promoting reverse discrimination, providing unwarranted preferential treatment, creating set asides or quota programs, or allowing businesses to be selected based on race, ethnicity, or gender regardless of the business' ability to provide a quality product or service at a competitive price. Some commenters urged that the creation of ethnic or gender-based contracting goals was not narrowly tailored to address a compelling state interest or to remedy discrimination. Others asserted that the HUB program was not "narrowly tailored" due to the failure to expressly state a sunset date. Some suggested that the established good faith effort goals should be based on actual availability rather than potential availability which was the standard proposed in the rules published on March 14, 1995. Others urged the adoption of goals based on potential availability and at least one commenter questioned whether potential availability had been underestimated.

A number of commenters questioned the appropriateness of the goals within certain of the four procurement categories used in the Disparity Study, arguing that the procurement categories were too broad or narrow, e.g. that certain object codes are improperly catego-

rized or that geographical adjustments are necessary. Others questioned the appropriateness of continuing goals for certain minorities or women within those categories based on a perceived unavailability of qualified women or minorities for certain types of work, e.g. heavy construction. At least one commenter recommended that goals be discontinued for groups where an "overutilization" was documented in the Disparity Study, i.e, where the actual utilization rate exceeded 80% of the expected utilization rate (based on actual availability).

A number of commenters recommended technical amendments to §111.13 and §111.14 to remove one or more of the following phrases: "best efforts," "to award," and "shall be allocated," as each phrase reportedly suggested an illegal "set-aside."

C. Other Annual Procurement Utilization Goals Issues (§111.13) A number of commenters were opposed to the adoption of former §111.13 (f), now §111.13(d), which would allow state agencies to demonstrate a good faith contracting effort by producing evidence of contracting with non-certified HUBs. At least one commenter opined that the section would remove the teeth from the certification program and invite abuse by businesses that cannot meet the criteria of being owned by ethnic or gender groups who own at least 51% of the business and demonstrate active participation or control.

D. Other Subcontracting Issues (§111.14) Some commenters stated that subcontracting opportunities may not be applicable to all awarded contracts, and contractors should only be required to meet overall HUB procurement goals. Others opined that requiring contractors to solicit five businesses in each of the possible race and gender categories would be an unfair burden or that compliance with the good faith subcontracting checklist would be too time consuming. The commission received one comment suggesting there should be no evaluation of good faith effort in negotiations between contractors and subcontractors and there should be no meetings to discuss rejections of subcontractors. This commenter was concerned that meetings held to discuss rejections of subcontractors may lead to price shopping abuses. Another commenter recommended that the expenditure of tax dollars on subcontracts, if not prime contracts, should grant preference only to Texas resident HUBs.

One commenter recommended that responsibility for publishing or transmitting notices of available subcontracting opportunities in a manner designed to reach qualified HUBs, should be shifted to state agencies under §111.14 or §111.15. In the alternative, contractors should have electronic access to the HUB directory so that they will have more current information.

commenters recommended technical amendments to subsections (c)(1) and (e)(1) to read: "Shall divide the contract work into the smallest feasible parts in accordance with standard construction practices." It was also recommended that subsection (c)(2) be amended to require "adequate information about the plans" rather than "shall include a copy of the specifications."

E. Comments on Agency Planning Responsibilities (§111.15) One commenter recommended that proposed subsections (a) and (b) be deleted and replaced to read: " The provisions of this act (sic) shall not apply to any state agency that has a program approved by a branch of the federal government, or specific statutory authority to have a HUB or DBE program."

F. State Agency Reporting Requirements (§111.16) A number of commenters recommended that contractors and suppliers be required to report information related to HUB utilization no more frequently than quarterly, consistent with other reporting responsibilities. Another commenter recommended that a reporting matrix be developed that would allow for crediting of minority participation within a firm which is not minority or women-owned within the definition of the statute. According to the commenter, this arrangement would better track the utilization of state tax dollars. At least one commenter opined that subsection (c), which requires contractors to document all subcontract payments with copies of invoices, is excessive.

G. Certification Process (§111.17) A number of commenters recommended that subsection (b) be amended to exempt financial records and client lists from the documentation that must be provided to the commission for purposes of certification. The stated reason for the recommendation was to prevent required disclosure under the Open Records Act. One commenter recommended adding the following language to subsection (b): "If the articles of incorporation or a stock ownership agreement adequately serve to demonstrate that a business qualifies for HUB certification, then financial reports need not be submitted. The certifying agency may privately review financial records, but shall not make them part of the public record."

H. HUB Certification Directory (§111.22) Two commenters requested that contractors be given the ability to access the HUB Directory electronically. Another commenter noted that, under the proposed rules, HUB vendors who do not pay the fee to be listed on the central bid list (CMBL) will continue to be listed as certified, but information on the class and items for the commodities or services they provide will no longer appear as part of the computer file. According to the commenter, requiring HUBs to pay the CMBL fee operates to deprive state agencies of the best information on available HUBs. The commenter suggested that the rules or systems be modified to provide electronic access to available HUBs by class and item.

I. Graduation Requirements (§111.23) One commenter who supported the graduation requirement additionally recommended that §111.13 be amended to allow adjustments in HUB goals to reflect changes in actual availability brought about by graduation. Some commenters urged that professional organizations should establish the measures used to graduate businesses from the HUB program. It was also recommended that the proposed period for graduation from the state's program be extended from two to three years to correspond with the provisions of 13 Code of Federal Regulations 121.60.

K. Additional Costs to Contractors and Agencies (1) Costs to Contractors: Several commenters stated that the proposed rules will unduly delay the procurement process and will result in increased costs for contractors and the state. (2) Costs to Agencies: Some commenters suggested that the HUB subcontracting program will increase bid processing time and administrative staff for program tracking and compliance functions. Others commented that setting a $100,000 threshold would minimize direct and indirect costs.

For: The L.B.J. School of Public Affairs at the University of Texas, Texas Rehabilitation Commission, Minority Contractors Alliance of Texas, J. J. Nita Burgoon Company, Coastal Record Service, Inc., Micromal Computer Consulting, NAACP-Austin Branch, Carter Design Associates, Texas Coalition of Black Democrats/Texas, TAMAC, Austin Minority and Women Alliance, and African American Chambers of Commerce.

Against: Parkhill, Smith & Cooper Inc., Datum Engineering Incorporated, Texas Department of Criminal Justice, Texas Department of Transportation, Texas Department of Health, Texas Lottery Commission, Texas Society of Professional Engineering, the Associated General Contractors of America-Texas Building Branch, Consulting Engineers Council, Fulton Construction Corporation/Coastcon Corporation, Diamond Roofing & Construction, Gary Donaldson Architecture, Hunter Industries, Inc., BLGY, Dan Williams Company, J. L. Steel, Inc. AS Rehabilitation Commission, the University of Texas System, Texas Department of Agriculture, Texas Society of Architects, River City Materials Inc., Texas Department of Human Services, Texas Employment Commission, H.A. Lott, Inc.

A. Definitions (§111.12) The Commission has amended the definitions of "American Women," "Historically Underutilized Businesses" and "Term Contract" in accordance with comments received. Section 111.12(A)(iii) is amended to read: "American Women-which includes women of any ethnicity except those specified in clauses (i), (ii), (iv), and (v)." A related change was made in §111.16, subsection (f) as previously described.

B. HUB Contracting and Procurement Goals (§111.13 and §111.14) The commission disagrees that the rules provide a quota system or otherwise guarantee business contracts based on ethnicity or gender. The proposed rules are designed to insure that the State of Texas makes a good faith effort to include HUBs in all contracting opportunities. At no time are the numerical goals represented as mandatory or a "set-aside." Instead, "good faith efforts" are described in §111.13 and §111.14 as an outreach process.

The commission agrees that HUB goals should be based upon actual availability of HUBs within the relevant industry and geographical area. The Legislature directed the commission to promulgate rules as necessary to implement the findings, conclusions and recommendations contained in the Disparity Study that was commissioned by the Comptroller of Public Accounts and developed by the National Economic Research Association (NERA) in consultation with the

L.B.J. School of Public Affairs at the University of Texas. The Disparity Study, in turn, provides information that would permit the adoption of goals based on either actual or potential availability. Actual and potential HUB availability data is also reported in the Disparity Study as a percentage of vendors or as a percentage of contract dollars. Accordingly, the commission has revised §111.13, subsection (b) to establish three separate contracting goals for the construction industries and separate goals for professional services, other services and commodities. The goals are based on actual HUB availability as a percentage of contract dollars as reported in Table 3.12 and Appendix H of the Disparity Study. Section 111.13, subsection (c) as amended expressly allows state agencies to set higher or lower program goals than those outlined in subsection (b) based on HUB availability, geographical considerations, the contractual scope of work or other relevant factors.

The commission agrees with comments recommending that different or additional procurement categories should be established. Section 111.13 as revised, establishes three (sub)categories for construction contracts. i.e., heavy construction unrelated to building construction, building construction, and specialty trades consistent with the discreet SIC codes for each referenced in Appendix H of the Disparity Study. The (sub)categories for construction contracts showed wide variations in HUB availability so the goals for each subcategory have been amended accordingly.

The commission disagrees that utilization goals should be deleted for women within some or all of the construction contract categories and for Asians and Native Americans in the professional services contract category based upon the comments received and further consideration of the findings in the Disparity Study. The commission has, instead, established overall HUB goals and deleted former §111.13, subsection (c) which provided specific racial and gender-based goals for each contractual category. In the commission's view, it would be unfair to remove women, Asians and Native Americans from contractual categories based on data that was collected primarily in 1987 and to a lesser extent, in 1990. Thus, the goals provided within these rules may fairly be regarded as interim.

C Other Annual Procurement Utilization Goals Issues (§111.13) The commission has amended §111.13, subsection (f), now §111.13, subsection (d) , to address both the concerns of state agencies that contract in good faith with non-certified women and minority-owned businesses and the concerns of those who fear abuse by businesses that may not qualify for HUB certification. As amended, the section will allow state agencies to submit a supplemental letter and other documentation prescribed by the commission, as evidence of good faith efforts. Amendments also clearly indicate, however, that agencies may not use decertified and graduated HUBs to satisfy the good faith efforts standard.

D. Other Subcontracting Issues (§111.14) The commission agrees that requiring contractors to solicit five businesses in each of the possible categories could be burdensome and that subcontracting opportunities may not be applicable to all awarded contracts. The rules require solicitation from a total of five HUBs for contracting opportunities (one from each category or any combination). The commission also has amended §111.14(a) which allows for contractors to be evaluated for making a good faith effort in accordance with the goals set forth in §111.13(b). The commission disagrees with the request that negotiations between contractors and subcontractors be exempted from evaluation of good faith efforts and any requirement of explaining the subcontracting selection. State agencies should consider not only the different kinds of efforts the contractor has made, but also the quantity and intensity of those efforts. For the use of the checklist, good faith means not rejecting HUBs who qualify as the lowest, responsive bidder.

E. Comments on Agency Planning Responsibilities (§111.15) The commission does not agree that agencies which are subject to federal DBE guidelines or alternative statutory HUB programs should be exempted from the application of the rules when engaged in contracting or procurements that are subject to Article 601b. Moreover, the intent of the Legislature as expressed in Chapter 684, Acts 73rd Legislature, Regular Session, §65(c), (1993), was that the General Services Commission would promulgate rules necessary to implement the findings, conclusions and recommendations of the Disparity Study mandated by that Act.

F. State Agency Reporting Requirements (§111.16) The commission agrees that contractors and suppliers should be required to report information related to HUB utilization on a quarterly basis and has amended §111.16(c) accordingly. The commission disagrees that agencies should be credited with the award of a contract to a HUB prime or subcontractor based on a percentage of minorities or women who are employed by the contractor, but do not possess the requisite level of ownership and management. By statute, the HUB goals must be applied to women or minority-owned businesses only.

G. Certification Process (§111.17) The commission responds that its ability to withhold documentation that is collected and used to determine HUB certification eligibility is governed by provisions of the Open Records Act, Chapter 552, Government Code. It should also be noted that certain documents collected by the commission for certification reviews, such as tax returns, are confidential by law and thus, not subject to mandatory disclosure under the Open Records Act.

H. HUB Certification Directory (§111.22) The commission has amended §111.22, subsection (a), to better reflect the groups to which the commission makes the directory available and to substitute the words " in hard copy, on floppy diskette, or on magnetic tape" for the words "or in another format." The latter change specifies the alternative formats of the directory which are available. The commission's electronic database is currently available in hard copy, on diskette, on tape, or through the Department of Commerce Marketplace electronic bulletin board. In addition, the commission's automation team is in the process of creating and activating direct access to its information server. Agencies will also be required to include a list of HUBs with the bid information packet. The commission disagrees that the failure to waive the Centralized Master Bidders List fee for HUBs operates to deprive state agencies of information related to the services or commodities HUBs provide. The CMBL fee is a standard cost of doing business for and is uniformly applied to both HUB and non-HUB vendors. State agencies can also retrieve product descriptions for codes for commodities and services by using vendor names or vendor identification numbers.

I. Graduation Requirements (§111.23) The commission agrees that it may be unfair to graduate HUBs based on their financial performance during a two-year period, but disagrees that the period should be coextensive with federal rules governing the Texas Department of Transportation's minority contracting programs. The commission's certification and central Bid List are both two-year renewal cycles; A four-year period will allow completion of two HUB program cycles and be more cost efficient than the recommended three-year graduation period. The Commission has also adopted specific graduation ceilings for each of the contract categories referenced in §111.12 and §111.13. The new ceilings were culled from federal standards and reduced by 25% to ensure broader distribution of business among eligible HUBs.

K. Additional Costs to Contractors and Agencies (1) To Contractors: At this time it is not possible to estimate the potential fiscal impact to contractors. The commission's experience shows no evidence of related price increases in construction, term contracts, open markets, or professional services (bids or proposals) since the implementation of the HUB program in Fiscal Year 1994. (2) To Agencies: At this time it is not possible to estimate the potential fiscal impact to all agencies resulting from the adoption of these rules. During Fiscal Year 1994 and Fiscal Year 1995, GSC experienced a $20,000 annual fiscal impact for administering the HUB program, but no new or additional fiscal impact for staffing is anticipated for the period Fiscal Years 1996-2000. GSC estimates that the graduation program will result in expenses for automation resources, equipment and other operating functions in the amount of $113,776 for Fiscal Years 1996-2000. The Commission has adopted the $100,000 subcontracting threshold as recommended by several state agencies to ameliorate the potential impact.

The new rules are adopted under the authority of Chapter 684, §65(c), Acts 73rd Legislature, Regular Session (1993), which provides the General Services Commission with the authority to promulgate rules necessary to implement the findings.

§111.12. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless

the context clearly indicates otherwise.

Applicant-A corporation, sole-proprietorship, partnership, joint venture, or supplier that applies to the commission as an historically underutilized business.

Application-A written request for certification as an historically underutilized business in the required format submitted to the commission.

Commodities-Materials, supplies, or equipment.

Comptroller-Comptroller of Public Accounts.

Contractor-A supplier of commodities or services to a state agency under a purchase order contract or other contract.

Directory-The Texas Certified Historically Underutilized Business Directory.

Disparity Study-The State of Texas Disparity Study, performed by the National Economic Research Associates, Inc. ("NERA").

Historically Underutilized Business-A business outlined in subparagraph (C), (D), (E), (F), (G) and (H) in which the owner(s):

(A) have a proportionate interest and demonstrate active participation in the control, operation, and management of the entities' affairs; and

(B) have been socially disadvantaged because of their identification as members of the following groups:

(i) Black Americans-which includes persons having origins in any of the Black racial groups of Africa;

(ii) Hispanic Americans-which includes persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish or Portuguese culture or origin, regardless of race;

(iii) AmericanWomen-which includes all women of any ethnicity except those specified in clauses (i), (ii), (iv), and (v) of this subparagraph;

(iv) Asian Pacific Americans-which includes persons whose origins are from Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa, Guam, the U.S. Trust Territories of the Pacific, the Northern Marianas, and Subcontinent Asian Americans which includes persons whose origins are from India, Pakistan, Bangladesh, Sri Lanka, Bhutan or Nepal; and

(v) Native Americans-which includes persons who are American Indians, Eskimos, Aleuts, or Native Hawaiians; and

(C) a corporation formed for the purpose of making a profit in which at least 51% of all classes of the shares of stock or other equitable securities are owned by one or more persons described by subparagraphs (A) and (B); or

(D) a sole proprietorship created for the purpose of making a profit that is 100% owned, operated, and controlled by a person described by subparagraphs (A) and (B) of this section; or

(E) a partnership formed for the purpose of making a profit in which 51% of the assets and interest in the partnership is owned by one or more persons who are described by subparagraphs (A) and (B) of this section; or

(F) a joint venture in which each entity in the joint venture is an historically underutilized business under this subdivision; or

(G) a supplier contract between an historically underutilized business under this subdivision and a prime contractor under which the historically underutilized business is directly involved in the manufacture or distribution of the supplies or materials or otherwise warehouses and ships the supplies.

(H) a business other than described in subparagraphs (D), (F), and (G) of this section, which is formed for the purpose of making a profit and is otherwise a legally recognized business organization under the laws of the State of Texas, provided that at least 51% of the assets and interest and 51% of any classes of stock and equitable securities are owned by one or more persons described by subparagraphs (A) and (B) of this section.

NERA-National Economic Research Associates, Inc.

Non-Treasury Funds-Funds paid by a state agency that are not treasury funds.

Other services-all services other than construction and professional services, including consulting services subject to Texas Government Code, Chapter 2254, Subchapter B.

Person-U.S. citizen, born or naturalized.

Professional services-Services of accountants, architects, engineers, land surveyors, and physicians that must be purchased by state agencies under Texas Government Code, Chapter 2254, Subchapter A.

Subcontractor-A supplier of commodities or services to a contractor.

Subcontractor Funds-Payments made to certified historically underutilized businesses by a contractor or supplier under contract with the state.

Term Contract-A contract establishing a source or sources of supply for a specified period of time as defined in §113.2 of this title (relating to Annual Procurement Utilization Goals).

Treasury Funds-Funds maintained in the state treasury and paid through the comptroller's office for each state agency.

USAS-Uniform Statewide Accounting System for the State of Texas.

§111.13. Annual Procurement Utilization Goals.

(a) In accordance with the commission's policy of encouraging the use of HUBs in state procurement, and based upon the findings of the Disparity Study, each state agency shall make a good faith effort to utilize HUBs in contracts for construction, services, including professional and consulting services, and commodities purchases. Each agency may achieve the annual program goals by contracting directly with HUBs or indirectly through subcontracting opportunities.

(b) Each state agency shall make a good faith effort to assist HUBs in receiving a portion of the total contract value of all contracts that the agency expects to award in a fiscal year in accordance with the following percentages.

(1) 11.9% for heavy construction other than building contracts;

(2) 26.1% for all other building construction, including general contractors and operative builders contracts;

(3) 57.2% for all special trade construction contracts;

(4) 20% for professional services contracts;

(5) 33% for all other services contracts; and

(6) 12.6% for commodities contracts.

(c) Each agency shall make a good faith effort to meet or exceed the goals outlined in subsection (b) of this section. The percentage goals established in subsection (b) are overall annual program goals for each state agency applicable to the total annual dollar amount of an agency's contracts for each of the specific types of contracts. It may not be practicable to apply these goals to each contract. For each contract, state agencies may set higher or lower program goals than those outlined in this subsection. Agencies may consider HUB availability, HUB utilization, geographical location of the project, the contractual scope of work or other relevant factors. By implementing the following procedures, an agency shall be presumed to have made a good faith effort:

(1) prepare and distribute information on procurement procedures in a manner that encourages participation in state contracts by all businesses;

(2) divide proposed requisitions into reasonable lots in keeping with industry standards and competitive bid requirements;

(3) assess bond and insurance requirements and design such requirements to reasonably permit more than one business to perform the work;

(4) specify reasonable, realistic delivery schedules consistent with an agency's actual requirements;

(5) ensure that specifications, terms, and conditions reflect an agency's actual requirements, are clearly stated and do not impose unreasonable or unnecessary contract requirements;

(6) provide contractors with referenced list of certified HUBs for subcontracting;

(7) determine whether specific agency-wide goals are appropriate under the Disparity Study because some HUB groups have not been underutilized within applicable contracting categories and should not be included in the HUB goals for that category.

(d) A state agency may also demonstrate good faith under this section by including a supplemental letter with documentation as prescribed by the commission:

(1) identifying the percentage of contracts awarded to women and/or minority-owned businesses that are not certified as HUBs;

(2) demonstrating that a different goal from that identified in subsection (b) of this section was appropriate given the agency's mix of purchases;

(3) demonstrating that a different goal was appropriate given the particular qualifications required by an agency for its contracts; or

(4) demonstrating that a different goal was appropriate given that graduated HUBs cannot be counted toward the goal.

§111.14. Subcontracts.

(a) Each agency's bid and contract documents for construction, professional services, other services, and commodities exceeding $100,000 shall include HUB subcontracting good faith effort guidelines and goals as established in §111.13. Therefore, a contractor shall be required to make a good faith effort to award necessary subcontracts to HUBs in accordance with the goals set forth in §111.13(b) of this title (relating to Annual Procurement Utilization Goals). When the contractor is a HUB, it must satisfy the good faith effort requirements by performing at least 25% of the contract work with its employees as defined by the Internal Revenue Service. The HUB prime contractor may subcontract the remaining 75% of the contract with HUB or non-HUB subcontractors. Any contractor that seeks to satisfy the good faith effort requirement in this manner shall report quarterly to the contracting agency, in the form required by the agency, the volume of work performed under the contract and the portion of the work that was performed with its employees. If a HUB contractor performs less than 25% of the cumulative total contract with its employees, then for the next quarter, the contractor shall report its subcontractors as required by a non-HUB contractor.

(b) A state agency shall require a potential contractor to state whether it is a Texas certified HUB and whether one or more subcontractors will be used to perform the contract. The contractor shall submit a copy of the notice described in subsection (c)(2) below with its offer, and shall submit a statement within seven working days following its offer that specifies the expected percentage of work, if any, to be subcontracted.

(c) By implementing the following procedures, a contractor shall be presumed to have made a good faith effort:

(1) To the extent consistent with prudent industry practice, divide the contract work into reasonable lots.

(2) Notify HUBs of the work that the contractor intends to subcontract. The notice shall be in writing. The notice shall include a description of the subcontracting opportunities and identify the location to review contract specifications. The notice shall be provided to potential subcontractors prior to submission of the contractor's bid.

(3) The contractor shall send the notice described in paragraph (2) of this subsection to at least five businesses in the current commission directory of certified HUBs that perform the type of work required in the area in which the work will be performed.

(4) If a non-HUB subcontractor is selected through means other than competitive bidding, or a HUB bid is the lowest price responsive bidder to a competitive bid, but not selected, the contractor will be required to document the selection process.

(5) The contractor shall maintain business records documenting its compliance with this §111.14 and shall make a compliance report to the contracting agency and report in the format required by the agency's contract documents, provided that reporting shall be required at least once for each calendar quarter during the term of the contract.

(6) If the contract is a state lease contract, the contractor or lessor shall comply with the requirements of this section from and after the occupancy date provided in the lease, or such other time as may be specified in the invitation for bid for the lease contract.

(d) If the commission's directory does not include at least five businesses, the contractor shall send the notice to HUBs on lists of minority and women-owned businesses maintained by other government agencies or organizations. If a contractor uses a source other than the commission's directory, the selected HUB subcontractor must become certified by the commission in accordance with the procedures set forth in §111.17 of this title.

(e) An agency shall ensure that a contractor has complied with this section as a condition of awarding any contract.

(f) In making a determination that a good faith effort has been made, a state agency shall require the contractor to complete a checklist, and submit supporting documentation explaining in what ways the contractor has made a good faith effort according to each requirement, within 14 days following selection but prior to award of the contract. The checklist shall include at least the following:

(1) Whether the contractor provided written notices to at least five qualified HUBs or the contractor advertised in general circulation, trade association, and/or minority/women focus media concerning subcontracting opportunities.

(2) Whether the contractor provided written notice to at least five qualified HUBs allowing sufficient time for HUBs to participate effectively.

(3) Whether the contractor divided the contract work into the reasonable portions in accordance with standard industry practices.

(4) Whether the contractor documented reasons for rejection or met with the rejected HUB to discuss the rejection.

(5) Whether the contractor provided qualified HUBs with adequate information about bonding, insurance, the plans, the specifications, scope of work and requirements of the contract.

(6) Whether the contractor negotiated in good faith with qualified HUBs, not rejecting qualified HUBs who are also the lowest responsive bidder.

(g) Contractors are encouraged to use the services of available minority and

women; community organizations contractor groups; local, state, and federal business assistance offices, and other organizations that provide support services to HUBs.

(h) State agencies shall review the checklist and attached documentation submitted by the contractor and issue a written notice of acceptance or deficiency of a good faith effort within 14 days of the agency's receipt. The notice of deficiency shall state the reasons for deficiency.

§111.15. Agency Planning Responsibilities.

(a) Agencies are required to prepare a written plan for the use of HUBs in purchasing, and in public works contracts in accordance with Texas Government Code, Chapter 2056 and Article 601b, §1.03(l).

(b) An agency may adopt the requirements of §§111.11-111.14 of this title (relating to Executive Administration Division) as part of its required strategic plan.

§111.16. State Agency Reporting Requirements.

(a) The comptroller will report to the commission not later than March 15 of each year regarding the previous six-month period, and on September 15 of each year regarding the preceding fiscal year, the payments made for the purchase of goods, services and public works awarded and actually paid from treasury funds by each state agency. Subject to the capabilities of the comptroller's USAS system, the comptroller shall identify state agencies' purchases from state term contracts which are paid from treasury funds so that those purchases awarded and actually paid under term contracts may be included in the commission's report of its own purchases.

(b) State agencies will report to the commission, not later than March 15 of each year regarding the previous six-month period and on September 15 of each year regarding the preceding fiscal year, the payments made for the purchase of goods and services awarded and actually paid from non-treasury funds by the state agency. The report shall include information requested by the commission and shall be in a form prescribed by the commission. State agencies' purchases from state term contracts which are paid from non-treasury funds must be identified on the report as such so that they may be reflected on the commission's report of its own purchases.

(c) State agencies will continuously maintain, and compile monthly, information relating to the agency's use, and the use by each operating division of the agency, of historically underutilized businesses, including information regarding subcontractors. This information shall include, but is not limited to the information required in subsections (a) and (b) of this section. On a quarterly basis, state agencies shall require a contractor to whom a state agency has awarded a contract to report to the agency the identity and the amount paid to each historically underutilized business to whom the contractor has awarded a subcontract for the purchase of supplies, materials, and equipment. Contractors should document progress payments made to subcontractors, professionals consultants or suppliers certified as historically underutilized businesses by submitting invoices to the paying state agency.

(d) State agencies will report to the commission, not later than March 15 of each year regarding the previous six-month period and on September 15 of each year regarding the preceding fiscal year, the total dollar amount of historically underutilized business subcontracting participation in all of the agencies' contracts for the purchase of goods, services and public works payments. State agencies must include subcontracting participation paid from Treasury and Non-Treasury funds.

(e) State agencies that participate in a group purchasing program under §3.01(a)(5) of the Act shall include a separate report to the commission, not later than March 15 of each year regarding the previous six-month period and September 15 of each year regarding the preceding fiscal year, of purchases that are made through the group purchasing program and shall report the dollar amount of each purchase that is allocated to the reporting agency.

(f) The commission shall prepare a consolidated report based on a compilation and analysis of the reports submitted by each state agency and information provided by the comptroller in the format specified by the commission. These reports of historically underutilized business purchasing and contracts shall form a record of each agency's purchases in which the agency selected the vendor. If the vendor was selected by the commission as part of its state term contract program, the purchase will be reflected on the commission's report of its own purchases. The commission report will contain the following information:

(1) the total dollar amount of payments made by each state agency;

(2) the total number of HUBs receiving payments from each state agency and actually paid by each state agency to the following groups as defined in §111.12 of this title (relating to Definitions) and certified by the commission;

(A) Black Americans;

(B) Hispanic Americans;

(C) American Women;

(D) Asian Pacific Americans; and

(E) Native Americans.

(g) On April 15 of each year, the commission shall submit the consolidated report regarding the previous six-month period to the joint committee, referenced in House Bill 2626, §3, charged with monitoring the implementation of the historically underutilized business goals. The commission shall submit a consolidated report on October 15 of each year regarding the preceding fiscal year to the presiding officer of each house of the legislature, the members of the legislature and the joint select committee.

§111.22. Texas Historically Underutilized Business Certification Directory. The commission shall compile in the most cost-efficient format a directory of businesses certified as historically underutilized businesses. The commission shall update the directory semiannually and provide a copy to state agencies, local governments and the public on a cost recovery basis. The commission shall provide access to the directory either electronically or in hard copy, on floppy diskette, or on magnetic tape, depending on the needs of the each state agency. The commission and state agencies shall use the directory to solicit bids from certified HUBs for state purchasing and public works contracts.

§111.23. Graduation Procedures.

(a) A HUB shall be graduated from being used to fulfill HUB procurement utilization goals when it has maintained gross receipts or total employment levels for four consecutive years which exceed 75% of the following schedule which is extracted from the U.S. Small Business Administration's size standard for firms within similar primary four-digit Standard Industrial Classification codes as stated in 13 Code of Federal Regulations 121.601:

(1) for heavy construction other than is building construction, $17,0000,000;

(2) for building construction, including general contractors and operative builders, $17,000,000;

(3) for special trade construction, $7,000,000;

(4) for medical, financial and accounting services, $3,500,000;

(5) for architectural/engineering and surveying services, $3,500,000;

(6) for other services including legal services, $3,500,000;

(7) for commodities wholesale, 100 full-time equivalent employees;

(8) for commodities manufacturers 500 full-time equivalent employees.

(b) Firms which have achieved the size standards identified in subsection (a) of this section will be assumed to have reached a competitive status in overcoming the effects of discrimination. The commission shall review as part of the certification or recertification process the financial revenue or relevant data of firms to determine whether the size standards identified in subsection (a) have been met.

(c) Businesses that have graduated from the HUB program in accordance with this section or have been decertified in accordance with §§111.17-111. 22 of this title (relating to Executive Administration Division) may not be included in meeting agency goals.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511712 David Ross Brown
Assistant General Counsel
General Services Commission

Effective date: October 4, 1995

Proposal publication date: March 14, 1995

For further information, please call: (512) 463-3960

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TITLE 4. AGRICULTURE

Part I. Texas Department of Agriculture

Chapter 5. Quarantines

Pink Bollworm Quarantine

• 4 TAC §§5.171-5.179

The Texas Department of Agriculture (the department) adopts the repeal of §§5.171-5.179, concerning pink bollworm quarantine, without changes to the proposed text as published in the August 11, 1995, issue of the *Texas Register* (20 TexReg 6061).

The repeals are adopted in order to allow the department to make the regulations consistent with House Bill 3003 passed in the 74th Legislative Session (now codified at Texas Agriculture Code (the Code), Chapter 6 (Vernon Supplement 1995)).

The department is submitting separately adopted new sections in order to substitute those for these sections.

No comments were received regarding the adoption of the repeals.

The repeals are adopted under the Texas Agriculture Code, §74.006, which provides the Texas Department of Agriculture with the authority to adopt rules as necessary for the efficient enforcement and control and administration of the Cotton Pest Law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511642 Dolores Alvarado Hibbs
Chief Administrative Law Judge
Texas Department of Agriculture

Effective date: October 2, 1995

Proposal publication date: August 11, 1995

For further information, please call: (512) 463-7583

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Chapter 6. Boll Weevil Control

• 4 TAC §§6.1-6.6

The Texas Department of Agriculture (the department) adopts the repeal of §§6.1-6.6, concerning boll weevil control, without changes to the proposed text as published in the August 11, 1995, issue of the *Texas Register* (20 TexReg 6061).

The repeals are adopted in order to allow the department to make the regulations consistent with House Bill 3003 passed in the 74th Legislative Session (now codified at Texas Agriculture Code (the Code), Chapter 6 (Vernon Supp. 1995).

The department is submitting separately adopted new sections in order to substitute those for these sections.

No comments were received regarding adoption of the repeals.

The repeals are adopted under the Texas Agriculture Code, §74.006, which provides the Texas Department of Agriculture with the authority to adopt rules as necessary for the efficient enforcement and control and administration of the Cotton Pest Law.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511641 Dolores Alvarado Hibbs
Chief Administrative Law Judge
Texas Department of Agriculture

Effective date: October 2, 1995

Proposal publication date: August 11, 1995

For further information, please call: (512) 463-7583

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Chapter 6. Cotton Pest Control

• 4 TAC §§6.1-6.10

The Texas Department of Agriculture (the department) adopts new §§6.1-6. 10, concerning cotton pest control. Section 6.9 is adopted with changes to the proposed text as published in the August 11, 1995, issue of the *Texas Register* (20 TexReg 6062). Sections 6.1-6.8 and 6.10 are adopted without changes and will not be republished.

These new sections are being adopted in accordance with statutory changes made by the 74th Legislature, Regular Session, 1995 in accordance with House Bill 3003. Section 6.9 is adopted with changes to subsection (b), paragraph (4) by adding new subparagraph (E) which allows for extensions for cotton stalk destruction when other extenuating circumstances are determined by the department.

The department is adopting new §§6.1-6.10 to combine the current pink bollworm and boll weevil regulations into one consolidated rule which assists in controlling and minimizing the spread of cotton pests.

No comments were received regarding adoption of the new sections.

The new sections are adopted under the Texas Agriculture Code, §74.006, which provides the Texas Department of Agriculture with the authority to adopt rules as necessary for the efficient enforcement and administration of the Cotton Pest Law. The new sections concerning quarantines are proposed under the Texas Agriculture Code, §74.010, which permits the regulation of cotton pests and quarantines; and the Texas Agriculture Code Chapter 71, Subchapter A, which authorizes inspections, quarantines, and control and eradication zones for dangerous insect pests.

§6.9. Authorized Planting and Stalk Destruction Dates.

(a) All cotton plants in any of the pest management zones set forth in §6.7 of this title (relating to Pest Management Zones) shall be planted within and mechanically destroyed by the authorized planting and stalk destruction dates indicated for each zone. Destruction shall be accomplished by the methods described as follows.

(1) Zone 1.

(A) Planting dates: February 1-April 20.

(B) Cotton destruction date: on or before September 1. Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(2) Zone 2.

(A) Area (1).

(i) Planting dates: February 1-April 15.

(ii) Cotton destruction date: on or before September 10.

(iii) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(B) Area (2).

(i) Planting dates: February 1-April 15.

(ii) Cotton destruction date: on or before September 25.

(iii) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(C) Area (3).

(i) Planting dates: March 1-May 1.

(ii) Cotton destruction date: on or before October 1;

(iii) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(3) Zone 3.

(A) Area (1).

(i) Planting dates: March 5-May 15.

(ii) Cotton destruction date: on or before October 1.

(iii) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(B) Area (2).

(i) Planting dates: March 5-May 15;

(ii) Cotton destruction date: on or before October 15.

(iii) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(4) Zone 4.

(A) Planting dates: March 5-May 10.

(B) Cotton destruction date: on or before October 10. Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(5) Zone 5.

(A) Planting dates: March 10-May 20.

(B) Cotton destruction date: on or before October 20. Destruction shall be accomplished by shredding and/or plowing out the plants to prevent further growth of any cotton plants.

(6) Zone 6.

(A) Planting dates: March 10-May 20.

(B) Cotton destruction date: on or before October 31. Destruction shall be accomplished by shredding and/or plowing out the plants to prevent further growth of any cotton plants.

(7) Zone 7.

(A) Planting dates: March 20-May 31.

(B) Cotton destruction date: on or before November 30. Destruction shall be accomplished by shredding and/or plowing out the plants to prevent further growth of any cotton plants.

(8) Zone 8. Cotton destruction date: on or before February 1.

(A) Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(B) Plowing shall be performed with an implement which dislodges the root and leaves the soil in a ridged and roughened condition.

(9) Zone 9.

(A) Planting dates: March 15-May 31.

(B) Cotton destruction date: on or before February 1. Destruction shall be accomplished by shredding and plowing out the plants to prohibit the presence of any cotton plants.

(b) The department may, on written request by a farm owner and/or operator, grant an extension of the cotton planting or destruction dates. The department may also, on written request by a farm owner and/or operator, authorize an alternative to the method of mechanical destruction of cotton prescribed by these rules. Requests for extensions or changes in the method of the destruction of cotton stalks, regrowth cotton or volunteer cotton may be granted for the reasons listed in paragraph (4) of this subsection.

(1) A written request must include the Consolidated Farm Service Agency (CFSA) Farm/Tract Number, the reason for the request, the amount of acreage subject to the request, and the amount of time needed to complete planting or destruction.

(2) All requests for extensions on initially un-destroyed or un-planted cotton or for approval of an alternative method of cotton destruction must be postmarked on or prior to the last planting date or cotton destruction date, whichever is applicable. An extension may be requested after the last planting date if sufficient information is provided by the owner or operator documenting that the crop was initially planted prior to the planting deadline and re-planting is necessary, or after the cotton destruction date if the stalks were previously destroyed prior to the deadline. Extensions may be granted based on the criteria in paragraph (4) of this subsection.

(3) Failure to submit an extension request when required constitutes a violation and shall subject the farm owner and/or operator to administrative penalties as allowed by the Texas Agriculture Code, Chapter 74, and the Texas Agriculture Code, §12.020.

(4) Extension requests will be considered for approval only if compliance with subsection (a) of this section is delayed for one or more of the following reasons:

(A) research;

(B) weather conditions;

(C) illness;

(D) mechanical failure; or

(E) other good cause.

(c) Where there is conflict between the planting and cotton destruction dates set for counties in the pest management zones established under this chapter, and the planting and stalk destruction dates set for those same counties under other federal, state or county regulations, the dates set under this chapter shall take precedence, unless otherwise specified.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511640 Dolores Alvarado Hibbs
Chief Administrative Law Judge
Texas Department of Agriculture

Effective date: October 2, 1995

Proposal publication date: August 11, 1995

For further information, please call: (512) 463-7583

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Part II. Texas Animal Health Commission

Chapter 41. Fever Ticks

• 4 TAC §41.1

The Texas Animal Health Commission adopts an amendment to §41.1, concerning tick eradication, without changes to the proposed text as published in the July 25, 1995, issue of the *Texas Register* (20 TexReg 5458).

The amendment is necessary to allow the Executive Director to authorize research programs and field studies vary from standard tick quarantine requirements.

One comment in favor of the regulation was received from Heart-Bar Deer Farms. The Texas Animal Health Commission agrees with this comment that regulation will facilitate field studies that may advance eradication of the fever tick.

The amendment is adopted under the Texas Agriculture Code, Texas Civil Statutes, Chapter 161, which provides the Commission with the authority to adopt rules to eradicate ticks.

The amendment implements the Agriculture Code, §167.003 and §167.029, which authorizes the Commission to adopt necessary rules to eradicate ticks and to provide conditions for the handling and movement of livestock.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511612 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Effective date: October 15, 1995

Proposal publication date: July 25, 1995

For further information, please call: (512) 719-0714

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Chapter 43. Tuberculosis

Subchapter A. Cattle

• 4 TAC §43.1

The Texas Animal Health Commission adopts an amendment to §43.1, concerning the movement of cattle exposed to tuberculosis, without changes to the proposed text as published in the July 28, 1995, issue of the *Texas Register* (20 TexReg 5561).

The amendment is necessary to allow cattle exposed to tuberculosis to move to designated pens if tested negative to tuberculosis within 60 days prior to entry.

No comments were received regarding adoption of the amendment.

The amendment is proposed under the Texas Agriculture Code, Texas Civil Statutes, Chapter 162, which provides the Commission with the authority to enter into a cooperative program to eradicate tuberculosis.

The amendment implements the Agriculture Code, §§162.002, 162.003, 161. 041, and 161.061, which provides the Commission with the authority to establish rules relating to tuberculosis, establish testing requirements, protect livestock from tuberculosis, and establish quarantines.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511610 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Effective date: October 15, 1995

Proposal publication date: July 28, 1995

For further information, please call: (512) 719-0714

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Chapter 47. Requirements and Standards for Approved Personnel

• 4 TAC §47.1

The Texas Animal Health Commission adopts an amendment to §47.1, concerning changing the vaccination age of female cattle from 120 and 365 days to four and ten months, without changes to the proposed text as published in the July 25, 1995, issue of the *Texas Register* (20 TexReg 5459).

The amendment is necessary to lower the maximum age for official calfhood vaccination.

No comments were received regarding adoption of the amendment.

The amendment is adopted under the Texas Agriculture Code, Texas Civil Statutes, Chapter 163, which provides the Commission with the authority to promulgatge rules to eradicate brucellosis.

The amendment implements the Agriculture Code, §163.064, which provides the Commission with the authority to regulate and require vaccination.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511611 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Effective date: October 15, 1995

Proposal publication date: July 25, 1995

For further information, please call: (512) 719-0714

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Chapter 55. Swine

• 4 TAC §55.4

The Texas Animal Health Commission adopts an amendment to §55.4, concerning livestock markets handling swine, without changes to the proposed text as published in the July 25, 1995, issue of the *Texas Register* (20 TexReg 5460).

The amendment is necessary to increase disease surveillance for swine by testing and identification.

One comment was received regarding adoption of the amendment. The Texas Pork Producers opposed the exemption from post-sale testing for swine with disease-free status or a negative test within 30 days prior to sale. The Commission deferred consideration of eliminating the exemption rather than postponing adoption of the livestock testing program.

The amendment is adopted under the Texas Agriculture Code, Texas Civil Statutes, §165.022, which provides the Commission with the authority to promulgate rules for eradication of swine diseases.

The amendment implements the Agriculture Code, §165.021 and §165.022, which provide the Commission with the authority to act to eradicate swine diseases.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511614 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Effective date: October 15, 1995

Proposal publication date: July 25, 1995

For further information, please call: (512) 719-0714

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TITLE 7. BANKING AND SECURITIES

Part II. Banking Department of Texas

Chapter 29. Sale of Checks Act

• 7 TAC §29.1

The Banking Commissioner of Texas (the commissioner) adopts new §29.1, concerning permissible investments for licensees under the Sale of Checks Act, Texas Civil Statutes, Article 489d (the Act), without changes to the proposed text as published in the July 28, 1995, issue of the *Texas Register* (20 TexReg 5575).

The Act, §9, provides that licensees with a net worth of not less than $5 million must maintain permissible investments equal to the aggregate face amount of all of their outstanding checks sold in the United States. Under the Act, §9A, the commissioner has the authority to approve investments other than those specified in the Act as "permissible investments" for purposes of the Act, §9 and §9A. The commissioner also is empowered to adopt and enforce reasonable rules to implement §9A. The section as adopted expands the list of investments that would qualify as permissible investments under §9A.

No comments were received regarding adoption of the new section.

The new section is adopted under Texas Civil Statutes, Article 489d, §9A, which authorize the commissioner to approve investments other than those specified in that section as permissible investments for purposes of the Act and to adopt and enforce reasonable rules to implement that section.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511630 Everette D. Jobe
General Counsel
Banking Department of Texas

Effective date: October 2, 1995

Proposal publication date: July 28, 1995

For further information, please call: (512) 475-1300

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TITLE 13. CULTURAL RESOURCES

Part I. Texas State Library and Archives Commission

Chapter 7. Local Records

Standards and Procedures for Management of Electronic Records

• 13 TAC §§7.71-7.78

The Texas State Library and Archives Commission adopts amendments to §§7.71-7.78, concerning standards and procedures for the management of electronic records of local governments. Section 7.75 is adopted with changes to the proposed text as published in the May 30, 1995, issue of the *Texas Register* (20 TexReg 3946). Sections 7.71-7.74 and 7.76-7.78 are adopted without changes and will not be republished.

Amendments are being adopted to provide electronic recordkeeping requirements that are more clearly stated and that update the rules with newly published national standards. Subsection (c) of §7.75 is amended based on comments received from a government records management official that the requirements for records stored on rewritable media should apply to all electronic records within the scope of the rules to support the integrity and authenticity of the records.

Adoption of the amendments makes the rules for electronic records easier to use by removing definitions for records of varying retention periods, as these distinctions serve no purpose in the context of the requirements of these sections; by setting out in full, rather than by reference, requirements concerning temperature and humidity requirements for the storage of optical disks and the expungement of information from a certain type of optical disk; and by removing references to state agencies in order to make these sections language specific to local governments. The opportunity for local governments to appropriately use digital imaging systems is enhanced by adding a standard for the scanning of microforms that has become available since the rules were originally adopted.

The commission received one comment regarding adoption of a change to §7. 75, which was incorporated into the rules. This comment was received from Laura McGee, Records Management Officer, City of Dallas.

The amendments are adopted under the Local Government Code, §205.003(a), which provides the Texas State Library and Archives Commission with the authority to adopt rules establishing standards and procedures for the electronic storage of local government records. The amendments were approved by the Local Government Records Committee, as required by the Government Code, §441.165, at an open meeting held in Austin on June 20, 1995.

The Local Government Code, §205.003, is affected by the amendments.

§7.75. Security of Electronic Records.

(a) Local governments must implement and maintain an electronic records security program for office and storage areas that:

(1)-(5) (No change.)

(b) (No change.)

(c) For records stored on rewritable electronic media, the system must ensure that read/write privileges are controlled and that an audit trail of rewrites is maintained.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511620 Raymond Hitt
Assistant State Librarian
Texas State Library and Archives Commission

Effective date: October 2, 1995

Proposal publication date: May 30, 1995

For further information, please call: (512) 463-5460

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TITLE 22. EXAMINING BOARDS

Part IV. Texas Cosmetology Commission

Chapter 89. General Rules and Regulations

• 22 TAC §§89.4, 89.6, 89.11, 89.14, 89.20, 89.34, 89.41, 89. 53, 89.54, 89.56, 89.72, 89.75, 89.76

The Texas Cosmetology Commission adopts amendments and new section to §89.4, concerning cosmetology instructor on duty; §89.6, concerning new location or change in floor plan of school; §89.11, concerning daily attendance register; §89.14, concerning concurrent enrollments and make-up hours; §89.20, concerning length of courses; §89.34, concerning applicants for licensure through reciprocity; §89.41, concerning change of location of a salon or independent contractor; §89.53, concerning minimum requirements for both private and public cosmetology schools; §89.54, concerning independent contractor/booth rental license; §89.72, concerning curriculum; §89.75, concerning field trips; and §89.76, concerning minimum requirements for cosmetology school separate facility; and new §89.56, concerning administrative processing fees. Sections 89.20, 89.34, 89.41, 89.53, 89.54, and 89.72 are adopted with changes to the proposed text as published in the August 8, 1995, issue of the *Texas Register* (20 TexReg 5984). Changes are the result of public comments received in

open meeting September 9, 1995. Amended §§89.4, 89.6, 89.11, 89.14, 89.75, and 89.76; and new 89.56 are adopted without changes and will not be republished.

The amendments and new section are adopted to comply with Senate Bill 1502 and House Bill 1, 74th Texas Legislature, Regular Session.

The amended and new sections will bring the Texas Cosmetology Commission into compliance with Senate Bill 1502 and House Bill 1, 74th Legislature, Regular Session.

No comments were received regarding the adoption of the amendments and new section.

The amendments and new section are adopted under Texas Civil Statutes, Article 8451a, §4(a), which provide the Texas Cosmetology Commission with the authority to "issue rules consistent with this Act after a public hearing", to protect the public's health and welfare.

§89.20. Length of Courses.

(a)-(h) (No change.)

(i) Manicurist: The manicuring course shall be for 600 hours in an approved school.

(j)-(k) (No change.)

(l) Recommendations for approving validation of hours:

(1)-(7) (No change.)

(8) The guidelines recommended above will be pro-rated based upon the number of hours required for the speciality license or instructor license. Required course hours for licensure are based on current hour requirements at the time of reinstatement.

§89.34. Applicants for Licensure through Reciprocity.

(a) Any person who seeks licensure in the State of Texas through reciprocity from any other state shall:

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

(4) the applicant must present the same number of hours as required by the State of Texas for the applied license;

(5) In addition, the state from which the applicant holds a current license or certificate must grant reciprocity for Texas license or certificate holders.

(b) Any person who seeks licensure in the State of Texas through reciprocity from another nation shall:

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

(4) the applicant must present the same number of hours as required by the State of Texas for the applied license; and

(5) (No change.)

(6) In addition, the state from which the applicant holds a current license or certificate must grant reciprocity for Texas license or certificate holders.

(c) (No change.)

§89.41. Change of Location of a Salon or School. A salon or school may move and continue to operate with the current license, but must be inspected and approved under the current requirements in the new location. The salon or school must notify the commission office in writing of the change of address as soon as the change of address becomes available.

§89.53. Minimum Requirements for Both Private and Public Cosmetology Schools.

(a) The following are the requirements for a private cosmetology school as authorized by the Texas Cosmetology Commission:

(1) A building to house a cosmetology school must be fireproof and of permanent type of construction, and contain a minimum of 3,500 square feet of floor space, with separate restrooms for male and female students. The building must be divided into two separate areas: one for classroom instruction and one clinic work area.

(2)-(15) (No change.)

(b) (No change.)

§89.54. Independent Contractor/Booth Rental License.

(a)-(d) (No change.)

(e) The original and renewal booth rental license fee shall be $50 and shall be valid for two years from date of issue. If a booth rental license is delinquent for less than 30 days, the delinquency fee shall be $10, over 30 days the delinquency fee shall be $25.

(f) Independent Contractors practicing cosmetology in more than one location must exhibit an original booth rental license at each location.

(g) Independent Contractors must post in a location visible at all times the following information. It must be posted on the outside of the booth or the door where it can be read by visitors or prospective clients:

(1) Operators name.

(2) Operators license number.

(3) Hours of business.

(h) The lessor to an independent contractor must maintain a list of all renters that includes:

(1) Name of renter.

(2) Cosmetology license number of the renter.

(3) Hours of business of the renter.

(i) The lessor must supply the inspector with a list of renters upon request. Failure to provide the list can result in a violation of such significance to require a hearing.

§89.72. Curriculum. The curriculum listed has been established by the Texas Cosmetology Commission and must be followed by all cosmetology schools. The curriculum shall be posted in a conspicuous place in the school. A current syllabus and lesson plans for each course shall be maintained by the school and be available for inspection.

(1) Operator curriculum.

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

(D) Manicure curriculum:

(i)-(iv) (No change.)

(v) procedures, 320 hours;

(I)-(IX) (No change.)

(X) application of nail extensions;

(-a-)-(-d-) (No change.)

(-e-) Odorless product

(vi) arms and hands;

(I) (No change.)

(II) muscles-ten hours:

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

(III) (No change.)

(IV) skin-ten hours;

(-a-)-(-e-) (No change.)

(V) nails-50 hours;

(-a-)-(-d-) (No change.)

(vii) bactoriology, sanitation and safety measures-100 hours;

(I)-(IV) (No change.)

(viii) professional practices-80 hours;

(I)-(II) (No change.)

(ix) total, 600 hours.

(x) Theory is construed to mean any topic of instruction (See listed in this subparagraph) in the classroom or practical area.

(E)-(I) (No change.)

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511638 Dick G. Strader
Executive Director
Texas Cosmetology Commission

Effective date: October 2, 1995

Proposal publication date: August 8, 1995

For further information, please call: (512) 454-4674

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• 22 TAC §89.5, §89.73

The Texas Cosmetology Commission adopts the repeal of §89.5, concerning specialty instructor on duty; and §89.73, concerning fashion photography salon requirements, without changes to the proposed text as published in the August 4, 1995, issue of the *Texas Register* (20 TexReg 5850).

The repeals are adopted to comply with Senate Bill 1502, 74th Texas Legislature, Regular Session.

Rule 89.5 defined the requirements for speciality instructors on duty in schools of cosmetology. Rule 89.73 defined the requirements for fashion photography salons.

No comments were received regarding adoption of the repeals.

The repeals are adopted under Texas Civil Statutes, Article 8451a, §4(a), which provide the Texas Cosmetology Commission with the authority to "issue rules consistent with this Act after a public hearing", to protect the public's health and welfare.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511639 Dick G. Strader
Executive Director
Texas Cosmetology Commission

Effective date: October 2, 1995

Proposal publication date: August 4, 1995

For further information, please call: (512) 454-4674

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Part XI. Board of Nurse Examiners

Chapter 211. Bylaws

• 22 TAC §211.7

The Board of Nurse Examiners adopts an amendment to §211.7, concerning Committees of the Board, without changes to the proposed text as published in the July 28, 1995, issue of the *Texas Register* (20 TexReg 5578).

In accordance with the Health and Safety Code, §142.016, the Board of Nurse Examiners and the Texas Department of Health (TDH) entered into a memoranda of understanding (MOU) and is adopting rules to address the relationship in regard to the MOU.

The amendment will comply with the legislative directive and clarify that jurisdiction granted to each agency follows the statutory delegation of authority from the legislature.

There were no comments received regarding adoption of the amendment.

The amendment is adopted under the Nursing Practice Act, (Texas Civil Statutes, Article 4514), §1, which provides the Board of Nurse Examiners with the authority and power to make and enforce all rules and regulations necessary for the performance of its duties and conducting of proceedings before it.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511634 Kathy Thomas, MN, RN, CPNP
Interim Executive Director
Board of Nurse Examiners

Effective date: October 2, 1995

Proposal publication date: July 28, 1995

For further information, please call: (512) 835-8675

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Chapter 217. Licensure and Practice

• 22 TAC §217.3

The Board of Nurse Examiners adopts an amendment to §217.3, concerning Temporary Permit, without changes to the proposed text as published in the July 28, 1995, issue of the *Texas Register* (20 TexReg 5587).

The Computer Adaptive Test (CAT), implemented in 1994, offers daily testing of candidates, rather than twice a year as previously done with the paper and pencil exam. As candidates complete all requirements for graduation and testing, they are deemed eligible for the examination. Currently, the temporary permit is only valid for 60 days or until the results of the exam are received. This has caused numerous problems with for the candidates and their employers. Extending the length of time for the temporary permit will benefit the candidates, employers and office staff.

The amendment will provide additional time for application and results process ing and license mailing to occur, will increase the time in which graduates can test and will inform educators, employers and graduate nurses of the period the permit is valid.

There were no comments received regarding adoption of the amendment.

The amendment is adopted under the Nursing Practice Act, (Texas Civil Statutes), Article 4514, §1, which provides the Board of Nurse Examiners with the authority and power to make and enforce all rules and regulations necessary for the performance of its duties and conducting of proceedings before it.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511635 Kathy Thomas, MN, RN, CPNP
Interim Executive Director
Board of Nurse Examiners

Effective date: October 2, 1995

Proposal publication date: July 28, 1995

For further information, please call: (512) 835-8675

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TITLE 25. HEALTH SERVICES

Part VII. Texas Medical Disclosure Panel

Chapter 601. Informed Consent

The Texas Medical Disclosure Panel (panel) adopts the repeal of existing §§601.1-601.4 and adopts new §§601.1-601.6 concerning informed consent. Section 601.2 and §601.3 are adopted with changes to the proposed text as published in the April 7, 1995, edition of the *Texas Register* (20 TexReg 2593). Section 601.1 and §§601.4-601.6 and the repealed sections are adopted without changes to the proposed text and therefore will not be published.

Specifically, the new sections cover the purpose of the chapter; the panel's procedures requiring full disclosure (list A) and procedures requiring no disclosure (list B); the panel's disclosure and consent form; the panel's radiation therapy disclosure and consent form; and the history of the rules of the panel.

The repeal of §§601.1-601.4 allow for the adoption of the new sections in Texas Register format. New §601.1 relates

generally to the panel and sets out the purpose of the sections which are to implement the requirements of the Medical Liability and Insurance Improvement Act of Texas, Texas Civil Statutes, Article 4590i, Subchapter F relating to informed consent. This section also makes reference to list A in the new §601.2 and list B in the new §601.3.

Section 601.2 and §601.3 have been put into proper Texas Register format so that the full text of the rules, including list A and list B, will be published in future volumes of the Texas Administrative Code. At this time the actual list A and list B are adopted by reference and are not published in the code. There are no changes to the procedures listed or to the risks and hazards assigned to the listed procedures. The only purpose of the new sections is to place the existing procedures and risks and hazards into Texas Register format.

In some places it was necessary to add additional language stating that no other procedures or risks are assigned at this time. This language was added in order to create the proper outline form of having two items, such as subparagraphs (A) and (B) in each list. This change is found in new §601.2(a) (1)(B), (2)(B), (3)(B), (c)(2), (e)(2), (h)(2), and (q)(2). In §601.3 this change is found in subsections (b)(2) and (h)(2). In addition, since the disclosure and consent form has been moved to new §601.4, the reference to the form has been changed in new §601.2 (a)(1)(A), (2)(A), and (3)(A). In addition, punctuation or capitalization has been corrected in ten places in new §601.2 and in one place in new §601.3. In new §601.3, subsection (n) under radiology has been changed to use lower case letters instead of capital letters in paragraphs (11), (16), (18), (20), (23), (24)-(27), and (31) and in paragraph (11) "gastrointestinal" is spelled out.

In new §601.4 the disclosure and consent form is being adopted so that it will be published in the Texas Administrative Code. There have been no changes to the language of the disclosure and consent form. This is still the same form originally adopted by the panel in 1982. New §601.5 adopts the radiation therapy disclosure and consent form which was originally adopted by the panel in 1990. There have been no changes to the form.

New §601.6 lists the history of the rules adopted by the panel. The history is listed in order to assist individuals in identifying the rules in effect on a certain date. This history was previously included in existing §601.1.

The Texas Department of Health (department) accepted comments on the proposal for a 30-day period beginning April 7, 1995. The department received the following comments from department staff to correct errors in terminology. No other comments were received.

Comment: One commenter suggested changing the word "uncontrolled" in §601.2(g)(5)(A) relating to removing fibroids, (7)(A) relating to removal of the nerves to the uterus (presacral neurectomy), (8)(A) relating to removal of the cervix, and (10)(A) relating to abdominal suspension of the bladder (retropubic urethropexy), to "uncontrollable" in order to maintain consistency with §601.2(g)(1)(A), (2)(A), and (6)(A), and because the term "uncontrollable" better describes the condition.

Response: The department agrees and has changed the term "uncontrolled" in subparagraphs (5)(A), (7)(A), (8)(A) and (10)(A) to "uncontrollable." The term "uncontrolled" was used in the panel's existing rules at §§601.1.7.5.1, 601.1.7.7.1, 601.1.7.8.1, and 601.1.7.10.1 which are being repealed and replaced.

Comment: One commenter asked if the words "shinny" and "contratrue" in §601.2(r)(8)(B)(i) relating to skin should be "shiny" and "contracture."

Response: The department agrees and has made the change. The words were misspelled in the panel's existing rules at §§601.1.18.8.2.1 which are being repealed and replaced.

Comment: One commenter asked if the term "stereotaxic" should be "stereotactic" in §601.3(m)(7) relating to nervous system.

Response: The department agrees and has made the change. The word was misspelled in the panel's existing rules at §601.2.13.7.

Comment: One commenter asked if the term "dachrocystography" should be "dacryocystography" in §601.3(n)(15) relating to radiology.

Response: The department agrees and has made the change. The term was misspelled in the panel's existing rules at §601.2.14.15 which is being repealed and replaced.

Comment: One commenter asked if the term "cystolitholopaxy" should be "cystolitholapaxy" in §601.3(p)(4) relating to urinary system.

Response: The department agrees and has made the change. The term was misspelled in the panel's existing rules at §601.2.16.4 which is being repealed and replaced.

Medical Treatments and Surgical Procedure Established by the Texas Medical Disclosure Panel

• 25 TAC §§601.1-601.4

The repeals are adopted under the Medical Liability and Insurance Improvement Act of Texas, Texas Civil Statutues, Article 4590i, §6.04 which authorizes the Texas Medical Disclosure Panel to prepare lists of medical treatments and surgical procedures that do and do not require disclosure by physicians and health care providers of the possible risks and hazards and to prepare the form for the treatments and procedures which do require disclosure.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511685 John Yatsu, M.D.
Chairman
Texas Medical Disclosure Panel

Effective date: October 3, 1995

Proposal publication date: April 7, 1995

For further information, please call: (512) 458-7236

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• 25 TAC §§601.1-601.6

The new sections are adopted under the Medical Liability and Insurance Improvement Act of Texas, Texas Civil Statutes, Article 4590i, §6.04, which authorizes the Texas Medical Disclosure Panel to prepare lists of medical treatments and surgical procedures that do and do not require disclosure by physicians and health care providers of the possible risks and hazards and to prepare the form for the treatments and procedures which do require disclosure.

§601.2. Procedures Requiring Full Disclosure-List A.

(a) Anesthesia.

(1) Epidural.

(A) Risks are enumerated in the form in §601.4 of this title (relating to Disclosure and Consent Form).

(B) No other risks are assigned at this time.

(2) General.

(A) Risks are enumerated in the form in §601.4 of this title.

(B) No other risks are assigned at this time.

(3) Spinal.

(A) Risks are enumerated in the form in §601.4 of this title.

(B) No other risks are assigned at this time.

(b) Cardiovascular system. No procedures are assigned at this time.

(c) Digestive system treatments and procedures.

(1) Cholecystectomy with or without common bile duct exploration.

(A) Pancreatitis.

(B) Injury to the tube between the liver and the bowel.

(C) Retained stones in the tube between the liver and the bowel.

(D) Narrowing or obstruction of the tube between the liver and the bowel.

(E) Injury to the bowel and/or intestinal obstruction.

(2) Other procedures. No other procedures are assigned at this time.

(d) Ear treatments and procedures.

(1) Stapedectomy.

(A) Diminished or bad taste.

(B) Total or partial loss of hearing in the operated ear.

(C) Brief or long-standing dizziness.

(D) Eardrum hole requiring more surgery.

(E) Ringing in the ear.

(2) Reconstruction of auricle of ear for congenital deformity or trauma.

(A) Less satisfactory appearance compared to possible alternative artificial ear.

(B) Exposure of implanted material.

(3) Tympanoplasty with mastoidectomy.

(A) Facial nerve paralysis.

(B) Altered or loss of taste.

(C) Recurrence of original disease process.

(D) Total loss of hearing in operated ear.

(E) Dizziness.

(F) Ringing in the ear.

(e) Endocrine system treatments and procedures.

(1) Thyroidectomy.

(A) Injury to nerves resulting in hoarseness or impairment of speech.

(B) Injury to parathyroid glands resulting in low blood calcium levels that require extensive medication to avoid serious degenerative conditions, such as cataracts, brittle bones, muscle weakness and muscle irritability.

(C) Lifelong requirement of thyroid medication.

(2) Other procedures. No other procedures are assigned at this time.

(f) Eye treatments and procedures.

(1) Eye muscle surgery.

(A) Additional treatment and/or surgery.

(B) Double vision.

(C) Partial or total loss of vision.

(2) Surgery for cataract with or without implantation of intraocular lens.

(A) Complications requiring additional treatment and/or surgery.

(B) Need for glasses or contact lenses.

(C) Complications requiring the removal of implanted lens.

(D) Partial or total loss of vision.

(3) Retinal or vitreous surgery.

(A) Complications requiring additional treatment and/or surgery.

(B) Recurrence or spread of disease.

(C) Partial or total loss of vision.

(4) Reconstructive and/or plastic surgical procedures of the eye and eye region, such as blepharoplasty, tumor, fracture, lacrimal surgery, foreign body, abscess, or trauma.

(A) Worsening or unsatisfactory appearance.

(B) Creation of additional problems.

(i) Poor healing or skin loss.

(ii) Nerve damage.

(iii) Painful or unattractive scarring.

(iv) Impairment of regional organs, such as eye or lip function.

(C) Recurrence of the original condition.

(5) Photocoagulation and/or cryotherapy.

(A) Complications requiring additional treatment and/or surgery.

(B) Pain.

(C) Partial or total loss of vision.

(6) Corneal surgery, such as corneal transplant, refractive surgery and pterygium.

(A) Complications requiring additional treatment and/or surgery.

(B) Possible pain.

(C) Need for glasses or contact lenses.

(D) Partial or total loss of vision.

(7) Glaucoma surgery by any method.

(A) Complications requiring additional treatment and/or surgery.

(B) Worsening of the glaucoma.

(C) Pain.

(D) Partial or total loss of vision.

(8) Removal of the eye or its contents (enucleation or evisceration).

(A) Complications requiring additional treatment and/or surgery.

(B) Worsening or unsatisfactory appearance.

(C) Recurrence or spread of disease.

(9) Surgery for penetrating ocular injury, including intraocular foreign body.

(A) Complications requiring additional treatment and/or surgery, including removal of the eye.

(B) Chronic pain.

(C) Partial or total loss of vision.

(g) Female genital system treatments and procedures.

(1) Abdominal hysterectomy (total).

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(2) Vaginal hysterectomy.

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(F) Completion of operation by abdominal incision.

(3) All fallopian tube and ovarian surgery with or without hysterectomy, including removal and lysis of adhesions.

(A) Injury to the bowel and/or bladder.

(B) Sterility.

(C) Failure to obtain fertility (if applicable).

(D) Failure to obtain sterility (if applicable).

(E) Loss of ovarian functions or hormone production from ovary(ies).

(4) Abdominal endoscopy (peritoneoscopy, laparoscopy).

(A) Puncture of the bowel or blood vessel.

(B) Abdominal injection and complications of infection.

(C) Abdominal incision and operation to correct injury.

(5) Removing fibroids (uterine myomectomy).

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(6) Uterine suspension.

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(7) Removal of the nerves to the uterus (presacral neurectomy).

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(F) Hemorrhage, complications of hemorrhage, with additional operation.

(8) Removal of the cervix.

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(F) Completion of operation by abdominal incision.

(9) Repair of vaginal hernia (anterior and/or posterior colporrhaphy and/or enterocele repair).

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Sterility.

(D) Injury to the tube (ureter) between the kidney and the bladder.

(E) Injury to the bowel and/or intestinal obstruction.

(10) Abdominal suspension of the bladder (retropubic urethropexy).

(A) Uncontrollable leakage of urine.

(B) Injury to bladder.

(C) Injury to the tube (ureter) between the kidney and the bladder.

(D) Injury to the bowel and/or intestinal obstruction.

(11) Conization of cervix.

(A) Hemorrhage with possible hysterectomy to control.

(B) Sterility.

(C) Injury to bladder.

(D) Injury to rectum.

(E) Failure of procedure to remove all of cervical abnormality.

(12) Dilation and curettage of uterus (diagnostic).

(A) Hemorrhage with possible hysterectomy.

(B) Perforation of the uterus.

(C) Sterility.

(D) Injury to bowel and/or bladder.

(E) Abdominal incision and operation to correct injury.

(13) Dilation and curettage of uterus (obstetrical).

(A) Hemorrhage with possible hysterectomy to control.

(B) Perforation of the uterus.

(C) Sterility.

(D) Injury to the bowel and/or bladder.

(E) Abdominal incision and operation to correct injury.

(F) Failure to remove all products of conception.

(h) Hematic and lymphatic system.

(1) Transfusion of blood and blood components.

(A) Fever.

(B) Transfusion reaction which may include kidney failure or anemia.

(C) Heart failure.

(D) Hepatitis.

(E) A.I.D.S. (acquired immune deficiency syndrome).

(F) Other infections.

(2) Other procedures. No other procedures are assigned at this time.

(i) Integumentary system treatments and procedures.

(1) Radical or modified radical mastectomy. (Simple mastectomy excluded).

(A) Limitation of movement of shoulder and arm.

(B) Swelling of the arm.

(C) Loss of the skin of the chest requiring skin graft.

(D) Recurrence of malignancy, if present.

(E) Decreased sensation or numbness of the inner aspect of the arm and chest wall.

(2) Reconstruction and/or plastic surgical operations of the face and neck.

(A) Worsening or unsatisfactory appearance.

(B) Creation of several additional problems.

(i) Poor healing or skin loss.

(ii) Nerve damage.

(iii) Painful or unattractive scarring.

(iv) Impairment of regional organs, such as eye or lip function.

(C) Recurrence of the original condition.

(j) Male genital system.

(1) Orchidopexy (reposition of testis(es)).

(A) Removal of testicle.

(B) Atrophy (shriveling) of the testicle with loss of function.

(2) Orchiectomy (removal of the testis(es)).

(A) Decreased sexual desire.

(B) Difficulties with penile erection.

(3) Vasectomy.

(A) Loss of testicle.

(B) Failure to produce permanent sterility.

(k) Maternity and related cases.

(1) Delivery (vaginal).

(A) Injury to bladder and/or rectum, including a hole (fistula) between bladder and vagina and/or rectum and vagina.

(B) Hemorrhage possibly requiring blood administration and/or hysterectomy and/or artery ligation to control.

(C) Sterility.

(D) Brain damage, injury or even death occurring to the fetus before or during labor and/or vaginal delivery whether or not the cause is known.

(2) Delivery (cesarean section).

(A) Injury to bowel and/or bladder.

(B) Sterility.

(C) Injury to tube (ureter) between kidney and bladder.

(D) Brain damage, injury or even death occurring to the fetus before or during labor and/or cesarean delivery whether or not the cause is known.

(E) Uterine disease or injury requiring hysterectomy.

(l) Musculoskeletal system treatments and procedures.

(1) Arthroplasty of all joints with mechanical device.

(A) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.

(B) Blood vessel or nerve injury.

(C) Pain or discomfort.

(D) Fat escaping from bone with possible damage to a vital organ.

(E) Failure of bone to heal.

(F) Bone infection.

(G) Removal or replacement of any implanted device or material.

(2) Mechanical internal prosthetic device.

(A) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.

(B) Blood vessel or nerve injury.

(C) Pain or discomfort.

(D) Fat escaping from bone with possible damage to a vital organ.

(E) Failure of bone to heal.

(F) Bone infection.

(G) Removal or replacement of any implanted device or material.

(3) Open reduction with internal fixation.

(A) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.

(B) Blood vessel or nerve injury.

(C) Pain or discomfort.

(D) Fat escaping from bone with possible damage to a vital organ.

(E) Failure of bone to heal.

(F) Bone infection.

(G) Removal or replacement of any implanted device or material.

(4) Osteotomy.

(A) Impaired function such as shortening or deformity of an arm or leg, limp or foot drop.

(B) Blood vessel or nerve injury.

(C) Pain or discomfort.

(D) Fat escaping from bone with possible damage to a vital organ.

(E) Failure of bone to heal.

(F) Bone infection.

(G) Removal or replacement of any implanted device or material.

(5) Ligamentous reconstruction of joints.

(A) Failure of reconstruction to work.

(B) Continued loosening of the joint.

(C) Degenerative arthritis.

(D) Continued pain.

(E) Increased stiffening.

(F) Blood vessel or nerve injury.

(G) Cosmetic and/or functional deformity.

(6) Children's orthopedics (bone, joint, ligament or muscle).

(A) Growth deformity.

(B) Additional surgery.

(m) Nervous system treatments and procedures.

(1) Craniotomy (craniectomy) for excision of brain tissue, tumor, vascular malformation and cerebral revascularization.

(A) Additional loss of brain function including memory.

(B) Recurrence or continuation of the condition that required this operation.

(C) Stroke.

(D) Blindness, deafness, inability to smell, double vision, coordination loss, seizures, pain, numbness and paralysis.

(2) Craniotomy (craniectomy) for cranial nerve operation including neurectomy, avulsion, rhizotomy or neurolysis.

(A) Numbness, impaired muscle function or paralysis.

(B) Recurrence or continuation of the condition that required this operation.

(C) Seizures.

(3) Spine operation, including laminectomy, decompression, fusion, internal fixation or procedures for nerve root or spinal cord compression; diagnosis; pain; deformity; mechanical instability; injury; removal of tumor, abscess or hematoma (excluding coccygeal operations).

(A) Pain, numbness or clumsiness.

(B) Impaired muscle function.

(C) Incontinence or impotence.

(D) Unstable spine.

(E) Recurrence or continuation of the condition that required the operation.

(F) Injury to major blood vessels.

(4) Peripheral nerve operation; nerve grafts, decompression, transposition or tumor removal; neurorrhaphy, neurectomy or neurolysis.

(A) Numbness.

(B) Impaired muscle function.

(C) Recurrence or persistence of the condition that required the operation.

(D) Continued, increased or different pain.

(5) Correction of cranial deformity.

(A) Loss of brain function.

(B) Seizures.

(C) Recurrence or continuation of the condition that required this operation.

(6) Transphenoidal hypophysectomy or other pituitary gland operation.

(A) Spinal fluid leak.

(B) Necessity for hormone replacement.

(C) Recurrence or continuation of the condition that required this operation.

(D) Nasal septal deformity or perforation.

(7) Cerebral spinal fluid shunting procedure or revision.

(A) Shunt obstruction or infection.

(B) Seizure disorder.

(C) Recurrence or continuation of brain dysfunction.

(n) Radiology.

(1) Angiography, aortography, arteriography (arterial injection of contrast media-diagnostic).

(A) Injury to artery.

(B) Damage to parts of the body supplied by the artery with resulting loss of function or amputation.

(C) Swelling, pain, tenderness or bleeding at the site of the blood vessel perforation.

(D) Aggravation of the condition that necessitated the procedure.

(E) Allergic sensitivity reaction to injected contrast media.

(2) Myelography.

(A) Chronic pain.

(B) Transient headache, nausea, vomiting.

(C) Numbness.

(D) Impaired muscle function.

(3) Angiography with occlusion techniques-therapeutic.

(A) Injury to artery.

(B) Loss or injury to body parts.

(C) Swelling, pain, tenderness or bleeding at the site of the blood vessel perforation.

(D) Aggravation of the condition that necessitated the procedure.

(E) Allergic sensitivity reaction to injected contrast media.

(4) Angioplasty (intravascular dilatation technique).

(A) Swelling, pain tenderness, or bleeding at the site of vessel puncture.

(B) Damage to parts of the body supplied by the artery with resulting loss of function or amputation.

(C) Injury to the vessel that may require immediate surgical intervention.

(D) Recurrence or continuation of the original condition.

(E) Allergic sensitivity reaction to injected contrast media.

(5) Splenoportography (needle injection of contrast media into the spleen).

(A) Injury to the spleen requiring blood transfusion and/or removal of the spleen.

(B) No other risks are assigned at this time.

(o) Respiratory system treatments and procedures.

(1) Excision of lesion of larynx, vocal cords, trachea. No risks or hazards assigned at this time.

(2) Rhinoplasty or nasal reconstruction with or without septoplasty.

(A) Deformity of skin, bone or cartilage.

(B) Creation of new problems, such as septal perforation or breathing difficulty.

(3) Submucous resection of nasal septum or nasal septoplasty.

(A) Persistence, recurrence or worsening of the obstruction.

(B) Perforation of nasal septum with dryness and crusting.

(C) External deformity of the nose.

(p) Urinary system.

(1) Partial nephrectomy (removal of part of the kidney).

(A) Incomplete removal of stone(s) or tumor, if present.

(B) Obstruction of urinary flow.

(C) Leakage of urine at surgical site.

(D) Injury to or loss of the kidney.

(E) Damage to adjacent organs.

(2) Radical nephrectomy (removal of kidney and adrenal gland for cancer).

(A) Loss of the adrenal gland.

(B) Incomplete removal of tumor.

(C) Damage to adjacent organs.

(3) Nephrectomy (removal of kidney).

(A) Incomplete removal of tumor if present.

(B) Damage to adjacent organs.

(C) Injury to or loss of the kidney.

(4) Nephrolithotomy and pyelolithotomy (removal of kidney

stone(s)).

(A) Incomplete removal of stone(s).

(B) Obstruction of urinary flow.

(C) Leakage of urine at surgical site.

(D) Injury or loss of the kidney.

(E) Damage to adjacent organs.

(5) Pyeloureteroplasty (pyeloplasty or reconstruction of the kidney drainage system).

(A) Obstruction of urinary flow.

(B) Leakage of urine at surgical site.

(C) Injury to or loss of the kidney.

(D) Damage to adjacent organs.

(6) Exploration of kidney or perinephric mass.

(A) Incomplete removal of stone(s) or tumor, if present.

(B) Leakage of urine at surgical site.

(C) Injury to or loss of the kidney.

(D) Damage to adjacent organs.

(7) Ureteroplasty (reconstruction of ureter (tube between kidney and bladder)).

(A) Leakage of urine at surgical site.

(B) Incomplete removal of the stone or tumor (when applicable).

(C) Obstruction of urine flow.

(D) Damage to other adjacent organs.

(E) Damage to or loss of the ureter.

(8) Ureterolithotomy (surgical removal of stone(s) from ureter (tube between kidney and bladder)).

(A) Leakage of urine at surgical site.

(B) Incomplete removal of stone.

(C) Obstruction of urine flow.

(D) Damage to other adjacent organs.

(E) Damage to or loss of ureter.

(9) Ureterectomy (partial/complete removal of ureter (tube between kidney and bladder)).

(A) Leakage of urine at surgical site.

(B) Incomplete removal of tumor (when applicable).

(C) Obstruction of urine flow.

(D) Damage to other adjacent organs.

(10) Ureterolysis (partial/complete removal of ureter (tube between kidney and bladder from adjacent tissue)).

(A) Leakage of urine at surgical site.

(B) Obstruction to urine flow.

(C) Damage to other adjacent organs.

(D) Damage to or loss of ureter.

(11) Ureteral reimplantation (reinserting ureter (tube between kidney and bladder) into the bladder).

(A) Leakage of urine at surgical site.

(B) Obstruction to urine flow.

(C) Damage to or loss of ureter.

(D) Backward flow of urine from bladder into ureter.

(E) Damage to other adjacent organs.

(12) Prostatectomy (partial or total removal of prostate).

(A) Leakage of urine at surgical site.

(B) Obstruction to urine flow.

(C) Incontinence (difficulty with urinary control).

(D) Semen passing backward into bladder.

(E) Difficulty with penile erection (possible with partial and probable with total prostatectomy).

(13) Total cystectomy (removal of urinary bladder).

(A) Probable loss of penile erection and ejaculation in the male.

(B) Damage to other adjacent organs.

(C) This procedure will require an alternate method of urinary drainage.

(14) Partial cystectomy (partial removal of urinary bladder) .

(A) Leakage or urine at surgical site.

(B) Incontinence (difficulty with urinary control).

(C) Backward flow of urine from bladder into ureter (tube between kidney and bladder).

(D) Obstruction of urine flow.

(E) Damage to other adjacent organs.

(15) Urinary diversion (ileal conduit, colon conduit).

(A) Blood chemistry abnormalities requiring medication.

(B) Development of stones, strictures or infection.

(C) Routine lifelong medical evaluation.

(D) Leakage of urine at surgical site.

(E) Requires wearing a bag for urine collection.

(16) Ureterosigmoidostomy (placement of kidney drainage tubes into the large bowel).

(A) Blood chemistry abnormalities requiring medication.

(B) Development of stones, strictures or infection.

(C) Routine lifelong medical evaluation.

(D) Leakage of urine at surgical site.

(E) Difficulty in holding urine in the rectum.

(17) Urethroplasty (construction/reconstruction of drainage tube from bladder).

(A) Leakage of urine at surgical site.

(B) Stricture formation.

(C) Additional operations(s).

(q) Psychiatric procedures.

(1) Electroconvulsive therapy with modification by intravenous muscle relaxants and sedatives.

(A) Memory changes of events prior to, during, and immediately following the treatment.

(B) Fractures or dislocations of bones.

(C) Significant temporary confusion requiring special care.

(2) Other Procedures. No other procedures are assigned at this time.

(r) Radiation therapy. A child is defined for the purpose of this subsection as an individual who is not physiologically mature as determined by the physician using the appropriate medical parameters.

(1) Head and neck.

(A) Early reactions.

(i) Reduced and sticky saliva, loss of taste and appetite, altered sense of smell, nausea.

(ii) Sore throat, difficulty swallowing, weight loss, fatigue.

(iii) Skin changes: redness, irritation, scaliness, blistering or ulceration, color change, thickening, hair loss.

(iv) Hoarseness, cough, loss of voice, and swelling of airway.

(v) Blockage and crusting of nasal passages.

(vi) Inflammation of ear canal, feeling of "stopped up" ear, hearing loss, dizziness.

(vii) Dry and irritable eye(s).

(viii) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(ix) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Dry mouth and altered sense, or loss, of taste.

(ii) Tooth decay and gum changes.

(iii) Bone damage, especially in jaws.

(iv) Stiffness and limitation of jaw movement.

(v) Changes in skin texture and/or coloration, permanent hair loss, and scarring of skin.

(vi) Swelling of tissues, particularly under the chin.

(vii) Throat damage causing hoarseness, pain or difficulty breathing or swallowing.

(viii) Eye damage causing dry eye(s), cataract, loss of vision, or loss of eye(s).

(ix) Ear damage causing dryness of ear canal, fluid collection in middle ear, hearing loss.

(x) Brain, spinal cord or nerve damage causing alteration of thinking ability or memory, and/or loss of strength, feeling or coordination in any part of the body.

(xi) Pituitary or thyroid gland damage requiring long-term hormone replacement therapy.

(xii) In children, there may be additional late reactions.

(I) Disturbance of bone and tissue growth.

(II) Bone damage to face causing abnormal development.

(III) Brain damage causing a loss of intellectual ability, learning capacity, and reduced intelligence quotient (I. Q.).

(IV) Second cancers developing in the irradiated area.

(2) Central nervous system.

(A) Early reactions.

(i) Skin and scalp reaction with redness, irritation, scaliness, blistering, ulceration, change in color, thickening, hair loss.

(ii) Nausea, vomiting, headaches.

(iii) Fatigue, drowsiness.

(iv) Altered sense of taste or smell.

(v) Inflammation of ear canal, feeling of "stopped-up" ear, hearing loss, dizziness.

(vi) Depression of blood count leading to increased risk of infection and/or bleeding.

(vii) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(viii) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Permanent hair loss of variable degrees, altered regrowth, texture and color of hair.

(ii) Persistent drowsiness and tiredness.

(iii) Brain damage causing a loss of some degree of thinking ability or memory, or personality changes.

(iv) Scarring of skin.

(v) Spinal cord or nerve damage causing loss of strength, feeling or coordination in any part of the body.

(vi) Damage to eye(s), or optic nerve(s) causing loss of vision.

(vii) Ear damage causing dryness of ear canal, fluid collection in middle ear, hearing loss.

(viii) Pituitary gland damage requiring long-term hormone replacement therapy.

(ix) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to spine, causing stunting of growth, curvature and/or reduction in height.

(III) Bone damage to face, or pelvis causing stunting of bone growth and/or abnormal development.

(IV) Brain damage causing a loss of intellectual ability, learning capacity, and reduced intelligence quotient (I.Q.).

(V) Second cancers developing in the irradiated area.

(3) Thorax.

(A) Early reactions.

(i) Skin changes: redness, irritation, scaliness, ulceration, change in color, thickening, hair loss.

(ii) Inflammation of esophagus causing pain on swallowing, heartburn, or sense of obstruction.

(iii) Loss of appetite, nausea, vomiting.

(iv) Weight loss, weakness, vomiting.

(v) Inflammation of the lung with pain, fever and cough.

(vi) Inflammation of the heart sac with chest pain and palpitations.

(vii) Bleeding or creation of a fistula resulting from tumor destruction.

(viii) Depression of blood count leading to increased risk of infection and/or bleeding.

(ix) Intermittent electric shock-like feelings in the lower spine or legs on bending the neck.

(x) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(xi) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Changes in skin texture and/or coloration, permanent hair loss and scarring of skin.

(ii) Lung scarring or shrinkage causing shortness of breath.

(iii) Narrowing of esophagus causing swallowing problems.

(iv) Constriction of heart sac which may require surgical correction.

(v) Damage to heart muscle or arteries leading to heart failure.

(vi) Fracture of ribs.

(vii) Nerve damage causing pain, loss of strength or feeling in arms.

(viii) Spinal cord damage causing loss of strength or feeling in arms and legs, and/or loss of control of bladder and rectum.

(ix) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to spine, causing stunting of growth, curvature and/or reduction in height.

(III) Underdevelopment or absence of development of female breast.

(IV) Second cancers developing in the irradiated area.

(4) Breast.

(A) Early reactions.

(i) Skin changes: redness, irritation, scaliness, blistering, ulceration, coloration, thickening, and hair loss.

(ii) Breast changes including swelling, tightness, or tenderness.

(iii) Inflammation of the esophagus causing pain or swallowing, heartburn, or sense of obstruction.

(iv) Lung inflammation with cough.

(v) Inflammation of heart sac with chest pain and palpitations.

(B) Late reactions.

(i) Changes in skin texture and/or coloration, permanent hair loss, scarring of skin.

(ii) Breast changes including thickening, firmness, tenderness, shrinkage.

(iii) Swelling of arm.

(iv) Stiffness and discomfort in shoulder joint.

(v) Rib or lung damage causing pain, fracture, cough, shortness of breath.

(vi) Nerve damage causing pain, loss of strength or feeling in arm.

(vii) Damage to heart muscle or arteries or heart sac leading to heart failure.

(5) Abdomen.

(A) Early reactions.

(i) Skin changes: redness, irritation, scaliness, ulceration, coloration, thickening, hair loss.

(ii) Loss of appetite, nausea, vomiting.

(iii) Weight loss, weakness, fatigue.

(iv) Inflammation of stomach causing indigestion, heartburn, and ulcers.

(v) Inflammation of bowel causing cramping and diarrhea.

(vi) Depression of blood count leading to increased risk of infections and/or bleeding.

(vii) In children, these reactions are likely to be intensified by chemotherapy before, during and after radiation therapy.

(viii) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Changes in skin texture and/or coloration, permanent hair loss, scarring of skin.

(ii) Stomach damage causing persistent indigestion, pain, and bleeding.

(iii) Bowel damage causing narrowing or adhesions of bowel with obstruction, ulceration, or bleeding which may require surgical correction, chronic diarrhea, or poor absorption of food elements.

(iv) Kidney damage leading to kidney failure and/or high blood pressure.

(v) Liver damage leading to liver failure.

(vi) Spinal cord or nerve damage causing loss of strength or feeling in legs and/or loss of control of bladder and/or rectum.

(vii) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to spine causing stunting of growth, curvature and/or reduction in height.

(III) Bone damage to pelvis causing stunting of bone growth and/or abnormal development.

(IV) Second cancers developing in the irradiated area.

(6) Female pelvis.

(A) Early reactions.

(i) Inflammation of bowel causing cramping and diarrhea.

(ii) Inflammation of rectum and anus causing pain, spasm, discharge, bleeding.

(iii) Bladder inflammation causing burning, frequency, spasm, pain, bleeding.

(iv) Skin changes: redness, irritation, scaliness, blistering or ulceration, coloration, thickening, hair loss.

(v) Disturbance of menstrual cycle.

(vi) Vaginal discharge, pain, irritation, bleeding.

(vii) Depression of blood count leading to increased risk of infection and/or bleeding.

(viii) In children, these reactions are likely to be intensified by chemotherapy before, during, or after radiation therapy.

(ix) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Bowel damage causing narrowing or adhesions of the bowel with obstruction, ulceration, bleeding, chronic diarrhea, or poor absorption of food elements and may require surgical correction or colostomy.

(ii) Bladder damage with loss of capacity, frequency of urination, blood in urine, recurrent urinary infections, pain, or spasm which may require urinary diversion and/or removal of bladder.

(iii) Changes in skin texture and/or coloration, permanent hair loss, scarring of skin.

(iv) Bone damage leading to fractures.

(v) Ovarian damage causing infertility, sterility, or premature menopause.

(vi) Vaginal damage leading to dryness, shrinkage, pain, bleeding, or sexual dysfunction.

(vii) Swelling of the genitalia or legs.

(viii) Nerve damage causing pain, loss of strength or feeling in legs, and/or loss of control of bladder or rectum.

(ix) Fistula between the bladder and/or bowel and/or vagina.

(x) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to pelvis and hips causing stunting of bone growth and/or abnormal development.

(III) Second cancers developing in the irradiated area.

(7) Male pelvis.

(A) Early reactions.

(i) Inflammation of bowel causing cramping and diarrhea.

(ii) Inflammation of rectum and anus causing pain, spasm, discharge, bleeding.

(iii) Bladder inflammation causing burning, frequency, spasm, pain, and/or bleeding.

(iv) Skin changes: redness, irritation, scaliness, blistering or ulceration, coloration, thickening, hair loss.

(v) Depression of blood count leading to increased risk of infection and/or bleeding.

(vi) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(vii) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Bowel damage causing narrowing or adhesions of the bowel with obstruction, ulceration, bleeding, chronic diarrhea, or poor absorption of food elements and may require surgical correction or colostomy.

(ii) Bladder damage with loss of capacity, frequency of urination, blood in urine, recurrent urinary infections, pain, or spasm which may require urinary diversion and/or removal of bladder.

(iii) Changes in skin texture and/or coloration, permanent hair loss, scarring of skin.

(iv) Bone damage leading to fractures.

(v) Testicular damage causing reduced sperm counts, infertility, sterility, or risk of birth defects.

(vi) Impotence (loss of erection) or sexual dysfunction.

(vii) Swelling of the genitalia or legs.

(viii) Nerve damage causing pain, loss of strength or feeling in legs, and/or loss of control of bladder or rectum.

(ix) Fistula between the bowel and other organs.

(x) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to pelvis and hips causing stunting of bone growth and/or abnormal development.

(III) Second cancers developing in the irradiated area.

(8) Skin.

(A) Early reactions.

(i) Redness, irritation, or soreness.

(ii) Scaliness, ulceration, crusting, oozing, discharge.

(iii) Hair loss.

(iv) These reactions are likely to be intensified by chemotherapy.

(B) Late reactions.

(i) Changes in skin texture causing scaly or shiny smooth skin, thickening with contracture, puckering, scarring of skin.

(ii) Changes in skin color.

(iii) Prominent dilated small blood vessels.

(iv) Permanent hair loss.

(v) Chronic or recurrent ulcerations.

(vi) Damage to adjacent tissues including underlying bone or cartilage.

(vii) In children, second cancers may develop in the irradiated area.

(9) Extremities.

(A) Early reactions.

(i) Skin changes: redness, irritation, scaliness, ulceration, coloration, thickening, hair loss.

(ii) Inflammation of soft tissues causing tenderness, swelling, and interference with movement.

(iii) Inflammation of joints causing pain, swelling and limitation of joint motion.

(iv) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(v) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Changes in skin reaction and/or coloration, permanent hair loss and scarring of the skin.

(ii) Scarring or shrinkage of soft tissues and muscle causing loss of flexibility and movement, swelling of the limb.

(iii) Nerve damage causing loss of strength, feeling or coordination.

(iv) Bone damage causing fracture.

(v) Joint damage causing permanent stiffness, pains and arthritis.

(vi) Swelling of limb below the area treated.

(vii) In children, there may be additional late reactions.

(I) Disturbances of bone and tissue growth.

(II) Bone damage to limbs causing stunting of bone growth and/or abnormal development.

(III) Second cancers developing in the irradiated area.

(10) Total body irradiation.

(A) Early reactions.

(i) Loss of appetite, nausea, vomiting.

(ii) Diarrhea.

(iii) Reduced and sticky saliva, swelling of the salivary gland(s), loss of taste.

(iv) Hair loss.

(v) Sore mouth and throat, difficulty swallowing.

(vi) Permanent destruction of bone marrow leading to infection, bleeding, and possible death.

(vii) Inflammation of the lung with fever, dry cough and difficulty breathing with possible fatal lung failure.

(viii) Damage to liver with possible fatal liver failure.

(ix) In children, these reactions are likely to be intensified by chemotherapy before, during or after radiation therapy.

(x) In children, depression of blood count leading to increased risk of infection and/or bleeding is more common.

(B) Late reactions.

(i) Lung scarring causing shortness of breath, infection, and fatal lung failure.

(ii) Cataract formation in the eyes, possible loss of vision.

(iii) Testicular damage in males causing sterility.

(iv) Ovarian damage in females causing premature menopause and sterility.

(v) Increased risk of second cancer.

§601.3. Procedures Requiring No Disclosure-List B.

(a) Anesthesia.

(1) Local.

(2) Other forms of regional anesthesia.

(b) Cardiovascular system.

(1) Excision and ligation of varicose veins of the leg.

(2) No other procedures are assigned at this time.

(c) Digestive system.

(1) Appendectomy.

(2) Hemorrhoidectomy with fistulectomy or fissurectomy.

(3) Hemorrhoidectomy.

(4) Incision or excision of perirectal tissue.

(5) Local excision and destruction of lesion, anus and rectum.

(6) Operations for correction of cleft palate.

(7) Repair of inguinal hernia.

(8) Repair and plastic operations on anus and rectum.

(9) Resection of colon (segmental).

(10) Tonsillectomy with adenoidectomy.

(11) Tonsillectomy without adenoidectomy.

(d) Ear.

(1) Myringotomy.

(2) Reconstruction of auricle of ear for skin cancer.

(3) Tympanoplasty without mastoidectomy.

(e) Endocrine system. No procedures assigned at this time.

(f) Eye.

(1) Administration of topical, parenteral (such as IV), or oral drugs or pharmaceuticals, including, but not limited to, fluorescein angiography, orbital injection or periocular injections.

(2) Removal of extraocular foreign bodies.

(3) Chalazion excision.

(g) Female genital system. No procedures assigned at this time.

(h) Hematic and lymphatic system.

(1) Biopsy of lymph nodes.

(2) Other procedures. No other procedures are assigned at this time.

(i) Integumentary system.

(1) Biopsy of breast.

(2) Cutting and preparation of skin grafts or pedicle flaps.

(3) Removal or treatment of local skin or subcutaneous lesion.

(4) Excision of pilonidal sinus or cyst.

(5) Suture of skin.

(6) Wide or radical excision of skin lesion with or without graft.

(7) Z plasty without excision.

(8) Biopsy of skin or mucus membrane.

(9) Incision and drainage of skin or mucus membrane lesion.

(10) Debridement of ulceration of the skin.

(j) Male genital system.

(1) Biopsy of testicle.

(2) Placement of testicular prosthesis.

(3) Hydrocelectomy (removal/drainage of cyst in scrotum).

(4) Circumcision.

(5) Cystoscopy.

(k) Maternity and related cases. No procedures assigned at this time.

(l) Musculoskeletal system.

(1) Arthrotomy.

(2) Closed reduction without internal fixation.

(3) Excision of lesion, muscle, tendon, fascia, bone.

(4) Excision of semilunar cartilage of knee joint.

(5) Needle biopsy or aspiration, bone marrow.

(6) Partial excision of bone.

(7) Removal of internal fixation device.

(8) Traction or fixation without manipulation for reduction.

(m) Nervous system.

(1) Cranioplasty.

(2) Lumbar puncture.

(3) Closure of meningomyelocele.

(4) Ventriculostomy with or without air ventriculogram.

(5) Cisternal puncture (diagnostic).

(6) Craniectomy or craniotomy for intracranial hematoma, abscess or penetrating injury.

(7) Stereotactic surgery for dystonia.

(8) Insertion of skeletal tongs.

(9) Intravenous cut-down.

(10) Elevation of depressed skull fracture.

(11) Cervical 1-2 puncture (diagnostic).

(n) Radiology.

(1) Injection of contrast media or imaging media into the spinal canal for diagnostic encephalography and/or cisternography.

(2) Intravascular infusion technique-therapeutic.

(3) Lymphangiography.

(4) Percutaneous transhepatic (liver) catheter placement.

(5) Discography.

(6) Venography (Venogram) with contrast media.

(7) Cholangiography with contrast media.

(8) Urography (IVP) with contrast media.

(9) Digital Subtraction Angiography with contrast media.

(10) Radionuclide scans and/or blood flow studies.

(11) Gastrointestinal (G.I.) tract radiography and fluoroscopy.

(12) Oral cholecystography.

(13) Fistula or sinus tract injection.

(14) Sialography.

(15) Dacryocystography.

(16) Cystography, cystourethrography.

(17) Retrograde and antegrade urography.

(18) Larynogography, bronchography.

(19) Hysterosalpingography.

(20) E.R.C.P. (Endoscopic retrograde cholangio pancreatography).

(21) Galactography.

(22) T-tube cholangiography.

(23) Skeletal radiography and/or fluoroscopy (skull, mastoids, sinuses and facial bones; spine, ribs, pelvis; extremities).

(24) Foreign body radiography and/or fluoroscopy.

(25) Chest and abdomen radiography and fluoroscopy.

(26) Portable radiography/fluoroscopy.

(27) Pelvimetry, fetogram.

(28) Computer tomography scan with and without contrast media.

(29) Ultrasound and Doppler studies.

(30) Laminography, polytomography.

(31) Soft-tissue radiography including xerography and zeromammography.

(32) Kidney or bile duct stone manipulation through percutaneous tube or tube tract.

(33) Pacemaker lead placement.

(34) Arthrography.

(35) Percutaneous nephrostogram and/or internal stint or external drainage of the kidney.

(36) Percutaneous transhepatic cholangiogram and/or internal stint or external drainage of the liver.

(37) Percutaneous abscess drainage.

(o) Respiratory system.

(1) Aspiration of bronchus.

(2) Biopsy of lesion of larynx, trachea, bronchus, esophagus.

(3) Lung biopsy.

(4) Needle biopsy, lung.

(5) Segmental resection of lung.

(6) Thoracotomy.

(7) Thoracotomy with drainage.

(8) Reduction of nasal fracture.

(9) Tracheostomy.

(p) Urinary system.

(1) Nephrotomy (placement of drainage tubes).

(2) Biopsy of prostrate, bladder or urethra.

(3) Cystolithotomy (surgical removal of stone(s) from the bladder).

(4) Cystolitholapaxy (cystoscopic crushing and removal of bladder stone(s)).

(5) Cystostomy (placement of tube into the bladder).

(6) Urethrotomy (incision of the urethra).

(7) Diverticulectomy of the bladder (removal of outpouching of the bladder).

(8) Diverticulectomy or diverticulotomy of the urethra (repair or drainage of outpouching of the urethra).

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel

and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511686 John Yatsu, M.D.
Chairman
Texas Medical Disclosure Panel

Effective date: October 3, 1995

Proposal publication date: April 7, 1995

For further information, please call: (512) 458-7236

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• 25 TAC §601.7

The Texas Medical Disclosure Panel (panel) adopts new §601.7, relating to informed consent for electroconvulsive therapy, without changes to the proposed text as published in the May 12, 1995, issue of the *Texas Register* (20 TexReg 3559), and therefore will not be republished.

The new section addresses consent to electroconvulsive therapy as required by the Health and Safety Code (HSC), §578.003. HSC, §578.003 requires the Texas Department of Mental Health and Mental Retardation (MHMR) to adopt a written consent form for electroconvulsive therapy. In addition to the information required by §578.003, the form must include the information required by the panel for electroconvulsive therapy. HSC, §578.003 states that use of the consent form prescribed by MHMR in the manner prescribed by HSC, §578.003 creates a rebuttal presumption that the disclosure requirements of the Medical Liability and Insurance Improvement Act of Texas, Texas Civil Statutes, Article 4590i, §6.05 and §6.06 have been met.

The new section states that if the MHMR consent form for electroconvulsive therapy is in compliance with the HSC, §578.003 and contains the minimum information required by the panel, a physician or health care provider using the MHMR form for electroconvulsive therapy is not required also to use the panel's disclosure and consent form. The section also states that it does not constitute approval of the MHMR current form or of MHMR's assessment of the risks and hazards associated with electroconvulsive therapy. The intent of this section is to clarify the issue which has arisen as to whether a physician or health care provider must use both forms or may use only the MHMR form.

The Texas Department of Health did not receive any comments concerning the new section during the 30-day comment period.

The new section is adopted under the Medical Liability and Insurance Improvement Act of Texas, Texas Civil Statutes, Article 4590i, §6.04, which authorizes the panel to prepare lists of the medical treatments and surgical procedures that do and do not require disclosure by physicians and health care providers of the possible risks and hazards and to prepare the form for the treatments and procedures which do require disclosure.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511687 John Yatsu, M.D.
Chairman
Texas Medical Disclosure Panel

Effective date: October 3, 1995

Proposal publication date: May 12, 1995

For further information, please call: (512) 458-7236

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TITLE 28. INSURANCE

Part I. Texas Department of Insurance

Chapter 19. Agent's Licensing

Subchapter H. Variable Contract Agents

• 28 TAC §19.701, §19.702

The Commissioner of Insurance adopts amendments to §19.701 and §19. 702, concerning the licensing of variable contract agents, with changes to the proposed text as published in the May 12, 1995, issue of the *Texas Register* (20 TexReg 3561).

The amendments of §19.701 and §19.702 will enable the Texas Department of Insurance (department) to exempt from securities examination those variable contract agents who sell products which are exempt from registration under state and federal securities law. The amendment will bring the department's rules into conformity with those securities laws. In response to comments, several changes were made to §19.701. Language was added to subsection (b) of §19.701 to clarify that agents who sell to qualified plans are exempt from both examination requirements listed in subsection (a). A new subsection (c) of §19.701 was added, which provides an exemption from state securities laws examination for variable contract agents whose sales are limited to variable contracts. The language of subsection (d) was moved from subsection (b) of §19.701, and changed to require an applicant claiming exemptions under subsections (b) or (c) to so certify on the application. Old subsection (d) of §19.701 was relettered as subsection (e).

Amended §19.701 and §19.702 set out the circumstances under which certain applicants for licensure as variable contract agents are eligible for exemption from the examination requirements listed in §19.701(a). Subsections (b) and (c) of §19.701 set out the bases for exemption from the securities examination requirement. Subsection (d) of §19.701 requires an applicant claiming an exemption from testing to so certify on the application. Subsection (e) of §19.701 provides that an applicant for an original license or renewal of a license (applicant), must state whether any administrative or judicial action has been taken against the individual by any insurance or securities regulatory agency or any securities industry association. Section 19.702 states that certification of successful completion of the securities examination required in §19.701 meets the examination requirements of the department.

For: Nationwide Life Insurance Company, Investment Product Operations For with changes: Variable Annuity Life Insurance Company. For with changes: Principal Mutual Life Insurance Company.

Comment: One commenter provided general support for the amended sections, stating that they bring the department's rules into conformity with state and federal law, while continuing to protect Texas citizens.

Agency Response: The department agrees.

Comment: Another commenter supports the amendment, but suggests adding an additional subsection which would exempt certain applicants from taking either a state securities law examination administered by the State Securities Board, or the Uniform Agents State Law Examination (USASLE) Series 63. The commenter proposes that this exemption apply to any applicant whose sales are limited to variable contracts.

Agency Response: The department agrees with the exemption proposed by the commenter. The suggested change has been made.

Comment: One commenter requested that language be added to §19.701(b) to clarify that an agent selling to qualified plans are exempt from both exam requirements listed in subsection (a).

Agency Response: The department agrees. The suggested clarification has been made.

The amendments are adopted pursuant to the Insurance Code, Articles 3.75 and 1.03A, and the Government Code, §§2001.004 et seq (Administrative Procedure Act). Article 3.75 authorizes the Texas Department of Insurance to establish fair and reasonable rules, regulations, or limitations for the augmentation and implementation of the article. Article 1.03A provides that the Commissioner of Insurance may adopt rules and regulations to execute the duties and functions of the Texas Department of Insurance. The Government Code, §§2001.004 et seq authorize and require each state agency to adopt rules of practice setting forth the nature and requirements of available procedures and to prescribe the procedures for adoption of rules by a state agency.

§19.701. Variable Contract Agent's License.

(a) As a condition of licensure, an individual, partnership, or corporation acting as a variable contract agent (agent) must hold a valid life insurance agent's license issued under authority of the Insurance Code, Article 21.07-1. Additionally, an individual, as a condition for licensure as a variable contract agent, must meet the following requirements:

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

(b) Notwithstanding subsection (a), no securities examination listed in subsection (a)(1) or securities law examination listed in subsection (a)(2) shall be required as a condition for licensure as a variable contract agent for any individual whose variable contract sales are limited to variable annuity contracts sold to:

(1) a stock bonus, pension or profit sharing plan which meets the requirements for qualification under Section 401 of the Internal Revenue Code of 1986;

(2) an annuity plan which meets the requirements for the deduction of the employer's contributions under §404(a)(2) of such Code; or

(3) a governmental plan as defined in §414(d) of such Code.

(c) Notwithstanding subsection (a) of this section, neither the examination on state securities law, or the Uniform Securities Agents State Law Examination (USASLE) Series 63 shall be required as a condition for licensure as a variable contract agent for any individual whose sales are limited to variable contracts.

(d) Applicants claiming an exemption from examination under subsections (b) or (c) shall so certify on the application.

(e) Upon application for an initial license or for renewal of license, an agent shall state whether any insurance or securities regulatory agency or any securities industry association, including the National Association of Securities Dealers or any recognized stock exchange has, at any time prior to the filing of the application or renewal application, taken any judicial or administrative action against the agent.

§19.702. Examination. Certification of successful completion of the securities examinations as required in §19.701 of this title (relating to Variable Contract Agent's License) is sufficient to meet the examination requirements of the Texas Department of Insurance.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511708 Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Effective date: October 3, 1995

Proposal publication date: May 12, 1995

For further information, please call: (512) 463-6327

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Part II. Texas Workers' Compensation Commission

Chapter 126. General Provisions Applicable to All Benefits

• 28 TAC §126.10

The Texas Workers' Compensation Commission (the commission) adopts new §126.10, with changes to the proposed text as published in the March 21, 1995, issue of the *Texas Register* (19 TexReg 2023). The commission is simultaneously adopting an amendment to §130.6, concerning designated doctor general provisions. The majority of the changes were made in response to public comment and testimony received at a public hearing held on May 3, 1995. Changes made in response to public comment are described in the summary of comments portion of this preamble. Other changes made were for clarification or to correct typographical or grammatical errors and are as follows.

The commission has clarified the meaning of the term "party" by adding the following definition to subsection (a)(6), "Any of the following entities including any of their agents or representatives: the insurance carrier, health care provider (including designated doctor and treating doctor), injured employee, or employer." The commission has clarified subsection (a)(1) by adding the following phrase taken from the statutory definition of designated doctor "and make recommendations" following the phrase, "perform medical evaluations".

The commission changed subsection (b)(5) to allow 48 hours rather than 24 hours to notify the commission field office of a disqualifying association. The commission has added the following statement to subsection (b)(8), "not self-refer for treatment or become the injured employee's treating doctor for the medical condition evaluated by the designated doctor.", as this will assist in ensuring an unbiased designated doctor determination of maximum medical improvement (MMI) and impairment rating (IR). Noncompliance by a designated doctor could warrant suspension and/or removal from the designated doctor list. The commission has clarified the requirement for a designated doctor to comply with all provisions of this rule and §130.6 in subsection (b)(6) by adding the phrase, "this section and" before the reference to §130. 6. In addition, the word "doctor" has been pluralized in subsection (b)(6). The term "medical" has been deleted from subsection (b)(7) to include all doctor types since doctors of chiropractic don't have medical practices.

The commission has clarified requirements for completion and filing of the Designated Doctor List Application by revising the first sentence in subsection (c) as follows, "Doctors may request to be on the Designated Doctor List by filing with the division form TWCC-72, Designated Doctor List Application, in the form and manner prescribed by the commission." The word "will" has been replaced with "shall" in subsection (c) to be consistent with rule making requirements established by the *Texas Register*.

The commission has clarified subsection (d)(7) by adding the word "doctor's" in front of the phrase "licensing body" to ensure that staff evaluates disciplinary actions from all appropriate licensing bodies.

The commission has added the reference to §130.6 in subsection (f)(2) in addition to §130.1 because of the reference to filing the TWCC-69 which appears in that rule. In addition, the phrase "or incomplete" has been added to this subsection to help ensure that the forms submitted to the commission are timely and complete. This clarifies what is required. The commission has clarified subsection (f)(7) by rewording the section to prohibit the "submission of an inaccurate or inappropriate impairment rating" rather than "failure to examine and analyze" testing results. This will provide a standard that is more easily enforced. The commission has modified the sentence structure of subsection (f)(4) and (5) by replacing the statements, "misrepresenting or omitting", with "misrepresentation or omission of".

The commission has substituted the word "shall" for "will" throughout subsection (g) for consistency with the other references in this rule. The commission has clarified subsection (g) by replacing "suspension" with "temporary suspension" to ensure that doctors are not put on a permanent suspension without first being afforded the opportunity to rebut the reasons for suspension and having the division consider the rebuttal. Subsection (g)(4) has been modified to require the doctor to submit a signed, completed Designated Doctor List application, (TWCC-72), when requesting reinstatement to ensure the doctor agrees with all the requirements for being a designated doctor.

The new rule establishes: a list of doctors approved by the commission and afforded the privilege to perform medical evaluations to make recommendations for resolution of disputes regarding certification of maximum medical improvement and/or assignment of impairment rating. This process of training and qualifying designated doctors allows the commission to assemble and maintain a pool of highly qualified designated doctors. Because the medical opinion of a designated doctor is given presumptive or conclusive weight in dispute resolution, it is important that the doctor be well-trained in the certification of maximum medical improvement and assignment of impairment ratings. It is also important that the doctor be trained in use of the 3rd edition of the *AMA Guides to Impairment*. The statute mandates use of the 3rd edition, which is different from the most recent version adopted by the AMA. The requirement of commission-approved training for designated doctors will result in superior medical evaluation of an injured employee. A designated doctor's assessment impacts all parties to a workers' compensation case. The payment of temporary income benefits ceases when the injured employee reached maximum medical improvement. Impairment income benefits are paid based upon assignment of an impairment rating, and the percentage of impairment is determinative of

whether supplemental income benefits are paid. Accurate, timely and unbiased medical evaluations by well-trained, impartial designated doctors are therefore essential to preserve the integrity and trust of the designated doctor system and balance the interests of all parties. Time frames for scheduling appointments in the new rule will expedite the dispute resolution process and provisions defining and prohibiting disqualifying associations will prevent conflicts of interest between the doctor and the injured employee.

The new rule requires designated doctors to be active on the Approved Doctor List as well as have commission-approved training in the assignment of impairment ratings. It requires doctors to apply to the commission for addition to the list of designated doctors and establishes specific criteria for approval, suspension, and removal from the Designated Doctor List. The rule lists items the division may consider in adding, deleting, or suspending a doctor from the Designated Doctor List and allows a waiver of requirements for an out of state doctor to serve as a designated doctor. Doctors recommended for removal or suspension from the Designated Doctor List will be given notice of the reasons for the removal or suspension and an opportunity to rebut those reasons. This process affords a doctor any due process which may be required for withdrawal of such a privilege while also ensuring that the commission has considered the available information.

Designated doctors are required by the rule to comply with a list of criteria which include the provisions of §130.6 of this title (relating to Designated Doctor: General Provisions) and are required to adhere to time limits set in the rule for scheduling and rescheduling appointments. These time limits provide the framework for timely dispute resolution, which facilitates the employee's receipt of appropriate benefits. Section 126.10 also establishes a three year active practice criteria for designated doctors, which will assure that the designated doctor is up-to-date on the latest medical developments, have a working knowledge of medical treatments and diagnoses, and have similar experience as the treating doctor. The new rule prohibits self-referral of an employee for treatment, to avoid a conflict of interest between the designated doctor and the employee. SUMMARY OF COMMENTS AND RESPONSES are as follows.

Comments on the proposed new rule were received from: Texas Healthcare System; Straughan Abrams Management Services, Inc.; Texas Orthopedics, Sports and Rehabilitation Associates; Professional Medical Services; Texas Medical Association; Texas Workers' Compensation Insurance Fund; Alliance of American Insurers; Sports and Spine Association; American Insurance Association; Travelers Insurance; and four individuals.

Testimony regarding the proposed new rule was received at the May 3, 1995 public hearing from: Disability Evaluation Center; Impairment Rating Facts; the Texas Chiropractic Association; Hammerman and Gainer; the Texas Workers' Compensation Insurance Fund; the Alliance of American Insurers; Sports and Spine Associates; the Texas Medical Association; the American Insurance Association; Phillip and Akers; Sedgewick Claims Management Services; and six individuals.

All commenters were generally in support of the proposal, while making suggestions for some revisions.

The following comments were received regarding subsection (a).

COMMENT: One commenter recommended that the most recently published AMA Guide be used.

COMMENT: Another commenter stated that the AMA Guide is really not a very good guide and needs to be changed.

COMMENT: A third commenter stated that the commission should think seriously about upgrading to the fourth edition of the Guides.

RESPONSE: The commission disagrees. The Texas Labor Code, §408.124 (relating to Impairment Rating Guidelines), mandates that, "(b) The commission shall use for determining the existence and degrees of an employee's impairment Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association."

The following comments were received regarding subsection (b).

COMMENT: Several commenters agreed that "commission approved training in the assignment of impairment ratings would be an excellent idea."

RESPONSE: The commission agrees that commission-approved training is necessary for designated doctors.

COMMENT: One commenter agreed that the proposed rule for required training is "greatly needed" and recommended a qualifying written examination be added to the requirements.

COMMENT: Another commenter requested that a written examination could be mailed instead of requiring attendance at a training.

COMMENT: A third commenter agreed with the training requirement in subsection (b)(2), but disagreed that the cost will be minimal to attend such training.

RESPONSE: The commission agrees with the necessity of a written examination and has modified subsection (b)(2) to add this requirement for designated doctors. A group of health care providers including doctors and other providers has been organized to develop recommendations for a commission-approved curriculum for the impairment rating training which will include a written examination.

The commission disagrees that the examination could be mailed since the training and therefore the examination will include many hands-on activities. The commission will continually monitor the vendors to ensure the costs are not excessive and primarily cover the expenses of the training.

COMMENT: One commenter recommended training one time over a five- to ten-year period, as opposed to every two years as specified in §126.10(b); and inquired where the training will be held.

COMMENT: Another commenter recommended training be required every four years instead of every two years since the designated doctor's skills and accuracy should improve with experience.

COMMENT: A third commenter recommended deletion of the two year retraining requirement.

COMMENT: A fourth commenter remarked that the first training class was done over two years ago and those doctors who attended the first training will already be up for renewal.

RESPONSE: The commission disagrees that the two-year training timeframe should be modified. Continuing education is a key component for health care providers to maintain medical licensure. The commission is in the process of developing a core curriculum which will be taught at the impairment rating training. In addition, the two-year timeframe is critical for the first few years since the training will provide the opportunity to update doctors on the latest changes and decisions relating to impairment rating assignment. The training courses will continue to be offered in cities throughout the state.

The commission agrees with the commenter's concept that according to the new rule previously trained doctors may be up for renewal and has added (b)(2) (ii) to the rule, providing that previously trained doctors be "grandfathered" and that their training timeframe start from the latest training they attended. In addition, these doctors will be required to pass the impairment rating training written examination within the timeframe specified by the Medical Review Division in order to remain active on the Designated Doctor List. The wording for subsection (b)(2) has been changed as follows:

"(2) meet the following training requirements:

i. have successfully completed commission-approved training in the proper use of the AMA Guides prior to submission of an application;

ii. successfully complete commission-approved training at least every two years from the date of the last training as required in subsection (b)(2)(i); and

iii. have passed the commission-approved written examination for impairment rating training within the timeframe as specified by the Division."

COMMENT: A commenter recommended establishing a process for determining who can be a vendor for the additional training.

RESPONSE: The commission agrees, although it would not be appropriate to include in this rule. A group of health care providers has been organized to develop recommendations for a commission-approved curriculum for the impairment rating training. The commission will establish procedures for approving vendors who agree to follow the training requirements as specified in the impairment rating training core curriculum.

COMMENT: Several commenters recom-

mended increasing time for setting appointment from 14 days to 21, 28 or 30 days because a doctor can be removed from the Designated Doctor list for multiple refusals to meet this timeframe.

RESPONSE: The commission agrees that the 14 day timeframe from the Commission notice to the designated doctor examination is too restrictive. The Commission has established a window of time for the examination to occur from when the commission processes a notice of the dispute. Upon notice of the dispute, staff will concurrently begin the designated doctor appointment process and coordinate with the carrier and injured worker for possible agreement on a designated doctor. This concurrent running of timeframes will save ten days in the overall process. If the parties agree on a designated doctor, the commission will terminate the commission selected designated doctor process.

The proposed rules, §130.6 and §126.10, both refer to §130.4 and §130.5 for the timeframes for setting an appointment (currently 14 days). The commission has moved the timeframes which apply to designated doctors to §130.6 and §126.10 which specifically address the designated doctor list and responsibilities. In addition, the timeframe for setting appointments has been changed from 14 days to appointments occurring no earlier than 14 days and not later than 24 days from the date of the commission order assigning a designated doctor and setting an appointment. This change would be included in §130.6(a) and (d) and then §126.10(b)(3) would refer to §130.6.

COMMENT: One commenter supported the proposed changes to subsection (b) and believed training is essential and will result in better medical evaluations of injured employees. The commenter recommended adding the following requirements to subsection (b):

be actively practicing in their specialty for a minimum of five years;

be residency trained and board certified in their specialty, if a medical doctor or a doctor of osteopathy; and,

be surgically trained and board certified, if a podiatrist.

COMMENT: Other commenters requested that designated doctors maintain an active practice.

COMMENT: Several commenters felt that, in general, the new provisions are setting a very high standard for designated doctors which will preclude them from also having an active office practice and that continued active patient care is essential for qualified objective designated doctors.

RESPONSE: The commission disagrees with establishing additional requirements for board certification for medical doctors, osteopathic doctors, and podiatrists since the requirements cannot apply to all doctor groups.

The commission agrees that all designated doctors must have been actively practicing and has included a provision requiring active practice for at least the past three years and maintain an active treatment practice. This will allow the designated doctor to be up-to-date on the latest medical developments, have a working knowledge of medical treatments and diagnosis, and to have similar qualifications as the treating doctors. The commission has added the following wording as subsection (b)(7): "have maintained for the past three years and continue to maintain routine office hours for the treatment of patients in an active practice";

The commission disagrees that the proposed rule will prevent designated doctors from having an active practice since the scheduling of appointments will be on a rotating basis to equally distribute designated doctor appointments and prevent the overuse of a particular doctor.

COMMENT: One commenter stated that as a doctor of chiropractic, he would not feel confident evaluating body systems outside of the neuro-musculoskeletal system and recommended that a designated doctor have experience in the area being evaluated and a minimum number of years of experience in private practice.

RESPONSE: The commission agrees in part and disagrees in part. Active practice in treating patients is valuable experience for designated doctors and a requirement has been added that a designated doctor be actively practicing for a minimum of three years and maintain an active practice. In addition, designated doctors will be required to successfully complete commission-approved training and should be capable of evaluating most body systems covered in the AMA Guides. House Bill 1089 amends the Texas Labor Code §408.122 to require, to the extent possible, a designated doctor be in the same discipline and licensed by the same board of examiners as the employee's doctor of choice, which will minimize the commenter's concern. §130.6(b)(4) includes this same provision, but the commission disagrees that the rule should make experience in the area being evaluated a mandatory requirement.

COMMENT: Several commenters questioned the vagueness of "commission-approved training" and what AMA authority would be used to teach the training. Although the commenters supported the concept of training, they believe that the medical community needs to be involved in establishing curriculum.

COMMENT: Another commenter expressed a hope that TMA would remain active in the training process.

COMMENT: Another commenter stated that better education is needed.

COMMENT: Another commenter expressed concern that the designated doctor should be well trained, particularly in the use of the AMA Guides.

RESPONSE: The commission disagrees that additional clarification is necessary in this rule. Recommendations for the commission-approved curriculum for the impairment rating training are currently being developed by a group of health care providers. Vendors will be required to follow and teach the curriculum to be allowed to provide this training. The AMA Guides will continue to be used for determining impairment as required by statute.

COMMENT: Several commenters recommended increasing the timeframe to reschedule a designated doctor examination to 21 or 27 working days to allow the doctors more flexibility in scheduling and to receive all medical records.

RESPONSE: The commission agrees with the recommendation that the timeframe to reschedule an appointment should be increased from 72 hours, but disagrees that 27 working days should be allowed. The rule requires that a cancelled appointment be rescheduled to occur within seven days of the original examination date to ensure timely resolution of the dispute.

The proposed rules, §130.6 and §126.10, both refer to §130.4 and §130.5 for the timeframes for rescheduling an appointment, currently 72 hours. As §130.4 and §130.5 are in the process of being revised. As a result, the timeframes which apply to designated doctors have been moved to §130.6 and §126.10 which specifically address the Designated Doctor List and responsibilities. In addition, the timeframe for rescheduling appointments has been increased from 72 hours to seven days. This change is included in §130.6(g) and then §126.10(b)(4) refers to §130.6.

COMMENT: One commenter supported the requirement for commission-approved training as outlined in subsection (b)(2).

COMMENT: Another commenter supported the requirements for education and requested that failure to obtain education be a ground for suspension.

RESPONSE: The commission agrees. The reasons for suspension already include noncompliance with any provision of commission rules, including the training requirement, but to clarify, the following has been added to subsection (f): "(11) failure to successfully complete training requirements as specified in subsection (b)(2) of this rule."

COMMENT: One commenter requested that TWCC's energy be directed toward more sophisticated education than on review of practices after the fact.

RESPONSE: The commission agrees with the intent of the commenter to ensure that a preventative instead of punitive approach is focused on. The commission disagrees, however, that a rule amendment would be appropriate. A group of health care providers has been organized to develop recommendations for the impairment rating training curriculum that is required to meet the objectives of being a designated doctor; however, in addition to training, it is imperative that TWCC closely monitor the performance of the designated doctors to ensure that designated doctors are implementing the training and that injured workers are directed to a qualified and trained doctor to resolve their dispute.

COMMENT: One commenter stated that designated doctors should have a separate office from their normal treating/practice office to ensure proper independence and sole dedication to the review of the injured worker.

COMMENT: Another commenter stated that it is more comfortable evaluating patients

where you are not intimately familiar with the physicians in the area to ensure impartiality.

COMMENT: A third commenter stated that one important aspect of being a traveling designated doctor is the objectivity from not being in practice in the same town as the other providers who provided treatment for the injured worker.

RESPONSE: The commission disagrees that designated doctors should be required to maintain separate facilities for the sole purpose of conducting designated doctor examinations as this would be too costly for small businesses. The commission does not discourage designated doctors from this type of separation but with over 3,000 appointments being scheduled per month, it would not be feasible for the number of doctors the commission needs to perform these examinations to incur this additional expense.

The commission agrees that some doctors find travelling to another location for the purpose of performing impairment ratings to be more impartial and objective.

COMMENT: Several commenters suggested that the designated doctors be required to maintain a certain percentage of their practice for designated doctor work (e.g. 10-20%).

RESPONSE: The commission disagrees with requiring a set amount of a doctor's practice be dedicated to designated doctor examinations since the number of designated doctor assignments is controlled by the commission, not the doctor.

The following comments were received regarding subsection (c).

COMMENT: One commenter believed that attaching contracts to the Designated Doctor List application is a breach of confidentiality between providers and HMOs or PPOs.

RESPONSE: The commission agrees that contracts for managed care need not be attached to the application and has included in the definition of disqualifying association in subsection (a) an exclusion of managed care arrangements. In addition, the requirement to attach other contracts to the application as specified in subsection (b)(5) and subsection (c) has been deleted and the following language added: "within 48 hours of receiving notice of being selected as a designated doctor, notify the commission field office of any disqualifying association." The designated doctor application will include a specific provision that a designated doctor must notify the commission if any disqualifying association or perceived bias may exist on an assigned case.

COMMENT: Another commenter requested that any economic association with employee organizations or representatives of employees, labor organizations, or treating doctors be disclosed as well as those with carriers.

COMMENT: A third commenter believed that economic association between a designated doctor and the treating doctor should be addressed, "If we're going to assume bias, let's assume everyone is biased."

RESPONSE: The commission agrees that the designated doctor should be completely impartial and remove him/herself from any case where a perceived bias may occur. The rule and the designated doctor application include a requirement that designated doctors notify the field office within 48 hours of assignment as a designated doctor, if a disqualifying association or perceived bias may exist, so that another designated doctor can be assigned. In addition, a definition of disqualifying association has been added to §126.10(a) which includes associations with any persons or entities that may reasonably be perceived as having potential to influence the conduct or decisions of the designated doctor.

The following comments were received regarding subsection (d).

COMMENT: One commenter recommended adding another item to subsection (d) to specify that any violations of §130.6(p)(3) would subject the doctor to suspension and/or removal.

RESPONSE: The commission disagrees with the need to specifically list this as a ground for suspension. Subsection (d)(6) already specifically allows the commission to suspend and/or remove a doctor for, "any violation of the Texas Workers' Compensation Act or commission rules". This subsection provides the link for staff to take action against a doctor who fails to comply with requirements set forth in §130.6, as well as other rules and the Act.

COMMENT: Another commenter voiced concern regarding the vagueness of the term "accuracy of impairment ratings" and recommends that the doctor be notified when there is a grievance or a complaint; and the doctor should be given an opportunity to rebut before the suspension process begins.

RESPONSE: The commission disagrees that the term "accuracy" requires additional explanation in that this will be determined on a case-by-case basis by the appropriate commission staff through review of medical records, designated doctor's documentation, and the AMA Guides. The commission agrees with the commenter's intent that doctors should be contacted when an impairment rating is questioned; as a result, whenever staff conducts case reviews and a pattern of poor performance is indicated, the doctors will be contacted to respond to the review. The commission disagrees that this needs to be stated in the rule. The opportunity to respond before suspension is addressed in the responses to comments on subsection (g).

COMMENT: Another commenter requested clarification on the definition of self-referral as it appears contradictory in §126.10(d) and §130.6(m).

RESPONSE: The commission agrees that the term "self-refer" requires clarification and has added the following definition to subsection (a)(5): "Treatment by the designated doctor or referral for treatment to another health care provider with which the designated doctor has a disqualifying association." Section 130.6(m) addresses the designated doctor referring the injured worker for testing in order to complete an impairment rating and this type of testing is not considered treatment; whereas §126.10(d) addresses the designated doctor referring the injured worker specifically for treatment. The commission has clarified the requirement set forth in subsection (d)(3) by changing the subsection to read as follows, "non-certification of maximum medical improvement followed by the designated doctor self-referring for treatment;" In addition, the following clarifying statement has been added regarding self-referring as subsection (b)(8), "not self-refer for treatment or become the injured employee's treating doctor for the medical condition evaluated by the designated doctor. The designated doctor may indicate in the narrative report any treatment recommendations for the treating doctor to consider, but should not assist in any manner or facilitate the receipt of this treatment."

COMMENT: Another commenter requested that substantiated patient complaints be deleted as a reason for suspension and only include the substantiated complaints from the licensing boards.

COMMENT: Another commenter requested the addition of substantiated carrier complaints as reasons to suspend doctors in subsection (d)(5).

COMMENT: Another commenter remarked that §126.10(d)(5) is vague.

RESPONSE: The commission disagrees with limiting substantiated complaints to complaints from the licensing boards. Licensing boards do not enforce or research concerns regarding workers' compensation rules or guidelines; thus, TWCC must evaluate all patient complaints to determine if designated doctors are following commission rules, guidelines and established requirements through the core curriculum of the impairment rating training.

The commission agrees with including complaints from other parties in addition to patient complaints. Subsection (d)(5) has been changed to delete the word "patient" in order for all complaints to be evaluated by the commission.

COMMENT: Another commenter requested restructuring of the rule lists to omit 1-4 in subsection (d) and include those items in subsection (f).

RESPONSE: The commission disagrees with eliminating items 1-4 from subsection (d) because the commission should have the discretion to consider these items when adding, removing or suspending a doctor from the list. However, the language in subsection (d) and (f) has been modified to clarify that the items listed in subsection (d) apply to adding designated doctors but may also be the basis for suspending or removing doctors from the list. Additionally, items listed in subsection (f) apply to suspending/removing designated doctors from the list. The following changes have been made: Modify the first sentence of subsection (d) to read, "The division may, in addition to the documentation submitted with the doctor's request, consider the following in determining whether to add a doctor to the Designated Doctor List: " Modify the first sentence in subsection (f) by deleting the last phrase starting with "or actions" and replace with the following sentence to be consistent

with subsection (d), "The division may also consider and take action to suspend or remove a doctor from the Designated Doctor List based on, but not limited to, any of the following:" Subsection (f)(10) has been added to clarify that all factors listed in subsection (d) can be considered in a removal or suspension action.

COMMENT: Another commenter remarked that if a statewide profile is going to be used for benchmarking designated doctors, then why not apply the statewide average to all injured workers and eliminate designated doctor appointments.

COMMENT: Another commenter stated that comparing previous ratings to like injuries as criteria for inclusion or exclusion from the designated doctor list is inappropriate.

RESPONSE: The commission disagrees. The Texas Workers' Compensation Act requires the resolution of disputes through the use of designated doctors. Each injured worker's condition varies and must be reviewed on a case by case basis; however, using statewide averages is a good indicator of the doctor's application and knowledge of the AMA Guides. Doctors who fall significantly outside the averages may not be applying the AMA Guides in the same manner as other doctors, which creates unnecessary disputes. Likewise, the commission recognizes that due to specialization in the medical field, some doctors regularly treat the more complex cases and therefore, might acceptably have an impairment record that deviates from the statewide average. This factor is just one which the division will consider in evaluating doctors.

COMMENT: One commenter expressed support for the proposed criteria for adding, suspending or removing a doctor from the designated doctor list.

RESPONSE: The commission agrees.

The following comments were received on subsection (e).

COMMENT: One commenter requested that out-of-state doctors meet the same criteria as outlined in this rule.

RESPONSE: The commission agrees with the intent, but believes that in unusual circumstances where injured workers have moved out of state, a timely resolution of the dispute may require the waiver of some of the requirements in the rule. Subsection (e) has been revised by adding the phrase, "to facilitate a timely resolution of the dispute" to the end of the sentence, in order to clarify the basis for the waiver. To clarify when the waiver is appropriate, the phrase, "because the injured worker is temporarily located or residing out-of-state", has been added following, "when deemed necessary." In addition, the word "serve" has been substituted for "perform" to clarify the meaning of the subsection.

The following comments were received on subsection (f).

COMMENT: Several commenters recommended increasing the number of refusals in a 90 day period as specified in §126.10(f)(1), from "two" to "three" or "four".

RESPONSE: The commission agrees with increasing the number of refusals within a 90 day period and consecutive refusals from 2 to 4 in subsection (f) (1) to ensure that designated doctors are not removed from the designated doctor list unfairly. In addition, staff will consider any extenuating or mitigating circumstances prior to taking suspension or removal action against the doctor to determine whether the reason for refusal is justified (e.g., TWCC requested five appointments in one month.)

COMMENT: Other commenters recommended adding the following criteria to subsection (f):

failure to successfully complete commission-approved training as required by §126.10(b)(2);

failure to maintain accurate records as required by §130.6(o); and

failure to refund the insurance carrier for an improper or incomplete examination or report, as required by §130.6(p)(3).

RESPONSE: The commission disagrees with the need to explicitly list these as reasons for suspension. While the commission agrees with the concept of these suggestions, it disagrees with duplicating information that is already contained in §130.6 and §126.10. Subsection (d)(6), "any violation of the Texas Workers' Compensation Act or commission rules", provides the link for staff to take action against a doctor that fails to comply with the Texas Workers' Compensation Act or the commission rules.

COMMENT: One commenter recommended substituting the word "shall" for the word "may" in the first sentence to clearly establish the consequences associated with failure to comply.

RESPONSE: The commission disagrees. The commission will review noncompliance of doctors based on the criteria defined in subsection (f) but will also consider extenuating circumstances on a case-by-case basis during review, prior to taking suspension action against a doctor. It is the intent of the commission to maintain a list of qualified doctors. The commission will make impartial and fair determinations based on the criteria and performance of the doctors. In addition, this comment brought to the commission's attention that subsection (d) uses the word "shall". As a result, "The division shall", has been changed to "The division may". The inclusion of the word "shall" implies that it is mandatory for the division to have and consider all the information listed in §126.10(d) to make a determination for approval to the Designated Doctor List. This is not practical. The intent of the rule is to give the division some discretion to consider the items in subsection (d) when they are available.

COMMENT: Another commenter recommended that subsection (f)(9) be changed to make clear if "overturned assignments" refers to BRC, CCH and or court decisions and to add the word "consistently" at the beginning of this statement.

RESPONSE: The commission agrees to clarify the intent of subsection (f)(9) by modifying it to read: "assignments of maximum medical improvement and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision." The commission disagrees with adding the word "consistently" to this statement as it does not provide any additional clarification and staff will evaluate doctors on a case-by-case basis to determine if suspension is warranted.

COMMENT: One commenter requested clarification of who will determine unnecessary tests and inaccurate examinations.

RESPONSE: The commission disagrees that clarification is needed in this rule. The commission is charged with the implementation of all aspects of the rule and the division will make the determination of unnecessary tests and inaccurate examinations.

COMMENT: One commenter expressed concern that the causes for suspension listed in the proposed rule will leave the commission without designated doctors. The commenter also requested that subsection (f)(7) be reworded as follows: "failure to examine the complete set of medical records and analyze a referred/supervised health care providers testing results to insure appropriate application of the AMA Guides."

RESPONSE: The commission disagrees. The designated doctor's responsibilities are set out in §130.6, these include review of medical history. Failure to review records in the designated doctor's possession would be a violation of §126.10(f). Punitive action against the designated doctor is not appropriate for failing to review records which were not in the doctor's possession. The commission has clarified subsection (f)(7) as follows: "submission of an inaccurate or inappropriate impairment rating due to insufficient examination and analysis of a referred/supervised health care provider's testing results which must be in accordance with the AMA Guides."

COMMENT: One commenter expressed a concern that seven-day timeframe for return of the medical report is unreasonable.

RESPONSE: The commission disagrees. The timeframe for completing the reports as established in §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment) is necessary to ensure timely resolution of the injured worker's dispute.

COMMENT: One commenter applauded the Medical Review Division for boldly addressing the issues which can unfairly and adversely affect an impairment rating. The commenter supported the proposed criteria for suspending or removing a doctor from the designated doctor list.

RESPONSE: The commission agrees.

COMMENT: Several commenters stated that it is a privilege to be selected as a designated doctor.

COMMENT: Another commenter stated that doctors or any health care practitioners need to have somebody keep an eye on them to make sure they're doing the best job they can.

RESPONSE: The commission agrees.

COMMENT: One commenter expressed concern that the rule seemed to be a punitive approach and would tend to drive away good designated doctors.

RESPONSE: The commission disagrees. The role of a designated doctor is a privilege and an important part of the Workers' Compensation system. The commission is responsible for outlining all expectations of the doctors for them to be fully aware of their obligations and the ramifications should they fail to meet the expected standards.

The following comments were received on subsection (g).

COMMENT: Several commenters recommended adding specific wording to allow a suspended designated doctor to complete currently scheduled examinations, but to prohibit acceptance or assignment of additional examinations as of the suspension date and of any case not yet scheduled for examination. RESPONSE: The commission agrees that an exception may be appropriate. When the reason for suspension is untimely appointments and the designated doctor has a timely appointment scheduled, the commission may allow the timely appointment to continue. However, when a doctor has been suspended from the list for any other reason, the grounds for suspension will be such that performing additional examinations in the role as a designated doctor would be inappropriate until corrective action has occurred to ensure all workers receive fair and impartial resolution of their dispute from this doctor. The phrase, "notice if pre-scheduled appointments are cancelled or should be performed", has been added to the rule to clarify the division's discretion to reassign pending appointments. The commission's suspension notice will include whether appointments may occur or will be cancelled and the automated scheduling system will identify any pending appointments that may require reassignment to another designated doctor.

COMMENT: One commenter requested a timeframe of 30 days for the TWCC to respond to the designated doctor's rebuttal to a suspension and for the response to be sent by certified mail to document transmission and receipt of the response.

RESPONSE: The commission disagrees that a response timeframe should be included by rule. Rebuttals will be reviewed on a case-by-case basis and will be responded to timely. The commission routinely sends letters regarding sanctions to providers by certified mail, to ensure proper notification.

COMMENT: One commenter requested the right to appeal a suspension or removal from the Designated Doctor List in an APA hearing.

COMMENT: Other commenters contested what they see as a lack of due process in the rule. One commenter felt the proposed rule usurped the powers of the commission.

COMMENT: One commenter requested that removal from the designated doctor list be similar to the spinal surgery process whereby recommendations for removal are submitted to the commissioners.

RESPONSE: The commission disagrees that the rule lacks due process. Participation in the designated doctor process is voluntary and does not constitute a right. Service as a designated doctor is a privilege and as such can be revoked; however, the commission's intent is to include all willing and qualified doctors on the designated doctor list. Subsection (g) has been revised as to procedure so that when the division deems a doctor unqualified or unwilling to serve as a designated doctor, the doctor will be given notice of the reasons for suspension or removal from the Designated Doctor List and an opportunity to rebut those reasons. This procedure affords a doctor the due process which may be required for withdrawal of such a privilege, and therefore does not necessitate the complexity and formality of an APA hearing.

COMMENT: One commenter supported the need for doctors to be monitored to ensure they perform the best job possible. The commenter recommended reprimanding doctors who are noncompliant with the designated doctor rule. Several reprimands may warrant removal of the doctor from the Designated Doctor List, "three strikes and you're out."

RESPONSE: The commission agrees with this general concept as most of the sanctions will occur based on a pattern of inappropriate actions, but disagrees that the rule needs revision to do this. There may be some instances when allowing "three strikes" would be inappropriate.

The following miscellaneous comments were received on the proposed rule.

COMMENT: A commenter requested that the selection of designated doctors be on a rotating basis and that records be kept documenting referrals.

RESPONSE: The commission agrees that selection of designated doctors should be on a rotating basis, but disagrees that this needs to be in the rule. The selection of designated doctors is being automated to be on a rotating basis, to the extent possible, by proximity of the designated doctor to the injured worker. Experience with the rules and procedures will show the extent to which this is feasible.

COMMENT: One commenter requested that the selection of designated doctors be chosen without regard to professional affiliation.

COMMENT: Another commenter recommended that the designated doctor be the same medical provider class as the treating doctor.

RESPONSE: The commission is unclear on what commenters meant by the phrases "professional affiliation" and "medical provider class". House Bill 1089 requires that to the extent possible, a designated doctor must be in the same discipline and licensed by the same board of examiners as the employee's doctor of choice. The commission is developing procedures to ensure that this occurs and has included this language be incorporated in §130.6(b)(4).

COMMENT: One commenter requested that designated doctors be selected by specialty so that, as an example, a pulmonary problem is not scheduled with an orthopedist.

COMMENT: Another commenter stated that you don't need to be a specialist in a particular area (e.g., ear, nose, throat, visual, GI) to be able to render impairment ratings, but you do need to know the Guides.

RESPONSE: The commission disagrees with selecting designated doctors by specialty as opposed to licensing board as required in House Bill 1089. The designated doctor may refer to a specialist for appropriate testing as applicable (e.g., pulmonary testing).

COMMENT: One commenter remarked that one and one-half days training is not adequate.

RESPONSE: The commission agrees that the length of training should be evaluated and a determination made as to the necessary length. A group of health care providers has been organized to make recommendations regarding the necessary curriculum to ensure that a doctor is properly trained to serve as a designated doctor.

The following commenters recommended additions to §126 10.

COMMENT: One commenter recommended adding to §126.10 that the responsible doctor must be notified each time an assignment of MMI or impairment rating is overturned.

RESPONSE: The commission agrees that doctors should be notified of overturned assessments, but does not feel it needs to be addressed in the rule. When a dispute arises regarding the assignment of impairment rating or MMI, frequently the doctor is contacted for clarification during the dispute process. The commission will develop procedures for notifying designated doctors of any impairment rating and/or MMI which is overturned at the commission level to keep the doctor apprised.

COMMENT: One commenter suggested that the commission may want to formulate an approved list of psychologists, physical therapists, speech pathologists, occupational therapists, audiologists, etc., who perform specific testing for designated doctors because this would aid in accuracy and quality of overall examinations.

RESPONSE: The commission disagrees that this needs to be in the rule. The ancillary providers performing range of motion, sensory, and strength testing services for the designated doctor examinations are required by §130.6(l) to have successfully completed commission-approved training in the proper use of the AMA Guides. For other than range of motion, sensory, and strength testing, a referral provider is not required to attend training on the AMA Guides because such testing does not involve the Guides. The designated doctor assigned to the case must analyze the referral provider's results and incorporate these results into the assessment of the patient in accordance with the AMA Guides. The designated doctor is ultimately responsible for the integrity of the evaluation process.

The following positive comments were received regarding the proposed rule.

COMMENT: One commenter stated "I believe that the proposed rule has several good points. Continuing education stands out as a major one. Establishing protocols for the addition and removal of Designated Doctors is another."

COMMENT: Another commenter stated "I feel that there are some positive changes presented in the proposed rule." (§126.10)

COMMENT: One commenter stated "I feel many of the proposed changes are indeed needed, and will be a significant addition and improvement to the current system."

COMMENT: One commenter stated "The Fund believes adoption of a rule which allows the commission to select highly qualified doctors as designated doctors will result in better medical evaluations of injured employees and reduce the number of disputes. In addition, we believe the proposed rule will allow the commission to evaluate designated doctors and suspend those designated doctors who do not perform as well as their peers."

The new rule is adopted pursuant to Texas Labor Code §402.061, which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers' Compensation Act; the Texas Labor Code, §401.011(15), which gives the definition of a designated doctor; the Texas Labor Code, §408.023, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which describes the commission's list of approved doctors, mandates that he commission establish criteria for deleting a doctor from the list and for reinstatement of a doctor to the list; Texas Labor Code §408.122, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which describes the criteria for deciding an employee's eligibility for impairment income benefits, gives the commission the authority to choose a designated doctor to examine the employee, grants the report of the designated doctor presumptive weight in dispute resolution, and mandates that designated doctor qualification standards and impairment rating training be developed; Texas Labor Code, §408.125, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which describes the dispute resolution process to be used when there is a dispute as to an impairment rating and prohibits certain communication with the designated doctor; Texas Labor Code §413.002, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which gives the commission authority to monitor and evaluate health care providers (including designated doctors), insurance carriers, and workers' compensation claimants to ensure compliance with the rules adopted by the commission; the Texas Labor Code, §413.011, which requires the commission by rule to establish medical policies and guidelines relating to: fees charged or paid for medical services for employees who suffer compensable injuries, use of medical services by employees, and fees charged, as well as requiring the commission to design medical policies to ensure the quality of medical care and to achieve effective cost control; and the Texas Labor Code, §413.053, which requires the commission by rule to establish standards of reporting and billing governing both form and content; and Texas Labor Code §413.044, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which empowers the commission to seek sanctions against a designated doctor who is not in compliance with the Workers' Compensation Act or commission rules.

§126.10. Commission Approved List of Designated Doctors.

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

(1) Designated Doctor List–A list of doctors approved by the commission and afforded the privilege to perform medical evaluations and make recommendations to resolve disputes regarding certification of maximum medical improvement and/or assignment of impairment rating.

(2) AMA Guides–*Guides to the Evaluation of Permanent Impairment*, third edition, second printing, dated February 1989, published by the American Medical Association.

(3) Division–The Medical Review Division of the Texas Workers' Compensation Commission.

(4) Disqualifying Association–Any association which may reasonably be perceived as having potential to influence the conduct or decision of the designated doctor.

(A) A disqualifying association between a designated doctor and a party may include:

(i) receipt of income, compensation, or payment of any kind not related to medical services provided by the doctor;

(ii) shared investment or ownership interest;

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

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

(v) personal or family relationships.

(B) Receipt of normal payments rendered for services provided pursuant to managed care/preferred provider contracts or any payment in accordance with the Texas Workers' Compensation Act and rules, is not considered a disqualifying association.

(5) Self-Refer–Treatment by the designated doctor or referral for treatment to another health care provider with which the designated doctor has a disqualifying association.

(6) Party–Any of the following entities including any of their agents or representatives: the insurance carrier, health care provider (including designated doctor and treating doctor) , injured employee, or employer.

(b) Doctors included in the Designated Doctor List shall:

(1) be currently active on the list of approved doctors as set forth in the Texas Labor Code, §408.023 (relating to List of Approved Doctors);

(2) meet the following training requirements:

(A) have successfully completed commission-approved training in the proper use of the AMA Guides prior to submission of an application;

(B) successfully complete commission-approved training at least every two years from the date of the last training as required in subparagraph (A) of this paragraph; and

(C) have passed the commission-approved written examination for impairment rating training within the timeframe as specified by the division;

(3) schedule appointments to examine employees for a date as set forth in §130.6 of this title (relating to Designated Doctor: General Provisions);

(4) reschedule the examination for a date as set forth in §130.6 of this title (relating to Designated Doctor: General Provisions) when notified by the injured employee of a scheduling conflict;

(5) within 48 hours of receiving notice of being selected as a designated doctor, notify the commission field office of any disqualifying association;

(6) comply with all the provisions for designated doctors as specified in this rule and §130.6 of this title (relating to Designated Doctor: General Provisions);

(7) have maintained for the past three years and continue to maintain routine office hours for the treatment of patients in an active practice; and

(8) not self-refer for treatment

or become the injured employee's treating doctor for the medical condition evaluated by the designated doctor. The designated doctor may indicate in the narrative report any treatment recommendations for the treating doctor to consider, but should not assist in any manner or facilitate the receipt of this treatment.

(c) Doctors may request to be on the Designated Doctor List by filing with the division form TWCC-72, Designated Doctor List Application, in the form and manner prescribed by the commission. The division shall notify the doctor of the approval or denial of the application.

(d) The division may, in addition to the documentation submitted with the doctor's request, consider the following in determining whether to add a doctor to the Designated Doctor List:

(1) any impairment ratings previously assessed, compared to like injuries;

(2) accuracy of previously assessed impairment ratings and certification of maximum medical improvement;

(3) non-certification of maximum medical improvement followed by the designated doctor self-referring for treatment;

(4) previous billing or treatment practices;

(5) substantiated complaints against the doctor;

(6) any violation of the Texas Workers' Compensation Act or commission rules; and

(7) any doctor's licensing body or regulatory agency disciplinary action.

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

(f) Doctors may be suspended or removed from the Designated Doctor List for noncompliance with requirements of this section. The division may also consider and take action to suspend or remove a doctor from the Designated Doctor List based on, but not limited to, any of the following:

(1) four refusals within a 90 day period, or four consecutive refusals to perform within the required time frames, a commission requested appointment for which the doctor is qualified;

(2) two untimely or incomplete submissions within a 90 day period of medical evaluation reports in accordance with §130.1 of this title (relating to Reports of Medical Evaluation, Maximum Medical Improvement and Permanent Impairment) and §130.6 of this title (relating to Designated Doctor: General Provisions);

(3) failure to amend patterns of practice after being advised by the commission of performance requiring correction;

(4) misrepresentation or omission of information in the designated doctor application process;

(5) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;

(6) unnecessary referrals for the assignment of impairment rating or determination of maximum medical improvement (MMI);

(7) submission of an inaccurate or inappropriate impairment rating due to insufficient examination and analysis of a referred/supervised health care provider's testing results which must be in accordance with the AMA Guides;

(8) failure to timely respond to request for clarification from the commission regarding an examination;

(9) assignments of maximum medical improvement and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision;

(10) any of the factors listed in subsection (d) of this section; or

(11) failure to successfully complete training requirements as specified in subsection (b)(2) of this section.

(g) The division shall notify a doctor in writing by certified mail, return receipt requested, or by personal delivery with receipt acknowledged, of temporary suspension from the Designated Doctor List pending division action. The notification shall include the division's proposed action, the reasons for the proposed action, details regarding the doctor's opportunity to rebut those reasons and notice if pre-scheduled appointments are cancelled or should be performed.

(1) The temporary suspension will be effective from the date of receipt of the notice by the doctor.

(2) A doctor may submit a written rebuttal specifically addressing each reason for the proposed action. The rebuttal must be received by the division within 14 days after the doctor's receipt of the temporary suspension notice and must be sent by certified mail, return receipt requested, or by personal delivery with receipt acknowledged. Failure to respond within the timeframe will result in the division's proposed action becoming effective without further notification.

(3) The division shall review the rebuttal and determine the appropriate action to take including: reinstatement to; suspension from; or removal from the Designated Doctor List. The division shall notify a doctor in writing of the action taken.

(4) A doctor who has been suspended or removed from the Designated Doctor List, may submit a written request to the division requesting reinstatement to the Designated Doctor List, and shall include a completed Designated Doctor List Application (TWCC-72), and information regarding corrective measures undertaken to resolve the suspension or removal issue. The division will evaluate the request and make a determination of the doctor's reinstatement to the Designated Doctor List and notify the doctor of approval or denial of the reinstatement request.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511734

Susan Cory
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Texas Workers' Compensation Commission

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For further information, please call: (512) 440-3700

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Chapter 130. Impairment and Supplemental Income Benefits

Subchapter A. Impairment and Income Benefits

• 28 TAC §130.6

The Texas Workers' Compensation Commission (the commission) adopts an amendment to §130.6, concerning general provisions regarding designated doctors, is adopted with changes to the proposed text as published in the March 21, 1995 issue of the *Texas Register* (20 TexReg 2023). The commission is simultaneously adopting new §126.10, concerning the commission-approved list of designated doctors. The majority of the changes were made in response to public comment and testimony received at a public hearing held on May 3, 1995. Changes made in response to public comment are described in the summary of comments portion of this preamble. Other changes were made for clarification or to correct typographical or grammatical errors. These changes include the following.

The commission has added language to subsection (b)(4) to emphasize the requirements

from House Bill 1089 that a designated doctor shall, to the extent possible, be from the same discipline and licensed by the same board of examiners as the employee's doctor of choice. The commission has deleted the phrase "with regard to the same injury" in subsection (b), as it relates to the prohibition of past treatment and replaced it with "with regard to the medical condition being evaluated by the designated doctor" to clarify the restriction.

The commission has clarified the wording and sentence structure in subsection (c) to ensure that the timeframes are more easily understood. The revised language is as follows: "(c) After sending the order to the employee and the insurance carrier as specified in subsection (a) of this section, the commission shall allow the employee and insurance carrier to agree on a designated doctor. If at the end of the tenth day from the date of the order, the commission has not received notification from the insurance carrier or injured employee that a designated doctor has been agreed upon, the commission will presume that an agreement is not possible and the employee is required to attend the commission-selected designated doctor examination as specified in subsection (a) of this section." The second sentence in subsection (c) relating to the notification of the employee has been moved to subsection (a) (5), in order to clarify who will notify the employee of his/her rights.

The commission has added professional license number to the required contents of the notice which is generated by the carrier for an agreed-upon designated doctor in §130.6(e)(4). This information will assist field office staff in determining if the agreed-upon doctor is on the approved Designated Doctor list.

The term "parties" in subsection (f) has been replaced with "the injured employee and carrier" to clarify the reference.

The commission has clarified the intent of subsection (h) by combining the last two sentences into one sentence using the conjunction "and". The commission has replaced the word "should" with "shall" in subsection (h) to require the designated doctor to notify the commission of any noncompliance regarding submission of unmarked, unhighlighted medical records. The commission has clarified that a signed statement from the injured employee for release of medical records is not required by adding the following language to subsection (h): "The treating doctor and insurance carrier are both responsible for sending to the designated doctor all the employee's medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession without a signed release from the employee. "

In subsection (i) the word "before" has been replaced with the words "prior to" to clarify that the designated doctor can communicate with the employee or an appropriate member of the commission staff at any time "prior to" the actual physical examination.

The commission has added the following language to subsection (j) to clarify that the doctor should not determine an impairment rating when MMI has not been reached: "When maximum medical improvement and impairment rating are in dispute and the designated doctor determines that the employee has not reached MMI, the designated doctor shall not assign an impairment rating."

The commission has modified subsection (j) to clarify the commission's intent that only doctors and health care providers that have successfully completed commission-approved training should be allowed to perform the range of motion, sensory, and strength testing for the designated doctor impairment rating. The following language has been added: "Although any doctor or any other provider who has successfully completed the training outlined in §126. 10(b)(2) of this title, (relating to commission Approved List of Designated Doctors) may compare the clinical findings on a particular patient with the criteria in the AMA Guides, the designated doctor shall conduct a physical evaluation and is responsible for the integrity of the evaluation process."

The commission has broadened the restrictions for a designated doctor or anyone who assists in the designated doctor process by disallowing anyone who has previously treated or examined the injured employee from performing a designated doctor examination of the employee. This will help to ensure potential biases are minimized. The commission has added the following phrase to the end of subsection (l), "... must not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor...". The commission has revised the last sentences of subsection (l) to add a time limit for completing testing to ensure the dispute is resolved in a timely manner. In addition, reference to §126.10(b)(2) has been added to ensure other health care providers are required to meet all training and testing requirements. The modified subsection (l) is as follows: "(l) If this testing is not performed by the designated doctor, the health care provider performing the testing must have successfully completed commission-approved training as outlined in §126. 10(b)(2) in the proper use of the AMA Guides, must not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor, and must complete testing within seven days of the designated doctor's physical examination of the employee."

To ensure that the designated doctor is making referrals for the impairment rating only, and not for opinions on maximum medical improvement, subsection (m) has been clarified by deleting "to determine whether maximum medical improvement has been reached".The commission has also revised the last sentences of subsection (m) to add a time limit for completing testing to ensure the dispute is resolved in a timely manner as follows: "(m) Any additional testing required by the AMA Guides for the assignment of an impairment rating is not subject to preauthorization requirements in accordance with the Texas Labor Code, §413.014 (relating to Preauthorization) and additional testing must be completed within seven days of the designated doctor's physical examination of the injured employee."

The commission has clarified subsection (p)(3) by making the last phrase into two phrases, one for examinations performed and one for reports submitted.

To ensure that the carrier considers the cost to the injured worker for travel, language consistent with the spinal surgery second opinion rule has been added to subsection (r)(1). The commission has added subsection (r)(6) to clearly establish that reimbursement is contingent upon receipt of the impairment rating report by the carrier.

The amendment to §130.6 is adopted to clarify the commission requirements for doctors who serve in the capacity as designated doctors and to clarify the process for assigning designated doctors. If a dispute relating to either assignment of impairment rating or determination of maximum medical improvement exists, the amended rule provides for a designated doctor, either agreed to by the insurance carrier and injured employee or appointed by the commission to examine the employee. The amended rule requires all designated doctors to meet the conditions set forth by §126.10 of this title (related to Commission Approved List of Designated Doctors). If a doctor is not on the Designated Doctor List, the amendment clarifies that he or she may not serve as a designated doctor for the commission. The amended rule provides that to serve in a particular case, a designated doctor must be on the Approved Doctor List, not have previously treated or examined the injured employee within the last 12 months; not have any disqualifying associations; to the extent possible, be in the same discipline and licensed by the same board of examiners. The amended rule also: includes the requirement for commission staff to notify the employee of the commission's requirement to adopt the impairment rating made by a mutually agreed upon designated doctor and to explain when a designated doctor's opinion has presumptive weight; requires the treating doctor and carrier to forward medical records to the designated doctor; limits communication with the designated doctor before and after the examination; requires the designated doctor to perform a physical examination of the employee; holds the designated doctor responsible for the integrity of testing performed by a referral health care provider; requires submission of the medical evaluation report in accordance with §130.1 of this title (relating to Reports of Medical Evaluation; Maximum Medical Improvement); requires the designated doctor to maintain certain records relating to the examination and referrals; addresses the timeframe within which a carrier must begin payment of income benefits after a designated doctor's report; and establishes billing procedures and reimbursement amounts for designated doctor services until such time as the Medical Fee Guideline specifically addresses this issue.

The amendment to §130.6 provides the details of the designated doctor dispute resolution process. The amended rule sets out the procedure to be followed in the selection of a designated doctor, either by the agreement of the employee and the carrier or assignment

by the commission. Time limits are set for each stage of the process to ensure timely resolution of disputes. As a means of expediting dispute resolution, the amendment to §130.6 provides for the notice of dispute and the notice of appointment of designated doctor to be issued simultaneously. This procedure allows the timeframes for agreement on a designated doctor, for setting appointments for commission-assigned designated doctors, and for forwarding medical records to the designated doctor to run concurrently, thereby shortening the time required for dispute resolution. In view of the fact that only 2.0% of designated doctors are agreed upon by the employee and carrier, delaying the process to wait for such an agreement is not justified. Under the previous §130.6, timeframes for setting and scheduling designated doctor exams overlapped with the timeframes for receiving medical records, creating a situation where appointments could be scheduled for a date before the medical records were even supposed to have arrived at the designated doctor's office. The amendment should resolve this conflict.

The payment of temporary income benefits ceases when the injured employee reaches maximum medical improvement. Impairment income benefits are paid based upon assignment of an impairment rating, and the percentage of impairment is determinative of whether supplemental income benefits are paid. As a result timely resolution of disputes is essential to the employee's receipt of appropriate benefits.

In the past, designated doctors have had problems receiving complete medical records prior to their scheduled examination of the injured employee. Because designated doctors must review the employee's medical history to render an opinion on maximum medical improvement and/or impairment rating, difficulty in receiving records has greatly hindered the designated doctor process. Passage of House Bill 1089, 74th Legislature, 1995, makes several changes to the Texas Workers' Compensation Act which address designated doctors. One of these changes is a provision which prohibits communication with the designated doctor by anyone except the injured employee and appropriate commission staff prior to the designated doctor examination. The purpose of this provision is to prevent undue influence on a designated doctor's decisions. Because the mere forwarding of unaltered medical records to a designated doctor does not impose an undue influence on a doctor, in the amended §130.6, the word, "communication" has been interpreted to exclude the forwarding of unaltered medical records to the designated doctor. This interpretation avoids the time consuming process of sending records to the treating doctor or the commission, who would then have to forward them to the designated doctor. Instead, under amended §130.6, the insurance carrier and the treating doctor can send medical records directly to the designated doctor but the records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. This will transmit more records to the designated doctor in a shorter period of time.

Subsection (b) of the amended rule sets out criteria which must be met for a doctor to be assigned as a designated doctor for a particular dispute. The purpose of these provisions is to assure that designated doctors are impartial and also perceived to be impartial in the dispute they are asked to resolve. In response to changes made to Texas Labor Code §408.122 by House Bill 1089, the amendment also requires that, to the extent possible, a designated doctor should be in the same discipline and licensed by the same board of examiners as the employee's treating doctor.

The requirements for a designated doctor examination are set out in the amended rule as are provisions for testing by a specialist when necessary. Procedures and timeframes for rescheduling a designated doctor examination are included to ensure that the process continues expeditiously.

There has been a question regarding what issues a designated doctor assigned to a case should consider. In a case where the designated doctor is asked to resolve a dispute on assignment of impairment rating, some designated doctors have gone further and rendered a decision on maximum medical improvement. Subsection (j) answers this question by requiring the designated doctor to address only the issue in dispute. This will speed the resolution process and prevent re-examination of issues previously resolved or not in dispute.

Accurate record-keeping and timely filing of reports is important in the designated doctor process to enable the commission to meet its statutory duty to monitor health care providers and ensure compliance with the Act and commission rules relating to health care, medical policies, fee guidelines, and impairment rating.

Again, in response to changes made to the Texas Labor Code by House Bill 1089 74th Legislature, 1995, subsection (p) provides sanctions which may be imposed on noncompliant designated doctors. The penalties imposed will encourage compliance.

Subsection (m) exempts designated doctor examinations from the requirements for preauthorization of additional testing when it is required by the AMA Guides for determining an impairment rating. This exemption was made for three reasons. 1) Preauthorization requires coordination with the employee's treating doctor who would be required to request the authorization. This process could create a conflict of interest if the treating doctor did not agree with the designated doctor regarding the necessity of the testing, particularly if it is the treating doctor's determination that is being challenged. 2) Preauthorization takes time and would cause a delay in the timely resolution of the dispute. 3) Testing ordered by designated doctors will be monitored through the commission's proposed automated reporting system which will alert the Medical Review division to abuses of the system due to unnecessary testing. In addition, testing necessary to assign an impairment rating will be specified in the AMA Guides and therefore, not simply at the discretion of the designated doctor.

Part of the impetus to set fees for designated doctors arose as a result of the wide disparity of charges for designated doctor examinations and perceived bias when some doctors are paid more than others. The fee schedule set out in the proposed amendment to §130.6 was a graduated schedule based on the length of treatment. In response to public comment, the methodology for the fee schedule has been modified to take into account all components necessary for a designated doctor examination, including length of treatment. This fee schedule gives more flexibility by using a greater number of variables. The most important part of this concept is to separate the basic examination from the variable component of the number of body areas reviewed. Including length of time from the date of injury in the formula adjusts the fee for the complexity of the injury. In cases where additional testing is required and the designated doctor must incorporate the findings of a specialist into the report, an additional reimbursement is allowed. The monetary value of the component is based on fees for the component services as set in the commission's Medical Fee Guideline as well as a monetary consideration for factors that only affect designated doctors, such as scheduling and paperwork requirements, imposed by commission rules. The fee structure prohibits the fee for impairment ratings performed by more than one health care provider to exceed the fee which would be charged if the designated doctor had performed the complete impairment rating. This provision results from the philosophy that fees should be fair and reasonable, based on the value of the service performed, regardless of the number of health care providers performing the service. The new fee schedule is designed to ensure the quality of medical care by adequately compensating designated doctors and to achieve effective medical cost control by establishing limits.

The public benefit anticipated as a result of enforcing the rule will be possible lower costs for the health care provided because the rule establishes standard reimbursement for the designated doctor services as well as indicates all services which are included in the fee. Previously such services may have been billed for separately. With the increased requirements placed on designated doctors for their expertise in application of the AMA Guides, a potential decrease in the number of dispute proceedings to resolve the issues of certification of maximum medical improvement and assessment of impairment may result. In addition, the number of designated doctor determinations overturned by the appeals panel process should be greatly reduced. Fewer disputes may result in savings to both insurance carriers and health care providers. Summary of comments and responses are as follows.

Comments on the proposed new rule were received from: Texas Healthcare System; Straughan Abrams Management Services, Inc.; Texas Orthopedics, Sports and Rehabilitation Associates; Professional Medical Services; Texas Medical Association; Texas Workers' Compensation Insurance Fund; Alliance of American Insurers; Sports and Spine Association; American Insurance Association;

Travelers Insurance; and four individuals.

Testimony regarding the proposed new rule was received at the May 3, 1995 public hearing from: Disability Evaluation Center; Impairment Rating Facts; the Texas Chiropractic Association; Hammerman and Gainer; the Texas Workers' Compensation Insurance Fund; the Alliance of American Insurers; Sports and Spine Associates; the Texas Medical Association; the American Insurance Association; Phillip and Akers; Sedgewick Claims Management Services; and six individuals.

All commenters were generally in support of the proposal, while making suggestions for some revisions.

The following comments were received on subsection (a).

COMMENT: One commenter recommended adding the word "written" to the last phrase of (a), prior to subsection (1). The commenter felt this would establish a means for the commission to verify compliance with §130.6(c) and (d).

RESPONSE: The commission agrees with adding the word "written" as this addition would provide clarification to all parties. As amended, this phrase would read, "The commission's written order shall also:"

The following comments were received on subsection (b).

COMMENT: One commenter recommended adding that the rule stipulate, "(1) Designated doctor may not become the injured employee's treating doctor after the exam. (2) Designated doctor should only address those issues in dispute."

COMMENT: Several commenters agreed with the provision that precludes a doctor who has previously treated or examined an employee from becoming a designated doctor for a dispute involving that employee and recommends expanding this to preclude doctors who are currently or who may in the future treat the employee from acting as a designated doctor. One commenter added however, that he felt the Texas Labor Code, §408.122(b) allows treating physicians to act as designated doctors if the employee and the insurance carrier or employer agree.

COMMENTER: Another commenter recommended prohibiting the designated doctor from addressing issues that neither party disputes.

RESPONSE: The commission agrees that a previous treating doctor cannot be the designated doctor as specified in subsection (b) and has modified §126. 10(b)(8) to also prohibit a designated doctor from subsequently becoming the treating doctor. The language of (b)(2) has also been modified to disallow a doctor from becoming the designated doctor for a dispute if the doctor has treated the employee in the past 12 months or with regard to the medical condition to be evaluated by the designated doctor. This same restriction is applied to an ancillary tester in subsection (l). This will assist in ensuring an unbiased designated doctor determination of maximum medical improvement (MMI) and impairment rating (IR). Noncompliance by a designated doctor could warrant suspension and/or removal from the designated doctor list.

The commission agrees that the issue in dispute should be the only issue the designated doctor addresses. The commission has added the following to subsection (a) "disputes maximum medical improvement; an assigned impairment rating; or maximum medical improvement and an assigned impairment rating" and to subsection (j) "The designated doctor shall address the issue(s) in dispute and confine the report as described in subsection (n) to only those issues. When the impairment rating is the only issue in dispute, the doctor shall assess an impairment rating without regard to maximum medical improvement."

COMMENT: Commenters are concerned that the term economic association as used in subsection (b)(3) is overly broad and recommend defining the term.

RESPONSE: The commission agrees and has added the following definition of disqualifying association be included in §126.10(a)(4):

"(4) Disqualifying Association-Any association which may reasonably be perceived as having potential to influence the conduct or decision of the designated doctor.

(A) A disqualifying association between a designated doctor and a party may include:

(i) receipt of income, compensation, or payment of any kind not related to medical services provided by the doctor;

(ii) shared investment or ownership interest;

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

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

(v) personal or family relationships.

(B) Receipt of normal payments rendered for services provided pursuant to managed care/preferred provider contracts or any payment in accordance with the Texas Workers' Compensation Act and rules, is not considered a disqualifying association."

The commission has modified 130.6(b)(3) to read as follows:

"not have any disqualifying association as specified in §126.10(a) of this subtitle."

COMMENT: One commenter voiced concern that the economic association constraint is over broad and will unnecessarily exclude all doctors who are part of a managed care network with which an employer or workers' compensation carrier has contracted. The commenter believed that there is no statutory authority to preclude doctors who share office space or are economically associated with the employer or carrier from being designated doctors and points out that affiliation with personal injury attorneys, labor unions and employee organizations are not addressed. The commenter recommended that economic associations or office location not disqualify the doctor from serving as a designated doctor, or in the alternative, the doctor should be required to disclose the extent of these affiliations to TWCC.

RESPONSE: The commission agrees that the term economic association could be construed too broadly and therefore has substituted the term "disqualifying association" as defined in Section 126.10(a). In addition, the commission agrees that the doctor should report these affiliations to TWCC and has incorporated this language in §126.10(b)(5) "within 48 hours of receiving notice of being selected as a designated doctor notify the commission field office of any disqualifying association." This requirement has been incorporated into the application which the doctor must submit requesting to be added to the Designated Doctor List. Section 126.10(b)(5) and (c) have been modified to exclude the requirement of submitting copies of contracts to the commission and to require a designated doctor to notify the commission of disqualifying associations.

COMMENT: Two commenters expressed concern that doctors belonging to managed care groups would be suspect and withdrawn from the designated doctor list. In addition, commenters recommended that other economic interests such as with personal injury attorneys, labor unions, and employee associations should also be declared.

RESPONSE: The commission recognizes the concern expressed by the commenter and has included a definition of the term "disqualifying association" in §126.10(a). The commission disagrees with the commenters conclusions that the designated doctor will be withdrawn from the list of approved doctors based solely on disclosure of economic associations. It is economic association which may reasonably be perceived as having the potential to influence the conduct or decision of the designated doctor that are sought to be addressed.

The commission agrees with the commenters recommendation that any economic association should be disclosed to the commission, not just the employer and carrier. Therefore, the current language in (b)(3) has been deleted and replaced with the following language: "not have any disqualifying association as specified in §126.10(a) of this title; and"

This language regarding disqualifying association has also been incorporated into the designated doctor application.

COMMENT: One commenter agreed with current policy requiring doctors to declare economic interest in other facilities or services in which they may have a financial interest but not declare economic associations.

RESPONSE: The commission agrees that the doctors must notify the commission and carrier of any financial interest which is greater than 5.0% in a referral provider's practice as required by §134.100 and §134.101. The commission disagrees that

this requirement is sufficient in notifying the doctors of the commission's expectations that they avoid perceived bias due to economic or other associations as they serve as designated doctors.

The following comments were submitted regarding subsection (d).

COMMENT: Several commenters expressed the view that 14 days to set a designated doctor appointment does not allow sufficient time for notification, scheduling and receipt of records and recommended increasing time for setting the appointment from 14 days to 21, 28 or 30 days. The commenters were particularly concerned because a doctor can be removed from the Designated Doctor list for multiple refusals to meet this timeframe.

COMMENT: Another commenter recommended increasing time for the appointment to occur to 21-28 days or require the final TWCC-69 report with all documentation be returned 35 days from the date the appointment was made.

RESPONSE: The commission agrees that the 14 day timeframe from the commission notice to the scheduling of the required designated doctor examination is too restrictive because timeframes for setting and rescheduling designated doctor examinations overlap with the timeframes for receiving medical records, creating a situation where the appointments occur before the medical records are even scheduled to arrive. The commission has established a window of time for the examination to occur from when the commission processes a notice of the dispute. Upon notice of the dispute, staff will concurrently begin the designated doctor appointment process. The designated doctor is required to set an examination date between 14 and 24 days of the commission order for a designated doctor appointment. This process has been clarified by modifying §130.6 as follows:

- creating an initial order that includes both the dispute notification, assignment of a designated doctor, designated doctor appointment information, and notification of opportunity to agree on a designated doctor in subsection (a);

- establishing the timeframe for commission staff to schedule the designated doctor appointment in subsection (a);

- including in subsection (c) the employee's requirement to attend the commission assigned designated doctor appointment if no agreement is reached;

- deleting subsection (d) in its entirety;

- modifying subsection (e) [now (d) and (e)] to clarify the procedure to be followed when an agreement is reached on designated doctor selection;

- adding a statement providing that a timely agreement will supersede the initial order identifying a commission-selected designated doctor in subsection (f); and

- clarifying the agreement process in (e) to minimize the confusion between the commission order and the agreement. The commission has deleted the requirement for the carrier to notify the injured employee allowing the commission's order to be sufficient notice; The proposed rules, §130.6 and §126.10, both refer to §130.4 and §130.5 of this title (relating to Presumption that Maximum Medical Improvement has been Reached and Resolution When MMI has not been Certified; and Impairment Rating Disputes, respectively) for the timeframes for setting an appointment, (currently 14 days). As §130.4 and §130.5 are in the process of being revised, the timeframes which apply to designated doctors have been moved to §130.6 and proposed new §126.10, which specifically address the Designated Doctor List and responsibilities. In addition, the timeframe for setting appointments has been changed from 14 days, to appointments occurring no earlier than 14 and not later than 24 days from the date of the commission order assigning the designated doctor. This change is included in §130.6(a), and new §126.10(b)(3) refers to §130.6.

The commission disagrees with requiring the TWCC-69 to be filed 35 days from the date the appointment was made since §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment) requires the form to be submitted within seven days of the examination. A change in the filing time for the TWCC-69 would need to be addressed at the time of a revision of §130.1 of this title. In addition, an increase in the filing time of this magnitude would defeat the goal of reaching quick decisions to resolve disputes in a timely manner. However, subsection (n) does allow an extension when additional testing must be performed.

COMMENT: One commenter expressed concern that TWCC staff is not providing information to the designated doctor relating to medical records, nature of injury and previous treatment, when setting up the examination. Then during the examination, "the doctor many times hasn't a clue to what part of the body is injured and must make his impairment evaluation from a variety of ailments apparently including but not limited to the compensable injury."

COMMENT: Several commenters stated that a more accurate assessment could take place if the doctor was given an indication of what the injury was and told what the accepted compensable injury(s) is beforehand.

COMMENT: Another commenter recommended that the notification letter include the accepted compensable injury.

COMMENT; Another commenter recommended that time and letters could be saved if TWCC would notify the designated doctor of the injury, especially in cases where multiple claims have been established.

RESPONSE: The commission disagrees. The extent and level of the compensable injury may change throughout the life of the claim as different body areas are affected or treated. Therefore, non-medical commission staff would be responsible for reviewing the medical records submitted to attempt to determine the specific body parts involved in the compensable injury. This could cause inaccurate information to be transmitted. The designated doctor is responsible for determining the extent of injury based on review of medical records and physical examination of the injured employee which should include discussion of patient complaints. An addition to §130.6(h) to clarify the responsibilities of both the carrier and treating doctor should aid in getting all the records to the designated doctor. The following language has been added to subsection (h): "The treating doctor and insurance carrier are both responsible for sending to the designated doctor all the employee's medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of maximum medical improvement and impairment rating disputes. The medical records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. The medical records must be received by the designated doctor at least three days prior to the date of the appointment as specified in the commission order. If the medical records are marked, highlighted, altered, or unrelated to the medical condition to be evaluated by the designated doctor, the designated doctor shall notify the commission and report the noncompliance of the treating doctor and/or insurance carrier. Noncompliance with this subsection is a Class C administrative violation under the Texas Labor Code §408.125 and may be subject to an administrative penalty not to exceed $1000. If the designated doctor has not received the medical records at least three days prior to the examination, the designated doctor's office shall notify the commission at the appropriate field office and the appropriate commission staff will send an order to the treating doctor and/or insurance carrier for the delivery of medical records."

COMMENT: One commenter recommends adding the designated doctor's mailing address to the EES-16 letter in order for the treating doctor to forward medical records to the proper address.

RESPONSE: The commission agrees with adding the designated doctor's mailing address to the EES-16 letter since this may expedite the receipt of medical records by the designated doctor. In addition, the commission has in subsections (a)(1) and (e)(4) replaced the term "business address" with "practice address" to clarify where the examination will take place.

The following comments were received on subsection (e).

COMMENT: One commenter recommended adding to subsection (e) the following information to the carrier's letter: "the treating doctor's name, business address and telephone number". The commenter believes that this will facilitate communication between the designated doctor and the treating doctor.

RESPONSE: The commission disagrees with adding this information because the revision as outlined in subsections (d) and (e) will eliminate the need for a notification to go to the designated doctor from the carrier.

COMMENT: Another commenter recommends modifying (e)(2) by adding the following language: "and if known, the employee's telephone number".

RESPONSE: The commission agrees with modifying subsection (e)(2) by adding the recommended injured worker information. The addition of the employee's telephone number will be beneficial to the commission to assist in contacting the employee for confirmation of the agreement.

COMMENT: One commenter recommended adding the carrier's name, billing address and name of adjuster to the notice required by subsection (e). This would speed up both the report and the initiation of impairment income benefits.

RESPONSE: The commission disagrees because this notice will be sent to the commission, not to the designated doctor; however, the commission's notice of the designated doctor appointment will contain the carrier's name.

The following comments were received on subsection (f). COMMENT: One commenter recommended adding a timeframe of 48 hours, from receipt of the notification from the insurance carrier, for the commission to contact the injured employee to confirm a designated doctor agreement and send the order confirming the agreement.

RESPONSE: The commission agrees with the intent of the commenter that a timeframe should be established for the commission response but disagrees that it should be in the rules. The commission is currently developing a mechanism to automate these letters and will develop internal procedures to ensure that notifications are processed timely.

In order to further clarify confirming agreements, a final sentence has been to subsection (f) as follows, "If the commission cannot confirm the agreement with the employee, the commission will presume that an agreement was not made and the initial order directing the employee to be examined by a designated doctor selected by the commission shall remain in effect." This should ensure the most timely resolution and processing of agreements. The word "timely" has also been added in the first sentence of subsection (f) to ensure understanding that the commission will not consider any agreement valid if the commission does not receive a timely and proper notice about the agreement.

The following comments were received regarding subsection (g).

COMMENT: One commenter recommended that the employee be required to notify the carrier, in addition to the commission, of the time and date of the rescheduled examination to allow the carrier to contact the employee to determine if the employee has any transportation needs. This provision would also allow carriers to establish records needed to process bills for examinations cancelled or not attended.

RESPONSE: The commission agrees that the carrier should be notified because the carrier is responsible for payment of any commission ordered examinations which were rescheduled within 24 hours of the appointment and therefore, should be notified of rescheduled appointments. The commission disagrees that the injured employee should be responsible for these notifications and has required that the designated doctor's office perform the notifications. The last sentence of subsection (g) has been changed as follows: "Within 24 hours of rescheduling, the designated doctor shall contact the commission field office and the insurance carrier with the time and date of the rescheduled examination."

COMMENT: Several commenters requested that an emergency situation be defined by rule and suggested adding language similar to that in §130.4(i).

RESPONSE: The commission agrees to clarify an emergency situation by modifying the language in subsection (g) to read as follows: "The 24 hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency)."

COMMENT: Several commenters recommended adding a provision for designated doctors who encounter emergencies to reschedule appointments within 27 working days. One commenter suggested adding the following, "The rescheduled examination shall be set for a date within 27 working days from the original exam date."

RESPONSE: The commission agrees that the designated doctor may need to reschedule and has changed the first sentence of subsection (g) to read as follows: "The designated doctor and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24 hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency)."

The commission disagrees that 27 days should be allowed to reschedule appointments when the designated doctor must cancel the appointment. Rescheduled examinations are to occur within seven days of the original examination date to ensure timely resolution of the dispute. Therefore, the references to §130.4 of this title (relating to Presumption that Maximum Medical Improvement has been Reached and Resolution When MMI has not been Certified) and §130.5 of this title (relating to Impairment Rating Disputes) have been deleted and subsection (g) has been modified to state: "The rescheduled examination shall be set for a date within seven days of the originally scheduled examination, unless an extension is granted by the field office."

COMMENT: One commenter recommended allowing a physician partner to substitute for the designated doctor, should an emergency arise.

RESPONSE: The commission disagrees. The designated doctor assigned to the dispute should fulfill that duty within the required timeframe. The designated doctor's partner will have different disqualifying associations. If circumstances exist beyond the doctor's control which would cause the doctor to be unable to perform the examination, the doctor must reschedule or, if rescheduling is not feasible, contact the local field office and the commission will assign another designated doctor.

The following comments were received regarding subsection (h).

COMMENT: One commenter recommended deleting the statement in §130.6(h) regarding the responsibility of the designated doctor to notify the commission of records not received three days prior to the visit. The commenter recommended that the rule require the doctor to wait to notify the commission when the patient arrives, if the records are not available.

RESPONSE: The commission disagrees. In order to expedite the impairment rating process, the medical records should be received and reviewed prior to the examination. In addition, the doctor may have to schedule a subsequent examination after receiving the records if new information is discovered after the review of records. This requirement is not intended to be a burden upon the doctor or the doctor's staff, but rather to increase the efficiency of the process and provide assistance as needed.

COMMENT: One commenter recommended that the TWCC take the extra step necessary to ensure that all the appropriate medical records are forwarded to the designated doctor prior to the patient's scheduled examination.

COMMENT: Another commenter questioned how all the medical records would be provided to the designated doctor especially when a new treating doctor has been assigned and may not have all the records.

RESPONSE: The commission agrees. The commission provides written notification of a designated doctor examination to all parties including the carrier and treating doctor. The commission will implement procedures to modify the notification order to include specific directions for the carrier and treating doctor to forward all applicable medical records to the designated doctor prior to the date of the appointment. If either party fails to comply with this order, the commission should be notified by the designated doctor in order for the field office staff to assist in obtaining the records as specified in subsection (h). The commission has modified subsection (h) as follows: "...The medical records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. The medical records must be received by the designated doctor at least three days prior to the date of the appointment as specified in the commission order. If the medical records are marked, highlighted, altered, or unrelated to the medical condition to be evaluated by the designated doctor, the designated doctor shall notify the commission and report the noncompliance of the treating doctor and/or insurance carrier. Noncompliance with this subsection is a Class C administrative violation under the Texas Labor Code §408.125

and may be subject to an administrative penalty not to exceed $1000." This last sentence, regarding noncompliance and Class C administrative violations, has also replaced the last sentence in subsection (i) for consistency.

COMMENT: One commenter recommended increasing the number of days the designated doctor has to notify the field office when medical records have not been received from three days to seven days which will allow field office staff more time to assist in obtaining the records.

Another commenter recommends increasing the number of days for forwarding medical records from three to five to ensure that the doctor has sufficient time to review them.

A third commenter expressed concern regarding the three day timeframe.

RESPONSE: The commission disagrees with expanding the timeframe because three days should provide the appropriate amount of time necessary to obtain the required medical records from the carrier and/or treating doctor. It is the commission's intent for the designated doctor to have the medical records prior to the examination and the designated doctor can notify the field office at any time after the carrier's and treating doctor's timeframe for submission to the designated doctor has expired.

COMMENT: A commenter recommended specifying the reports to be included with the medical records which the treating doctor is responsible for forwarding by adding, "independent medical examination reports, referral doctor reports." The commenter believed the reference to specific reports increases the chances of the designated doctor receiving medical records from all doctors.

RESPONSE: The commission disagrees. The carrier will be able to send the required medical exam reports and any referral doctor reports the treating doctor may not have. The treating doctor will be able to send reports of the most recent treatment and services that the carrier won't have. Listing specific reports does not add to the requirements of the rule. In addition, if the designated doctor believes that the records received are insufficient, the field office staff's assistance in procuring the additional records should be requested.

COMMENT: One commenter recommended that the carrier be permitted to forward medical records to the commission which could forward missing records to the designated doctor upon request and that the commission notify the carrier if and when the commission forwards medical records to a designated doctor.

COMMENT: Another commenter recommended that the carrier forward records to the commission or the carrier forward records directly to the designated doctor with a form letter listing all records attached.

COMMENT: Another commenter recommended that the carrier forward well-organized, clean copy of all medical records, without highlighting or comments to the designated doctor with copies to TWCC and the worker.

COMMENT: Another commenter stated that carriers need to be cautious with regard to contacting designated doctors and since the commission pushed for an amendment to House Bill 1089 which would preclude contact, the commission should be responsible for forwarding medical records to the designated doctor.

RESPONSE: The commission agrees that a serious problem exists with providing medical records to the designated doctor but disagrees with forwarding these records through the commission. In order to expedite the dispute resolution process, the treating doctor and the carrier will be required to send to the designated doctor medical records which do not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor.

COMMENT: Several commenters recommended that TWCC send the HR-16 letter (notification of commission-selected designated doctor appointment) to all previous treating physicians, consulting and RME physicians, psychologists and other health care providers in order for all the previous providers to forward medical records to the designated doctor so that the designated doctor may obtain complete records. One commenter expressed concern with the proposed rule's placement of the responsibility on the designated doctor to coordinate and assure receipt of all medical records and stated that this is "illogical, impractical and often impossible."

COMMENT: Several commenters recommended that all previous providers be required to submit medical records to the designated doctor without a release of information request. One commenter added that the commission field office should be contacted if a provider refuses to forward records without a release.

COMMENT: Another commenter questioned if TWCC would request medical records from previous treating physicians.

RESPONSE: The commission disagrees with the solution of sending a notice to all previous providers because the commission may not know all the previous providers and determining this from the carrier will cause unnecessary delays. In addition, this would cause an administrative burden and result in an excessive postage expense. However, the commission recognizes the problem and has included a requirement that both the carrier and treating doctor forward medical records directly to the designated doctor which should ensure that the designated doctor has all the medical records.

COMMENT: One commenter requested that the field offices send notices to the employee and treating doctor in adequate time to allow the treating doctor 10 days to submit records in accordance with §133.2 of this title (relating to Sharing Medical Reports and Test Results) and recommends that the following language be used, "The treating doctor, all other health care providers, required medical exam doctors, and healthcare facilities involved in either treatment, diagnosis or evaluation of the work related injury are responsible for forwarding copies of the employee's medical records in accordance with §133.2(a) including reports, radiographic films, and test results to the designated doctor. The commission field office may be contacted if a provider or facility refuses to send records without a release of information request on a worker's compensation patient. If the designated doctor has not received the medical records at least three days prior to the examination, the designated doctor's office shall notify the commission at the appropriate field office...".

RESPONSE: The commission agrees that §133.2 allows 10 days for a treating doctor to submit records to a designated doctor, but the commission does not want the parties to wait any longer than necessary to send them, as this will decrease the timeliness of the resolution of the dispute. Therefore no timeframe is included in §130.6.

COMMENT: One commenter expressed concern that the order requiring the treating doctor to forward medical records may go unnoticed since it is on the second page of the designated doctor appointment order.

RESPONSE: The commission agrees. The commission is currently working on automation of letters for the designated doctor process which includes modifying the current structure of the commission orders for commission selected designated doctor appointments and agreed-upon designated doctor appointments. The commission will incorporate the commenters' recommendation when the content and style of the letters are revised.

The following comments were received on subsection (i).

COMMENT: Several commenters expressed the view that the designated doctor could most readily obtain medical records from the insurance carriers and recommends that subsection (i) be amended to allow the designated doctor to initiate communication with the insurance carrier and/or with any doctor who has previously treated or examined the employee for the work-related injury to obtain complete records.

COMMENT: Another commenter recommended that subsection (i) be revised to allow the designated doctor to contact the insurance carrier for the sole purpose of obtaining records, if necessary.

COMMENT: A third commenter recommended allowing the carrier to contact the designated doctor to ensure complete medical records are available. Further, the commenter agrees that all parties should be prohibited from initiating communications with the designated doctor before the employee is examined.

COMMENT: A fourth commenter requested that the carrier be allowed to send a letter to the designated doctor addressing relevant data on the claimant's condition with copies sent to the claimant, treating doctor and TWCC.

RESPONSE: The commission agrees that the insurance carrier is an appropriate party to forward medical records. Recently passed

House Bill 1089 prohibits certain communication with a designated doctor to prevent undue influence on the designated doctor's decision. The forwarding of medical records by the treating doctor and insurance carrier that are without any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor, is not a communication which was meant to be prohibited by House Bill 1089. The designated doctor can contact other doctors that have previously treated or examined the injured employee for the work related injury. The commission disagrees that it is appropriate for the designated doctor to contact the insurance company or for the insurance company to send the designated doctor a letter. If the designated doctor fails to receive records within 3 days of the appointment, the doctor should contact the commission field office.

COMMENT: One commenter recommended rewording subsection (i) to allow the designated doctor to contact previous doctors before and after the examination to obtain medical records and to contact the insurance adjustor for the sole purpose of obtaining a complete set of records. The commenter also recommended that violation of the provision be an administrative violation.

RESPONSE: The commission agrees in part. House Bill 1089 amends the Texas Labor Code §408.125 to limit contact with the designated doctor to avoid undue influence on the doctor's decision. This provision prohibits an insurance carrier from communicating with a designated doctor but allows a designated doctor to initiate communication at any time with any doctor who has previously treated or examined the injured employee for the work-related injury. If the designated doctor needs to contact anyone else, this can be done through commission staff. Violation of this provision is a Class C Administrative Violation. Section 130.6(h) provides the procedure for the designated doctor to receive medical records from the treating doctor and insurance carrier that are without any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor, to ensure the designated doctor receives a more complete set of medical records.

COMMENT: Several commenters expressed concern that an Ombudsman may contact a designated doctor and recommends defining exactly what staff are approved to contact the designated doctor.

RESPONSE: The commission agrees with the concern that an ombudsman is not an appropriate party to contact the designated doctor and has added the following statement to subsection (i) to clarify this issue, "An ombudsman is not considered appropriate staff to contact the designated doctor and should communicate with a designated doctor only through appropriate commission personnel."

The following comments were received on subsection (k).

COMMENT: One commenter recommended increasing the timeframe for retesting in §130.6(k) from seven days to 30 days to allow time for a muscle spasm or other acute medical condition to resolve.

RESPONSE: The commission disagrees. The impairment rating process should not be delayed since it is critical to timely resolution of the dispute. Retesting should be performed as soon as possible and seven days should be sufficient time to obtain proper testing results.

COMMENT: Several commenters recommended adding specific wording to clarify the intent of this subsection with regard to how often a test may be rescheduled before the test is declared invalid and to eliminate retesting ad infinitum. Some commenters suggested that retesting be limited to one time, while others would leave it to the designated doctor's clinical judgment or require commission approval for retesting.

COMMENT: Other commenters questioned the practicality of this section. One commenter felt that the wording of subsection (k) presupposes that inconsistency is a bad thing in testing and questioned whether a test that shows improvement would have to be rescheduled simply because it was inconsistent with previous examinations.

COMMENT: Another commenter recommended changing the wording in subsection (k) from "invalid to inconclusive" and requiring rescheduling be within 27 working days. If there is a clinical basis for no further testing designated doctors should make this recommendation.

COMMENT: Another commenter challenged the use of the terms "consistency" and "validity" as used in subsection (k).

RESPONSE: The commission agrees that the subsection needs clarification as to when retesting should be performed and subsection (k) has been reworded as follows: "When performing range of motion testing, if the AMA Guides specifies that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first testing unless there is no clinical basis for retesting and then the designated doctor must document this in the narrative notes with the clinical explanation for not recommending re-examination."

The commission disagrees with establishing an inflexible limit of one additional test and prefers to leave this decision to the designated doctor's medical judgment within the AMA Guides. All designated doctors will complete the commission-approved training, which will include in its curriculum guidance for determining how often retesting may be necessary under the AMA Guides.

The following comments were received regarding subsection (l).

COMMENT: One commenter pointed out that requiring a physical therapist, who is performing impairment rating tests on a range of motion measuring machine rather than an inclinometer, to complete the commission-approved training, seems unnecessary. These type machines are accurate and do not require the physical therapist to analyze the data.

RESPONSE: The commission disagrees. The testing must be performed in accordance with the requirements set forth in the AMA Guides. Therefore, the provider performing the testing must be proficient in the application of the AMA Guides and receive commission-approved training. In addition, sole use of the "computer generated" programs used to assist in conducting measurements without knowledge of the impairment rating processes as required by the AMA Guides may result in inaccurate application of the AMA Guides and unnecessary disputes.

COMMENT: One commenter questioned the training and tracking of ancillary testing providers within their scope of practice as related to the TWCC impairment rating system.

RESPONSE: The commission disagrees that subsection (l) needs to clarify the training requirements for ancillary testing providers. A group of health care providers has been organized to make recommendations to staff regarding the curriculum for commission-approved impairment rating training which will include components necessary to address proper performance by ancillary testing providers. In addition, the designated doctor will be responsible for ensuring that an ancillary testing provider chosen has successfully completed the required training which includes passing the written examination when it is available. The language in this subsection has been revised for clarity.

COMMENT: Several commenters recommended deleting "or psychological testing" from subsection (l) because training psychologists in the use of the AMA Guides for impairment rating of areas outside their scope of practice is impractical and unnecessary. One commenter recommended adding psychological testing to subsection (m).

RESPONSE: The commission disagrees with adding psychological testing to subsection (m) and agrees with deleting "or psychological testing" in subsection (l) because psychological testing is not specifically required by the AMA Guides in order to perform an impairment rating.

COMMENT: One commenter recommended that the taking of measurements for the impairment rating examination should be performed by the doctor or taken right in front of the doctor under the doctor's direct supervision.

RESPONSE: The commission disagrees with requiring the designated doctor to conduct the measurements. The designated doctor is responsible for the integrity of the entire evaluation process including the testing component. As specified in subsection (l), key testing components of the impairment rating examination should be performed by the designated doctor or by qualified, trained health care providers that the designated doctor can rely on. Section 126.10(f) indicates that a doctor may lose the privilege to serve as a designated doctor when the integrity of ancillary providers' testing is not properly analyzed or examined prior to submitting the final impairment rating.

COMMENT: Another commenter questioned what commission-approved training would consist of, who will provide the training, who will be allowed to participate in development

of the training and how often will training be required for ancillary personnel.

RESPONSE: A group of health care providers including doctors and other providers, has been organized to make recommendations for a commission-approved curriculum for the impairment rating training which will include a written examination. The commission disagrees that the rule needs to clarify the training requirements for ancillary testing providers; training for these providers will be included in the commission-approved curriculum. In addition, the commission will establish procedures for approving vendors to provide the training.

The following comments were received on subsection (m).

COMMENT: One commenter requested clarification on the definition of "self-referral" as it appears contradictory in §126.10(d) and §130.6(m).

RESPONSE: The commission disagrees with defining the term "self-referral" in §130.6, but has included a definition for "self-refer" in new §126.10(a) (5). The commission disagrees that the two rules are contradictory as subsection (m) references the referral of patients to complete the impairment rating examination, not for treatment.

COMMENT: One commenter recommended specific wording be added to reflect that the treating doctor maintain oversight and management of the overall treatment of the employee including additional testing.

COMMENT: Another commenter expressed concern that this subsection appears contradictory to §133.3 in which the treating doctor shall approve or recommend all health care and recommends that subsection (m) be revised to provide that the designated doctor will recommend additional testing, but the treating doctor would order the testing and forward results to the designated doctor. The commenter also recommended adding the following sentence to subsection (m), "Should the treating doctor not agree with the proposed recommendations, the designated doctor will presume MMI has been reached and assess the impairment accordingly."

RESPONSE: The commission disagrees. The designated doctor is responsible for ordering additional testing as necessary to perform an impairment rating and should not be required to go through the treating doctor for approval or coordination of this testing. The commission agrees that the treating doctor maintain oversight and management of the overall treatment, but obtaining testing for the one-time assignment of an impairment rating is not considered ongoing treatment that requires oversight and management by the treating doctor. Because coordination with the treating doctor is not required for impairment rating testing, there is no need for a provision in the rule for presumption of MMI.

COMMENT: One commenter questioned what would happen if the request for preauthorization for psychological testing was denied and the designated doctor is forced to assess an impairment rating without an accurate mental assessment.

RESPONSE: The commission agrees with the commenter's concern that preauthorization could unduly delay timely resolution of the dispute. The commission has modified subsection (m) to NOT require preauthorization of testing required to complete the impairment rating in accordance with the AMA Guides. In addition, the word "authorize" has been replaced with "perform" in this subsection because "authorize" may imply preauthorization.

The following comments were received regarding subsection (n).

COMMENT: One commenter contended that a seven-day timeframe is too short to provide quality evaluation reports and recommends that the requirement in §130.6(n), for completion and submission of the evaluation report, be increased from seven days to 14 days.

Another commenter expressed concern regarding the seven day time frame for submitting the report following retesting.

A third commenter felt a seven day time limit for filing a completed evaluation report did not allow sufficient preparation time and suggested that a more reasonable timeframe would be 14 to 21 days.

RESPONSE: The commission disagrees. The seven day timeframe for filing the Report of Medical Evaluation (TWCC-69) is required in §130.1(h). Section 130. 6(n) establishes a new timeframe for the extenuating circumstance when the patient must be referred for additional testing and allows an additional seven days for doctors to submit a completed report following re-testing. This timeframe is necessary for timely resolution of the issues.

COMMENT: One commenter recommended adding a new section preceding subsection (n) which would set out specifically what items should be included in a designated doctor's report.

RESPONSE: The commission disagrees that the definition of a designated doctor report should be (1) limited to designated doctors and (2) included in §130.6. The Report of Medical Evaluation is defined by §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment) and any recommendations for clarification or definition of the report should be addressed by that rule which is currently in the process of being revised. However, the commission agrees with the concept of clearly defining which elements should be included in the report for any MMI/IR examination and will consider this addition in the appropriate rules.

The following comments were received regarding subsection (o).

COMMENT: One commenter questioned if a "specific logging form" would be developed to document compliance with the documentation requirements listed in §130.6(o).

RESPONSE: The commission disagrees with the need for TWCC to require specific logging forms. The designated doctor can maintain accurate records to reflect the items listed in §130.6(o) using his/her office's documentation processes.

COMMENT: Another commenter questioned that §130.6(o) referred to the receipt of medical records from the treating doctor or "any other party" and wanted to know if this allowed carriers to submit records to the designated doctor.

RESPONSE: The commission agrees that the proposed wording causes confusion and has clarified the provision of forwarding and receiving medical records in subsection (h) by stating that the carrier and treating doctor will forward records directly to the designated doctor as explained previously in responses to comments on subsection (h).

COMMENT: One commenter recommended substituting the term "any other party" with "person or organization" as "party" has been used to delineate persons with a direct interest in a dispute such as the carrier, claimant or subclaimant.

RESPONSE: The commission agrees to replace the term "party" with "person or organization" in subsection (o)(4) to provide clarification to the rule.

COMMENT: One commenter supported documenting the no-shows for employees so that when the patient doesn't show up for an appointment, there is documentation of noncompliance.

RESPONSE: The commission agrees. As specified in subsection (o), the designated doctor must maintain records to reflect the circumstances regarding a cancellation, no-show or other situation where the examination did not occur. This information will assist the commission in determining if the employee is being non-compliant. In addition, if the doctor cancels the appointment, the same information must be maintained and again, this information will assist the commission in determining compliance by the doctor as well. The commission has revised subsection (o)(2) to clearly apply to rescheduled examinations, as well as, the initially scheduled examination.

The following comments were received regarding subsection (p).

COMMENT: One commenter expressed concern that the proposed rule would penalize doctors for divergent interpretations when there is no definitive authority at the commission who can provide the doctors with guidance.

RESPONSE: The commission disagrees that a rule change is needed since there is no penalty for divergent interpretations when an explicit policy of TWCC or explicit indications in the AMA Guides do not exist. However, the commission has recognized that differing interpretations of the AMA Guides exist; thus, the impairment rating training curriculum will provide guidance for designated doctors on the use and interpretation of the AMA Guides. In addition, the commission will use statewide averages as an indicator of the doctor's application and knowledge of the AMA Guides. Doctors who fall significantly outside the averages may not be applying the AMA Guides in the same manner as other doctors, which creates unnecessary disputes. Likewise, the commission recognizes that due to specialization in the medical field, some doctors reg-

ularly treat the more complex cases and therefore, might acceptably have an impairment rating that deviates from the statewide average. This factor is just one which the division will consider in evaluating doctors.

COMMENT: Several commenters expressed concern about how "improper or incomplete examinations or reports," referred to in §130.6(p)(3) which pro ,pt a refund to a carrier, will be determined. The commenters also questioned who would be responsible for determination of when an examination was improper or incomplete.

RESPONSE: The commission disagrees that additional clarification is necessary in the rule. Complete impairment ratings are listed in the components covered for reimbursement in subsection (r)(2), and additionally, through curriculum development, the components necessary for proper examinations and reports will be defined. Determinations of improper or incomplete examinations will be based upon elements explicitly required by TWCC, the AMA Guides, or through objectives in the impairment rating training curriculum. commission staff will use these criteria to make assessments of improper or incomplete examinations.

COMMENT: One commenter recommended amending subsection (p)(3) by adding the phrase, "failure to make the refund payment within 30 days of the commission's order to do so, shall subject the provider to the provisions of §126.10(d)", after the word, "performed".

RESPONSE: The commission agrees with the intent of this recommendation, but disagrees that this additional wording is necessary to ensure compliance with an order issued pursuant to §130.6(p)(3). Compliance with commission orders, including refund orders, have specific timeframes and penalties. Under §126. 10(d)(6) all violations of the Act and rule may result in suspension and/or removal from the Designated Doctor List.

The following comments were received on subsection (q).

COMMENT: One commenter did not object to shortening the timeframe to pay income benefits to five days after the receipt of the designated doctor's report, but expressed concern with requiring payment upon receipt of a commission order because this could require payment before the five days have expired. The commenter felt that the five day timeframe is fast enough.

RESPONSE: The commission disagrees that subsection (q) should be revised because the intent is not to require payment prior to five days but to allow the commission to order payment if the report is not received within five days to ensure benefits begin as soon as possible.

COMMENT: One commenter expressed concern that there is no way for the carrier to withhold payment if they are contesting the designated doctor's findings and suggests that an expedited BRC be held.

COMMENT: Another commenter expressed concern with dispute process and overpayment of benefits pending setting of a benefit review conference (BRC) and clarification of designated doctor's reports.

RESPONSE: The commission disagrees. The carrier must pay benefits in accordance with this subsection and if the commission determines that the designated doctor's report was in error, and benefits were paid inappropriately, the commission will issue an order for the carrier to recoup the payments from future benefits to be paid. Per statute, the designated doctor's impairment rating has presumptive weight and it is the commission's position that the benefits should be paid based on the designated doctor's assessment of maximum medical improvement and/or impairment rating. In addition, the commission may schedule expedited BRCs when warranted and in extreme cases the carrier should request an expedited BRC.

The following comments were received regarding subsection (r).

COMMENT: Several commenters disagreed with the reimbursement levels and the rationale to derive these levels proposed in §130.6(r). One commenter detailed the services required of a designated doctor and the time necessary to perform the services to support the proposition that the fees proposed are not sufficient.

COMMENT: One commenter recommended the following as "a good starting point" for determining designated doctor reimbursement and was of the opinion that the same reimbursement rates should apply to all doctors other than the treating doctor. The commenters categories include components for time, history and examination, number of previous providers and testing. Although a breakdown of how the fees were derived was not indicated, a value was assigned to each category as follows:

Brief Evaluation $250

Limited Evaluation $400

Extended Evaluation $750

Comprehensive Evaluation $950

COMMENT: Another commenter explained that the medical evaluations are variable with respect to the examination, the injured body area, reporting, and time ("which may easily range from two to four hours of physician time on each required medical evaluation by the designated doctor").

COMMENT: Another commenter expressed support for establishing fees that will encourage doctors to participate in the designated doctor process and recommended reevaluating the criteria for establishing the reimbursement to include: single site versus multiple site injury; nonsurgical versus surgical; number of doctors who have treated the employee; and amount of medical records reviewed.

COMMENT: A commenter recommended reevaluating the criteria for establishing the reimbursement to include: length of time since date of injury; number of body parts involved; number of physicians seen; and psychological issues are involved.

COMMENT: A commenter recommended the designated doctor reimbursement should be a flat rate taking into consideration the time elapsed from the date of injury, body regions involved and clinical complexity. In addition, the commenter recommends the following reimbursement levels: Level 1: less than six months from the date of injury, $550; Level 2: More than six months from date of injury but less than one year, $750; Level 3: More than one year from date of injury, $950; Level 4: Two or more injury sites and greater than 18 months from the date of injury: $1,200.

COMMENT: A commenter expressed concern about unreasonable fees, and with the exception of recommending a $900 fee for level 3 examinations, recommended the same reimbursement levels as those in previous comments, in addition to reimbursing a no show at $200.

COMMENT: A commenter noted that the reimbursement levels appear reasonable provided there is only one injury site and recommends adding an additional sentence to subsection (r)(3)(A)-(C): If there are multiple injury sites, an additional $150 will be reimbursed for each additional site.

COMMENT: A commenter recommended the reimbursement criteria include the number of diagnoses, complexity of clinical presentation, and the amount of records to review.

COMMENT: A commenter believed the reimbursement set out in subsection (r) is appropriate, but recommends adding a level IV to the proposed reimbursement levels for cases where it has been more than one year since injury, that are rather complicated, and which include two, three or more body areas.

COMMENT: A commenter recommended reimbursement based on time spent in the examination and reporting process at $150 per hour with a maximum allowable of $1500, whichever is less. The commenter stated that basing fees on length of treatment was not customary and did not take into account the time required to produce a valid, complete report that will withstand close scrutiny in a complex case.

COMMENT: A commenter felt the fees set in subsection (r) are below the reasonable and customary fees in Texas and recommended omitting subsection (r) (2)(A)-(C) reasoning that fees should be based solely on clinical considerations including complexity of injury and frequency type of testing, not timeframes from date of injury.

COMMENT: A commenter expressed concern that the proposed fees would drive out doctors that want to spend the kind of time necessary to teach the patients and produce the most comprehensive, intensive, correct report possible. The commenter provided the following detail regarding the components which make up the examination: The doctor typically spends 25-45 minutes face-to-face with the employee at which time the majority of measurements are taken using the goniometer and inclinometer personally. The commenters whole time with the patient is 45 minutes to one hour; and, then the report is dictated, usually about 5-6 pages, which should be reimbursed as well. Additionally, the commenter recommended a graduated scale reimbursement and specified that $750 would be an average reimbursement.

COMMENT: A commenter recommended the reimbursement be paid according to the difficulty and length of the task including the size and amount of records to be reviewed and complexity of the examination.

COMMENT: A commenter questioned whether the elapsed time between date of injury and the examination should be the sole criteria used to fix levels of reimbursements for evaluations and suggested that the criteria be further defined to include the complexity of review and the time spent on review and decision-making.

RESPONSE: The commission agrees. The proposed reimbursement methodology for designated doctor services does not sufficiently address the components affecting the examination and service.

Because the methodology used to calculate the proposed reimbursement levels only accounts for length of time from the date of injury, the fee provisions have been revised to incorporate additional elements from the commenters' recommendations to allow for a graduated reimbursement. The commission determined the fee amounts by researching the component services in the Medical Fee Guideline as well as taking into consideration factors that only affect designated doctors and the additional requirements placed on them in this rule. Reimbursements for designated doctor services are to be calculated according to the following formula: Base + Body Area(s) = Reimbursement. Ranges for reimbursement are as follows: (Base Ranges from $200 to $400) + (Body Area(s) Range(s) from $300 to $600) = Total Reimbursement Range from $500 to $1,000. The reimbursement criteria allows for a reimbursemont range from $500 (with one body area) to $1,000 (with all body areas affected). The dollar amounts were determined by analyzing the individual components required to complete a designated doctor exam. The most important part of this concept is to separate the basic exam component from the variable component of the number of body areas reviewed and assessed. Including length of time from the date of injury in the formula adjusts the fee for the complexity of the body areas. In cases where additional testing is required and the designated doctor must incorporate the findings of a specialist into the report, an additional reimbursement is allowed. The commission has deleted subsection (r)(3) and (4) and replaced them with the following criteria and reimbursement:

(3) Regardless of the maximum allowable reimbursement specified in this subsection, the designated doctor's charge for services should correlate with the actual time and level of service involved with each patient and reimbursement from the carrier shall be the lesser of the charge amount or the fees set forth as follows:

(A) Total reimbursement is equal to the base reimbursement plus the area(s) rated.

(B) The base reimbursement is inclusive of the physical examination, patient consultation and education, detailed narrative report, and factors affecting the service as a designated doctor such as ensuring availability of appointments, timeliness of reports and responding to the need for further clarification, explanation or reconsideration. Length of time elapsed from date of injury will indicate the base reimbursement as follows: i. greater than or equal to two years is reimbursed at $400 and indicated by using modifier L1 on the billing form; ii. greater than or equal to one year and less than two years is reimbursed at $300 and indicated by using modifier L2 on the billing form; iii. less than one year is reimbursed at $200 and indicated by using modifier L3 on the billing form.

(C) Areas that can be reimbursed when rated include body areas and specialty areas as indicated below: i. The reimbursement for body areas that must be rated because of the compensable injury is inclusive of testing, records reviewed, impairment rating calculations, and documentation. The designated doctor may bill for a maximum of three body areas, defined as the Spine and Pelvis; Upper Extremities and Hands; and, Lower Extremities. The reimbursement for one body area is $300 and each additional body area is $150 ii. The reimbursement for specialty areas that must be rated where referred testing is required such as psychological, audiologic and/or ophthalmologic testing, is $50 for incorporating one or more specialists' report information into the final impairment rating. This reimbursement will only be allowed once per examination. The referred specialist will be reimbursed separately from the fees in this rule.

(D) The designated doctor must indicate the number of areas rated in the units column on the billing form with the maximum being four units/areas.

(E) When the outcome of the evaluation is that maximum medical improvement has not been reached, the designated doctor shall receive the base reimbursement as outlined in subsection (r)(3)(B). No additional reimbursement will be allowed.

(F) If the employee fails to attend the examination or cancels the commission-ordered examination within 24 hours of the appointment, reimbursement shall be $100.

(4) If testing is performed by a health care provider other than the designated doctor as specified in subsection (l) of this section, each health care provider must bill for their respective services using the code and modifiers as prescribed by the commission. If the technical and professional components of the impairment rating are billed separately, reimbursement will be made at 20% for the technical and 80% for the professional of the total reimbursement as outlined in paragraph (3)(A). When the designated doctor performs all components of the service without any referred testing, the designated doctor shall bill using the code as prescribed by the commission with modifier -WP for the whole procedure.

COMMENT: One commenter was concerned about unfair reductions in the designated doctor fee and recommended that a standard criteria (checklist) be applied to each bill in order to determine which level of reimbursement should apply. The commenter had no objection to the levels of reimbursement set forth in the proposed rule as long as the standard criteria were met.

RESPONSE: The commission disagrees with requiring carriers to use a commission-developed check list to determine if all the required documentation was submitted with a bill. By this rule, the commission has established standard fees for reimbursement and outlined the criteria required for each level of reimbursement. The documentation submitted with the bill must support the level of services provided and billed.

COMMENT: One commenter recommended retaining the fees established for designated doctors in this rule and not allow the Medical Fee Guideline to supersede this rule.

RESPONSE: The commission disagrees as the intent is to incorporate the fee structures outlined in this rule into the revised Medical Fee Guideline. In addition, it is the intent of the commission to have all fees included in the fee guidelines; however, until the fee guidelines are updated, it is imperative that controls and consistency be established for designated doctor reimbursement.

COMMENT: One commenter recommended that the wording in subsection (r)(1) be modified to exclude the word "reasonable". The commenter reasoned that this language is unnecessary since a fee guideline is being set and to add the word "reasonable" confuses the issue.

RESPONSE: The commission agrees to clarify subsection (r)(1) by adding the clause to the end of the sentence, "as set forth in the fee structure of this subsection."

COMMENT: One commenter recommended adding wording to subsection (r)(2)(c) which would limit the records reviewed to those available at the time of the examination.

RESPONSE: The commission disagrees. The fee structure includes the cost of reviewing records regardless of when they arrive at the designated doctor's office.

COMMENT: Several commenters recommended removing the words "up to" before each of the recommended reimbursement levels in subsection (r)(3). One commenter felt such language encouraged carriers to dispute designated doctor fees and recommended adding variables to be considered such as body parts involved, number of doctors seen and whether behavioral issues are involved.

COMMENT: Another commenter expressed concern with the "up to" wording.

COMMENT: Another commenter expressed concern with the loophole in the reimbursement which will allow a nurse reviewer or non-medical person to unfairly reduce fees.

RESPONSE: The commission agrees, as the intent of the rule is to establish a maximum reimbursement for designated doctors. The revised reimbursement schedule does not include the "up to" language and requires the carriers to pay the lesser of the charged amount or the express fees as outlined in subsection (r)(3).

COMMENT: One commenter recommends reimbursement on a "fair and reasonable" standard for narrative reports submitted as clarification to the commission. Commenter

finds this standard is already set by §130.106 of this title (relating to Permanent Loss of Entitlement to Supplemental Income Benefits) and to adopt the proposed §130.6(r)(3)(D) would be in conflict.

COMMENT: Other commenters recommended that clarifications of previous reports be reimbursed based on §133.106 of this title (relating to Fair and Reasonable Fees for Required Reports and Records).

RESPONSE: The commission disagrees that additional reimbursement is warranted for clarification of issues because this component of the designated doctor's service is inherent in the fee structure established by this subsection.

COMMENT: Two commenters requested deletion of subsection (r)(4) because it is inconsistent with a set fee system for healthcare reimbursement.

RESPONSE: The commission disagrees. The intent of this section is to ensure providers bill the charges which represent their usual and customary fees and not for them to escalate their prices to match the reimbursement values as listed in this subsection when the listed reimbursement fees do not represent their usual and customary services. The language previously in (r)(4) is now found in the introduction subsection (r)(3).

COMMENT: One commenter requested clarification of what constitutes a "complete medical evaluation report with required attachments", as used in subsection (r)(7).

RESPONSE: The commission disagrees that additional clarification is required in this rule. The elements necessary to "complete" an impairment rating report are found in §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment), and in the instructions for completion of the form TWCC-69. In addition, required attachments are already described in subsection (r)(2)(D). However, to ensure all documentation required in the AMA Guides is included in the report, subsection (r)(2)(D) has been modified by adding the term "figures" and removing the parenthesis from the term "worksheets".

COMMENT: One commenter detailed some of the difficulties designated doctors face in determining maximum medical improvement and impairment ratings and noted that many doctors may withdraw from the program without reasonable reimbursement. The commenter agrees that a limit on fees should be adopted but recommends an hourly rate as opposed to a flat fee.

RESPONSE: The commission agrees that a limit on fees be established, but disagrees that the best method of determining the level of reimbursement is to use an hourly rate. A complete explanation of the designated doctor reimbursement methodology is contained in previous responses to comments on subsection (r).

COMMENT: One commenter stated that she approves of the proposed Designated Doctor fees as published, and that the fees are a fair median.

RESPONSE: The commission agrees that the proposed reimbursement levels represent a fair median for reimbursement but acknowledge other commenters' concerns regarding the criteria for establishing the fees, therefore, the reimbursement schedule has been revised as explained in previous responses to comments on subsection (r).

COMMENT: One commenter was concerned that the language in subsection (r)(1) may exclude self-insureds and recommended adding self-insureds to this subsection.

RESPONSE: The commission disagrees. Additional clarification is not necessary based on the definition of insurance carrier found in the Texas Labor Code, §401.011(27): Insurance carrier means an insurance company; a certified self-insurer for workers' compensation insurance; or a governmental entity that self-insures, either individually or collectively.

COMMENT. One commenter recommended specific wording for subsection (r)(3)(E) which would limit the number of times a carrier is liable to pay for a cancelled appointment to one, unless the employee can show that a bona fide emergency existed which could not have been known to the employee earlier than 24 hours prior to the scheduled appointment.

COMMENT: Another commenter was concerned that the proposed rule allowed for $100 payment for no-shows but recommended that something have some teeth in it to make the patient show up for examinations and questioned whether the carrier should be solely responsible for that

RESPONSE: The commission agrees with the commenter's concern that the carrier should not be liable for payment for multiple missed appointments by employees, but disagrees with the suggested solution as it penalizes the health care provider for actions beyond his control

COMMENT: One commenter strongly disagrees with the proposed reimbursement, stating that the fees are all over the board and suggested adopting the fees submitted by advisory groups in 1992 with testing and the report reimbursed separately. The commenter related his experience with the California Workers' Compensation system and his opinion that reducing doctor fees in that system has resulted in the best doctors no longer participating in the impairment evaluation process.

COMMENT:The commenter expressed concern that the fees in the proposed rule were inclusive of all testing and felt this made the proposed fees too low and unfair to designated doctors. Commenter believes the fee schedule would be detrimental to the injured worker because it will discourage participation of doctors in the designated doctor program and also result in carriers paying more due to delay in assigning a designated doctor.

RESPONSE: The commission agrees, and further clarification of this issue has been included in this rule. The fees in this rule were developed with input from the Medical Advisory Committee and subsection (r)(5) previously (r) (6)) allows for additional reimbursement for additional testing required to assess an impairment rating. In addition, fees in this rule have been carefully reevaluated to ensure proper reimbursement for all components of the examination to include range of motion testing. The range of motion is such an inherent part of the impairment rating examination that it must be included in the developmental design of the reimbursement.

COMMENT: One commenter stated that the reimbursement of $100 for a cancelled appointment is considerably too low because you have tied up an entire evaluating team.

COMMENT: Another commenter recommended reimbursing a no show at $200.

RESPONSE: The commission disagrees. The preparation work performed by the designated doctor prior to a cancelled appointment will be reimbursed when the actual examination is performed. The $100 has been established to reimburse the designated doctor for making the appointment time available.

COMMENT: Several commenters recommended maintaining a billing procedure separate from the global procedure for any form of psychological evaluation in relation to an impairment rating since such testing is specialized and time consuming. One commenter felt inclusion of psychological testing in the global fee would discourage designated doctors from referring an employee to such testing when necessary.

RESPONSE: The commission disagrees because psychological testing is not specifically required by the AMA Guides in order to perform an impairment rating.

COMMENT: One commenter expressed concern that subsection (r)(5) appeared to be fee splitting and questioned if this was ethical and legal.

RESPONSE: The commission agrees with the concern raised by the commenter and has revised the wording in subsection (r)(4) as follows: "If testing is performed by a health care provider other than the designated doctor as specified in subsection (l) of this section, each health care provider must bill for their respective services using the code and modifiers as prescribed by the commission. If the technical and professional components of the impairment rating are billed separately, reimbursement will be made at 20% for the technical and 80% for the professional of the total reimbursement as outlined in paragraph (3)(A) of this subsection. When the designated doctor performs all components of the service without any referred testing, the designated doctor shall bill using the code as prescribed by the commission with modifier - WP for the whole procedure."

This will allow for a fair and reasonable amount of reimbursement for both sets of providers involved in the impairment rating and enable staff to monitor the billing and reimbursement patterns associated with designated doctor examinations.

COMMENT: The commenter expressed the opinion that outside testing (e.g., eye testing or pulmonary testing) should be reimbursed separately from the global fee of the impairment rating.

RESPONSE: The commission agrees. Outside testing such as the examples listed by the commenter are covered under subsection (r)(5) (previously (r)(6)) which allows for reimbursement separate from the impairment rating fees.

COMMENT: One commenter questioned the billing procedure in subsection (r)(5) (now (r)(4)) and was concerned that the doctor would have to monitor and be responsible for all providers charges to ensure the billing did not exceed 100% of the allowable reimbursement.

RESPONSE: The commission agrees that this area caused confusion and this section (now (r)(4)) has been revised to provide a specific percentage of the allowed reimbursement to be attributable to different components of the examination. It is the carrier's responsibility to monitor the reimbursement to ensure that 100% of the allowed reimbursement is not exceeded.

COMMENT: One commenter expressed concern about the fairness of allowing additional reimbursement for referrals when the designated doctor is not allowed to receive his/her usual fee for the time spent on the examination.

RESPONSE: The commission disagrees. The referral providers will receive the reimbursement amount allowed by the Medical Fee Guideline for the specific CPT code billed, which may or may not be the total amount charged by the provider. Additionally, the designated doctor will be reimbursed according to this rule at the appropriate level based on the documentation submitted with the bill to support the reimbursement criteria, again, this reimbursement may or may not be the total amount charged by the provider.

COMMENT: One commenter expressed confusion with the provision of subsection (r)(5) and (6) (now (r)(4) and (5)) stating, "In one section it states that if testing is performed by a health care provider other than a designated doctor, the total reimbursement of both providers shall not exceed 100%, however, in the next subsection (r)(6) (now (r)(5)), additional testing and referrals will be reimbursed."

RESPONSE: The commission disagrees. The reimbursement specified in subsection (r)(5) (now (r)(4)) is inclusive of the basic testing (range of motion, sensory, and strength testing) required to perform an impairment rating as specified in subsection (l). Testing outside of that described in subsection (l) is reimbursed in addition to the standard designated doctor fee as indicated in subsection (r)(6) (now (r)(5)).

The following miscellaneous comments were received on the proposed amendment to the rule.

COMMENT: One commenter made general complaints regarding TWCC's billing and reimbursement policies ("requires him {the doctor} to spend hours up front (prior to seeing the patient), verifying that the insurance company address and adjustor to bill are correct"; "insurance companies say TWCC has given them 45 days to pay from the time they receive the bill, the doctor must call the adjustor at least six to eight times per claim... most will take three to six months to pay, if they pay at all."

RESPONSE: The commission agrees that it is important for the designated doctor to know who the carrier is for proper billing and transmission of the impairment rating report. Therefore, the commission's notice will contain the carrier's name.

COMMENT: One commenter expressed concern that commission staff were notifying the injured employee of their right to dispute the treating doctor's finding of impairment rating or maximum medical improvement.

RESPONSE: The commission disagrees. The injured worker has the right to dispute the findings of the treating doctor, especially when a treating doctor has not attended the training in the proper use of the AMA Guides. The commission will inform injured employees of their right to dispute the findings of their treating doctor when the issue is raised by the employee. It is not the commission's policy to encourage disputes.

COMMENT: One commenter expressed concern that commission staff are allowing injured employees to change treating doctors after MMI has been established.

RESPONSE: The commission disagrees. The injured employee is entitled to his/her choice of treating doctor and the Act does not preclude the employee from changing doctors after MMI has been reached. The change of treating doctor may be necessary to ensure appropriate continued medical care, but is prohibited by the Texas Labor Code, §408.022(d) for the purpose of securing a new impairment rating or medical report. As a result, changing treating doctors after MMI has been established, should occur only when there are compelling reasons related to ensuring that the injured worker receives appropriate continued medical care.

COMMENT: One commenter stated that, "Many overpayments are made which the TWCC does not require the claimant to refund. This system is not objective and is certainly biased in favor of the claimant."

RESPONSE: The commission disagrees. TWCC strives to ensure that all parties are appropriately served in the workers' compensation system. Inequities may occur and these should be pointed out to the appropriate commission staff in order to properly resolve the overpayment issue. One of the goals of this rule is to speed up the dispute resolution process which will assist in minimizing overpayments.

The following general comments were received regarding the proposed amendment to the rule.

COMMENT: One commenter expressed the complaint that the Medical Advisory Committee (MAC) was not given an opportunity to work on the Designated Doctor rules prior to staff's presentation of the rules to the commissioners. The commenter also felt that the MAC was ignored regarding this rule revision.

RESPONSE: The commission disagrees. Pursuant to the Texas Labor Code, §413.005, the MAC advises the Medical Review Division in developing and administering the medical policies, fee guidelines, and utilization guidelines established under §413.012. The proposed designated doctor reimbursements were presented to the MAC as they were initially being developed and the recommendations of the MAC were taken into consideration as the designated doctor rules were being prepared.

The following positive comments were received regarding the proposed amendment to the rule.

COMMENT: One commenter stated: "I feel many of the proposed changes are indeed needed, and will be a significant addition and improvement to the current system."

COMMENT: Another commenter agreed with reducing the timeframes for each of the timeliness issues in this rule. "We believe the changes made affecting timeliness of dispute resolution are a positive step for quick resolution to getting appropriate benefits in the hands of the injured worker." Although the commenter suggested changes to the proposed rule, he stated that, "overall the vast majority of the proposal is very good."

COMMENT: A third commenter stated: "The Fund supports the commission's attempt to improve the designated doctor process via revising §130.6."

The amendment is adopted under the Texas Labor Code, §402.061, which requires the commission to adopt rules necessary for the implementation and enforcement of the Texas Workers Compensation Act; the Texas Labor Code, §408.025, which mandates that this commission adopt rules regarding reports and records of healthcare providers, establishes a treating doctor's responsibility for efficient utilization of health care and provides for the furnishing of records by a health care facility; the Texas Labor Code, §408.121, which describes when an employee becomes entitled to impairment income benefits, and when the benefits end, as well as when the insurance carrier begins to pay impairment income benefits, states that the benefits shall be paid for a period based on the impairment rating, unless that rating is disputed, and, if disputed, that the carrier shall pay the employee impairment income benefits for a period based on the carrier's reasonable assessment of the correct rating; the Texas Labor Code; §408.122, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which describes the criteria for deciding an employee's eligibility for impairment income benefits and gives the commission the authority to choose a designated doctor to examine the employee, grants the report of the designated doctor presumptive weight in dispute resolution and mandates that designated doctor qualification standards and impairment rating training be developed; the Texas Labor Code, §408.123, which states the procedural requirements for certification of maximum medical improvement and evaluation of the impairment rating; the Texas Labor Code, §408.124, which states that an award of impairment income benefits shall be based on the standards in *Guides to the Evaluation of Permanent Impairment*, third edition, second printing, dated February 1989, published by the American

Medical Association; the Texas Labor Code, §408. 125, as amended by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which describes the procedural requirements of the dispute resolution process when there is a dispute as to an impairment rating, and states that the presumptive opinion of a designated doctor mutually agreed upon by both parties to the dispute will control, and the designated doctor chosen by the commission has presumptive weight, unless the other medical evidence is to the contrary, in which case the commission shall adopt the impairment rating of one of the other doctors; and prohibits certain communication with the designated doctor; the Texas Labor Code §413.002, as amended by House Bill 1089, 74th Legislature, 1995, which gives the commission authority to monitor and evaluate health care providers (including designated doctors), insurance carriers, and workers' compensation claimants to ensure compliance with the rules adopted by the commission; the Texas Labor Code, §413.011, which mandates that the commission establish medical policies and guidelines; and the Texas Labor Code §413.044, as added by House Bill 1089, 74th Legislature, 1995, effective September 1, 1995, which empowers the commission to seek sanctions against a designated doctor who is not in compliance with the Texas Workers' Compensation Act or commission rules; the Texas Labor Code, §413.053, which mandates that the commission shall by rule establish standards of reporting and billing by health care providers.

§130.6. Designated Doctor: General Provisions.

(a) If the commission receives a notice from the employee or the insurance carrier that disputes maximum medical improvement; an assigned impairment rating; or maximum medical improvement and an assigned impairment rating, the commission shall issue a written order assigning a designated doctor, setting up a designated doctor appointment for a date no earlier than 14 days from the date of the commission order and no later than 24 days from the date of the commission order, and notifying the employee and the insurance carrier that the designated doctor will be directed to examine the employee. The commission's written order shall also:

(1) contain the designated doctor's name, license number, practice address and telephone number, and the date and time of the examination;

(2) explain that the injured employee may agree with the carrier on a different designated doctor and notify the commission of the agreement as described in subsection (e) of this section;

(3) state that there is a dispute and that the Texas Labor Code, §408.125 requires the commission to adopt the impairment rating made by a mutually agreed upon designated doctor;

(4) explain when the designated doctor's report has presumptive weight with respect to maximum medical improvement and/or impairment ratings as specified in the Texas Labor Code, §408.122 and §408.125;

(5) notify an unrepresented employee that commission staff are available to explain the contents of an agreement for a designated doctor and the possible effects of such an agreement on future benefits;

(6) order the employee to be examined by the designated doctor on the stated date and time, unless the commission is timely notified of an agreement; and

(7) require the treating doctor and insurance carrier to forward all medical records in compliance with subsection (h) of this section.

(b) In order to be a designated doctor for a dispute, the doctor shall:

(1) be on the Designated Doctor List as described in §126.10 of this title (relating to Commission Approved List of Designated Doctors);

(2) not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor;

(3) not have any disqualifying association as specified in §126.10(a) of this title (relating to Commission Approved List of Designated Doctors); and

(4) to the extent possible, be in the same discipline and licensed by the same board of examiners as the employee's doctor of choice.

(c) After sending the order to the employee and the insurance carrier as specified in subsection (a) of this section, the commission shall allow the employee and insurance carrier to agree on a designated doctor. If at the end of the tenth day from the date of the order, the commission has not received notification from the insurance carrier or injured employee that a designated doctor has been agreed upon, the commission will presume that an agreement is not possible and the employee is required to attend the commission-selected designated doctor examination as specified in subsection (a) of this section.

(d) If the employee and the insurance carrier agree on a designated doctor, the insurance carrier shall schedule an appointment for the designated doctor to examine the employee on a date no earlier than 14 days from the date of the commission order described in subsection (a) of this section and no later than 24 days from the date of the commission order.

(e) The carrier shall notify the commission field office within ten days of the date of the commission's order as described in subsection (a) when an agreement with the injured employee on the selection of a designated doctor is made. The notice shall include:

(1) the commission's claim file number;

(2) the employee's name, address, and social security number, and if known, the employee's telephone number;

(3) the date of the injury; and

(4) the designated doctor's name, license number, practice address and telephone number, and the time and date of the examination.

(f) Upon timely receipt of the notification from the insurance carrier that the injured employee and the carrier have agreed on a designated doctor, the commission shall contact the employee to confirm the agreement. Upon confirmation by the employee, the commission shall send to the carrier, designated doctor and the injured employee an order confirming the agreement, cancelling the commission-selected designated doctor appointment, and directing the employee to be examined by the agreed-upon doctor. The order shall remind the parties of the requirements in the Texas Labor Code, §408.122 and §408.125 as specified in subsection (a) of this section and require the treating doctor and insurance carrier to forward medical records in compliance with subsection (h) of this section. The order will supersede the initial order identifying a commission-selected designated doctor. If the commission cannot confirm the agreement with the employee, the commission will presume that an agreement was not made and the initial order directing the employee to be examined by a designated doctor selected by the commission shall remain in effect.

(g) The designated doctor and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24 hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination unless an extension is granted by the field office. Within 24 hours of rescheduling, the designated doctor shall contact the commission field office and the insurance carrier with the time and date of the rescheduled examination.

(h) The treating doctor and insurance carrier are both responsible for sending to the designated doctor all the employee's medical records relating to the medical con-

dition to be evaluated by the designated doctor that are in their possession without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of maximum medical improvement and impairment rating disputes. The medical records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. The medical records must be received by the designated doctor at least three days prior to the date of the appointment as specified in the commission order. If the medical records are marked, highlighted, altered, or unrelated to the medical condition to be evaluated by the designated doctor, the designated doctor shall notify the commission and report the noncompliance of the treating doctor and/or insurance carrier. Noncompliance with this subsection is a Class C administrative violation under the Texas Labor Code §408.125 and may be subject to an administrative penalty not to exceed $1000. If the designated doctor has not received the medical records at least three days prior to the examination, the designated doctor's office shall notify the commission at the appropriate field office and the appropriate commission staff will send an order to the treating doctor and/or insurance carrier for the delivery of medical records.

(i) To avoid undue influence on a person selected as a designated doctor under the Texas Labor Code, §408.125, only the employee or an appropriate member of the staff of the commission may communicate with the designated doctor about the case regarding the employee's medical condition or history prior to the examination of the employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the employee's medical condition or history may be made only through appropriate commission staff members. An ombudsman is not considered appropriate staff to contact the designated doctor and should communicate with a designated doctor only through appropriate commission personnel. The designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury. Noncompliance with this section is a Class C administrative violation under the Texas Labor Code, §408.125 and may be subject to an administrative penalty not to exceed $1,000.

(j) The designated doctor shall address the issue(s) in dispute and confine the report as described in subsection (n) of this section to only those issues. When the impairment rating is the only issue in dispute, the doctor shall assess an impairment rating without regard to maximum medical improvement. When maximum medical improvement and impairment rating are in dispute and the designated doctor determines that the employee has not reached MMI, the designated doctor shall not assign an impairment rating. An evaluation or certification under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), shall include a physical examination and evaluation by the designated doctor. Although any doctor or any other provider who has successfully completed the training outlined in §126.10(b)(2) of this title (relating to Commission Approved List of Designated Doctors) may compare the clinical findings on a particular patient with the criteria in the AMA Guides, the designated doctor shall conduct a physical evaluation and is responsible for the integrity of the evaluation process. This means the designated doctor must evaluate the complete clinical and non-clinical history of the medical condition(s), perform an examination of the employee, analyze the medical history with the clinical and laboratory findings and assess and certify an impairment rating according to the AMA Guides.

(k) When performing range of motion testing, if the AMA Guides specifies that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first testing unless there is no clinical basis for retesting and then the designated doctor must document this in the narrative notes with the clinical explanation for not recommending re-examination.

(l) Range of motion, sensory, and strength testing should be performed by the designated doctor, when applicable. If this testing is not performed by the designated doctor, the health care provider performing the testing must have successfully completed commission-approved training as outlined in §126.10(b)(2) in the proper use of the AMA Guides, must not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor, and must complete testing within seven days of the designated doctor's physical examination of the employee.

(m) For testing other than that listed in subsection (l) of this section, the designated doctor may perform additional testing or refer employees to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required by the AMA Guides for the assignment of the impairment rating is not subject to preauthorization requirements in accordance with the Texas Labor Code, §413.014 (relating to Preauthorization) and additional testing must be completed within seven days of the designated doctor's physical examination of the employee.

(n) The designated doctor shall complete and file the medical evaluation report in accordance with §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment) unless testing must be rescheduled or the employee is referred to another health care provider as specified in subsections (k)-(m) of this section, the medical evaluation report shall be completed and filed within seven days of the rescheduled testing or referral appointment date.

(o) The designated doctor shall maintain accurate records to reflect:

(1) the date and time of any designated doctor appointments scheduled with employees;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person or organization;

(5) the date the medical evaluation report was submitted to all parties in accordance with §130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment); and

(6) the name of all referral health care providers, date of appointments and reason for referral by the designated doctor.

(p) The commission may:

(1) issue an order requiring timely submission of medical evaluation reports or narrative reports;

(2) assess administrative violations;

(3) issue an order for refund to the insurance carrier of the examination payment if an improper or incomplete examination is performed or improper or incomplete report is submitted;

(4) take action to remove a doctor from the Designated Doctor List as described in accordance with §126.10 of this title (relating to Commission Approved List of Designated Doctors); and/or

(5) take action to remove a doctor from the Approved Doctor List in accordance with §126.8 of this title (relating to Commission Approved Doctor List).

(q) The insurance carrier shall pay

any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the report or upon receipt of an order by the commission, whichever is earlier.

(r) The designated doctor billing and reimbursement will be as established in this subsection until the designated doctor reimbursement is specifically addressed by the Medical Fee Guideline. At such time, the Medical Fee Guideline will supersede this subsection.

(1) The insurance carrier is responsible for paying the reasonable cost of a designated doctor examination as set forth in the fee structure of this subsection. In addition, the carrier shall pay for the reasonable travel expenses for an injured employee to attend a designated doctor appointment.

(2) The reimbursement for determination of maximum medical improvement and/or impairment ratings shall be inclusive of:

(A) the examination;

(B) consultation with the employee;

(C) review of records and films;

(D) the preparation and submission of reports, calculation tables, figures, and worksheets;

(E) range of motion, strength, and sensory testing and measurements; and

(F) other tests used to validate the impairment rating.

(3) Regardless of the maximum allowable reimbursement specified in this subsection, the designated doctor's charge for services should correlate with the actual time and level of service involved with each patient and reimbursement from the carrier shall be the lesser of the charge amount or the fees set forth as follows.

(A) Total reimbursement is equal to the base reimbursement plus the area(s) rated.

(B) The base reimbursement is inclusive of the physical examination, patient consultation and education, detailed narrative report, and factors affecting the service as a designated doctor such as ensuring availability of appointments, timeliness of reports, and responding to the need for further clarification, explanation or reconsideration. Length of time elapsed from date of injury will indicate the base reimbursement as follows.

(i) Greater than or equal to two years is reimbursed at $400 and indicated by using modifier L1 on the billing form.

(ii) Greater than or equal to one year and less than two years is reimbursed at $300 and indicated by using modifier L2 on the billing form.

(iii) Less than one year is reimbursed at $200 and indicated by using modifier L3 on the billing form.

(C) Areas that can be reimbursed when rated include body areas and specialty areas as follows.

(i) The reimbursement for body areas that must be rated because of the compensable injury is inclusive of testing, records reviewed, impairment rating calculations, and documentation. The designated doctor may bill for a maximum of three body areas, defined as the Spine and Pelvis; Upper Extremities and Hands; and, Lower Extremities. The reimbursement for one body area is $300 and each additional body area is $150.

(ii) The reimbursement for specialty areas that must be rated where referred testing is required such as psychological, audiologic and/or ophthalmologic testing, is $50 for incorporating one or more specialists' report information into the final impairment rating. This reimbursement will only be allowed once per examination. The referred specialist will be reimbursed separately from the fees outlined in this rule.

(D) The designated doctor must indicate the number of areas rated in the units column on the billing form with the maximum being four units/areas.

(E) When the outcome of the evaluation is that maximum medical improvement has not been reached, the designated doctor shall receive the base reimbursement as outlined in subparagraph (B) of this paragraph. No additional reimbursement will be allowed.

(F) If the employee fails to attend the examination or cancels the commission-ordered examination within 24 hours of the appointment, reimbursement shall be $100.

(4) If testing is performed by a health care provider other than the designated doctor as specified in subsection (l) of this section, each health care provider must bill for their respective services using the code and modifiers as prescribed by the commission. If the technical and professional components of the impairment rating are billed separately, reimbursement will be made at 20% for the technical and 80% for the professional of the total reimbursement as outlined in paragraph (3)(A) of this subsection. When the designated doctor performs all components of the service without any referred testing, the designated doctor shall bill using the code as prescribed by the commission with modifier -WP for the whole procedure.

(5) Additional testing or referrals specified in subsection (m) of this section will be reimbursed in addition to the fees specified in paragraph (3)(A)-(C) of this subsection if the additional testing was required to perform the assignment of impairment rating and/or determination of maximum medical improvement. These services should be billed using the appropriate CPT code as specified in the Medical Fee Guideline.

(6) A carrier's timeframe for reimbursement to the designated doctor does not begin until a complete medical evaluation report with required attachments has been received by the insurance carrier.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511735

Susan Cory
General Counsel
Texas Workers' Compensation Commission

Effective date: December 1, 1995

Proposal publication date: March 21, 1995

For further information, please call: (512) 440-3700

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

Part IV. Texas Commission for the Blind

Chapter 171. Cooperative Activities

• 40 TAC §171.3

The Texas Commission for the Blind adopts an amendment to §171.3, concerning memoranda of understanding between agencies, without changes to the proposed text as published in the July 25, 1995, issue of the *Texas Register* (20 TexReg 5496).

Amended §171.3(4) adopts by reference a memorandum of understanding between the Texas Education Agency, the Texas Commission for the Blind, the Texas Department of Human Services, the Texas Employment Commission, the Texas Department of Mental Health and Mental Retardation, and the Texas Rehabilitation Commission concerning transition planning for students receiving special education services. The adopted amendment revises the memorandum to clarify requirements regarding advance notice of a transition planning meeting.

Section 171.3(5) adopts by reference a memorandum of agreement between the Texas Department of Criminal Justice, the Texas Commission for the Blind, the Texas Commission for the Deaf and Hearing Impaired, the Texas Rehabilitation Commission, the Texas Department of Human Services, and the Texas Department of Health in compliance with Senate Bill 252 enacted by the 73rd Legislature. The memorandum establishes a continuity of care system for offenders with physical disabilities and offenders who are terminally ill or significantly ill and improves coordination between the parties to the memorandum.

The commission received no comments regarding adoption of the amendment.

The amendment is adopted under the Human Resources Code, Title 5, Chapter 91, which authorizes the commission to adopt rules prescribing the policies and procedures followed by the commission in the administration of its programs and which authorizes the agency to negotiate interagency agreements with other state agencies to extend and improve the regular services provided by the agencies.

This agency hereby certifies that the rule as adopted has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued in Austin, Texas, on September 11, 1995.

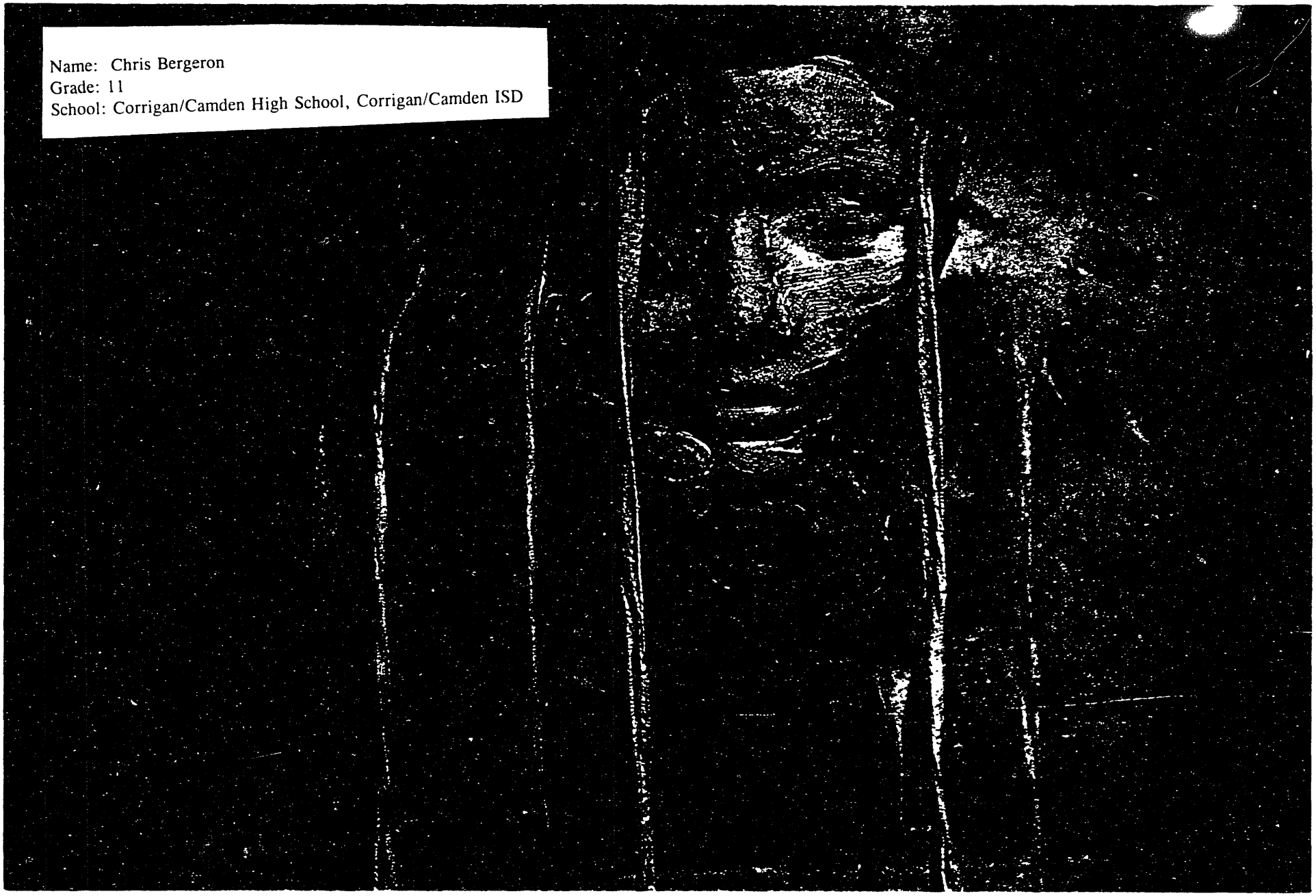
TRD-9511738

Pat D. Westbrook
Executive Director
Texas Commission for the Blind

Effective date: October 4, 1995

Proposal publication date: July 25, 1995

For further information, please call: (512) 459-2611


Name: Chris Bergeron
Grade: 11
School: Corrigan/Camden High School, Corrigan/Camden ISD

OPEN MEETINGS

Agencies with statewide jurisdiction must give at least seven days notice before an impending meeting. Institutions of higher education or political subdivisions covering all or part of four or more counties (regional agencies) must post notice at least 72 hours before a scheduled meeting time. Some notices may be received too late to be published before the meeting is held, but all notices are published in the ***Texas Register***.

Emergency meetings and agendas. Any of the governmental entities listed above must have notice of an emergency meeting, an emergency revision to an agenda, and the reason for such emergency posted for at least two hours before the meeting is convened. All emergency meeting notices filed by governmental agencies will be published.

Posting of open meeting notices. All notices are posted on the bulletin board at the main office of the Secretary of State in lobby of the James Earl Rudder Building, 1019 Brazos, Austin. These notices may contain a more detailed agenda than what is published in the ***Texas Register***.

Meeting Accessibility. Under the Americans with Disabilities Act, an individual with a disability must have an equal opportunity for effective communication and participation in public meetings. Upon request, agencies must provide auxiliary aids and services, such as interpreters for the deaf and hearing impaired, readers, large print or braille documents. In determining type of auxiliary aid or service, agencies must give primary consideration to the individual's request. Those requesting auxiliary aids or services should notify the contact person listed on the meeting summary several days prior to the meeting by mail, telephone, or RELAY Texas (1-800-735-2989).

Texas State Board of Public Accountancy

Friday, September 22, 1995, 9:00 a.m.

333 Guadalupe, Room 910

Austin

CPE Committee Meeting

AGENDA:

A. Consideration of request to lift suspension of licensees who received a board sanction for non-compliance with CPE requirements

ACTION REQUIRED

1. Gene S. Bertcher
2. L. Mark Price
3. David G. Clay
4. Miles McKellar
5. George Ray Malone
6. Robert J. Petit

B. Consideration of special request for approval to claim CPE by Barbara Wilson

ACTION REQUIRED

C. Review of statistical information concerning CPE

NO ACTION REQUIRED

D. Consideration of notification to sponsors of CPE regarding renewal and consideration of to renew registration of Toastmasters

ACTION REQUIRED

E. Consideration of ethics course submitted for approval

ACTION REQUIRED

1. White Petrov McHone
2. H. C. Advisory Services
3. Nita J. Clyde
4. Microcomputer Productions

F. Consideration of CPE complaints against licenses for failure to comply with CPE requirements

NO ACTION REQUIRED

G. Consideration of date for next meeting

ACTION REQUIRED

Contact: J. Randel (Jerry) Hill, 333 Guadalupe, Tower III, Room 900, Austin, Texas 78701-3900, (512) 505-5542.

Filed: September 12, 1995, 3:03 p.m.

TRD-9511699

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State Office of Administrative Hearings

Monday, October 2, 1995, 10:00 a.m.

TNRCC, Building A, Room 310 A and D, 12124 Park 35 Circle

Austin

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by James A. Dyche doing business as Crest Water Company for an increase in water rates effective July 1, 1995, for its service area located in Johnson, Hill, and Somervell counties, Texas. TNRCC Docket Number 95-1112-UCR.

Contact: Susan Prior, Maid Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 10:33 a.m.

TRD-9511669

Tuesday, October 3, 1995, 10:00 a.m.

TNRCC, Building C, Room 107W, 12124 Park 35 Circle

Austin

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on two applications made to the Texas Natural Resource Conservation Commission by United Water Supply Corporation (WSC):

Application Number 30746-S to acquire the facilities and assets of Willis Water Company, Inc. and transfer Certificate of Convenience and Necessity (CCN) Number 11079 from Willis Water Company, Inc. to United Water Supply Corporation (WSC). CCN Number 11079 authorizes the provision of water utility service in Grayson County,

Texas. The area being transferred is approximately two miles north of downtown Gordonville, Texas and is generally bounded by Highway 377 on the west, Hillcrest Drive on the south, County Road on the west, Arapaho Drive on the south, and Lake Road on the east and north. TNRCC Docket Number 95-1062-UCR.

Application Number 30747-S to acquire Wells Land and Cattle Company, Inc. doing business as Clear Lakes Water System and to transfer and cancel Certificate of Convenience and Necessity (CCN) Number 11587 from Wells Land and Cattle Company, Inc. doing business as Clear Lakes Water System to United WSC. CCN Number 11587 authorizes the provision of water utility service in Wood County, Texas. The area being transferred and cancelled is approximately one mile south of downtown Quitman, Texas, and is generally bounded by Highways 37 and 778. TNRCC Docket Number 95-1063-UCR.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 10:33 a.m.

TRD-9511670

Thursday, October 5, 1995, 9:00 a.m.

Reber Memorial Library, Meadows Annex, 190 North Fourth

Raymondville

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by North Alamo Water Supply Corporation for Proposed Permit Number 13747-01 to authorize a discharge of treated domestic wastewater effluent at a volume not to exceed an average flow of 100,000 gallons per day. The wastewater treatment facility is to be approximately 1/3 mile south of State Highway 186 and 1/2 mile west of FM Road 1015 in Willacy County, Texas. The effluent is discharged into a series of ditches and drains; thence into the Laguna Madre in Segment Number 2491 of the bays and estuaries. TNRCC Docket Number 95-1334-MWD.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 2:59 p.m.

TRD-9511694

Thursday, October 5, 1995, 10:00 a.m.

TNRCC, Building C, Room 131E, 12124 Park 35 Circle

Austin

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by Clearwater Estates Water System for an increase in water rates effective June 1, 1995, for its service area located in Comal County, Texas. TNRCC Docket Number 95-1130-UCR.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 10:34 p.m.

TRD-9511671

Wednesday, October 11, 1995, 10:00 a.m. (Rescheduled from June 1, 1995.)

Washington County Courthouse, Conference Room 105, 100 East Main

Brenham

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by City of Brenham for renewal of Permit Number 10388-01 which authorizes a discharge of treated domestic wastewater effluent at a final volume not to exceed an average flow of 2,550,000 gallons per day. The wastewater treatment facilities are at 2005 East Alamo Street, south of and adjacent to Hog Branch in the City of Brenham, in Washington County, Texas. The effluent is discharged into Hog Branch; thence to Little Sandy Creek; thence to New Year Creek; thence to Brazos River below Navasota River in Segment Number 1202 of the Brazos River Basin. TNRCC Docket Number 95-0577-MWD.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 3:00 p.m.

TRD-9511697

Thursday, October 12, 1995, 9:00 a.m.

San Angelo City Hall, Council Chambers, Fourth Floor, 72 West College Avenue

San Angelo

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by Don Phelps for Proposed Permit Number 03796 to authorize the disposal of waste and wastewater from a dairy. The dairy will consist of a maximum of 650 head. The waste treatment facilities will include one storage pond and related appurtences for washdown water, flushwater and stormwater retention. Wastewater from the ponds will be disposed of by irrigation on 39 acres of agricultural land. Manure and separated solids are to be applied as fertilizer on 478 acres of agricultural land. No discharge of pollution into the waters of the State is authorized by this permit. The dairy is located on the southeast corner of the intersection of Ballard Road and Grape Creek Road, approximately 2.5 miles north of U.S. Highway 87 in Tom Green County, Texas. This location is in the drainage area of the Grape Creek, a tributary of the North Concho River above O. C. Fisher Reservoir in Segment Number 1425 of the Colorado River Basin. TNRCC Docket Number 95-1291-AGR.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 2:59 p.m.

TRD-9511695

Thursday, October 12, 1995, 9:00 a.m.

Henderson County Courthouse Annex Building, Third Floor Conference Room, 101 East Tyler

Athens

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by Lake Water Companies for an increase in water rates effective July 22, 1995, for its service area located in Henderson County, Texas.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 2:58 p.m.

TRD-9511693

Thursday, October 26, 1995, 10:00 a.m. (Rescheduled from August 22, 1995.)

Victoria County Courthouse, Commissioner's Courtroom, Second Floor, 115 North Bridge

Victoria

AGENDA:

For a hearing before an administrative law judge of the State Office of Administrative Hearings on an application made to the Texas Natural Resource Conservation Commission by Quail Creek Municipal Utility District for an amendment to Permit Number 12226-01 to authorize an increase in the discharge of treated domestic wastewater effluent from a final volume not to exceed an average flow of 130,000 gallons per day to a final volume not to exceed an average flow of 220,000 gallons per day. The permit

currently authorizes a discharge of treated domestic wastewater effluent at a volume not to exceed an average flow of 130,000 gallons per day in the interim phase, which will remain the same. The Aloe Field Wastewater Treatment Facilities are approximately 2.5 miles west of the intersection of U.S. Highway 59 and U.S. Highway 77 in Victoria County, Texas. The effluent is discharged into a drainage ditch; thence to Dry Creek; thence to the Guadalupe River below San Marcos River in Segment Number 1803 of the Guadalupe River Basin. TNRCC Docket Number 95-1036-MWD.

Contact: Susan Prior, Mail Code 102, P.O. Box 13087, Austin, Texas 78711-3087, (512) 239-4100.

Filed: September 12, 1995, 3:00 p.m.

TRD-9511696

Monday, December 11, 1995, 10:00 a.m.

7800 Shoal Creek Boulevard

Austin

Public Utility Division

AGENDA:

A hearing on the merits is scheduled for the above date and time in SOAH Docket Number 473-95-51169: Petition of Southwestern Public Service Company for findings of special circumstances and for associated waivers (PUC Docket Number 14499).

Contact: J. Kay Trostle, 7800 Shoal Creek Boulevard, Austin, Texas 78757, (512) 458-0233.

Filed: September 13, 1995, 3:41 p.m.

TRD-9511764

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Texas Department on Aging

Friday, September 22, 1995, 9:30 a.m.

1949 South IH-35, Third Floor Large Conference Room

Austin

Options for Independent Living Advisory Committee

AGENDA:

Consider and possibly act on: Welcome and introductions. Overview of Options Program. Update on recently completed request for proposals (RFP) process. Charge to committee from August 16, 1995 meeting of Texas Board on Aging. Election of chairman. Discussion to include: ways to increase Options awareness; ways to increase Options funding; methods for allocation of Options funding and for statewide expansion. Other items. Set date of next meeting. Adjourn.

Contact: Mary Sapp, P.O. Box 12786, Austin, Texas 78704, (512) 444-2727.

Filed: September 12, 1995, 10:36 a.m.

TRD-9511677

♦ ♦ ♦

Texas Bond Review Board

Thursday, September 21, 1995, 10:00 a.m.

300 West 15th Street, Committee Room #5, Clements Building, Fifth Floor

Austin

AGENDA:

I. Call to order

II. Approval of minutes

III. Consideration of proposed issues

A. Texas Public Finance Authority–Tax-Exempt General Obligation Commercial Paper Notes for projects for Texas Department of Criminal Justice

B. Comptroller of Public Accounts–Lease purchase of a remittance processing system

C. Texas Veterans Land Board–State of Texas Veterans' Housing Assistance Refunding Bonds

D. Texas Department of Housing and Community Affairs

(1) Single Family Mortgage Revenue Bonds;

(2) Single Family Mortgage Revenue Refunding Bonds;

(3) Taxable Single Family Mortgage Revenue Refunding Bonds;

(4) Single Family Mortgage Revenue Commercial Paper Notes–extension of program; and

(5) Single Family Mortgage Revenue Refunding Bonds, Series 1996A-L

IV. Other business

A. Discussion of proposed amendments to rules for the private activity bond allocation program

B. Future meeting dates

C. Approval of biennial operating plan for submission to Department of Information Resources

Contact: Albert L. Bacarisse, 300 West 15th Street, Suite 409, Austin, Texas 78701, (512) 463-1741.

Filed: September 13, 1995, 4:16 p.m.

TRD-9511766

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Children's Trust Fund of Texas Council

Tuesday, September 26, 1995, 1:30 p.m.

8929 Shoal Creek Boulevard, Suite 200

Austin

AGENDA:

Introduction

Chairperson's report

Executive director's report

Discussion of future plans and tasks

New business

Adjourn

Contact: Sue Marshall, 8929 Shoal Creek Boulevard, Suite 200, Austin, Texas 78757-6854, (512) 458-1281.

Filed: September 13, 1995, 3:24 p.m.

TRD-9511762

♦ ♦ ♦

Texas Department of Commerce

Thursday, September 21, 1995, 10:00 a.m.

1700 North Congress Avenue, Stephen F. Austin Building, Second Floor, Conference Room 210-F

Austin

Capital Certified Development Corporation Board of Directors

AGENDA:

10:00 a.m.–Call meeting to order

10:01 a.m.–Approve minutes:

June 15, 1995

Annual members meeting

Board of Directors meeting

10:10 a.m.–Information items

Centralized processing

SBA Accredited Lender's Program

TDOC Organizational Chart

TDOC Programs update

10:30 a.m.–Action items

Resolution to allow prepayment of PI components

Resolution to elect assistant secretary

Accept resignation of Alan Causey and appoint a new board member

11:00 a.m.–Information items

Treasurer's report

Loan activity report

Performance projections

NADCO Regional VI annual meeting update

1995/1996 marketing plan

Noon–Adjourn

NOTICE: Persons with disabilities who plan to attend this meeting and who may need auxiliary aids or services are requested to contact Irene Reyes at least two days before this meeting so that arrangements can be made. Please also contact Irene Reyes at (512) 936-0265 if you need assistance in having English translated into Spanish.

Contact: Colleen Rowland, 1700 North Congress Avenue, Second Floor, Austin, Texas 78701, (512) 936-0178.

Filed: September 13, 1995, 8:16 a.m.

TRD-9511715

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State Board of Dental Examiners

Thursday, September 21, 1995, 1:00 p.m.

SBDE Offices, William Hobby Building, 333 Guadalupe, Tower Three, Suite 800

Austin

Settlement Conference Hearing

AGENDA:

I. Call to order

II. Discuss and consider the following complaints

A. #90-441S

B. #94-154-1215M

C. #94-176-1229M

D. #94-180-0103M

E. #94-223-0127M

F. #94-252-0218B

G. #94-331-0328R

H. #94-506-0803R

I. #94-575-0831R

J. #94-045-0930R

K. #95-091-1114R

L. #95-111-1130R

M. #95-214-0224R

N. #93-398-0426Y

III. Executive session to discuss pending contemplated litigation pursuant to Article 551.071, Texas Government Code, VTCS, 1994:

A. #90-441S

B. #94-154-1215M

C. #94-176-1229M

D. #94-180-0103M

E. #94-223-0127M

F. #94-252-0218B

G. #94-331-0328R

H. #94-506-0803R

I. #94-575-0831R

J. #94-045-0930R

K. #95-091-1114R

L. #95-111-1130R

M. #95-214-0224R

N. #93-398-0426Y

IV. Adjourn

Contact: Douglas A. Beran, Ph.D., 333 Guadalupe, Tower Three, Suite 800, Austin, Texas 78701, (512) 463-6400.

Filed: September 12, 1995, 4:22 p.m.

TRD-9511704

Friday-Saturday, September 22-23, 8:00 a.m.

SBDE, William Hobby Building, Hearing Room 100, 333 Guadalupe

Austin

Board Meeting

AGENDA:

I. Call to order

II. Roll call

III. Approval of past minutes

IV. Appearances before the board

A. Robert A. Norris, DDS, request to reinstate retired license

B. Dr. Jon Ousley, request to operate a mobile dental clinic

V. Enforcement

A. Discuss and consider approval/denial of settlement conference orders

B. Discuss and consider requests for modification to board orders: 1. Carole Ann Boyd, 2. Gary W. Ward, DDS

C. Enforcement Committee report

VI. Administration

A. Administration Committee report: 1. Discuss agency budget 2. Discuss status of vacant positions for investigators and two FTE's 3. Discuss agency space allocation plan 4. Discuss and consider approval of dental laboratory complaint form 5. Discuss and consider approval of dental laboratory registration form

B. Legislative Committee report

VII. Licensing and Examination

A. Discuss and consider approval/denial of sedation-anesthesia permits

B. Examination Committee report

C. Continuing Education report

D. Credentials Committee report

1. Discuss and consider approval/denial of applicants for licensure by credentials-dentists 2. Report on August 11 Credentials Committee meeting 3. Discuss and consider approval of dental hygiene applications forms for licensure by credentials 4. Discuss and consider approval of dental application forms for licensure by credentials

E. Dental Hygiene Advisory Committee report

VIII. Rules

A. Discuss and consider proposing amendments to Rule 102.1, fees

B. Discuss and consider adopting Rule 103.2 on an emergency basis, licensure by credentials for dental hygienists

C. Discuss and consider proposing Rule 103.2, licensure by credential for dental hygienists

D. Discuss and consider proposing amendments to Rule 101.7, licensure by credentials for dentists

E. Discuss and consider proposing continuing education rules for dentists and dental hygienists

IX. President's report

A. Appoint board liaisons to Peer Assistance Program

B. Appoint board liaisons to Dental Laboratory Certification Council

C. Discuss and consider approval of board members to attend non-scheduled meetings

D. Discuss information received from the International Academy of Oral Medicine and Toxicology regarding dental amalgams

X. Executive director's report

A. Discuss status of Health Professions Council

B. Discuss status of agency computer upgrade

C. Discuss status of voice mail system

D. Discuss budget reduction

E. Discuss consumer information brochure

F. Discuss dental laboratory booklet

G. Discuss child support update

H. Discuss Governor's Commission for Women's State Agency Council

XI. Public testimony

XII. Announcements

XIII. Adjourn

Contact: Douglas A. Beran, Ph.D., 333 Guadalupe, Tower Three, Suite 800, Austin, Texas 78701, (512) 463-6400.

Filed: September 12, 1995, 4:22 p.m.

TRD-9511706

Friday, September 22, 1995, 8:30 a.m.

SBDE Offices, 333 Guadalupe, Tower Three, Suite 800

Austin

Dental Hygiene Advisory Committee

AGENDA:

I. Call to order

II. Roll call

III. Approval of minutes from August 11, 1995 DHAC committee meeting

IV. Discuss and consider proposed rules 104.1, 104.2, 104.3, 104.4, 104.5 on continuing education for dental hygienist

V. Discuss and consider process for proposing rules and to develop criteria defining the educational qualifications for dental hygienist in Article 4545a, §2.

VI. Announcements

VII. Adjourn

Contact: Douglas A. Beren, Ph.D., 333 Guadalupe, Tower Three, Suite 800, Austin, Texas 78701, (512) 463-6400.

Filed: September 12, 1995, 4:22 p.m.

TRD-9511705

♦ ♦ ♦

Texas Education Agency

Saturday-Monday, October 28-30, 1995, 9:00 a.m. (Saturday-Sunday) and 8:00 a.m. (Monday), respectively.

IBM, 11400 Burnet Road

Austin

Science Essential Knowledge and Skills Writing and Framework Teams Meeting

AGENDA:

Welcome

Review of Connections Team meeting

Review of basic understandings in science

Consensus on basic understandings in science

Develop progress checkpoints for science at Grades 5, 8, and 12

Contact: Irene Pickhardt, 1701 North Congress Avenue, Austin, Texas (512) 463-9556.

Filed: September 13, 1995, 10:50 a.m.

TRD-9511745

♦ ♦ ♦

Fire Fighters' Pension Commission

Thursday, Friday, September 28-29, 1995, 5:00 p.m. and Noon, respectively.

The Sheraton Hotel, 500 North IH-35

Austin

Administrative Division

AGENDA:

The Senate Bill 411 Statewide Volunteer Fire Fighters' Retirement Fund Board of Trustees will meet for the purpose of hearing reports from consultant, investment managers, actuary, and CPA. Discussion and possible action on commissioner's report and plan administrator's report. Questions from Preston VFD and Attorney General Opinion Request Number #34011.

Contact: Helen Campbell, 3910 South IH-35, #235, Austin, Texas 78704, (512) 462-0222.

Filed: September 13, 1995, 4:42 p.m.

TRD-9511776

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Texas Department of Health

Saturday, September 30, 1995, 10:00 a.m.

Classroom A, Texas Department of Health Service Building, 1100 West 49th Street

Austin

Texas Radiation Advisory Board, Radioactive Waste and Industrial Committee

AGENDA:

The committee will discuss and possibly act on: Texas Regulations for Control of Radiation–Part 39 concerning irradiators; Texas Regulations for Control of Radiation–Part 36 concerning status of petition for rule change for well logging; Texas Regulations for Control of Radiation–Part 40 concerning status report on general licenses; update on low-level radioactive waste issues (waste processing; canister design; and waste container specifications); and items for discussion not requiring action.

Contact: Margaret Henderson, 1100 West 49th Street, Austin, Texas 78756, (512) 834-6688. For ADA assistance, call Richard Butler (512) 458-6410 or T.D.D. (512) 458-7708 at least two days prior to the meeting.

Filed: September 14, 1995, 9:30 a.m.

TRD-9511785

Saturday, September 30, 1995, 11:00 a.m.

Classroom A, Texas Department of Health Service Building, 1100 West 49th Street

Austin

Texas Radiation Advisory Board, Medical Committee

AGENDA:

The committee will discuss and possibly act on: status of regulation of lasers; review of medical misadministrations; health risk studies; Texas Regulations for Control of Radiation–Part 33 concerning status of petition for release of patients with temporary implants; and other items not requiring action.

Contact: Margaret Henderson, 1100 West 49th Street, Austin, Texas 78756, (512) 834-6688. For ADA assistance, call Richard Butler (512) 458-6410 or T.D.D. (512) 458-7708 at least two days prior to the meeting.

Filed: September 14, 1995, 9:30 a.m.

TRD-9511786

Saturday, September 30, 1995, 1:15 p.m.

Classroom A, Texas Department of Health Service Building, 1100 West 49th Street

Austin

Texas Radiation Advisory Board

AGENDA:

The board will discuss approval of the minutes from the previous meeting; and discuss and possibly act on: Radioactive Waste and Industrial Committee report (Texas Regulations for Control of Radiation–Part 39 concerning irradiators; Texas Regulations for Control of Radiation–Part 36 concerning status of petition for rule change for well logging; and Texas Regulations for Control of Radiation–Part 40 concerning status report on general licenses); Medical Committee report (status of regulation for lasers; review of medical misadministration; health risk studies; and Texas Regulations for Control of Radiation–Part 33 concerning status of petition for release of patients with temporary implant(s); report from chair; program reports (Texas Low-Level Radioactive Waste Disposal Authority; Texas Department of Health, Bureau of Radiation Control; Texas Natural Resource Conservation Commission; and Texas Railroad Commission); discussion not requiring board action; and next meeting date.

Contact: Margaret Henderson, 1100 West 49th Street, Austin, Texas 78756, (512) 834-6688. For ADA assistance, call Richard Butler (512) 458-6410 or T.D.D. (512) 458-7708 at least two days prior to the meeting.

Filed: September 14, 1995, 9:30 a.m.

TRD-9511784

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Department of Information Resources

Thursday, September 21, 1995, 9:00 a.m.

John H. Reagan Building, Room #101, 101 West 15th Street

Austin

Board

AGENDA:

1. Adoption of August meeting minutes

2. Review draft of Strategic Plan

3. Review of the Sunset Plan

4. Overview of training and education section

5. Quality Assurance Team report

6. Other business

7. Executive session to review personnel issues

Contact: Yvonne Montgomery, 300 West 15th Street, Suite 1300, Austin, Texas 78701, (512) 475-1715.

Filed: September 13, 1995, 11:54 a.m.

TRD-9511749

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Texas State Board of Medical Examiners

Wednesday, September 13, 1995, 4:30 p.m.

1812 Centre Creek Drive, Suite 300

Austin

Emergency Agenda

Disciplinary Panel

AGENDA:

1. Call to order

2. Roll call

3. Consideration of the application for temporary suspension of the license of Robert N. Berezoski, Jr., M.D., License E-0812.

4. Adjourn

Executive session under the authority of the Open Meetings Act, §551.071 of the Government Code, and Article 4495b, §2.07(b), §2.09(o), Texas Civil Statutes, to consult with counsel regarding pending or contemplated litigation.

Reason for emergency: Information has been received by the agency and requires prompt consideration.

Contact: Pat Wood, P.O. Box 149134, Austin, Texas 78714-9134, (512) 834-7728, Ext. 402.

Filed: September 13, 1995, 8:15 a.m.

TRD-9511714

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Texas Natural Resource Conservation Commission

Wednesday, September 20, 1995, 9:30 a.m.

12118 North Interstate 35, Building E, Room 201S

Austin

AGENDA:

Addendum to agenda to consider modifications to agreed order regarding Simpson Pasadena Paper Company, authorizing changes in emissions of sulfur dioxide.

Contact: Doug Kitts, 12100 Park 35 Circle, Austin, Texas 78753, (512) 239-3317.

Filed: September 12, 1995, 4:05 p.m.

TRD-9511702

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Texas Board of Nursing Facility Administrators

Friday, September 22, 1995, 10:00 a.m.

Room N-218, The Exchange Building, 8407 Wall Street

Austin

AGENDA:

The board will discuss and possibly act on election of officers.

Contact: Bobby Schmidt, 1100 West 49th Street, Austin, Texas 78756, (512) 834-6628. For ADA assistance, contact Richard Butler at (512) 458-6410 or T.D.D. at (512) 458-7708 at least two days prior to the meeting.

Filed: September 14, 1995, 9:31 a.m.

TRD-9511787

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Texas Optometry Board

Thursday-Friday, September 21-22, 1995, 9:30 a.m. and 8:30 a.m. respectively.

Driskill Hotel, 604 Brazos Street

Austin

AGENDA:

Consider reports of secretary-treasurer, legal counsel, executive director, committee chairpersons; consider matters involving FTC news release on contact lenses, Health Professions Council, correspondence regarding interpretation of Act, clarification of Rule 279.1 (fully written contact lens prescription), alternative to satisfying requirement for connecting door prohibition under §5.15, proposed meeting dates, general mailing to licensees, child support collection law, proposed rules clarifying language to National Board Rule 271. 6 administration of Jurisprudence Examination, diagnostic drug use and definition of "surgery" respectively; public comment time certain of 10:00 a.m. , with scheduled appearances of suspended licensee and candidate for licensure; executive session to be held in compliance with §551.071 of the Government Code to discuss contemplated and pending litigation with board attorney regarding matters sent to Attorney General; consideration and possible vote on matters discussed in executive session.

Contact: Lois Ewald, 333 Guadalupe, Suite 2-420, Austin, Texas 78701-3942.

Filed: September 12, 1995, 1:52 p.m.

TRD-9511690

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State Pension Review Board

Monday, September 25, 1995, 10:30 a.m.

300 West 15th Street, Clements Building, Fourth Floor, Room 406

Austin

AGENDA:

1. Meeting called to order

2. Welcome to new board members

3. Roll call

4. Recognition of former members

5. Reading and adoption of minutes of previous meeting

6. Special Committee on Derivatives: Consideration of final report

7. Chairman's report

8. Executive director's report

9. Committee reports

A. PRB Legislative Committee: Session wrap-up

B. Other committees

10. Compliance update: Ginger Smith

11. Discussion and possible action on old business: Update on electronic database/Kevin Deiters

12. Announcements and invitation for audience participation

13. Adjournment-Announce schedule of board meetings

Contact: Lynda Baker, P.O. Box 13498, Austin, Texas 78711, (512) 463-1736.

Filed: September 13, 1995, 9:03 a.m.

TRD-9511723

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Texas Public Finance Authority

Wednesday, September 20, 1995, 10:00 a.m.

300 West 15th Street, Committee Room 5, Fifth Floor

Austin

Board Meeting

AGENDA:

1. Call to order.

2. Approval of minutes of the August 16, 1995 board meeting.

3. Consideration of a request for financing from the Texas Department of Mental Health and Mental Retardation for $29,053,000 General Obligation Bonds and select method of sale.

4. Consideration of request for financing from the General Service Commission for a revenue bond issue of approximately $46,000,000 to finance construction of the Robert E. Johnson Building and select method of sale.

5. Consideration of request for financing from the Texas Youth Commission for $5,894,000 General Obligation Bonds and select method of sale.

6. Report on the structuring of the escrow for the Texas State Technical College defeasance and approve escrow agreement.

7. Consideration and contract for services related to risk management.

8. Consideration of extension of contract for human resources management and training.

9. Ratification of the Bond Review Board contract.

Persons with disabilities, who have special communication or other needs, who are planning to attend the meeting should contact Jeanine Barron or Patricia Logan at (512) 463-5544. Requests should be made as far in advance as possible.

Contact: Jeanine Barron, 300 West 15th Street, Suite 411, Austin, Texas 78701, (512) 463-5544.

Filed: September 12, 1995, 10:33 a.m.

TRD-9511668

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Texas Real Estate Research Center

Friday, September 22, 1995, 2:00 p.m.

Bayfront Plaza Convention Center, 1901 North Shoreline

Corpus Christi

Advisory Committee

AGENDA:

1) Opening remarks

2) Approval of minutes

3) Current budget report

4) Report on 1995-1996 plan of work

5) Election of officers

6) Other business

7) Adjournment

Contact: R. Malcolm Richards, Texas A&M University, College Station, Texas 77843-2115, (409) 845-9691.

Filed: September 13, 1995, 8:15 a.m.

TRD-9511713

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Sunset Advisory Commission

Wednesday, September 20, 1995, 10:00 a.m.

1400 North Congress Avenue, Room E1.030, Capitol Extension

Austin

AGENDA:

Wednesday, September 20, 1995-Call to order, discussion and possible action on position of executive director of the commission. The commission may meet in closed executive session to discuss agency personnel issues pursuant to §551.074 of the Texas Government Code. Discussion of proposed review schedule. Discussion of proposed meeting date schedule. Review of the Sunset Advisory Commission across-the-board recommendations. Approval of the operating budget. Other business. Selection of next meeting date. Adjourn.

Contact: Susan Kinney, 1400 North Congress, Room E2.002, Austin, Texas 78701, (512) 463-1300.

Filed: September 12, 1995, 10:33 a.m.

TRD-9511667

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Texas State Technical College System

Friday, September 22, 1995, 1:00 p.m.

TSTC Sweetwater Campus, Lance Sears Building, Conference Room

Sweetwater

Board of Regents

AGENDA:

Discussion and review of the following TSTC Policy Committee minute orders and reports:

Committee of the Whole-1:00 p.m.

Policy Committee for Instruction and Student Services-1:45 p.m.

Policy Committee for Human Resources and Development-2:30 p.m.

Policy Committee for Facilities-3:15 p.m.

Policy Committee for Fiscal Affairs-4:00 p.m.

Committee of the Whole-4:45 p.m.

Contact: Sandra J. Krumnow, 3801 Campus Drive, Waco, Texas 78705, (817) 867-4890.

Filed: September 13, 1995, 10:55 p.m.

TRD-9511746

Saturday, September 23, 1995, 9:00 a.m.

TSTC Sweetwater Campus, Lance Sears Building, Conference Room

Sweetwater

Board of Regents

AGENDA:

The Board of Regents will discuss and act on the following minute orders:

Ratification of Executive Committee's action of August 21, 1995-Delcaration of north residue of TSTC Amarillo properties as surplus and authorizing the disposition and sale, classes meeting less with than ten students, academic freedom and responsibility policy, minute orders to be rescinded, South Texas Community College agreement for services, First International Conference on Alternative Aviation Fuels, declaration of Building 17-11, 17-14, and 19-6 as not needed for educational and training purposes at TSTC Waco, extension of license agreement between the City of Marshall and TSTC East Texas Center, requests for budget change, renewal of lease agreement for golf course at TSTC Waco, addendum to contract with Bobbie Moss, lease agreement with Chrysler Technologies Airborne System (CTAS), sale of excess property at TSTC Waco, ratification of Executive Committee's action August 21, 1995-Approval of general contractor selected for construction of the Student Health and Recreation Center at TSTC Sweetwater, Texas Utilities Electric Easement for CTAS Hangar at TSTC Waco, demolition and removal or sale of Building 17-11, 17-14, and 19-6 at TSTC Waco, plans to tie-in the sewer system of the City of Waco by TSTC System, amendment to the 1994 Campus master plan for TSTC Waco, resolution of appreciation for Odelia M. Reyna McEachern and Bruce Cloud, policy prohibiting workplace violence, changes in Foundation operating plan.

Contact: Sandra J. Krumnow, 3801 Campus Drive, Waco, Texas 76705, (817) 867-4890.

Filed: September 13, 1995, 10:55 a.m.

TRD-9511747

Saturday, September 23, 1995, 9:15 a.m.

TSTC Sweetwater Campus, Lance Sears Building, Conference Room

Sweetwater

Board of Regents Executive Session

AGENDA:

Following Item VIII of the agenda and shown as Item X the Board of Regents will go into executive session in accordance with Chapter 551 of the Texas Government Code for the specific purpose provide in §551.074 and §551.075 and will discuss the following:

Contact: Sandra J. Krumnow, 3801 Campus Drive, Waco, Texas 76705, (817) 867-4890.

Filed: September 13, 1995, 10:55 p.m.

TRD-9511748

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University of Houston

Monday, September 18, 1995, 2:00 p.m.

SRII Building, Room 201, University of Houston, 4800 Calhoun Boulevard

Houston

Animal Care Committee

AGENDA:

To discuss and/or act upon the following:

Approval of August minutes

Renewal protocols

Committee member replacement

Contact: Rosemary Grimmet, 4800 Calhoun Boulevard, Houston, Texas 77204, (713) 743-9222.

Filed: September 12, 1995, 1:47 p.m.

TRD-9511684

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University of Houston System

Monday, September 18, 1995, 8:30 a.m.

Conference Room One, 1600 Smith, Suite 3400, UH System Offices

Houston

Asset Management Committee

AGENDA:

To discuss and/or approve the following: Endowment manager performance report by Fayez, Sarofim and Company; endowment performance report; non-endowed investment report; and endowment asset allocation analysis.

Contact: Peggy Cervenka, 1600 Smith, Suite 3400, Houston, Texas 77002, (713) 754-7440.

Filed: September 12, 1995, 3:01 p.m.

TRD-9511698

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Texas Board of Veterinary Medical Examiners

Thursday, September 28, 1995, 1:30 p.m.

333 Guadalupe, Room 2-330, William P. Hobby Building

Austin

Examination Review Committee

AGENDA:

The committee will meet to review the September examination results. The committee will convene in open session and then go into executive session in accordance with AG Opinions H-484, 1974 and JM 640, 1987.

Contact: Ron Allen, 333 Guadalupe, Suite 2-330, Austin, Texas 78701, (512) 305-7555.

Filed: September 13, 1995, 10:32 a.m.

TRD-9511744

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Texas Water Development Board

Wednesday, September 20, 1995, 3:00 p.m.

Stephen F. Austin Building, Room 513F, 1700 North Congress Avenue

Austin

Finance Committee

AGENDA:

1. Consider approval of the minutes of the meeting of July 19, 1995.

2. Consider a grant/loan to Starr County Water Control and Improvement District Number 2 (Starr County) for the design and construction and wastewater improvements to the existing system. (Economically Distressed Areas Account, Texas Water Development Fund.)

3. Briefing and discussion on the status of unsolicited proposals received from January 1, 1995 through August 31, 1995 for financial products and transactions.

4. Briefing on present and future EDAP projects.

5. Cash and securities management report.

6. Report on the status of approved contracts.

7. May consider items on the agenda of the September 21, 1995 board meeting.

Contact: Craig D. Pedersen, P.O. Box 13231, Austin, Texas 78711, (512) 463-7847.

Filed: September 12, 1995, 1:52 p.m.

TRD-9511689

Wednesday, September 20, 1995, 4:00 p.m.

Stephen F. Austin Building, Room 513-F, 1700 North Congress Avenue

Austin

Audit Committee

AGENDA:

1. Consider approve of the minutes of the meeting of July 19, 1995.

2. Briefing on activities related to agency cost-savings and efficiency initiatives.

3. Consider approval of the report of single audit findings and actions taken for fiscal year 1995.

4. Briefing on audit activities of the Development Fund Audit Section.

5. Briefing on general accounting items.

6. Briefing on current audit activities of the internal auditor.

7. Consider approval of the audit plan for fiscal year 1996.

8. May discuss items on the agenda of the September 21, 1995 board meeting.

Contact: Craig D. Pedersen, P.O. Box 13231, Austin, Texas 78711, (512) 463-7847.

Filed: September 12, 1995, 1:51 p.m.

TRD-9511688

Thursday, September 21, 1995, 9:00 a.m.

Stephen F. Austin Building, Room 118, 1700 North Congress Avenue

Austin

AGENDA:

The board will consider: minutes; executive, financial and committee reports; financial assistance for Italy, San Jacinto River Authority, Crockett, East Cedar Creek Fresh Water Supply District, Dove Meadows Municipal Utility District, Texas City, Guadalupe-Blanco River Authority/City of Lockhart, South Franklin Water Supply Corporation, Trinity Bay Conservation District, Orange Grove, San Patricio County, Cameron County, Webb County, and Weslaco; fiscal year 1996 intended use plan; research contracts and transfer of funds; amendments to Chapters 355, 363, and 375; procedures for Capital Improvement Plan loans; executive session to consider appointments to Lower Neches Valley Au-

thority board of directors and actions relating to the executive administrator's salary.

Contact: Craig D. Pedersen, P.O. Box 13231, Austin, Texas 78711, (512) 463-7847.

Filed: September 13, 1995, 2:58 p.m.

TRD-9511759

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Regional Meetings

Meetings Filed September 12, 1995

The Bandera County Appraisal District Appraisal Review Board will meet at the Bandera County Appraisal District, 1116 Main Street, Bandera, September 21, 1995, at 9:00 a.m. Information may be obtained from P. H. Coates, IV, P.O. Box 1119, Bandera, Texas 78003, (210) 796-3039, Fax: (210) 796-3672. TRD-9511691.

The Deep East Texas Council of Governments Grants Application Review Committee will meet at the Woodville Inn, 201 North Magnolia, Woodville, September 28, 1995, at 11:00 a.m. Information may be obtained from Rusty Phillips, 274 East Lamar Street, Jasper, Texas 75751, (409) 384-5704. TRD-9511678.

The Gulf Bend Center Board of Trustees will meet at 1502 East Airline, Victoria, September 19, 1995, at Noon. Information may be obtained from Agnes Moeller, 1502 East Airline, Victoria, Texas 77901, (512) 575-0611. TRD-9511703.

The Houston-Galveston Area Council Board of Directors will meet at 3555 Timmons Lane, Conference Room A, Second Floor, Houston, September 19, 1995, at 10:00 a.m. Information may be obtained from Cynthia Marquez, P.O. Box 22777, Houston, Texas 77227, (713) 627-3200. TRD-9511582.

The Hunt County Appraisal District Appraisal Review Board will meet at 4801 King Street, Greenville, October 12, 1995, at 9:30 a.m. Information may be obtained from Shirley Gregory, P.O. Box 1339, Greenville, Texas 75403, (903) 454-3510. TRD-9511683.

The Palo Pinto Appraisal District Board of Directors will meet at the Court House, Highway 180, Palo Pinto, September 20, 1995, at 3:00 p.m. Information may be obtained from Carol Holmes, P.O. Box 250, Palo Pinto, Texas 76484-0250, (817) 659-1281. TRD-9511700.

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Meetings Filed September 13, 1995

The Callahan County Appraisal District Board of Directors (Budget Hearing) met at 130-A West Fourth Street, Baird, September 18, 1995, at 7:30 p.m. Information may be obtained from Jane Ringhoffer, P.O. Box 806, Baird, Texas 79504, (915) 854-1165. TRD-9511740.

The Cash Water Supply Corporation Board of Directors met at the Corporation Office, FM 1564 at Highway 34, Greenville, September 18, 1995, at 7:00 p.m. Information may be obtained from Eddy M. Daniel, P.O. Box 8129, Greenville, Texas 75404-8129, (903) 883-2695. TRD-9511758.

The Education Service Center, Region XIII Board of Directors met at 5701 Springdale Road, Room H, Austin, September 18, 1995, at 12:30 p.m. Information may be obtained from Dr. Roy C. Benavides, 5701 Springdale Road, Austin, Texas 78723, (512) 929-1300. TRD-9511709.

The Guadalupe-Blanco River Authority (Revised Agenda.) Legal Committee will meet at 933 East Court Street, Seguin, September 19, 1995, at 9: 30 a.m. Information may be obtained from W. E. West, Jr., P.O. Box 271, Seguin, Texas 78156-0271, (210) 379-5822. TRD-9511767.

The Guadalupe-Blanco River Authority (Revised Agenda.) Policy Committee will meet at 933 East Court Street, Seguin, September 19, 1995, at 1: 00 p.m. Information may be obtained from W. E. West, Jr., P.O. Box 271, Seguin, Texas 78156-0271, (210) 379-5822. TRD-9511768.

The Guadalupe-Blanco River Authority (Revised Agenda.) Audit Committee will meet at 933 East Court Street, Seguin, September 19, 1995, at 2: 30 p.m. Information may be obtained from W. E. West, Jr., P.O. Box 271, Seguin, Texas 78156-0271, (210) 379-5822. TRD-9511769.

The Guadalupe-Blanco River Authority (Revised Agenda.) Retirement and Benefit Committee will meet at 933 East Court Street, Seguin, September 19, 1995, at 3:30 p.m. Information may be obtained from W. E. West, Jr., P.O. Box 271, Seguin, Texas 78156-0271, (210) 379-5822. TRD-9511770.

The Guadalupe-Blanco River Authority (Revised Agenda.) Board of Directors will meet at 933 East Court Street, Seguin, September 20, 1995, at 10:00 a.m. Information may be obtained from W. E. West, Jr., P.O. Box 271, Seguin, Texas 78156-0271, (210) 379-5822. TRD-9511771.

The Lower Neches Valley Authority Board of Directors will meet at 7850 Eastex Freeway, Beaumont, September 19, 1995, at 10:30 a.m. Information may be obtained from Robert Harris, P.O. Drawer 3464, Beaumont, Texas 77704, (409) 892-4011. TRD-9511773.

The Lubbock Regional MHMR Center Board of Trustees-Resource Committee met at 1602 Tenth Street, Board Room, Lubbock, September 18, 1995, at 5:00 p.m. Information may be obtained from Gene Menefee, P.O. Box 2828, Lubbock, Texas 79408, (806) 766-0202. TRD-9511772.

The Municipal Asset Pool Board of Director will meet at the Riverway Bank, Five Riverway, Board Room, Second Room, Houston, September 20, 1995, at 8:00 a.m. Information may be obtained from Debra J. Hall, P.O. Box 56572, Houston, Texas 77256, (713) 552-2642. TRD-9511743.

The Nortex Regional Planning Commission North Texas Private Industry Council will meet at 4309 Jacksboro Highway, Suite 200, Wichita Falls, September 27, 1995, at 12:15 p.m. Information may be obtained from Kelly Couch, 3917 Texas, Vernon, Texas 76384, (817) 322-5281. TRD-9511710.

The Toledo Bend Project Joint Operating Board will meet at the Texas Damsite Office, Route 1, Box 270, Burkeville, September 25, 1995, at 10: 30 a.m. Information may be obtained from Sam F. Collins, P.O. Box 579, Orange, Texas 77630, (409) 746-3200. TRD-9511765.

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Meetings Filed September 14, 1995

The Alamo Area Council of Governments Management Committee will meet at 118 Broadway, Suite 400, San Antonio, September 19, 1995, at 10:00 a.m. Information may be obtained from Al J. Notzon III, 118 Broadway, Suite 400, San Antonio, Texas 78205, (210) 225-5201. TRD-9511782.

The Dallas Housing Authority Dallas Housing Authority Board of Commissioners will meet at 3015 Oaklawn, The Melrose Hotel, Dallas, September 21, 1995, at 8:00 a.m. Information may be obtained from Elizabeth S. Horn, 3939 North Hampton Road, Dallas, Texas 75212, (214) 951-8301. TRD-9511783.

The Education Service Center, Region VII Board of Directors will meet at 214 Highway 79 South, Henderson, September 21, 1995, at Noon. Information may be obtained from Eddie J. Little, 818 East Main Street, Kilgore, Texas 75662, (903) 984-3071. TRD-9511781.

The North Texas Municipal Water District Board of Directors will meet at the Administration Office, 505 East Brown, Wylie, September 28, 1995, at 4:00 p.m. Information may be obtained from Carl W. Riehn, P.O. Box 2408, Wylie, Texas 75098. TRD-9511788.

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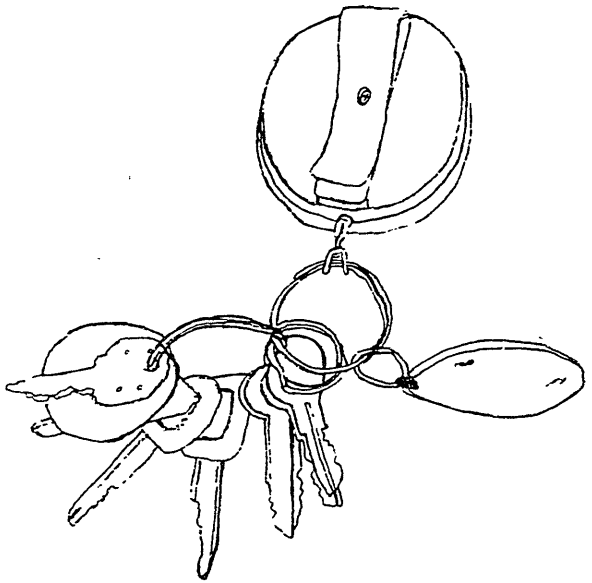
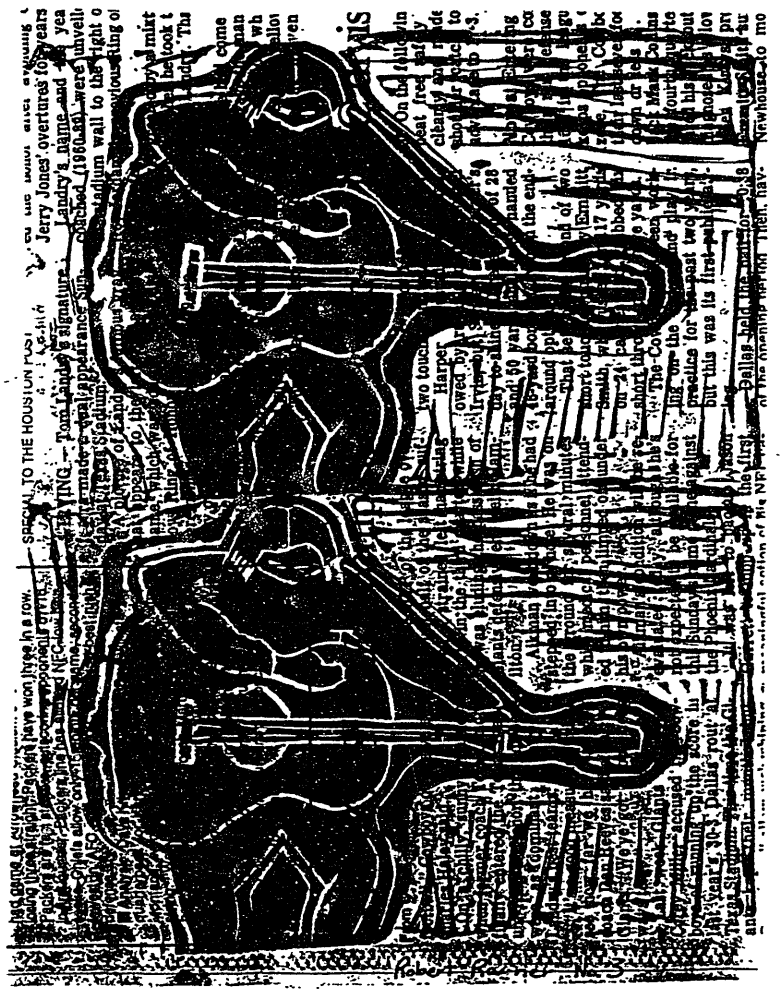


Name. Ernesto Paulino
Grade. 11
School: Corrigan/Camden High School, Corrigan/Camden ISD



Artist Name: ROBERT RAYNER
School District: CORRIGAN/CAMDEN I.S.D.
School: CORRIGAN/CAMDEN HIGH SCHOOL
Grade: 10TH
City: CORRIGAN, TX 75939

WINOLEUM BLOCK PRINT

IN ADDITION

The ***Texas Register*** is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings, changes in interest rate and applications to install remote service units, and consultant proposal requests and awards.

To aid agencies in communicating information quickly and effectively, other information of general interest to the public is published as space allows.

Texas Animal Health Commission

The Bi-National Committee Recommendations

At its regularly scheduled meeting on August 31, 1995, the Texas Animal Health Commission adopted the recommendations of the Bi-National Committee concurring that the Mexican states of Chihuahua, Coahuila, Nuevo Leon, Sonora, and Tamaluipas have implemented the Control/Preparatory Phase (Stage I) of the Mexican Tuberculosis Eradication Program. The Commission also adopted the Bi-National Committee recommendation to grant the Mexican states of Durango, San Luis Potosi, and Zacatecas provisional Stage I approval with follow-up review by the Bi-National Committee early in 1996. The Commission will grant other Mexican states that applied for Stage I approval prior to September 1, 1995, temporary approval until the next regularly scheduled Commission meeting if they are recommended for approval by the Bi-National Committee.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511617 Terry Beals, DVM
Executive Director
Texas Animal Health Commission

Filed. September 11, 1995

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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 Title 79, Texas Civil Statutes, Article 1.04, as amended (Texas Civil Statutes, Article 5069-1. 04).

Types of Rate Ceilings	Effective Period (Dates are Inclusive)	Consumer (1)/Agricultural/ Commercial (2) thru $250,000	Commercial(2) over $250,000
Indicated (Weekly) Rate - Art. 1.04(a)(1)	09/18/95-09/24/95	18.00%	18.00%

(1)Credit for personal, family or household use. (2)Credit for business, commercial, investment or other similar purpose.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511739 Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner

Filed: September 13, 1995

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Interagency Council on Early Childhood Intervention

Correction of Error

The Interagency Council on Early Childhood Intervention submitted a Request for Proposal. The request appeared in the September 12, 1995, issue of the *Texas Register* (20 TexReg 7221).

The following error occurred in the document that was submitted to the *Texas Register* Division.

In the Description of Service section, funding for early intervention services in Liberty, Montgomery, and Walker will provide a comprehensive array of services to approximately 119 families instead of 19 families which was published as submitted.

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Texas Education Agency
Correction of Error

The Texas Education Agency submitted an open meeting. The meeting appeared in the September 8, 1995, issue of the *Texas Register* (20 TexReg 7118) .

Two errors as published appeared in the open meeting notice for the Texas Education Agency Mathematics Writing Team-Essential Knowledge and Skills Clarification.

The notice omits the following information from the list of days, dates, and times of the meeting: "Tuesday, September 12, 1995, 9:00 a.m." Also, in the name of the group, the word "Tram" should be "Team."

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Request for Proposals Concerning Communicating with the Public about Clarification of the State Curriculum

Filing Authority. Request for Proposals (RFP) #701-95-046 is authorized under Goals 2000: Educate America Act, Public Law 103-227.

Eligible Proposers. The Texas Education Agency (TEA) is requesting proposals from private companies, individuals, colleges and universities, and regional education service centers to design and carry out a communications strategy regarding the revised state curriculum for kindergarten through Grade 12. Historically underutilized businesses (HUBs) are encouraged to submit a proposal.

Description. The purposes of this body of work are to design and carry out a communications strategy that will: inform the public and educators about the draft revised state curriculum for Texas public elementary and secondary schools and about ways to respond to the draft; analyze and report on the responses; and inform the public and educators about the adopted essential knowledge and skills.

With logistical and substantive support from other contractors and from writing teams, the TEA is coordinating clarification of the state curriculum in 14 content areas for kindergarten through Grade 12. The agency is interested in informing the public, educators, and other audiences about the clarification process, the content of the draft curriculum, and ways to review and respond to the draft curriculum. It will be the duty of the contractor to propose and carry out methods for: informing these audiences of the process; seeking responses to the draft curriculum; and reporting the results.

The selected contractor will coordinate this general communications strategy with the TEA, the teams' contractors, regional education service centers, and other relevant entities. Proposers must specify which aspects of the work will be conducted by the project manager and which aspects will be sub-contracted.

The TEA may or may not also amend this contract to include dissemination and public review of a draft revised Long-Range Plan for Technology at a later date.

Dates of Project. All services and activities related to this proposal will be conducted within specified dates. Proposers should plan for a starting date of no earlier than November 27, 1995, and an ending date of no later than September 30, 1997.

Project Amount. One contractor will be selected to receive a maximum of $217,000 during the contract period. This project is funded 100% from Goals 2000: Educate America Act, Public Law 103-227, federal funds.

Selection Criteria. Proposals will be selected based on the ability of the proposer to carry out all requirements contained in the RFP. The TEA will base its selection on, among other things, the demonstrated competence and qualifications of the proposer. The TEA reserves the right to select from the highest ranking proposals the one that addresses all requirements in the RFP.

The TEA is not obligated to execute a resulting contract, provide funds, or endorse any proposal submitted in response to this RFP. This RFP does not commit the TEA to pay any costs incurred before a contract is executed. The issuance of this RFP does not obligate the TEA to award a contract or pay any costs incurred in preparing a response.

Requesting the Proposal. A complete copy of RFP #701-95-046 may be obtained by writing the: Document Control Center, Room 6-108, Texas Education Agency, William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701, or by calling (512) 463-9304. Please refer to the RFP number in your request.

Further Information. For clarifying information about the RFP, contact Cynthia Levinson, Division of Curriculum, Assessment, and Professional Development, Texas Education Agency, (512) 463-9581.

Deadline for Receipt of Proposals. Proposals must be received in the Document Control Center of the Texas Education Agency by 5:00 p.m. (Central Standard Time), Friday, November 15, 1995, to be considered.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511720 Criss Cloudt
Associate Commissioner for Policy Planning and Research
Texas Education Agency

Filed: September 13, 1995

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Request for Proposals Concerning Texas Permanent School Fund Independent Audit and Other Accounting Services

Request for Proposals (RFP) #701-96-003 is authorized by the Texas Education Code, §43.006, as amended by §74.

Eligible Proposers. The State Board of Education is requesting proposals from qualified independent accounting firms to perform a financial audit of the Texas Permanent School Fund.

Description. The project requires that the proposer examine the fund's internal accounting and control systems, determine that the fund has complied with generally accepted accounting principles except where prescribed by statute, and perform other accounting or management services as requested.

Dates of Contract. All services related to this proposal will be conducted between November 13, 1995, and December 22, 1995, but the dates may be changed by the State Board of Education if deemed necessary.

Contract Amount. One accounting firm will be selected to perform the audit. The contract amount will be based on the proposal submitted by the selected accounting firm and which reflects a fair and reasonable price.

Selection Criteria. Proposals will be selected based on the ability of each proposer to carry out all requirements contained in the RFP. The State Board of Education will base its selection on, among other things, the demonstrated competence and qualifications of the proposer and on the reasonableness of the fee. The State Board of Education reserves the right to select from the highest ranking proposals those that address all requirements in the RFP.

The State Board of Education is not obligated to execute a resulting contract, provide funds, or endorse any proposal submitted in response to this RFP. This RFP does not commit the State Board of Education to pay any costs incurred before a contract is executed. The issuance of this RFP does not obligate the State Board of Education to award a contract or pay any costs incurred in preparing a response.

Requesting the Proposal. A complete copy of RFP #701-96-003 may be obtained by writing the Document Control Center, Room 6-108, Texas Education Agency, William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701, or by calling (512) 463-9304. Please refer to the RFP number in your request.

Further Information. For clarifying information about the RFP, contact Carlos Resendez, Executive Administrator, Texas Permanent School Fund, (512) 463-9169.

Deadline for Receipt of Proposals. Proposals must be received in the Document Control Center of the Texas Education Agency by 5:00 p.m. Central Daylight Savings Time, Monday, October 16, 1995.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511721 Criss Cloudt
Associate Commissioner for Policy Planning and Research
Texas Education Agency

Filed: September 13, 1995

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Texas Department of Health

Correction of Errors

The Texas Department of Health adopted amendments to §289.116 and §289. 122. The rules appeared in the August 25, 1995, issue of the *Texas Register* (20 TexReg 6656).

Due to an oversight on the department's part, the following errors need to be corrected.

On page 6656, the adoption preamble stated that "289.112 adopts by reference...", the correct site should be 289.122.

On page 6659, in a response to a comment, there is a reference made to §289.112 which is incorrect. The correct site should be §289.122.

On page 6664, a reference was made to the name of a commenter as being "Surgical Associates in Euless, Texas; Mobile Health, Inc." when the correct names should be the "Surgical Associates in Euless; Texas Mobile Health, Inc. in Houston."

On page 6666, subsection (c)(1) and (2) there are references to §289.112 of this title. The correct site should be §289.122.

On page 6670, subsection (e), the sentence "Except for paragraph (1)(I)(ii) and (iii) of this subsection, these requirements are effective October 1, 1995. " should be deleted.

On page 6670, subsection (e)(1)(F) language was left out at the end of the sentence and should read: ...specifications shall be within +\- 5.0% of the indicated kVp." The reference line to subparagraph (G) Figure 2: 25 TAC... should be separate from the language in subparagraph (F).

On page 6670, subsection (e)(1)(H), the fifth line of the subparagraph reads "shall be >/-kVp/100..." The statement should read "shall be kVp/100..."

on Page 6670, subsection (e)(1)(K), third line of the subparagraph reads "if one or more large areas +\- 1 square centimeter)..." The sentence should be "if one or more large areas > 1 square centimeter)..."

On page 6671, subsection (f)(6), the seventh line of the paragraph reads "applicable; (7); (8)-(13);..." and the tenth line of the paragraph reads "(n) (1)(B)-(F), and (G);..." The correct sites should be "applicable; (7)-(13);... " and "(n)(1)(B)-(G);..."

On page 6672, subsection (i)(2), add following sentence after first sentence in (i)(2): "Registrants utilizing relief interpreting physicians or technologists from a temporary service do not need to notify the agency unless these personnel will be at the facility for a period exceeding four weeks."

On page 6673, subsection (o)(1)(A)(IV), add the word "and" after "lactating; "

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The Texas Department of Health adopted new §289.251. The rule appeared in the August 22, 1995, issue of the *Texas Register* (20 TexReg 6435).

Due to errors in the department's submission, the following corrections are necessary.

In the adoption preamble, second paragraph, there is a reference to §189. 128, which should be §289.128.

On page 6440, subsection (f)(4), the reference to 12.1001 is incorrect and should be 21.1001.

On page 6440, subsection (g)(1)(A), the last sentence of the subparagraph has an incorrect site. The sentence reads "The general license in this subparagraph (A) of this paragraph does not authorize..." The sentence should read "The general license in this subparagraph does not authorize..."

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The Texas Department of Health adopted new §289.254. The rule appeared in the August 22, 1995, issue of the *Texas Register* (20 TexReg 6446).

Due to errors in the department's submission, the following corrections are necessary.

On page 6447, §289.254(b)(14), definition of reconnaissance level information, needs clarification. Where it reads

"...such as the Railroad Commission of Texas, the Texas Department of Water Resources,..." The definition should read "...such as the Railroad Commission of Texas, and the Texas Natural Resource Conservation Commission..."

On page 6453, §289.254(t)(2) instead of reading "No new site shall be located in a 100-year floodplain as designated by the Texas Natural Resource Conservation Commission or wetland", it should read "No new site shall be located in a 100-year floodplain as designated by the TNRCC or wetland."

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The Texas Department of Health adopted new §289.252. The rule appeared in the August 22, 1995, issue of the *Texas Register* (20 TexReg 6411).

Due to errors in the department's submission, the following corrections are necessary.

On page 6415, subsection (f)(3)(C), the word "milliroengtens" is misspelled and should be "milliroentgens."

On page 6418, subsection (h)(4)(C), 15th line, words were omitted and the sentence should read, "...mechanism and indicator, or remove the device from installation..."

On page 6425, subsection (r)(3)(B), 7th line, words were omitted and the sentence should read, "...in accordance with other requirements of this chapter may be submitted to fulfill..."

On page 6433, subsection (w)(5)(B)(iii), the parenthetical phrases concerning the effective date of the rule should be replaced with actual dates. The sentence should read, "...initiated before October 1, 1995 and completed by October 1, 1997 will be accepted..."

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Texas Department of Housing and Community Affairs

Public Notice

The Texas Department of Housing and Community Affairs announces that its annual Performance and Evaluation Report for Fiscal Year 1994 State Community Development Block Grant Program is available for review at the Texas Community Development Program, 811 Barton Springs Road, Suite 700, Austin, Texas, during regular business hours. The report includes the department's use of Community Development Block Grant funds for the year ending June 30, 1995; the nature of and reasons for changes in the program's objectives; indications of how the department would change its programs as a result of its experiences; and an evaluation of the extent to which its funds were used for activities that benefited low and moderate income persons.

Written comments may be submitted through September 29, 1995, to Ruth Cedillo, Director, Texas Community Development Program, Texas Department of Housing and Community Affairs, P.O. Box 13941, Austin, Texas 78711-3941.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511692 Larry Paul Manley
Executive Director
Texas Department of Housing and Community Affairs

Filed: September 12, 1995

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Texas Department of Human Services

Public Notice–Availability of Intended Use Report

The Texas Department of Human Services has published a report outlining the intended use of federal block grant funds during fiscal year 1996 for Title XX social services programs administered by the Texas Department of Human Services, the Texas Department of Health, and the Texas Department of Protective and Regulatory Services. The report describes services funded through this federal source and includes a distribution-of-funds section which provides financial information on the allocation of funds to all social services. On July 4, 1995, the proposed Intended Use Report was made available to the public for review and comment. No comments were received. TDHS received and responded to requests for the report.

To obtain free copies of the report: Send a written request to Nancy Murphy, Section Manager, Media and Policy Services, Mail Code E-205, Texas Department of Human Services, P.O. Box 149030, Austin, Texas 78714-9030. For further information, please call (512) 438-3765.

Issued in Austin, Texas, on September 12, 1995.

TRD-9511701 Nancy Murphy
Section Manager, Media and Policy Services
Texas Department of Human Services

Filed: September 12, 1995

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Texas Department of Insurance

Insurer Services

The following applications have been filed with the Texas Department of Insurance and are under consideration:

Application for admission in Texas for The Hanover National Insurance Company, a foreign fire and casualty company. The home office is in Bedford, New Hampshire.

Application for a name change in Texas for Taisho Marine and Fire Insurance Company of America, a foreign fire and casualty company. The proposed new name is Mitsui Marine and Fire Insurance Company of America. The home office is in New York, New York.

Application for a name change in Texas for Guarantee Mutual Life Company, a foreign life, accident and health company. The proposed new name is Guarantee Life Insurance Company. The home office is in Omaha, Nebraska.

Application for a name reservation in Texas for Parkland Community Health Plan, Inc., A Program of Dallas County Hospital District, a domestic health maintenance organization. The home office is in Dallas, Texas.

Any objections must be filed within 20 days after this notice was filed with the Texas Department of Insurance, addressed to the attention of Cindy Thurman, 333 Guadalupe Street, M/C 305-2C, Austin, Texas 78701.

Issued in Austin, Texas on September 12, 1995.

TRD-9511707 Alicia M. Fechtel
General Counsel and Chief Clerk
Texas Department of Insurance

Filed: September 12, 1995

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Texas Natural Resource Conservation Commission

Correction of Error

The Texas Natural Resource Conservation Commission (TNRCC) proposed an amendment to §116.150. The rule appeared in the September 5, 1995, issue of the *Texas Register* (20 TexReg 6910).

The following errors were published in the proposed section.

In §116.150(a), the words "nonattainment along with the associated omission levels which designate a major stationary source or major modification" should not have been printed in bold text. Also in that subsection the words "emission increases that equal or exceed forty tons per year in moderate, serious, and severe ozone nonattainment areas" should have been bolded, but were not.

In subsection (c)(1)(B) the words "offsets as specified in subsection (a)(3) of this section no later that January 1, 2000" should have been printed in bold. Finally, in subsection (c)(1)(C) the words "equal to or greater than 40 tons per year, as well as documentation of netting calculations for these increases, shall be submitted" should also have been bolded.

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Public Utility Commission of Texas

Notice of Application to Amend Certificate of Convenience and Necessity

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on July 10, 1995, to amend a Certificate of Convenience and Necessity pursuant to the Public Utility Regulatory Act of 1995, §§1.101(a), 2.201, 2.101(e), 2.252, 2.255, 3.252, and 3.254. A summary of the application follows.

Docket Title and Number: Application of Bowie-Cass Electric Cooperative, Inc. to Amend Certificated Service Area Boundaries within Bowie and Red River Counties, Docket Number 14414 before the Public Utility Commission of Texas.

The Application: In Docket Number 14414, Bowie-Cass Electric Cooperative, Inc. requests approval of its application to revise current certificated service area boundaries within Bowie and Red River Counties.

Persons who wish to intervene in the proceeding or comment upon action sought, should contact the Public Utility Commission of Texas, at 7800 Shoal Creek Boulevard, Suite 400N, Austin, Texas 78757, or call the Public Utility Public Information Division at (512) 458-0388, or (512) 458-0221 for teletypewriter for the deaf within 15 days of this notice.

Issued in Austin, Texas, on September 11, 1995.

TRD-9511618 Paula Mueller
Secretary of the Commission
Public Utility Commission of Texas

Filed: September 11, 1995

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Railroad Commission of Texas

Correction of Error

The Railroad Commission of Texas submitted an open meeting, which was published in the August 29, 1995, issue of the *Texas Register* (20 TexReg 6759).

The Railroad Commission's submission regarding the open meeting for Friday, September 29, 1995, contained an error in the agenda: the first time slot, printed as "1:00 to 1:30" should read "1:00 to 1:10," as evidenced by the second time slot of "1:10 to 1:30." The second error is a misspelling of the contact person's name: the name, "Thomas Peru" should be "Thomas Petru."

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Invitation for Bids

The Railroad Commission of Texas, Surface Mining and Reclamation Division (herein referred to as the "commission"), is soliciting bids for the backfilling of a collapsed mine opening at the Bastrop Underground AML Project (Fiscal Year 95) site. The site is located in Bastrop County, nine miles south of Elgin, Texas off State Highway 95.

As the designated state agency for implementation of the "Surface Mining Control and Reclamation Act of 1977 "(30 United States Code, §§1201 et seq), the commission will award a unit price contract to the lowest and best bidder for completion of this work. Sealed bids will be received until 2:00 p.m., October 25, 1995, at which time the bids will be publicly opened and read at the address given below. A mandatory pre-bid conference will be held at the site at 10:00 a.m., October 4, 1995.

The project will backfill a collapsed mine opening. Construction work items will include:

1. Mobilization;

2. Earthwork;

3. Topsoil Handling;

4. Temporary Revegetation.

Copies of the specifications, drawings and other contract documents are on file in Austin at the following address. The complete bid package may be obtained from the mailing address: Bastrop Underground AML Project (Fiscal Year 95); Surface Mining and Reclamation Division; Railroad Commission of Texas; P.O. Box 12967; 1701 North Congress Ave Austin, Texas 78711-2967; Attention: Melvin B. Hodgkiss, P.E., Director. All questions concern-

ing the work or bid document must be received by 5:00 p.m., October 11, 1995.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511736 Mary Ross McDonald
Assistant Director, Legal Division, Gas Utilities/LP Gas
Railroad Commission of Texas

Filed: September 13, 1995

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Texas Water Development Board

Request for Statement of Qualifications From Engineering Consultants Colonias Wastewater Treatment Assistance Program

The Texas Water Development Board (the Board) requests the submission of Statements of Qualifications from interested ENGINEERING CONSULTANTS leading to the possible award of a contract for Fiscal Years 1995 and 1996 to prepare regional water/wastewater engineering and planning for economically distressed areas (colonias) located in Hidalgo County. Guidelines for water/wastewater planning proposals which include a detailed Scope of Engineering Work and Engineering Consultant Evaluation Criteria will be supplied by the Board and must be obtained by each prospective consultant.

Description of Planning Purpose and Objectives: The purpose of this program is for the Board to prepare, with the assistance of consulting engineers and environmental specialist, regional facility plans to address water/wastewater facility needs for selected study areas. At a minimum the engineering work effort will include documentation of water/wastewater service needs, identification, evaluation and selection of feasible regional alternatives, including innovative/alternative wastewater collection, treatment and disposal technologies to meet water/wastewater needs, estimation of costs associated with providing regional water/wastewater treatment plants and transmission and collection systems, an identification of financial alternatives to implement the recommended facility plan, and coordination with the environmental consultants for this project. Discrete phases to implement regional water/wastewater facilities will be identified. Cost estimates shall be made for each respective implementation phase to determine the capital, operation and maintenance requirements for a 20-year planning period. Separate cost estimates shall be made for each regional system component.

Proposals for engineering consultants will be evaluated according to the following criteria and relative item importance:

1. History of timeliness and overall customer satisfaction. (10%)

2. Demonstrated knowledge and work experience with design, cost estimation, construction, facility start-up, operation and maintenance of conventional wastewater treatment technologies. (40%)

3. Demonstrated knowledge and work experience with design, cost estimation, construction, facility start-up, operation and maintenance of innovation alternative wastewater treatment technologies for small-scale and/or individual on-site applications. (40%)

4. Demonstrated knowledge and work experience with facility planning requirements of the Economic Distressed Areas Program (EDAP), State of Texas wastewater treatment facilities regulatory approval processes. (10%)

Description of Funding Consideration.

Under the terms of the Grant Agreement with the Environmental Protection Agency which provides funds for the study and in accordance with 42 USC Section 4370D, the State of Texas must insure to the fullest extent possible that at least 8.0% of the federal funds for prime contractors or subcontracts for supplies, construction, or services is made available to organizations owned or controlled by socially and economically disadvantaged individuals, women, and historically black colleges and universities. Prospective consultants intending to use subcontractors but unable to meet the 8.0% goal will be required to establish a good faith effort to reach this goal.

It is the intention of the Board to mail copies of this Request for Statement of Qualifications to consultants including those in Cameron and Hidalgo counties, and that 10% of the copies mailed be to disadvantaged businesses in compliance with Texas Civil Statutes, §3.10(b) and §5.36 (Vernons Supplement 1993); Texas Government Code, §§481.101 et seq (Vernons Supplement 1993); and Executive Order of the Governor of the State of Texas, AWR 93-7, March 23, 1993.

Pre-submittal meeting. There will be a pre-submittal meeting at 11:00 a.m. on October 2, 1995, in room 513F, Stephen F. Austin Building, 1700 North Congress Avenue, Austin, Texas for the purpose of reviewing submittal requirements, scope of work and answering any questions that may be brought to the attention of the Board's staff regarding this project. All interested consultants are encouraged to attend.

Deadline for Submittal, Review Criteria and Contact Person for Additional Information. Ten double-sided copies of a completed Statement of Qualifications must be filed with the Board prior to 5:00 p.m., October 11, 1995. Statements of Qualifications can be directed either in person to Phyllis Lightner-Gaynor, Texas Water Development Board, Stephen F. Austin Building, 1700 North Congress Avenue, Austin, Texas, or by mail to Phyllis Lightner-Gaynor, Texas Water Development Board, P.O. Box 13231, Austin, Texas 78711-3231. Requests for information, the Scope of Work and the consultant evaluation criteria should be directed to Phyllis Lightner-Gaynor at the preceding address or by calling (512) 463-3154.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511742 Craig D. Pedersen
Executive Administrator
Texas Water Development Board

Filed: September 13, 1995

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Request for Statement of Qualifications From Environmental Consultants Colonias Wastewater Treatment Assistance Program

The Texas Water Development Board (the Board) requests the submission of Statements of Qualifications from interested ENVIRONMENTAL CONSULTANTS leading to the possible award of a contract for Fiscal Years 1995 and 1996 to prepare regional water/wastewater engineering and

planning for economically distressed areas (colonias) located in Hidalgo County. Guidelines for water/wastewater planning proposals which include a detailed Scope of Environmental Work and Environmental Consultant Evaluation Criteria will be supplied by the Board and must be obtained by each prospective consultant.

Description of Planning Purpose and Objectives: The purpose of this program is for the Board to prepare with the assistance of consulting engineers and environmental specialists regional facility plans to address water/wastewater facility needs for selected study areas. The environmental consultant will be responsible for the preparation of environmental information, regulatory agency coordination, public participation in conjunction with the facility plans for the study areas, and coordination of environmental work with consulting engineers for the project. The information and public participation will be prepared to comply with §375.35 of the Texas Water Development Board Rules and related guidelines.

Proposals for environmental consultants will be evaluated according to the following criteria and relative item importance:

1. Demonstrable experience with preparing documents (EID-level) pursuant to the National Environmental Policy Act (NEPA), including consultation with other agencies and public participation. Examples, including copies of the findings, shall be submitted. (30%)

2. Demonstrable experience with completed (determinations issued) EID's for the Colonias Wastewater Treatment Assistance Program. (10%)

3. Demonstrable experience with completed (determinations issued) projects under §375.35 of the TWDB Rules. (10%)

4. Demonstrable expertise of staff to conduct biological surveys/habitat assessments pursuant to the Endangered Species Act and USF&WS regulations in the project. (10%)

5. Demonstrable expertise of staff to identify and delineate wetlands pursuant to the Clean Water Act and US Army Corps of Engineers regulations in the project area. (10%)

6. Demonstrable ability to work with consulting engineers and to prepare environmental information documents on schedule. References from consulting engineers. (10%)

7. Demonstrable ability to work with consulting engineers and to prepare environmental information documents on schedule. Project schedules showing contract date and submitted date. (10%)

8. Previous environmental work in the Cameron, Hidalgo, Willacy County area. (5.0%)

9. Demonstrable Spanish speaking capability on staff assigned to project. (5.0%)

Description of Funding Consideration.

Under the terms of the Grant Agreement with the Environmental Protection Agency which provides funds for the study and in accordance with 42 USC, Section 4370D, the State of Texas must insure to the fullest extent possible that at least 8.0% of the federal funds for prime contractors or subcontracts for supplies, construction, or services is made available to organizations owned or controlled by socially and economically disadvantaged individuals, women, and historically black colleges and universities. Prospective consultants intending to use subcontractors but unable to meet the 8.0% goal will be required to establish a good faith effort to reach this goal.

It is the intention of the Board to mail copies of this Request for Statement of Quaiifications to consultants including those in Cameron and Hidalgo Counties, and that 10% of the copies mailed be to disadvantaged businesses in compliance with Texas Revised Civil Statutes 3.10(b) and 5.36 (Vernons Supplement 1993); Texas Government Code, §§481.101 et seq (Vernons Supplement 1993); and Executive Order of the Governor of the State of Texas, AWR 93-7, March 23, 1993.

Pre-submittal meeting. There will be a pre-submittal meeting at 11:00 a.m. on October 2 1995, in room 513F, Stephen F. Austin Building, 1700 North Congress Avenue, Austin, Texas, for the purpose of reviewing submittal requirements, scope of work and answering any questions that may be brought to the attention of the Board's staff regarding this project. All interested consultants are encouraged to attend.

Deadline for Submittal, Review Criteria and Contact Person for Additional Information. Ten double-sided copies of a completed Statement of Qualifications must be filed with the Board prior to 5:00 p.m., October 11, 1995. Statements of Qualifications can be directed either in person to Phyllis Lightner-Gaynor, Texas Water Development Board, Stephen F. Austin Building, 1700 North Congress Avenue, Austin, Texas or by mail to Phyllis Lightner-Gaynor, Texas Water Development Board, P.O. Box 13231, Austin, Texas, 78711-3231. Requests for information, the Scope of Work and the consultant evaluation criteria should be directed to Phyllis Lightner-Gaynor at the preceding address or by calling (512) 463-3154.

Issued in Austin, Texas, on September 13, 1995.

TRD-9511741

Craig D. Pedersen
Executive Administrator
Texas Water Development Board

Filed: September 13, 1995

PUBLICATION SCHEDULE

The following is the 1995 Publication Schedule for the Texas Register. Listed below are the deadline dates for the June-December 1995 issues of the Texas Register. Because of printing schedules, material received after the deadline for an issue cannot be published until the next issue. Generally, deadlines for a Tuesday edition of the Texas Register are Wednesday and Thursday of the week preceding publication, and deadlines for a Friday edition are Monday and Tuesday of the week of publication. No issues will be published on July 7, November 10, November 28, and December 29. An asterisk beside a publication date indicates that the deadlines have been moved because of state holidays.

FOR ISSUE PUBLISHED ON	ALL COPY EXCEPT NOTICES OF OPEN MEETINGS BY 10 A.M.	ALL NOTICES OF OPEN MEETINGS BY 10 A.M.
42 Friday, June 2	*Friday, May 26	Tuesday, May 30
43 Tuesday, June 6	Wednesday, May 31	Thursday, June 1
44 Friday, June 9	Monday, June 5	Tuesday, June 6
45 Tuesday, June 13	Wednesday, June 7	Thursday, June 8
46 Friday, June 16	Monday, June 12	Tuesday, June 13
47 Tuesday, June 20	Wednesday, June 14	Thursday, June 15
48 Friday, June 23	Monday, June 19	Tuesday, June 20
49 Tuesday, June 27	Wednesday, June 21	Thursday, June 22
50 Friday, June 30	Monday, June 26	Tuesday, June 27
51 Tuesday, July 4	Wednesday, June 28	Thursday, June 29
Friday, July 7	NO ISSUE PUBLISHED	
52 Tuesday, July 11	Wednesday, July 5	Thursday, July 6
Friday, July 14	Second Quarterly Index	
53 Tuesday, July 18	Wednesday, July 12	Thursday, July 13
54 Friday, July 21	Monday, July 17	Tuesday, July 18
55 Tuesday, July 25	Wednesday, July 19	Thursday, July 20
56 Friday, July 28	Monday, July 24	Tuesday, July 25
57 Tuesday, August 1	Wednesday, July 26	Thursday, July 27
58 Friday, August 4	Monday, July 31	Tuesday, August 1
59 Tuesday, August 8	Wednesday, August 2	Thursday, August 3
60 Friday, August 11	Monday, August 7	Tuesday, August 8
61 Tuesday, August 15	Wednesday, August 9	Thursday, August 10
62 Friday, August 18	Monday, August 14	Tuesday, August 15
63 Tuesday, August 22	Wednesday, August 16	Thursday, August 17
64 Friday, August 25	Monday, August 21	Tuesday, August 22
65 Tuesday, August 29	Wednesday, August 23	Thursday, August 24
66 Friday, September 1	Monday, August 28	Tuesday, August 29