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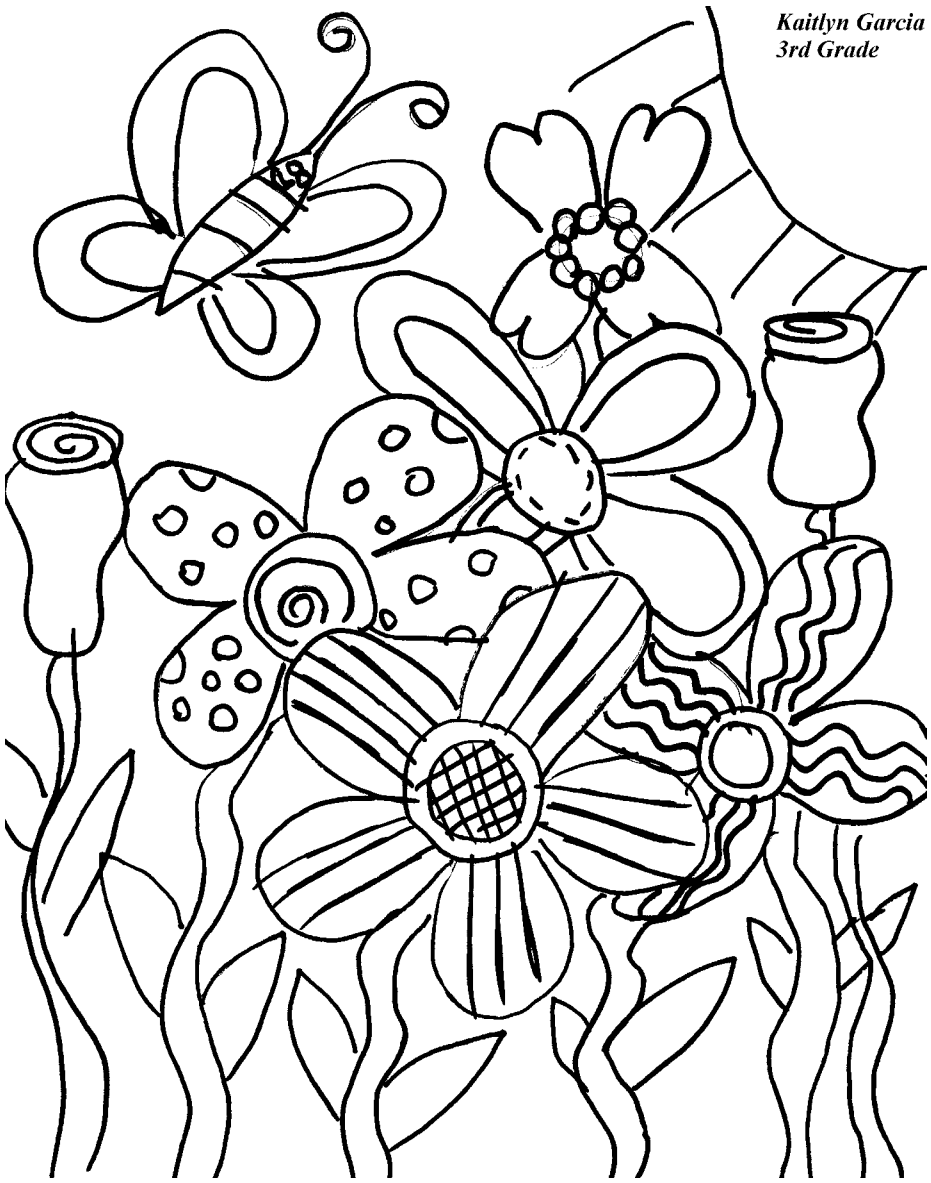

Kaitlyn Garcia
3rd Grade

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

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

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IN THIS ISSUE

THE GOVERNOR

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

Appointments

Appointments for July 6, 2012

Designating Steven Tull as presiding officer of the Texas Commission on Fire Protection for a term at the pleasure of the Governor. Mr. Tull is replacing Chief Christopher Connealy of Cedar Park as presiding officer.

Designating Matthew F. Kreisle, III as presiding officer of the Texas Historical Commission for a term at the pleasure of the Governor. Mr. Kreisle is replacing Sheri Krause of Austin as presiding officer.

Rick Perry, Governor

TRD-201203585

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

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

TITLE 16. ECONOMIC REGULATION

PART 2. PUBLIC UTILITY COMMISSION OF TEXAS

CHAPTER 26. SUBSTANTIVE RULES APPLICABLE TO TELECOMMUNICATIONS SERVICE PROVIDERS

SUBCHAPTER P. TEXAS UNIVERSAL SERVICE FUND

The Public Utility Commission of Texas (commission) proposes an amendment to §26.412, relating to the Lifeline Service Program, the repeal of the current §26.404, relating to the Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan, and new §26.404, relating to the Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan (SRILEC USP). The amendment and new rule will conform §26.404 and the amended §26.412 to Senate Bill 980 of the 82nd Legislature, Regular Session, enacted in 2011. Additionally, the amendment and new rule are proposed in compliance with §26.404(h), which requires a review of the SRILEC USP within 90 days of the Federal Communications Commission's (FCC) adoption of an order implementing new or amended federal universal service support rules for rural, insular, and high cost areas. The FCC released such an order on November 18, 2011 in WC Docket No. 05-337. Project Number 39938 is assigned to this proceeding.

New §26.404 provides for a reduction in SRILEC USP support over a four-year period that is equal to the amount of additional revenue that each telecommunications provider calculates will be generated if that telecommunications provider were to charge a reasonable rate, as determined by the commission, for basic local telecommunications service to all residential customers.

Dr. Mark Bryant, Wholesale Market Economist, Competitive Markets Division, has determined that for each year of the first five-year period the proposed sections are in effect, there will be no fiscal implications for state or local government as a result of enforcing or administering the sections.

Dr. Bryant has determined that for each year of the first five years that the sections are in effect, the public benefit anticipated as a result of enforcing the sections will be compliance with Senate Bill 980 and House Bill 2295. There will be no adverse economic effect on small businesses or micro-businesses as a result of enforcing the sections. Therefore, no regulatory flexibility analysis is required. There is no anticipated economic cost to persons who are required to comply with the sections as proposed.

Dr. Bryant has also determined that for each year of the first five years the sections are in effect, there should be no effect on local economy, and therefore no local employment impact statement is required under Administrative Procedure Act (APA), Texas Government Code §2001.022.

The commission staff will conduct a public hearing on this rulemaking if requested pursuant to the APA, Texas Government Code §2001.029, at the commission's offices located in the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701. The request for public hearing must be received by Thursday, August 9, 2012. Notice of such public hearing, if requested, will be filed with the commission under Project Number 39938.

Comments on the proposed sections may be submitted to the Filing Clerk, Public Utility Commission of Texas, 1701 North Congress Avenue, P.O. Box 13326, Austin, Texas 78711-3326, by Thursday, August 9, 2012. Reply comments may be submitted by Friday, August 24, 2012. When commenting on the proposed sections the commission is particularly interested in receiving specific, quantified estimates of how the proposed amendment and new rule or any suggested amendment or alternatives to them will impact future disbursements from the Texas Universal Service Fund, and correspondingly, quantifications of the anticipated impact of the proposed amendment and new rule or any suggested amendment or alternatives to them on customer rates. Sixteen copies of comments and reply comments on the proposed sections are required to be filed pursuant to §22.71(c) of this title. Comments and reply comments should be organized in a manner consistent with the organization of the amendment and new rule. All comments should refer to Project Number 39938.

16 TAC §26.404

(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 Public Utility Commission of Texas or in the Texas Register office, Room 245, James Earl Rudder Building, 1019 Brazos Street, Austin, Texas.)

The repeal is proposed under the Public Utility Regulatory Act, Texas Utilities Code Annotated §14.002 (West 2007 and Supp. 2011) (PURA), which provides the Public Utility Commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and specifically Senate Bill 980 of the 82nd Legislature, Regular Session and House Bill 2295 of the 82nd Legislature, Regular Session, which amended PURA §56.021.

Cross Reference to Statutes: PURA §14.002, Senate Bill 980 of the 82nd Legislature, Regular Session and House Bill 2295 of the 82nd Legislature, Regular Session, which amended PURA §56.021.

§26.404. Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan.

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

Filed with the Office of the Secretary of State on July 9, 2012.

TRD-201203521
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: August 19, 2012
For further information, please call: (512) 936-7223

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16 TAC §26.404, §26.412

The new section and amendment are proposed under the Public Utility Regulatory Act, Texas Utilities Code Annotated §14.002 (West 2007 and Supp. 2011) (PURA), which provides the Public Utility Commission with the authority to make and enforce rules reasonably required in the exercise of its powers and jurisdiction; and specifically Senate Bill 980 of the 82nd Legislature, Regular Session and House Bill 2295 of the 82nd Legislature, Regular Session, which amended PURA §56.021.

Cross Reference to Statutes: PURA §14.002, Senate Bill 980 of the 82nd Legislature, Regular Session and House Bill 2295 of the 82nd Legislature, Regular Session, which amended PURA §56.021.

§26.404. Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan.

(a) Purpose. This section establishes guidelines for financial assistance to eligible telecommunications providers (ETPs) that provide service in the study areas of small and rural ILECs in the state so that basic local telecommunications service or its equivalent may be provided at reasonable rates in a competitively neutral manner.

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

(1) Eligible line--A residential line or a single-line business line over which an ETP provides the service supported by the Small and Rural ILEC Universal Service Plan (SRILEC USP) through its own facilities, purchase of unbundled network elements (UNEs), or a combination of its own facilities and purchase of UNEs.

(2) Eligible telecommunications provider (ETP)--A telecommunications provider designated by the commission pursuant to §26.417 of this title (relating to Designation as Eligible Telecommunications Providers to Receive Texas Universal Service Funds (TUSF)).

(3) Small incumbent local exchange company--An incumbent local exchange (ILEC) that qualifies as a "small local exchange company" as defined in the Public Utility Regulatory Act (PURA), §53.304(a)(1).

(c) Application.

(1) Small or rural ILECs. This section applies to small ILECs, as defined in subsection (b) of this section, and to rural ILECs, as defined in §26.5 of this title (relating to Definitions), that have been designated ETPs.

(2) Other ETPs providing service in small or rural ILEC study areas. This section applies to telecommunications providers other than small or rural ILECs that provide service in small or rural ILEC study areas that have been designated ETPs.

(d) Service to be supported by the Small and Rural ILEC Universal Service Plan. The Small and Rural ILEC Universal Service Plan shall support the provision by ETPs of basic local telecommunications service as defined in §26.403(d) of this title (relating to Texas High Cost Universal Service Plan (THCUSP)).

(e) Criteria for determining amount of support under Small and Rural ILEC Universal Service Plan. The commission shall determine the amount of per-line support to be made available to ETPs in each eligible study area. The amount of support available to each ETP shall be calculated using the small and rural ILEC ETP base support amount and applying the annual reductions as described in this subsection.

(1) Determining base support amount available to ETPs. The initial per-line monthly base support amount for a small or rural ILEC ETP shall be the per-line monthly support amount for each small or rural ILEC ETP study area as specified in Docket Number 18516, annualized by using the small or rural ILEC ETP access line count as of January 1, 2012. The initial per-line monthly base support amount shall be reduced as described in paragraph (3) of this subsection.

(2) Determination of the reasonable rate. The reasonable rate for basic local telecommunications service shall be determined by the commission in a contested case proceeding. An increase to an existing rate shall not in any one year exceed an amount to be determined by the commission in the contested case proceeding.

(3) Annual reductions to the Small and Rural ILEC Universal Service Plan per-line support. As part of the contested case proceeding referenced in paragraph (2) of this subsection, for each small or rural ILEC ETP, the commission shall calculate the amount of additional revenue that would result if the small and rural ILEC ETP were to charge the reasonable rate for basic local telecommunications service to all residential customers. Without regard to whether a small or rural ILEC ETP increases its rates for basic local telecommunications service to the reasonable rate, the small or rural ILEC ETP's annual base support amount for each study area shall be reduced on January 1 of each year for four consecutive years, with the first reduction occurring on January 1, 2014. The small or rural ILEC ETP's annual base support amount shall be reduced by 25% of the additional revenue calculated pursuant to this paragraph in each year of the transition period. This reduction shall be accomplished by reducing support for each study area proportionally.

(f) Small and Rural ILEC Universal Service Plan support payments to ETPs. The TUSF administrator shall disburse monthly support payments to ETPs qualified to receive support pursuant to this section.

(1) Payments to small or rural ILEC ETPs. The payment to each small or rural ILEC ETP shall be computed by multiplying the per-line amount established in subsection (e) of this section by the number of eligible lines served by the small or rural ILEC ETP for the month.

(2) Payments to ETPs other than small or rural ILECs. The payment to each ETP other than a small or rural ILEC shall be computed by multiplying the per-line amount established in subsection (e) of this section for a given small or rural ILEC study area by the number of eligible lines served by the ETP in such study area for the month.

(g) Reporting requirements. An ETP eligible to receive support under this section shall report information as required by the commission and the TUSF administrator.

(1) Monthly reporting requirements. An ETP shall report the total number of eligible lines served by the ETP in its study area to the TUSF administrator on a monthly basis.

(2) Annual reporting requirements. An ETP shall confirm annually to the TUSF administrator that it is qualified to participate in the Small and Rural ILEC Universal Service Plan.

(3) Other reporting requirements. An ETP shall report any other information required by the commission or the TUSF administrator, including any information necessary to assess contributions and disbursements to the TUSF.

§26.412. Lifeline Service Program.

(a) - (e) (No change.)

(f) Lifeline support and recovery of support amounts.

(1) Lifeline discount amounts. All Lifeline providers shall provide the following Lifeline discounts to all eligible Lifeline customers:

(A) - (F) (No change.)

(G) Additional Small and Rural Incumbent Local Exchange Company Universal Service Plan (SRILEC USP) Area Discount--Beginning January 1, 2014, Lifeline providers operating in the service areas of those incumbent local exchange carriers that participate in the Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan (SRILEC USP ILEC) shall provide a reduction to Lifeline service rates equal to 25% of any actual increase by a SRILEC USP ILEC to its residential basic network service rate that occurs in a SRILEC USP ILEC's Public Utility Regulatory Act (PURA) Chapter 53 regulated exchanges and is consistent with §26.404 of this title (relating to Small and Rural Incumbent Local Exchange Company (ILEC) Universal Service Plan).

(2) (No change.)

(g) (No change.)

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

Filed with the Office of the Secretary of State on July 9, 2012.

TRD-201203522
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Earliest possible date of adoption: August 19, 2012
For further information, please call: (512) 936-7223

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PART 3. TEXAS ALCOHOLIC BEVERAGE COMMISSION

CHAPTER 31. ADMINISTRATION

16 TAC §31.1

The Texas Alcoholic Beverage Commission (commission) proposes an amendment to §31.1, relating to Separation of Duties Between Commission and Administrator to define the relationship of the office of the general counsel to the commission and the administrator.

To assure that it exercises its policy-making responsibilities in the best manner, the commission believes that the general counsel, as the attorney responsible for rendering legal advice to the commission, should report directly to the commission. At the same time, the commission recognizes that the effective implementation of the commission's policies requires the general counsel and the administrator to coordinate all of the agency's resources.

Shelby Eskew, Director of Business Services, has determined that for each year of the first five years that the proposed amendment will be in effect, there will be no fiscal impact on state or local government.

The proposed amendment will have no fiscal or regulatory impact on micro-businesses and small businesses or persons regulated by the commission. There is no anticipated negative impact on local employment.

José Cuevas, Jr., chairman, Steven M. Weinberg, MD, JD, and Melinda Fredricks, commissioners, have determined that for each year of the first five years that the proposed amendment will be in effect, the public will benefit because the agency will function more effectively.

Comments on the proposed amendment may be submitted in writing to Martin Wilson, Assistant General Counsel, Texas Alcoholic Beverage Commission, at P.O. Box 13127, Austin, Texas 78711-3127, or by facsimile transmission to (512) 206-3280. They may also be submitted electronically through the commission's public website at http://www.tabc.state.tx.us/laws/proposed_rules.asp. Comments will be accepted for 30 days following publication in the *Texas Register*.

The staff of the commission will hold a public hearing to receive oral comments on the proposed amendment on August 1, 2012 in the Commission Meeting Room on the first floor of the commission's headquarters at 5806 Mesa Drive in Austin, Texas. The public hearing will begin at 1:30 p.m. The Commission designates this public hearing as the opportunity to make oral comments if you wish to assure that the commission will respond to them formally under Government Code §2001.033. The commission's response to comments received at the public hearing will be in the preamble to the adopted amendment, if the commission chooses to adopt an amendment. Staff will not respond to comments at the public hearing. Persons with disabilities who plan to attend this hearing and who may need auxiliary aids or services (such as interpreters for persons who are deaf, hearing impaired readers, large print, or Braille) are requested to contact Gloria Darden Reed at (512) 206-3221 (voice), (512) 206-3259 (fax), or (512) 206-3270 (TDD), at least three days prior to the meeting so that appropriate arrangements can be made.

Martin Wilson, Assistant General Counsel of the Texas Alcoholic Beverage Commission, certifies that the proposed amendment has been reviewed by legal counsel and found to be within the agency's authority to adopt.

The proposed amendment is authorized by Alcoholic Beverage Code §5.12, which provides that the commission shall specify the duties and powers of the administrator by printed rules and regulations entered in its minutes and shall develop and implement policies that clearly separate the policy-making responsibilities of the commission and the management responsibilities of the administrator and the staff of the commission; by Alcoholic Beverage Code §5.34(b), which requires the commission

to develop and implement policies that clearly define the respective responsibilities of the commission and staff; and by Alcoholic Beverage Code §5.31, which grants authority to prescribe rules necessary to carry out the provisions of the Code.

The proposed amendment affects Alcoholic Beverage Code §§5.12, 5.31, and 5.34.

§31.1. Separation of Duties Between Commission and Administrator.

(a) This rule implements §5.12 [~~and §5.31~~] of the Alcoholic Beverage Code (Code), which requires the Texas Alcoholic Beverage Commission (commission) to adopt rules to clearly separate the policy-making authority of the commissioners from the management responsibilities of the administrator, and §5.34(b) of the Code, which requires the commission to develop and implement policies that clearly define the respective responsibilities of the commission and staff.

(b) The commission retains the duty and authority to:

(1) Establish agency policies and goals to carry out the duties and authority granted to the commission under the Code;

(2) Provide leadership and direction to ensure agency laws, rules, policies and goals are implemented in a responsible, effective and cost efficient manner;

(3) Ensure accountability and transparency within the agency and to the Governor, the Legislature, the public, and persons regulated;

(4) Appoint and remove the administrator;

(5) Adopt agency rules to implement statutory duties and agency policies;

(6) Employ or appoint and terminate or remove an internal auditor, adopt an audit plan, approve audit findings and ensure agency compliance with audit requirements;

(7) Exercise any authority and carry out any duty of the commission not delegated to the administrator; and[~~.~~]

(8) Employ and terminate the general counsel, who shall report directly to the commission.

(c) The commission delegates the following duties and authority to the administrator:

(1) Plan and implement an effective an efficient operational and organizational structure;

(2) Act as the agency liaison and resource to the executive and legislative branch;

(3) Prepare and submit the agency budget and appropriations requests;

(4) Employ or appoint an executive management team with the skills, knowledge and commitment necessary to achieve the goals and implement the policies adopted by the commission;

(5) Assign and delegate to each member of the executive management team and the general counsel the responsibility and authority necessary to effectively administer all agency operations, duties and functions, implement policy, and manage staff and resources, including the authority to further delegate and assign the essential duties and responsibilities of the agency to ensure the highest and best use of agency staff and resources;

(6) Develop, monitor and report measures or expectations for the administrative, regulatory and enforcement functions of the agency to ensure that the agency goals are accomplished and policies followed;

(7) Develop and implement comprehensive and agency-wide internal policies and procedures necessary to carry out each essential function, duty, policy or goal of the agency;

(8) Ensure that all agency staff has access to, knowledge of and responsibility for consistently following policies adopted by the commission and agency-wide internal policies and procedures;

(9) Administer the oath of office or commission to agency staff and agents;

(10) Render, or delegate to agency staff, the agency decision or order in any matter over which the agency has final decision-making authority.

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

Filed with the Office of the Secretary of State on July 9, 2012.

TRD-201203531
Martin Wilson
Assistant General Counsel
Texas Alcoholic Beverage Commission
Earliest possible date of adoption: August 19, 2012
For further information, please call: (512) 206-3443

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 5. PROPERTY AND CASUALTY INSURANCE

SUBCHAPTER H. CANCELLATION, DENIAL, AND NONRENEWAL OF CERTAIN PROPERTY AND CASUALTY INSURANCE COVERAGE

28 TAC §§5.7001, 5.7002, 5.7009

The Texas Department of Insurance proposes amendments to 28 TAC §§5.7001, 5.7002, and 5.7009, concerning cancellation, denial, and nonrenewal of certain property and casualty insurance coverage. These proposed amendments are necessary to clarify when an insurer may send a notice of cancellation to the insured for nonpayment of premium that satisfies the requirements of Insurance Code Chapter 551, Subchapter C. The proposed amendments are also necessary to update §§5.7001, 5.7002, and 5.7009 for consistency with Insurance Code Chapter 551, Subchapter C. Additionally, these amendments are proposed to update statutory references resulting from nonsubstantive revisions of the Insurance Code, amend existing text for clarification, correct grammar, and update internal references. As preparation for this proposal, the department made an informal posting on its website on March 30, 2012.

Amendments to §5.7001 conform the applicability provisions for consistency with Insurance Code §551.101 and §551.102. The amendment to §5.7001(a)(2) changes "homeowners or farm and ranch owners policies" to "homeowners or farm or ranch owners policies" for consistency with Insurance Code §551.102(2). Amendments to §5.7001(a)(3) add that this proposal applies to standard fire policies insuring the contents of an apartment as

provided under Insurance Code §551.102(3)(B). This proposal deletes §5.7001(a)(4) and proposes new §§5.7001(a)(4)(A) - (D) to delete outdated use of terms in §5.7001(a)(4) while moving pertinent text and rewording language for consistency with Insurance Code §551.102(4)(A) - (D).

New §5.7001(a)(4) clarifies that this proposal applies to insurance policies covering property and casualty coverage, other than a fidelity, surety, or guaranty bond, to governmental units, as provided under Insurance Code §551.102(4). New §5.7001(a)(4) also adds §5.7001(a)(4)(C)(ix) to include "a communication district" to the list of political subdivisions of this state subject to Insurance Code Chapter 551, Subchapter C, as provided under Insurance Code §551.102(4)(C)(ix).

Amendments to §5.7001 add subsection (d) to clarify the meaning of "insurer" and "company" used throughout Subchapter H for the purpose of the listed policies under subsection (a). New §5.7001(d) states that "[f]or the purpose of subsection (a) of this section, "insurer" and "company" have the same meaning as assigned in Insurance Code §551.101." The amendments to §5.7001 also update statutory references resulting from nonsubstantive revisions of the Insurance Code, amend existing text for clarification, and correct grammar.

Amendments to §5.7002 conform the cancellation provisions for consistency with Insurance Code §551.104. The amendment to §5.7002(a) updates the statutory period in which an insurer may cancel a personal automobile policy for reasons provided in Insurance Code §551.104(b)(1-3) and (d). Insurance Code §551.104(g) provides that an insurer may cancel a personal automobile insurance policy if it has been in effect for less than 60 days. Thus, an insurer may only cancel a personal automobile policy if it has been in effect for more than 59 days for the reasons listed in Insurance Code §551.104(b)(1-3) and (d).

The amendment to §5.7002(a)(3) adds "or any other law governing the business of insurance in this state" for consistency with Insurance Code §551.104(b)(3). As an additional reason that an insurer may cancel a policy after the specified number of days, the amendment to §5.7002(a) adds paragraph (4) to provide "the insured submits a fraudulent claim" for consistency with Insurance Code §551.104(b)(2). Amendments to §5.7002(a) also amend existing text for clarification, correct grammar, and update internal references.

The amendment to §5.7002(b) updates the statutory periods in which an insurer may cancel a homeowners policy and other listed types of policies under Insurance Code §551.102 and 28 TAC §5.7001(a) for the reasons provided under subsection (c) of §5.7002. Section 5.7002(b) does not apply to a personal automobile policy. Insurance Code §551.104(g) provides that an insurer may cancel any insurance policy, other than a personal automobile or homeowners insurance policy, if the policy has been in effect for less than 90 days. Thus, other than a personal automobile policy or homeowners insurance policy, an insurer may only cancel a policy listed under Insurance Code §551.102 and 28 TAC §5.7001(a) if it has been in effect for more than 89 days for the reasons listed under Insurance Code §551.104(b) and (c).

In addition, Insurance Code §551.104(g) provides that an insurer may cancel a homeowners insurance policy if the policy has been in effect for less than 60 days for the reasons provided under Insurance Code §551.104(g)(1) and (2). Thus, an insurer may only cancel a homeowners insurance policy if it has been in effect for more than 59 days for the reasons listed under Insurance Code §551.104(b) and (c).

An amendment to §5.7002(b) moves paragraphs (1) - (3) to new subsection (c) of §5.7002 to list the reasons that an insurer may cancel any of the policies under §5.7002(b) for consistency with Insurance Code §551.104(b) and (c). An amendment to paragraph (2) of §5.7002(c) adds language for consistency with Insurance Code §551.104(c). The amendment to paragraph (3) of §5.7002(c) adds "or any other law governing the business of insurance in this state" for consistency with Insurance Code §551.104(b)(3). New §5.7002(c)(4) is added for consistency with Insurance Code §551.104(b)(2) by providing, as an additional reason that an insurer may cancel a policy after the specified number of days, "the insured submits a fraudulent claim."

Additionally, the amendment to §5.7002 adds new subsection (d) to provide that "[a]n insurer may not date or send the notice of cancellation for nonpayment of premium until after the premium due date" for consistency with Insurance Code §551.104(e) and to clarify when an insurer may give notice of a cancellation for nonpayment of a premium.

Insurance Code §551.104(e) provides that cancellation of a policy under subsection (b), (c), or (d) does not take effect until the 10th day after the date the insurer mails notice of the cancellation to the insured. This proposal clarifies that an insurer may not give notice of a cancellation for nonpayment of a premium if the premium payment from the insured is not yet due. Some insureds receive a notice of cancellation in the same document as the billing statement (a "dual notice"). These dual notices of cancellation are sent before a reason for cancellation has occurred. Insurance Code §551.104(b)(1) permits an insurer to cancel a policy for nonpayment of the premium. If an insurer wishes to cancel a policy for nonpayment of a premium, it must separately mail the insured notice to inform the insured of the cancellation only after the insured has failed to timely pay the premium. The cancellation of a policy is not effective until the 10th day after the date the insurer mails the notice of the cancellation to the insured. Amendments to §5.7002(b) also amend existing text for clarification, correct grammar, and update internal references.

Amendments to §5.7009 update statutory references resulting from nonsubstantive revisions of the Insurance Code, amend existing text for clarification, correct grammar, and update internal references.

FISCAL NOTE. Melissa Hield, associate commissioner of the Consumer Protection Section, has determined that, for each year of the first five years the proposed amendments will be in effect, there will be no fiscal impact to state and local governments as a result of the enforcement or administration of the proposal. There will be no measurable effect on local employment or the local economy as a result of the proposal.

PUBLIC BENEFIT/COST NOTE. Ms. Hield also has determined that for each year of the first five years the amendments are in effect, the public benefit anticipated as a result of this proposal are rules to implement Insurance Code §551.104(e), to require insurers that wish to cancel an insurance policy for the nonpayment of a premium to send the notice of cancellation after the premium due date. As a result, this proposal reduces confusion as to when an insurer should process a notice of cancellation for nonpayment of a premium. This proposal further benefits the insured by requiring that the insured receive informed notice of cancellation for nonpayment of a premium from an insurer in a

manner that allows sufficient time to obtain other insurance coverage.

Estimated Costs for Persons Required to Comply with the Proposal. To the extent that insurers currently send a dual notice to insureds consisting of both the billing statement and cancellation notice for nonpayment of a premium when due, the department anticipates that for each of the first five years the proposed amended sections will be in effect, there will be costs to insurers to comply with Insurance Code §551.104(e) and this proposal by mailing a separate cancellation notice to the insureds for nonpayment of a premium when due. The costs to insurers to comply with this proposal include printing and mailing costs for the separate notice, and any necessary computer programming changes that may be necessary to provide the separate notice.

The department estimates that the printing and paper cost for the notice on a separate page cost approximately 3 cents per page (2 cents for paper and 1 cent for ink). The department anticipates that an insurer will only need to use one page to provide the notice of cancellation for nonpayment of the premium. The total estimated mailing cost would be approximately 50 cents per notice, 45 cents for the postage, plus an additional 5 cents for each standard envelope. A lower bulk rate may also be available, and each insurer has information on its bulk mailing costs. The department anticipates that each insurer will have staff, such as office clerks, to perform any tasks that are related to printing and mailing the notice. Based on the mean hourly wage in Texas for general office clerks working for insurance carriers, the department estimates a cost of $16.22 per hour. This estimate is based on wage information data provided to the Texas Workforce Commission (TWC) by the U.S. Department of Labor and is available in the latest Labor Market and Career Information Data (2010) on the TWC website. For each year of the first five years that the proposal will be in effect, the total annual costs for each insurer to print and mail the notice will depend on the number of insureds to whom the notice must be sent and how many times the notice must be sent to an insured.

For an insurer that chooses to modify its computer programming system to permit automatic electronic generation and distribution of the notice, these insurers may initially incur personnel costs to program electronic systems for compliance with the proposed rule. This may include programming to automatically generate the notice of cancellation for nonpayment of premium. Total programming costs will vary depending on the number of hours required, the skill level of the programmer or programmers, the complexity of the insurer's electronic systems, and whether the insurer will contract with outside computer programmers. Each insurer has the information needed to estimate its individual costs for such programming. However, based on TWC wage information data, the mean hourly wage for a computer programmer working for an insurance carrier in Texas is $38.92. The actual number, types, and cost of personnel or independent contractors will depend on the insurer's existing data systems and staffing. Once an electronic program generating and distributing the required notice is operational, the department expects continuing costs to be negligible. The department expects insurers that only automate the generation of the notice, but not the delivery, to incur the printing and mailing costs previously discussed.

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

The costs for compliance with this proposal will not vary between the smallest and largest businesses because they will both incur similar costs for printing and mailing the separate notice, and any necessary computer programming changes that may be necessary to provide the separate notice. However, in accordance with Government Code §2006.002(c), the department has determined that the amendments may have an adverse economic impact on 3 to 5 percent of authorized insurers writing property and casualty insurance in this state, including a county mutual insurance company, a Lloyd's plan, a reciprocal or interinsurance exchange, and a farm mutual insurance company, that qualify as small or micro businesses under Government §2006.001(1) and (2) and that must comply with these proposed rules if they cancel an insurance policy as provided by Insurance Code §551.104(e). The department bases its estimated number of small and micro businesses on its analysis of revenue reports in financial statements submitted to the department and its determination by the department of the insurers that are independently owned and operated. The adverse economic impact may result from the costs to comply with this proposal appearing in the public benefit/cost note part of this proposal.

Government Code §2006.002(c)(2) requires a state agency, before adopting a rule that may have an adverse economic effect on small businesses, to prepare a regulatory flexibility analysis that includes the agency's consideration of alternative methods of achieving the purpose of the proposed rule. Section 2006.002(c-1) of the Government Code requires that the regulatory analysis "consider, if consistent with the health, safety, and environmental and economic welfare of the state, using regulatory methods that will accomplish the objectives of applicable rules while minimizing adverse impacts on small businesses."

The department has considered that the purpose of the applicable statute, Insurance Code §551.104(e), is to inform the insured of a cancellation of a policy after the reason for cancellation has occurred in a manner that allows sufficient time to obtain other insurance coverage. Under this section, if an insurer wishes to cancel a policy for nonpayment of a premium, it must provide the insured with a separate mailing of the notice to inform the insured of the cancellation only after the insured has failed to timely pay the premium. The cancellation of a policy is not effective until the 10th day after the date the notice of the cancellation is mailed to the insured.

The department considered regulatory alternatives for achieving the purpose of the statute and this proposal to minimize any adverse impact on the estimated 3 to 5 percent of authorized insurers writing property and casualty insurance in this state that qualify as small or micro businesses under Government Code §2006.001(1) and (2). The department, in accordance with Gov-

ernment Code §2006.002(c-1), has considered exempting small business insurers from the separate notice requirement for nonpayment of a premium. The department has determined that this alternative is not viable because a separate mailing of the notice to inform the insured of the cancellation after the insured has failed to timely pay the premium is necessary to achieve the purpose of Insurance Code §551.104(e) and this proposal. Not requiring a small business to send a separate notice of cancellation if it wishes to cancel a policy for nonpayment of a premium would be inconsistent with Insurance Code §551.104(e) and not an acceptable alternative.

For these reasons, the department has determined, in accordance with §2006.002(c-1) of the Government Code, that there are no regulatory alternatives to the proposed amendment that will sufficiently protect the health, safety, environmental, and economic interests of Texas consumers and the welfare of the state.

TAKINGS IMPACT ASSESSMENT. The department has determined that this proposal does not affect any private real property interests, nor does it restrict or limit an owner's right to property that would otherwise exist in the absence of government action. Therefore, this proposal does not constitute a taking or require a takings impact assessment under Government Code §2007.043.

REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on August 20, 2012, to Sara Waitt, General Counsel, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Melissa Hield, Associate Commissioner, Consumer Protection Section, Mail Code 111-1A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, before the close of the public comment period. If the department holds a hearing, it will consider written and oral comments presented at the hearing.

STATUTORY AUTHORITY. The department proposes amendments pursuant to Insurance Code §551.112 and §36.001. Section 551.112 provides that the commissioner may adopt rules relating to the cancellation and nonrenewal of insurance policies. Section 36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

CROSS REFERENCE TO STATUTE. The proposal implements the following statutes: Insurance Code §551.102, §551.104 and Chapter 4051, Subchapter H.

§5.7001. Applicability.

(a) Sections 5.7002 - 5.7012 of this title (relating to Cancellations; Calculation of Time Period; Certain Acts Regarded as Cancellation; Special One-Year Rule Applicable Only to Personal Automobile Policies; Discontinuing the Writing of Certain Lines or Classes, Withdrawing from a Geographical Area, or Withdrawing from an Agency; Renewal of Policies; Records Required; [~~Texas~~] Insurance Code Chapter 4051, Subchapter H [~~, Article 21.11-1~~]; Endorsement Forms; Violations; and Reason for Declination, Cancellation, or Nonrenewal) apply [~~are applicable~~] to companies or insurers writing the following types of insurance policies which become effective on or after February 1, 1972, and to no other policies, except as otherwise provided in this section:

(1) personal automobile policies. Except for §5.7012 of this title [~~(relating to Reason for Declination, Cancellation, or Nonrenewal)~~], these sections do not apply [~~are inapplicable~~] to any automobile policy written through the Texas Automobile Insurance Plan;

(2) homeowners or farm or [~~and~~] ranch owners policies;

(3) standard fire policies insuring: [~~one family dwellings or duplexes or contents of either;~~]

(A) a one-family dwelling or a duplex; or

(B) the contents of a one-family dwelling, a duplex, or an apartment; or

(4) insurance policies providing property and casualty coverage, other than a fidelity, surety, or guaranty bond to governmental units. A governmental unit means the State of Texas and all of the several agencies of government which collectively constitute the government of the State of Texas, specifically including:

(A) this state;

(B) an agency of this state;

(C) a political subdivision of this state, including:

(i) a municipality or county;

(ii) a school district or junior college district;

(iii) a levee improvement district, drainage district, or irrigation district;

(iv) a water improvement district, water control and improvement district, or water control and preservation district;

(v) a freshwater supply district;

(vi) a navigation district;

(vii) a conservation and reclamation district;

(viii) a soil conservation district;

(ix) a communication district;

(x) a river authority; and

(xi) councils and courts; or

(D) any other governmental agency whose authority derives from the laws and constitution of this state.

[~~(4) all property policies insuring governmental units; a governmental unit means the State of Texas and all of the several agencies of government which collectively constitute the government of the State of Texas, specifically including, but not limited to, other agencies bearing different designations, all departments, bureaus, boards, commissions, offices, agencies, councils and courts; all political subdivisions, all cities, counties, school districts, levee improvement districts, drainage districts, irrigation districts, water improvement districts, water control and improvement districts, water control and preservation districts, fresh water supply districts, navigation districts, conservation and reclamation districts, soil conservation districts, river authorities, and junior college districts; and all institutions, agencies and organs of government whose status and authority is derived either from the constitution of the State of Texas or from laws passed by the legislature pursuant to such constitution.~~]

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

(d) For the purpose of subsection (a) of this section, "insurer" and "company" have the same meaning as assigned to "insurer" in Insurance Code §551.101.

§5.7002. Cancellations.

(a) An insurer may cancel a personal automobile policy if it has been in effect for more than 59 days [~~After a personal automobile policy has been in effect for 60 days, the company may cancel~~] for only the following reasons [~~and none other~~]:

(1) the failure of the insured to discharge his or her obligation in the payment of premium for the policy or any installment thereof, whether payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit;

(2) the suspension or revocation of the driver's license or motor vehicle registration of the named insured or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy. Provided, however, a company may not cancel if the policyholder consents to the attachment of an endorsement eliminating coverage when the [~~vehicle is being operated by the~~] driver whose license is suspended or revoked is operating the vehicle; [~~or~~]

(3) [~~a determination by~~] the department determines [~~State Board of Insurance~~] that the continuation of the policy would violate or place the company in violation of the Insurance Code or any other law governing the business of insurance in this state; or [~~.~~]

(4) the insured submits a fraudulent claim.

(b) An insurer may cancel a homeowners insurance policy if it has been in effect for more than 59 days for only the reasons provided under subsection (c) of this section. An insurer may cancel any of the following policies that have been in effect for more than 89 days for only the reasons provided under subsection (c) of this section:

(1) farm or ranch owners policies;

(2) standard fire policies insuring:

(A) a one-family dwelling or a duplex; or

(B) the contents of a one-family dwelling, a duplex, or an apartment; or

(3) insurance policies providing property and casualty coverage, other than a fidelity, surety, or guaranty bond, to:

(A) this state;

(B) an agency of this state;

(C) a political subdivision of this state, including:

(i) a municipality or county;

(ii) a school district or junior college district;

(iii) a levee improvement district, drainage district, or irrigation district;

(iv) a water improvement district, water control and improvement district, or water control and preservation district;

(v) a freshwater supply district;

(vi) a navigation district;

(vii) a conservation and reclamation district;

(viii) a soil conservation district;

(ix) a communication district;

(x) a river authority; and

(xi) councils and courts; or

(D) any other governmental agency whose authority derives from the laws and constitution of this state.

(c) An insurer may cancel any of the policies under subsection (b) of this section for only the following reasons:

[~~(b) All other types of policies subject to these sections may be cancelled by the company after they have been in effect for 90 days, for the following reasons and none other:~~]

(1) the failure of the insured to discharge his or her obligation in the payment of premium for the policy or any installment thereof, whether payable directly to the company or its agent or indirectly under any premium finance plan or extension of credit;

(2) increase in hazard within the control of the insured which would produce an increase in the premium rate of the policy; [~~or~~]

(3) [~~a determination by~~] the department determines [~~State Board of Insurance~~] that the continuation of the policy would violate or place the company in violation of the Insurance Code or any other law governing the business of insurance in this state; or[~~.~~]

(4) the insured submits a fraudulent claim.

(d) An insurer may not date or send the notice of cancellation for nonpayment of premium until after the premium due date.

§5.7009. Insurance Code Chapter 4051, Subchapter H [~~, Article 21.11-1~~].

[~~The State Board of Insurance directs attention to the~~] Insurance Code Chapter 4051, Subchapter H, [~~Article 21.11-1, which~~] deals with the relations between companies and their agents. Insurance Code Chapter 4051, Subchapter H, [~~This article~~] also contains provisions relative to cancellations and renewals of policies written through agencies which are subsequently terminated. All provisions of these sections shall be interpreted so as to give full effect to Insurance Code Chapter 4051, Subchapter H [~~Article 21.11-1~~]. Insurance Code Chapter 4051, Subchapter H, [~~Article 21.11-1~~] shall not be interpreted to impair any obligations which the company owes to the policyholder, even though the agent has no authority [~~is no longer empowered~~] to act on behalf of the company.

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

Filed with the Office of the Secretary of State on July 3, 2012.

TRD-201203495
Sara Waitt
General Counsel
Texas Department of Insurance
Earliest possible date of adoption: August 19, 2012
For further information, please call: (512) 463-6327

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 1. GENERAL LAND OFFICE

CHAPTER 15. COASTAL AREA PLANNING
SUBCHAPTER A. MANAGEMENT OF THE BEACH/DUNE SYSTEM

31 TAC §15.36

The General Land Office (GLO) proposes amendments to 31 TAC §15.36, relating to Certification Status of City of Galveston Dune Protection and Beach Access Plan.

The intent of this rulemaking is to fully certify the City of Galveston's Dune Protection and Beach Access Plan as well as Erosion Response Plan amendment to its Dune Protection and Beach Access Plan.

Copies of the City of Galveston Dune Protection and Beach Access Plan and the amendment to the Plan are available from the City of Galveston Department of Planning and Community Development, 823 Rosenberg, Galveston, Texas 77553, phone number (409) 797-3500 or on the internet at http://www.progressgalveston.com/sites/default/files/documents/12_0503_GALV_ERP_CC_FINAL_Adopted041212.pdf, and from the GLO's Archives Division, Texas General Land Office, P.O. Box 12873, Austin, TX 78711-2873, phone number (512) 463-5277.

BACKGROUND AND ANALYSIS OF PROPOSED AMENDMENTS

Section 15.36 (relating to Certification Status of City of Galveston Dune Protection and Beach Access Plan) changes the definition of "Dune Conservation Areas" and adds an area identified as "Enhanced Construction Zone."

FISCAL AND EMPLOYMENT IMPACTS

Ms. Helen Young, Deputy Commissioner for the General Land Office's Coastal Resources Program Area, has determined that for each year of the first five years the amended sections as proposed are in effect there will be no additional cost to state government as a result of enforcing or administering the amended sections.

Ms. Young has determined that there may be fiscal implications to local governments or additional costs of compliance for large and small businesses or individuals resulting from proposed amendments for implementation of The City of Galveston's Erosion Response Plan. However, these fiscal impacts cannot be estimated with certainty at this time, since development plans for construction seaward of the setback lines and the specific content of these plans are determined on a case by case basis depending on the type of construction. In addition, it is the opinion of the GLO that the costs of implementation of the provisions for construction in the Erosion Response Plan will be offset by a reduction in public expenditures for erosion and storm damage losses to private and public property. In addition, adoption of the enhanced construction standards in the City of Galveston's Erosion Response Plan may qualify individuals for reduced National Flood Insurance Program flood insurance policy rates.

Likewise, costs of compliance for businesses or individuals will be offset by reduction in losses due to storm damage. New structures that are constructed behind the building set-back line will have reduced losses because of a reduction in the intensity of storm surge and a delayed exposure to erosion. Additionally, the enhanced dune restoration and construction standards will result in increased protection for structures which are located landward of the dune conservation area. New structures constructed seaward of the building set-back line will have reduced losses because of stricter building standards and improvements in storm protection through upgrades to access points and foredune ridges. In addition, the presumption of compliance with dune mitigation sequence requirements for avoidance and minimization will simplify and reduce the cost to developers for crafting mitigation plans for construction seaward of the dune protection line.

GLO has determined that the proposed rulemaking will have no adverse local employment impact that requires an impact statement pursuant to Texas Government Code §2001.022.

PUBLIC BENEFIT

Ms. Young has determined that for the first five years the public will benefit from the proposed amendments because the General Land Office will be able to administer the coastal public land program more efficiently, providing the public more certainty and clarity in the process. The public will also benefit because coastal public land, and therefore the permanent school fund, will be protected with the certification of the City of Galveston's Dune Protection and Beach Access Plan.

In addition, the public will benefit from the adoption of the City of Galveston's Erosion Response Plan because of reduced public expenditures associated with loss of structures and public infrastructure due to storm damage and erosion, disaster response costs, and loss of life. The City of Galveston is proposing to establish a dune conservation zone starting at the 4-foot contour above mean sea level to 75 feet landward of the 4-foot contour and a building set-back line at 125 feet landward of the dune conservation area for a total of 200 feet from the 4-foot contour. Establishing a dune conservation area is important because natural dune processes are allowed to continue with minimal disturbance and the risk to life and property from storm damage and public expenses of disaster relief will be reduced by allowing a natural buffer against normal storm tides. By encouraging the placement of structures (especially taller and larger structures) further landward, the additional hazards created by tall buildings when subjected to storm surge will reduce their vulnerability to storm tide and erosion. In addition, larger structures are more difficult to move and create increased pressure on the state and local government for the construction of hard erosion control structures, further increasing public expenses.

The public will also benefit due to reduced storm damage loss to properties exempted from constructing landward of the building set-back line with the establishment of enhanced building requirements in the setback area. Additionally, existing structures and properties constructed seaward of the building set-back line will be protected by local government implementation of plans to improve foredune ridges and beach access points to protect against storm surge. Scientific and engineering studies considered by the GLO noted that during Hurricane Alicia in 1983, vegetation line retreat and landward extent of storm washover deposits were greater for developed areas than for natural areas (Bureau of Economic Geology Circular 85-5). This difference is attributed in part to the fact that naturally occurring vegetated dunes are stronger than reconstructed dunes due to greater root depths of dune vegetation. (Circular 85-5).

ENVIRONMENTAL REGULATORY ANALYSIS

GLO has evaluated the proposed rulemaking action in light of the regulatory analysis requirements of Texas Government Code §2001.0225 and determined that the action is not subject to §2001.0225 because it does not meet the definition of a "major environmental rule" as defined in the statute. "Major environmental rule" means a rule the specific intent of which is to protect the environment or reduce risks to human health from environmental exposure and that may adversely affect in a material way the economy, a sector of the economy, produc-

tivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state. The proposed amendments to Chapter 155 are not anticipated to adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, or the public health and safety of the state or a sector of the state because the proposed rulemaking implements legislative requirements in Texas Natural Resources Code §§33.101 - 33.136 relating to the board's ability to grant rights in coastal public land.

TAKINGS IMPACT ASSESSMENT

GLO has evaluated the proposed rulemaking in accordance with Texas Government Code §2007.043(b) and §2.18 of the Attorney General's Private Real Property Rights Preservation Act Guidelines to determine whether a detailed takings impact assessment is required. GLO has determined that the proposed rulemaking does not affect private real property in a manner that requires real property owners to be compensated as provided by the Fifth and Fourteenth Amendments to the United States Constitution or Article I, §17 and §19 of the Texas Constitution. Furthermore, GLO has determined that the proposed rulemaking would not affect any private real property in a manner that restricts or limits the owner's right to the property that would otherwise exist in the absence of the rule amendments. GLO has determined that the proposed rulemaking will not result in a taking of private property and that there are no adverse impacts on private real property interests inasmuch as the property subject to the proposed amendments is owned by the state. The City of Galveston's Erosion Response Plan establishes and implements a building set-back line and includes guidelines providing exemptions for property for which the owner has demonstrated that no practicable alternatives to construction seaward of the building set-back line exist. The definition of the term "practicable" in §15.2(55) of the Beach/Dune Rules allows a local government to consider the cost of implementing a technique such as the set-back provisions in determining whether it is "practicable" in a particular application for development. In applying its regulation, the City of Galveston will determine on a case-by-case basis to permit construction of habitable structures in the area seaward of the building set-back line and landward of the line of vegetation if it caused severe and unavoidable economic impacts and thus avoid an unconstitutional taking. In addition, a building set-back line adopted by local governments under that section would not constitute a statutory taking under the Private Real Property Rights Preservation Act inasmuch as Texas Natural Resources Code §33.607(h) as added by HB 2819 provides that Chapter 2007, Government Code, does not apply to a rule or local government order or ordinance authorized by §33.607.

CONSISTENCY WITH COASTAL MANAGEMENT PROGRAM

The proposed rulemaking is subject to the Coastal Management Program (CMP), 31 TAC §505.11(a)(1)(E) - (I) and §505.11(c), relating to the Actions and Rules Subject to the CMP. GLO has reviewed these proposed actions for consistency with the CMP's goals and policies. The applicable goals and policies are found at 31 TAC §501.12 (relating to Goals) and §501.26 (relating to Policies for Construction of in the Beach/Dune System). Because all requests for the use of coastal public land must continue to meet the same criteria for GLO approval, GLO has determined that the proposed actions are consistent with applicable CMP goals and policies. The proposed amendments will be distributed to the Commissioner in order to provide him an opportunity to provide comment on the consistency of the proposed new rules during the comment period.

The amended rule, the full certification of the City of Galveston's Dune Protection and Beach Access Plan and the Erosion Response Plan, is consistent with the CMP goals outlined in 31 TAC §501.12(1) - (3) and (6). These goals seek protection of CNRAs, compatible economic development and multiple uses of the coastal zone, minimization of the loss of human life and property due to the impairment and loss of CNRA functions, and coordination of GLO and local government decision-making through the establishment of clear, effective policies for the management of CNRAs. The Erosion Response Plan is tailored to the unique natural features, degree of development, storm, and erosion exposure potential for the City of Galveston. The City's Erosion Response Plan is also consistent with the CMP policies outlined in 31 TAC §501.26(a)(1) and (2) that prohibit construction within a critical dune area that results in the material weakening of dunes and dune vegetation or adverse effects on the sediment budget. The City's Erosion Response Plan will provide reduced impacts to critical dunes and dune vegetation by placement of structures further landward, reduce dune area habitat and biodiversity loss, and reduce structure encroachment on the beach which leads to interruption of the natural sediment cycle.

PUBLIC COMMENT REQUEST

To comment on the proposed rulemaking or its consistency with the CMP goals and policies, please send a written comment to Mr. Walter Talley, Texas Register Liaison, Texas General Land Office, P.O. Box 12873, Austin, TX 78711, facsimile number (512) 463-6311 or email to walter.talley@glo.state.tx.us. Written comments must be received no later than 5:00 p.m. thirty (30) days from the date of publication of this proposal.

STATUTORY AUTHORITY

The amendments are proposed under the Texas Natural Resources Code §33.607, relating to GLO's authority to adopt rules for the preparation and implementation by a local government of a plan for reducing public expenditures for erosion and storm damage losses to public and private property.

Texas Natural Resources Code §§33.601 - 33.613 are affected by the proposed amendments.

§15.36. Certification Status of City of Galveston Dune Protection and Beach Access Plan.

(a) The City of Galveston (City) has submitted to the General Land Office a dune protection and beach access plan which was adopted on August 12, 1993 and amended on February 9, 1995, June 19, 1997, February 14, 2002, March 13, 2003, January 29, 2004, February 26, 2004, and April 12, 2012. [~~and February 26, 2004.~~] The City's plan is fully certified as consistent with state law. [~~law with respect to the January 26, 2004, amendments and the February 26, 2004, amendments to change the boundaries of Seawall Urban Beach Park, and to establish or increase beach user fees to be collected at the Seawall Beach Urban Park, Stewart Beach, R.A. Apffel Park, Dellanera Park, and east and west areas of Galveston Island. The City's plan is certified as consistent with state law with respect to the geographic area west of the eastern boundary of Stewart Beach, and east of the western boundary of R.A. Apffel Park. The City's plan is conditionally certified as consistent with state law with respect to the geographic area between Access Points 1 and 2 (East Beach, extending from the eastern boundary of Stewart Beach to the western boundary of R.A. Apffel Park). The City must satisfy the conditions set forth below in accordance with the reasoning outlined in the final adoption notice for the amendment approving this conditional certification. The~~

conditional certification shall remain in effect until the General Land Office officially withdraws the conditional certification.]

(b) The General Land Office certifies as consistent with state law the City's Erosion Response Plan as an amendment to the Dune Protection and Beach Access Plan. [the following variances from §§15.4(c)(8), 15.5(b)(3), and 15.6(f)(3) of this title (relating to Dune Protection Standards, Beachfront Construction Standards, and Concurrent Dune Protection and Beachfront Construction Standards) in the City of Galveston's plan. The plan:]

[(1) provides that paving or altering the ground below the lowest habitable floor is prohibited in the area between the line of vegetation and 25 feet landward of the north toe of the dune;]

[(2) provides that paving used under the habitable structure and for a driveway connecting the habitable structure and the street is limited to the use of unreinforced fibercrete in 4 feet by 4 feet sections, which shall be a maximum of four inches thick with sections separated by expansion joists, or pervious materials approved by the City Department of Planning and Transportation, in that area 25 feet landward of the north toe of the dune to 200 feet landward of the line of vegetation;]

[(3) assesses a "Fibercrete Maintenance Fee" of $200.00 to be used to pay for the cleanup of fibercrete from the public beaches, should the need arise; and]

[(4) allows the use of reinforced concrete in that area landward of 200 feet from the line of vegetation.]

[(c) For purposes of this section, the phrase "completion of substantial physical improvements" shall mean the completion of all of the following criteria for development, as determined by the City's Director of the Department of Planning and Community Development:]

[(1) The filing of a final plat;]

[(2) Installation of public and private infrastructure;]

[(3) Installation of the associated beach access point parking, signage, and walkover consistent with §15.7(h)(1) of this title (relating to Local Government Management of the Public Beach); and]

[(4) The issuance of a building permit for a private residence or public building, excluding a sales office or accessory structure.]

[(d) In order to continue to restrict vehicular access to the public beach from the eastern boundary of Stewart Beach to the western boundary of R.A. Apffel Park, the City must amend its plan to comply with the presumptive criteria for parking spaces on or adjacent to the beach, spacing between beach ingress/egress ways, and conspicuous signage set forth in §15.7(h)(1) of this title within 180 days of the effective date of this amendment. The General Land Office will condition its affirmative finding that the Plan as amended preserves and enhances the public's right to use and access the public beach upon the inclusion in the amended Plan of the specific measures set forth in paragraph (1) of this subsection.]

[(1) With respect to the area between Access Points 1 through 2, the Plan must provide for the following:]

[(A) Two existing pedestrian ingress/egress ways between the Galvestonian and the west entrance to R.A. Apffel Park marked with conspicuous signage as public access;]

[(B) A pedestrian ingress/egress way with appropriate conspicuous signage must be provided between the Islander East and Galvestonian;]

[(C) A pedestrian ingress/egress way with appropriate conspicuous signage at the approximate location of an existing path that is located near the eastern end of the "restricted" or "special use" area;]

[(D) Interim off-beach parking on or adjacent to East Beach Road that meets the presumptive criterion for parking spaces on or adjacent to the beach set forth in §15.7(h)(1)(A) of this title of one parking space for each 15 linear feet of beach for the area from the eastern boundary of Stewart Beach Park to the ingress/egress way at R.A. Apffel Park Road, with at least one parking lot located between the Islander East and the Galvestonian, and at least one other parking lot located to the east of the Galvestonian in proximity to the existing pedestrian ingress/egress ways;]

[(E) A parking lot at the eastern end of Stewart Beach located immediately adjacent to the "special use" area with a sufficient number of free parking spaces to satisfy the requirements of state law; and]

[(F) Interim parking referred to in subparagraph (D) of this paragraph must be maintained by the City unless or until it is replaced with permanent parking on or adjacent to the beach south of East Beach Road.]

[(2) The City must open the beach from the eastern boundary of Stewart Beach to the western boundary of R.A. Apffel Park to vehicular traffic if it fails to amend the Plan within 180 days and take the specific measures set forth in paragraph (1) of this subsection within 270 days of the effective date of this amendment.]

[(e) The restriction of vehicular access to any portion of the public beach from the eastern boundary of the Playa San Luis subdivision to San Luis Pass is permitted only under the following circumstances:]

[(1) the completion of substantial physical improvements at the ingress/egress way adjacent to that portion of the public beach restricted to vehicular traffic including:]

[(A) dedication of pedestrian pathways for public use as identified in the City's plan;]

[(B) parking that meets the presumptive criterion for parking spaces on or adjacent to the beach set forth in §15.7(h)(1)(A) of this title of one parking space for each 15 linear feet of beach; and]

[(C) conspicuous signs which explain the nature and extent of vehicular controls, parking areas, and access points;]

[(2) notwithstanding the completion of substantial physical improvements at AP 38, 39 or 40, vehicular access to San Luis Pass via AP 36 (Salt Cedar Avenue) must be permitted until the road surface at the vehicular access at AP 41 is improved to provide reliable, regularly maintained vehicular access to the beach;]

[(3) ingress/egress ways to the public beach for Access Points 38 through 41 inclusive are located so that the distance between such ingress/egress ways represents no more than one-quarter mile variance from the one-half mile presumptive criterion of §15.7(h)(1)(B) of this title; and]

[(4) restriction of vehicular access to a portion, rather than all, of the beach from the eastern boundary of the Playa San Luis subdivision to San Luis Pass inclusive can occur only if such restriction does not create a section of beach open to vehicular access between two or more areas that are inaccessible to vehicular traffic.]

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

Filed with the Office of the Secretary of State on July 3, 2012.

TRD-201203491
Larry Laine
Chief Clerk, Deputy Land Commissioner
General Land Office
Earliest possible date of adoption: August 19, 2012
For further information, please call: (512) 475-1859

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WITHDRAWN RULES

Withdrawn Rules include proposed rules and emergency rules. A state agency may specify that a rule is withdrawn immediately or on a later date after filing the notice with the Texas Register. A proposed rule is withdrawn six months after the date of publication of the proposed rule in the Texas Register if a state agency has failed by that time to adopt, adopt as amended, or withdraw the proposed rule. Adopted rules may not be withdrawn. (Government Code, §2001.027)

TITLE 25. HEALTH SERVICES

PART 1. DEPARTMENT OF STATE HEALTH SERVICES

CHAPTER 229. FOOD AND DRUG

SUBCHAPTER K. TEXAS FOOD ESTABLISHMENTS

25 TAC §§229.162, 229.164, 229.165, 229.167, 229.171

The Executive Commissioner of the Texas Health and Human Services Commission, on behalf of the Department of State Health Services, withdraws amendments to §§229.162, 229.164, 229.165, 229.167, and 229.171, concerning Texas Food Establishment Rules, that were published in the January 27, 2012, issue of the *Texas Register* (37 TexReg 284).

Filed with the Office of the Secretary of State on July 9, 2012.

TRD-201203523
Lisa Hernandez
General Counsel
Department of State Health Services
Effective date: July 9, 2012
For further information, please call: (512) 776-6972

♦ ♦ ♦

25 TAC §229.173

The Executive Commissioner of the Texas Health and Human Services Commission, on behalf of the Department of State Health Services, withdraws the repeal of §229.173, concerning Texas Food Establishment Rules, that was published in the January 27, 2012, issue of the *Texas Register* (37 TexReg 284).

Filed with the Office of the Secretary of State on July 9, 2012.

TRD-201203524
Lisa Hernandez
General Counsel
Department of State Health Services
Effective date: July 9, 2012
For further information, please call: (512) 776-6972

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Adopted rules include new rules, amendments to existing rules, and repeals of existing rules. A rule adopted by a state agency takes effect 20 days after the date on which it is filed with the Secretary of State unless a later date is required by statute or specified in the rule (Government Code, §2001.036). If a rule is adopted without change to the text of the proposed rule, then the *Texas Register* does not republish the rule text here. If a rule is adopted with change to the text of the proposed rule, then the final rule text is included here. The final rule text will appear in the Texas Administrative Code on the effective date.

TITLE 19. EDUCATION

PART 2. TEXAS EDUCATION AGENCY

CHAPTER 66. STATE ADOPTION AND DISTRIBUTION OF INSTRUCTIONAL MATERIALS

The Texas Education Agency adopts amendments to §§66.1001, 66.1003, 66.1005, 66.1007, 66.1009, 66.1011, 66.1013, 66.1015, 66.1017, 66.1019, 66.1021, 66.1023, 66.1025, 66.1027, 66.1029, 66.1031, 66.1033, 66.1035, 66.1037, 66.1039, 66.1041, 66.1101, 66.1103, 66.1107, 66.1109, 66.1111, 66.1113, 66.1115, 66.1117, 66.1201, and 66.1203 and new §§66.1301, 66.1303, 66.1305, 66.1307, 66.1309, 66.1311, 66.1313, 66.1315, 66.1317, 66.1319, 66.1321, and 66.1323, concerning instructional materials. The amendments to §§66.1001, 66.1009, 66.1041, and 66.1101 and new §§66.1301, 66.1305, 66.1307, 66.1309, 66.1311, 66.1315, 66.1317, and 66.1319 are adopted with changes to the proposed text as published in the April 27, 2012, issue of the *Texas Register* (37 TexReg 2963). The amendments to §§66.1003, 66.1005, 66.1007, 66.1011, 66.1013, 66.1015, 66.1017, 66.1019, 66.1021, 66.1023, 66.1025, 66.1027, 66.1029, 66.1031, 66.1033, 66.1035, 66.1037, 66.1039, 66.1103, 66.1107, 66.1109, 66.1111, 66.1113, 66.1115, 66.1117, 66.1201, and 66.1203 and new §§66.1303, 66.1313, 66.1321, and 66.1323 are adopted without changes to the proposed text as published in the April 27, 2012, issue of the *Texas Register* (37 TexReg 2963) and will not be republished. The amended sections address the commissioner's list of electronic textbooks and instructional materials; state-developed open-source textbooks; and acceptable condition of public school textbooks, electronic textbooks, and technological equipment. The new sections address provisions for the instructional materials allotment. The adopted amendments and new rules implement the requirements of the Texas Education Code (TEC), Chapter 31, as amended by Senate Bill (SB) 6, 82nd Texas Legislature, First Called Session, 2011.

SB 6, 82nd Texas Legislature, First Called Session, 2011, made significant changes pertaining to the review, adoption, and purchase of instructional materials and technological equipment for public schools, including the establishment of the instructional materials allotment. This legislation requires the commissioner to provide funds from the instructional materials fund to every school district, open-enrollment charter school, and juvenile justice alternative education program. The funds can be used to acquire instructional materials, technological equipment, and technology services. The statutory changes resulting from SB 6 necessitate changes to the commissioner's rules in 19 TAC Chapter 66, as follows.

The adopted amendments to 19 TAC Chapter 66, Subchapters AA-CC, update the current definition of instructional materials and change the term "textbooks" to "instructional materials," including use of the term within subchapter and section titles. References to textbook credits and maximum costs were deleted. Additionally, the adopted amendments to 19 TAC Chapter 66, Subchapter AA, revise provisions relating to administrative penalties, add a timeframe for State Board of Education (SBOE) direction on removing material from the commissioner's list of electronic instructional materials, and update requirements relating to the selection of materials by school districts.

Adopted new 19 TAC Chapter 66, Subchapter DD, establishes provisions relating to the instructional materials allotment, including requirements for and certification of the use of the allotment. The adopted new rules also address high-enrollment growth; special instructional materials; bilingual instructional materials; title and custody; sale or disposal of instructional materials and technological equipment; local accountability; lost, damaged, or worn out instructional materials; and juvenile justice alternative education programs.

In response to public comments, changes were made in Subchapters AA, BB, and DD at adoption as follows.

Subchapter AA

Section 66.1001, Definitions, was modified in paragraph (2) to clarify the definition of a publisher.

Section 66.1009, Procedures Governing Violations of Statutes--Administrative Penalties, was modified to delete proposed subsection (a)(5), which would have assessed a $25,000 penalty for each factual error found in a student component. Subsequent paragraphs were renumbered accordingly.

Section 66.1041, Selection of Electronic Instructional Materials by School Districts, was modified in paragraph (2) to specify that the agency will process a technology application subscription change after receiving district notification through the Educational Materials (EMAT) system.

Subchapter BB

Section 66.1101, Definitions, was modified in paragraph (3) to clarify the definition of a publisher.

Subchapter DD

Section 66.1301, Definitions, was modified in paragraph (7) to clarify the definition of a publisher.

Section 66.1305, Certification of Instructional Materials, was modified in subsections (a)-(c) to require districts to submit supporting documentation describing the instructional materials on which the required Texas essential knowledge and skills (TEKS) certification is based; to require that the TEKS certification form be ratified by local boards in public, noticed meetings; and to

specify that the certification requirements are applicable to both adopted and non-adopted instructional materials.

Section 66.1307, Instructional Materials Allotment, was modified in subsection (c)(1)(I) to clarify that the instructional materials allotment may be used for technological equipment that contributes to student learning, including equipment that supports the use of instructional materials. Also in §66.1307, subsection (c)(2) was modified to clarify training and professional development. Language addressing access to technological equipment was removed from §66.1307(c)(2)(A) and added as new §66.1307(c)(2)(B). The existing language in §66.1307(c)(2)(B) was re-lettered as §66.1307(c)(2)(C). Additionally, subsection (d)(1)(B) was modified to clarify the unallowable acquisition of infrastructure equipment through the instructional materials allotment.

Section 66.1309, High-Enrollment Growth Adjustment, was modified in subsection (b) to change the time period for enrollment growth of 10% over the previous three years to the time period of the previous five years.

Section 66.1311, Special Instructional Materials, was modified in subsection (d) to require publishers to submit computerized files for print instructional materials to the state for the purposes of producing Braille or other versions of materials that will be used by students with disabilities.

Section 66.1315, Title and Custody, was modified by adding new subsection (b) to clarify school district and open-enrollment charter school ownership of instructional materials. Subsequent subsections were re-lettered accordingly.

Section 66.1317, Sale or Disposal of Instructional Materials and Technological Equipment, was modified by adding new paragraph (1)(B) to specify that the sale or disposal of online instructional materials is conditional on the terms of any applicable licensing agreement. Subsequent subparagraphs were re-lettered accordingly. Additionally, new paragraph (2)(D) was added to address disposition of instructional materials by regional education service centers.

Section 66.1319, Local Accountability, was modified in subsection (c) to clarify that the return of instructional materials applies to those in the students' physical possession.

Appropriate changes will be incorporated into the EMAT system. Adopted new 19 TAC Chapter 66, Subchapter DD, includes provisions that address the statutory requirement that a school district provide to the commissioner of education the title and publication information for any instructional materials requisitioned or purchased by the district with the district's instructional materials allotment. The adopted new subchapter also addresses the annual certification that must be submitted to the commissioner that students are provided with instructional materials that cover all elements of the TEKS. The adopted rule actions have no new locally maintained paperwork requirements. All reporting requirements will be incorporated into the EMAT system.

The TEA determined that there is no direct adverse economic impact for small businesses and microbusinesses; therefore, no regulatory flexibility analysis, specified in Texas Government Code, §2006.002, is required.

The public comment period on the proposal began April 27, 2012, and ended May 29, 2012. Following is a summary of the public comments received and corresponding agency responses regarding proposed amendments to 19 TAC Chapter 66, Subchapters AA-CC, and new Subchapter DD.

§66.1009. Procedures Governing Violations of Statutes--Administrative Penalties.

Comment: The Association of American Publishers, Inc., (AAP) commented that proposed §66.1009(b)(5) be deleted to remove an assessment of a $25,000 penalty for each factual error found in a student component.

Agency Response: The agency agreed and deleted proposed §66.1009(b)(5). This action aligns with the amendments to SBOE rules concerning penalties for factual errors.

Comment: The AAP commented that §66.1009(g) be amended and §66.1009(h) be deleted to allow publishers to make changes or remove content that does not affect coverage of TEKS.

Agency Response: This comment is outside the scope of the proposed rulemaking.

§66.1027. Electronic Instructional Materials Offered for Adoption by the Commissioner.

Comment: The Software & Information Industry Association (SIIA) commented that §66.1027(g) be amended to provide flexibility for emerging technologies and allow other methods to incorporate correlations to the electronic instructional material submitted for adoption.

Agency Response: The agency disagreed with amending §66.1027(g) and determined the rule provides industry standards that allow flexibility for emerging technologies.

§66.1029. Public Comment on Electronic Instructional Materials.

Comment: The SIIA commented that §66.1029(c) be amended to limit the opportunity for the SBOE to comment on the Commissioner's List of Electronic Instructional Materials from 90 days to 30 days.

Agency Response: The agency disagreed with amending §66.1029(c) due to the TEC, §31.0231(c), which requires that the SBOE be given the opportunity to comment on the Commissioner's List of Instructional Materials. The statute specifies that the SBOE may, not later than the 90th day after the date the material is placed on the list, require the commissioner to remove the materials from the list.

§66.1041. Selection of Electronic Instructional Materials by School Districts.

Comment: The SIIA commented that §66.1041(2) be amended to provide notification of a technology application subscription change through the EMAT system.

Agency Response: The agency agreed and modified §66.1041(2) to specify that the agency will process a technology application subscription change after receiving district notification through the EMAT system.

§66.1301. Definitions.

Comment: The SIIA commented that §66.1301(7) be amended to clarify the definition of a publisher.

Agency Response: The agency agreed and modified §66.1301(7) to clarify the definition that a publisher is an entity that develops or distributes instructional materials or online service. The agency also made the same modification to the definition of publisher in §66.1001(2) and §66.1101(3).

§66.1305. Certification of Instructional Materials.

Comment: The AAP commented that §66.1305(a)-(c) be amended to require districts to submit supporting documentation describing the instructional materials on which the required TEKS certification is based. The AAP also commented that the TEKS certification form must be ratified by local boards in public, noticed meetings and be applicable to both adopted and non-adopted instructional materials.

Agency Response: The agency agreed and modified §66.1305(a) to require districts to submit supporting documentation describing the instructional materials on which the required TEKS certification is based. The agency modified §66.1305(b) to require that the TEKS certification form be ratified by local boards in public, noticed meetings. The agency also modified §66.1305(c) to specify that the provisions in subsections (a) and (b) are applicable to both adopted and non-adopted instructional materials.

§66.1307. Instructional Materials Allotment.

Comment: The TechNet, Texas Computer Education Association (TCEA), and the Texas Association of School Administrators (TASA) commented that §66.1307(c)(1)(I) be amended to clarify that the instructional materials allotment may be used for technological equipment that contributes to student learning, including equipment that supports the use of instructional materials.

Agency Response: The agency agreed and modified §66.1307(c)(1)(I) to clarify that the instructional materials allotment may be used for technological equipment that contributes to student learning, including equipment that supports the use of instructional materials.

Comment: The TechNet, TCEA, and TASA commented that §66.1307(c)(2)(A) be amended by dividing the rule text into two sections to clarify training and professional development.

Agency Response: The agency agreed and modified §66.1307(c)(2) to clarify training and professional development. Language addressing access to technological equipment was removed from §66.1307(c)(2)(A) and added as new §66.1307(c)(2)(B). The existing language in §66.1307(c)(2)(B) was re-lettered as §66.1307(c)(2)(C).

Comment: The TechNet, TCEA, and TASA commented that proposed §66.1307(c)(2)(B) be amended to allow districts to use their instructional materials allotment to pay for teacher stipends.

Agency Response: The agency disagreed with amending proposed §66.1307(c)(2)(B), adopted as §66.1307(c)(2)(C), because teacher stipends are not an allowable instructional materials allotment expenditure.

Comment: The TechNet, TCEA, and TASA commented that §66.1307(d)(1)(B) be amended to clarify the unallowable acquisition of infrastructure equipment through the instructional materials allotment.

Agency Response: The agency agreed and modified §66.1307(d)(1)(B) to clarify examples of infrastructure equipment that would be unallowable such as cabling and wiring or electricity.

Comment: The TechNet, TCEA, and TASA commented that §66.1307(d)(2) be removed to allow the instructional materials allotment to be used to pay for travel expenses.

Agency Response: The agency disagreed with amending §66.1307(d)(2) because travel expenses are not an allowable instructional materials allotment expenditure.

§66.1309. High-Enrollment Growth Adjustment.

Comment: The Fast Growth School Coalition commented that §66.1309(b) be amended to change the time period for enrollment growth of 10% over the previous three years to a time period of the previous five years.

Agency Response: The agency agreed and modified §66.1309(b) to change the enrollment growth of 10% over the previous three-year period to a five-year period.

Comment: The Fast Growth School Coalition commented that §66.1309(b) be amended to clarify that districts will automatically receive the specified adjustment.

Agency Response: The agency disagreed with amending §66.1309(b) to clarify automatic receipt of the specified adjustment. The agency will review each request to determine if the high-enrollment request requirements have been sufficiently addressed.

§66.1311. Special Instructional Materials.

Comment: The SIIA commented that §66.1311(d) be amended to only require publishers to submit computerized files for print instructional materials to the state for the purposes of producing Braille or other versions of materials that will be used by students with disabilities.

Agency Response: The agency agreed and modified §66.1311(d) to require publishers to submit computerized files for print instructional materials to the state for the purposes of producing Braille or other versions of materials that will be used by students with disabilities.

§66.1315. Title and Custody.

Comment: The Texas Association of School Boards (TASB) commented that §66.1315(a) be amended to clarify school district and open-enrollment charter school ownership of previously adopted instructional materials.

Agency Response: The agency agreed to clarify school district and open-enrollment charter school ownership of instructional materials by adding new §66.1315(b) instead of amending §66.1315(a). Subsequent subsections were re-lettered accordingly.

§66.1317. Sale or Disposal of Instructional Materials and Technological Equipment.

Comment: The TASB commented that §66.1317(1)(A) be amended to clarify and determine which discontinued technological equipment owned by the district or open-enrollment charter school can be sold.

Agency Response: The agency disagreed with amending §66.1317(1)(A). The rule is clear that only discontinued technological equipment purchased with the instructional materials allotment can be sold.

Comment: The SIIA commented that §66.1317 include new rule text to authorize a board of trustees or governing body to sell or dispose of print or electronic instructional materials conditional on the terms of any applicable licensing agreement.

Agency Response: The agency agreed and modified §66.1317 by adding new paragraph (1)(B) to specify that the sale or disposal of online instructional materials is conditional on the terms of any applicable licensing agreement. The agency disagreed to include print in the new rule because licensing agreements are only applicable with online instructional materials.

Comment: Representatives of several regional education service centers (ESCs) commented that §66.1317 be amended to include guidance for the disposition of instructional materials at the ESCs.

Agency Response: The agency agreed and modified §66.1317 by adding new §66.1317(2)(D) to specify that ESCs may dispose of instructional materials one year after adoption by the SBOE.

§66.1319. Local Accountability.

Comment: The SIIA, TechNet, TCEA, and TASA commented that §66.1319(c) be amended to clarify the return of instructional materials and provide an exemption for the return of instructional materials if the licensing agreement allows the student to maintain possession beyond the school year.

Agency Response: The agency agreed and modified §66.1319(c) to clarify that the return of instructional materials applies to those that students physically possess. However, the agency disagreed with providing an exemption for the return of instructional materials if the licensing agreement allows the student to maintain possession. All instructional materials are required to be inventoried on an annual basis. The return of instructional materials facilitates that process.

SUBCHAPTER AA. COMMISSIONER'S RULE CONCERNING THE COMMISSIONER'S LIST OF ELECTRONIC INSTRUCTIONAL MATERIALS

19 TAC §§66.1001, 66.1003, 66.1005, 66.1007, 66.1009, 66.1011, 66.1013, 66.1015, 66.1017, 66.1019, 66.1021, 66.1023, 66.1025, 66.1027, 66.1029, 66.1031, 66.1033, 66.1035, 66.1037, 66.1039, 66.1041

The amendments are adopted under the Texas Education Code (TEC), §31.0231, which requires the commissioner of education to adopt rules as necessary to implement adoption of a list of electronic instructional materials.

The amendments implement the TEC, §31.0231.

§66.1001. Definitions.

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

(1) Instructional materials--Content that conveys the essential knowledge and skills of a subject in the public school curriculum through a medium or a combination of media for conveying information to a student. The term includes a book; supplementary materials; a combination of a book, workbook, and supplementary materials; computer software; magnetic media; DVD; CD-ROM; computer courseware; online services; or an electronic medium or other means of conveying information to the student or otherwise contributing to the learning process through electronic means, including open-source instructional materials.

(2) Publisher--Any developer or distributor of instructional materials or online service.

§66.1009. Procedures Governing Violations of Statutes--Administrative Penalties.

(a) Administrative penalties. The commissioner of education may impose a reasonable administrative penalty against a publisher found in violation of a provision of the Texas Education Code (TEC), §31.151(a), if the publisher fails to correct the errors within the time period provided by the commissioner. An administrative penalty shall be assessed only after the commissioner has granted the publisher a hearing in accordance with the TEC, §31.151, and the Administrative Procedure Act.

(b) Penalties for failure to correct factual errors.

(1) A factual error shall be defined as a verified error of fact that would interfere with student learning. The context, including the intended student audience and grade level appropriateness, shall be considered.

(2) A factual error repeated in a single item or contained in both the student and teacher components of adopted electronic instructional materials shall be counted once for the purpose of determining penalties.

(3) A penalty may be assessed for failure to correct a factual error identified in the list of corrections submitted by a publisher or for failure to correct a factual error identified by the electronic instructional materials review panel under §66.1031 of this title (relating to Consideration and Adoption of Electronic Instructional Materials) and required by the commissioner. The publisher shall correct any errors within 30 business days after receipt of notice from the commissioner.

(4) A penalty not to exceed $5,000 may be assessed for each factual error identified after the electronic instructional materials have been delivered to public schools.

(5) The amount of the penalty will be determined by the commissioner based on the severity of the factual error.

(6) The penalty may be reduced or waived if the publisher corrects the factual error within three business days of notification.

(c) Penalties may be assessed for failure to make adopted electronic instructional materials readily available, including teacher components, in a timely manner and with consistent access 24 hours a day and 7 days a week. The commissioner may assess penalties as allowed by law against publishers who fail to deliver adopted electronic instructional materials, including teacher components specified by §66.1027 of this title (relating to Electronic Instructional Materials Offered for Adoption by the Commissioner), in accordance with provisions in the contracts.

(d) Penalties may be assessed for selling adopted electronic instructional materials with factual errors. The commissioner may assess administrative penalties in accordance with the TEC, §31.151, against a seller of adopted electronic instructional materials.

(e) Penalties for failure to maintain websites in state-adopted products. The commissioner may assess administrative penalties against a publisher who:

(1) fails to maintain a website or provide a suitable alternative for conveying the information in the website or who otherwise fails to meet the requirements of this subsection; or

(2) fails to monitor, update, and maintain any in-house and third party electronic, web-based, or online products furnished as part of the adopted electronic instructional materials specified in the contract for the period determined by the commissioner for adopted electronic instructional materials.

(f) Replacement requirements. If the commissioner determines in a hearing that electronic, web-based, or online instructional materials furnished and supplied under the terms of a contract have outdated information during the contract period, the online instructional materials or information shall be updated by the publisher without cost to the state.

(g) Content update requests. The publisher must submit a request to the commissioner as specified in §66.1035 of this title (relating to Updates to Electronic Instructional Materials) for approval to substitute updated content or add content. The publisher shall not update or add content without prior commissioner approval. The commissioner shall respond to such a request within 30 business days after receipt of the request. Factual or software coding errors that require updates or changes shall not require commissioner approval.

(h) Content removal. The publisher agrees that electronic, web-based, or online instructional materials listed in the contract will not be altered in any way that would remove content from the curriculum or that would change content in the curriculum without prior commissioner approval. The commissioner shall respond to such a request within 30 business days after receipt of the request.

(i) Online requirements. The publisher will not allow advertising of any type to be placed in or associated with the materials. The publisher will not collect any information about the user or computer accessing the materials that would allow determination of personal information, including email addresses. The publisher will be allowed to collect information necessary for legitimate operational tasks, including authenticating and managing student access and detecting and preventing security vulnerabilities. The result of the information will be used to deliver the material and provide an educational value per the intended design. Use of such information will follow the federal Family Educational Rights and Privacy Act (FERPA).

(j) Internet links. The publisher may only add Internet links or redirect to other Internet or electronic sites as needed to correct an error or correct a broken link to the materials without the approval of the commissioner. The publisher will not redirect any user accessing the web-based or online instructional materials to other Internet or electronic sites unless a resource is no longer available or appropriate. The publishers shall provide such new or corrected Internet links to the commissioner at the time the addition or correction is made, and the commissioner shall have up to 30 business days to retroactively reject such changes.

(k) Commissioner discretion regarding penalties. The commissioner may, if circumstances warrant, waive or vary penalties contained in this section for first or subsequent violations based on the seriousness of the violation, any history of a previous violation or violations, the amount necessary to deter a future violation, any effort to correct the violation, and any other matter justice requires.

(l) Payment of fines. Each affected publisher shall issue credit to the Texas Education Agency in the amount of any penalty imposed under the provisions of this section. When circumstances warrant it, the commissioner is authorized to require payment of penalties in cash within ten business days. Each affected publisher who pays a fine for failure to deliver adopted electronic instructional materials in a timely manner will not be subject to the liquidated damages provision in the publisher's contract for the same failure to deliver adopted electronic instructional materials in a timely manner.

§66.1041. Selection of Electronic Instructional Materials by School Districts.

A school district or open-enrollment charter school that selects a subscription-based electronic instructional material from either the State Board of Education's adopted list or the Commissioner's List of Electronic Instructional Materials may cancel the subscription and subscribe to a new electronic instructional material if:

(1) the district or school has used the electronic instructional material for at least one year; and

(2) the Texas Education Agency (TEA) processes the change based on a written request to the TEA by the district or school via the educational materials (EMAT) system to change to another adopted product or request a disbursement for purchase of a non-adopted product.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2012.

TRD-201203496
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: July 23, 2012
Proposal publication date: April 27, 2012
For further information, please call: (512) 475-1497

SUBCHAPTER BB. COMMISSIONER'S RULE CONCERNING STATE-DEVELOPED OPEN-SOURCE INSTRUCTIONAL MATERIALS

19 TAC §§66.1101, 66.1103, 66.1107, 66.1109, 66.1111, 66.1113, 66.1115, 66.1117

The amendments are adopted under the Texas Education Code (TEC), §31.076, which authorizes the commissioner of education to adopt rules necessary to implement the purchase of state-developed open-source instructional materials.

The amendments implement the TEC, §31.076.

§66.1101. Definitions.

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

(1) Instructional materials--Content that conveys the essential knowledge and skills of a subject in the public school curriculum through a medium or a combination of media for conveying information to a student. The term includes a book; supplementary materials; a combination of a book, workbook, and supplementary materials; computer software; magnetic media; DVD; CD-ROM; computer courseware; online services; or an electronic medium or other means of conveying information to the student or otherwise contributing to the learning process through electronic means, including open-source instructional materials.

(2) Open-source instructional materials--Electronic instructional materials that are available for downloading from the Internet at no charge to a student and without requiring the purchase of an unlock code, membership, or other access or use charge, except for a charge to order an optional printed copy of all or part of the instructional materials.

(3) Publisher--Any developer or distributor of instructional materials or online service.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2012.

TRD-201203499

Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: July 23, 2012
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For further information, please call: (512) 475-1497

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SUBCHAPTER CC. COMMISSIONER'S RULE CONCERNING ACCEPTABLE CONDITION OF PUBLIC SCHOOL PRINTED INSTRUCTIONAL MATERIALS, ELECTRONIC INSTRUCTIONAL MATERIALS, AND TECHNOLOGICAL EQUIPMENT

19 TAC §66.1201, §66.1203

The amendments are adopted under the Texas Education Code (TEC), §31.104(d), which requires the commissioner to adopt by rule criteria for determining whether instructional materials and technological equipment are returned in an acceptable condition.

The amendments implement the TEC, §31.104(d).

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 3, 2012.

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Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
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Proposal publication date: April 27, 2012
For further information, please call: (512) 475-1497

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SUBCHAPTER DD. COMMISSIONER'S RULE CONCERNING INSTRUCTIONAL MATERIALS ALLOTMENT

19 TAC §§66.1301, 66.1303, 66.1305, 66.1307, 66.1309, 66.1311, 66.1313, 66.1315, 66.1317, 66.1319, 66.1321, 66.1323

The new sections are adopted under the Texas Education Code (TEC), §§31.0211, 31.0212, 31.0214, and 31.029, which authorize the commissioner to adopt rules necessary to implement the instructional materials allotment and instructional materials account, adjustment for high enrollment growth districts, and purchase of bilingual instructional materials.

The new sections implement the TEC, §§31.0211, 31.0212, 31.0213, 31.0214, and 31.029.

§66.1301. Definitions.

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

(1) Disbursement--A request made through the Texas Education Agency online ordering system for funds for non-adopted instructional materials, technological equipment, and/or technology services.

(2) Educational Materials (EMAT) system--The Texas Education Agency online ordering system through which school districts, open-enrollment charter schools, and juvenile justice alternative education programs submit requisitions for instructional materials and requests for disbursement.

(3) Instructional materials--Content that conveys the essential knowledge and skills of a subject in the public school curriculum through a medium or a combination of media for conveying information to a student. The term includes a book; supplementary materials; a combination of a book, workbook, and supplementary materials; computer software; magnetic media; DVD; CD-ROM; computer courseware; online services; or an electronic medium or other means of conveying information to the student or otherwise contributing to the learning process through electronic means, including open-source instructional materials.

(4) Instructional materials allotment--A specified enrollment-based amount of funds set aside from the state instructional materials fund, as determined by the commissioner in accordance with the Texas Education Code, §31.0211, allocated each school year to every Texas school district, open-enrollment charter school, and juvenile justice alternative education program.

(5) Juvenile justice alternative education program (JJAEP)--A juvenile justice alternative education program established under the Texas Education Code, §37.011.

(6) Open-source instructional materials--Electronic instructional materials that are available for downloading from the Internet at no charge to a student and without requiring the purchase of an unlock code, membership, or other access or use charge, except for a charge to order an optional printed copy of all or part of the instructional materials.

(7) Publisher--Any developer or distributor of instructional materials or online service.

(8) Requisition--A request made through the Texas Education Agency online ordering system for State Board of Education or commissioner of education adopted instructional materials.

(9) Special instructional materials--Instructional materials in Braille, large type, or any other medium or any apparatus intended for students who are blind or visually impaired that convey information to students or otherwise contribute to the learning process.

(10) Technological equipment--Hardware, device, or equipment necessary for instructional use in the classroom, including to gain access to or enhance the use of electronic instructional materials, or for professional use by a classroom teacher.

§66.1305. Certification of Instructional Materials.

(a) Prior to the beginning of each school year, each school district and open-enrollment charter school shall submit to the commissioner of education certification that for each subject in the required curriculum under the Texas Education Code, §28.002, other than physical education, and each grade level, the district or charter school provides each student with instructional materials that cover all elements of the essential knowledge and skills adopted by the State Board of Education. The certification shall be submitted in a format approved by the commissioner. Upon request by the commissioner, the certification shall include supporting documentation describing the instructional materials on which the certification is based.

(b) The certifications shall be ratified by local school boards in public, noticed meetings.

(c) The provisions in subsections (a) and (b) of this section are applicable both to state- and commissioner-adopted instructional materials and to non-adopted instructional materials.

(d) A school district or an open-enrollment charter school may not submit a requisition or request for disbursement through the EMAT system for the next school year until the required annual certification has been received by the commissioner for the current school year.

§66.1307. Instructional Materials Allotment.

(a) The commissioner of education shall determine the amount of the instructional materials allotment for a school district or an open-enrollment charter school based on Public Education Information Management System (PEIMS) student enrollment data on a date during the preceding school year specified by the commissioner.

(b) The amount of the instructional materials allotment determined by the commissioner is final and may not be appealed.

(c) The instructional materials allotment may be used to:

(1) purchase:

(A) instructional materials on the list adopted by the commissioner under the Texas Education Code (TEC), §31.0231;

(B) instructional materials on the list adopted by the State Board of Education under the TEC, §31.024;

(C) non-adopted instructional materials;

(D) consumable instructional materials;

(E) instructional materials for use in bilingual education classes, as provided by the TEC, §31.029;

(F) supplemental instructional materials, as provided by the TEC, §31.035;

(G) state-developed open-source instructional materials, as provided by the TEC, Chapter 31, Subchapter B-1;

(H) instructional materials and technological equipment under any continuing contracts of the school district or open-enrollment charter school in effect on September 1, 2011; and

(I) technological equipment that contributes to student learning, including equipment that supports the use of instructional materials; and

(2) pay:

(A) for training educational personnel directly involved in student learning in the appropriate use of instructional materials;

(B) for providing access to technological equipment for instructional use; and

(C) the salary and other expenses of an employee who provides technical support for the use of technological equipment directly involved in student learning.

(d) The instructional materials allotment may not be used to:

(1) purchase:

(A) services for installation;

(B) the physical conduit that transmits data such as cabling and wiring or electricity; or

(C) office and school supplies; or

(2) pay for travel expenses.

§66.1309. High-Enrollment Growth Adjustment.

(a) Calculations for high-enrollment growth at the district level will be adjusted automatically for the biennium based on current Public Education Information Management System (PEIMS) enrollment data before the EMAT system opens in the spring.

(b) A school district or an open-enrollment charter school that experiences a minimum enrollment growth of 10% over the previous five-year period for which the instructional materials allotment amount is being determined is eligible to receive an adjustment to accommodate high-enrollment growth.

(c) A school district or an open-enrollment charter school that is experiencing a student population growth that is not reflected in the state calculation may submit an application to be considered for additional funding if the district or charter experienced:

(1) a net increase of 3,500 students over the last 5 years; or

(2) an unexpected enrollment growth due to unforeseen circumstances.

(d) A school district or an open-enrollment charter school may request additional funding for its instructional materials allotment for high enrollment once during each school year in accordance with procedures established by the commissioner of education.

§66.1311. Special Instructional Materials.

(a) All laws and rules applying to instructional materials provided to students with no visual impairments that are not in conflict with the Texas Education Code, §31.028, or this section shall apply to the distribution and control of Braille and large type instructional materials, including, but not limited to, the following.

(1) A requisition for special instructional materials shall be based on actual student enrollment to meet individual student needs.

(2) Each school district or open-enrollment charter school shall conduct an annual physical inventory of all currently adopted accessible instructional materials that have been requisitioned by and delivered to the district or charter. The results of the inventory shall be recorded in the district's or charter's files and made available to the Texas Education Agency (TEA) upon request.

(b) Reimbursement and/or replacement shall be made for all volumes of Braille and large type instructional materials determined to be lost.

(c) Publishers shall grant permission to the state to have adopted instructional materials transcribed into Braille, large type, and audiotape without penalty or royalty.

(d) On or before the deadline specified in the schedule of adoption procedures, each publisher of newly adopted print instructional materials shall provide computerized files to the state as specified in the proclamation to be used for producing Braille or other versions of materials to be used by students with disabilities. All information contained in adopted instructional materials shall be included on the computerized files. Computerized files may be copied and distributed to a school district, upon request, for instructional use with a student with a disability who requires the use of computerized instructional materials, pursuant to an individualized plan developed for the student under the Rehabilitation Act, §504; the Americans with Disabilities Act; or the Individuals with Disabilities Education Act.

(e) The state shall make suitable student instructional materials available in large type. The commissioner of education shall develop specifications for large type instructional materials and notify publishers of student instructional materials suitable for production in large type. The publisher may elect to supply the large type materials,

or the commissioner may enter into contracts for producing large type instructional materials.

(f) Gifts of instructional materials for educating students who are blind or visually impaired tendered by individuals, groups, or school district officials may be accepted by the commissioner and shall become state property. Gift materials may be shipped by Free Matter for the Blind and Other Physically Handicapped Persons to the Special Textbook Redistribution Center or other location designated by the TEA.

(g) Copies of adopted instructional materials in Braille and large type needed by a person who is blind or visually impaired to carry out the duties of a teacher in the public schools of this state shall be furnished without cost. The materials are to be loaned to the public school districts as long as needed and are to be returned to the state when they are no longer needed. Materials in the medium needed by the teacher may be requisitioned by an instructional materials coordinator after the superintendent of schools has certified the following to the commissioner:

(1) the name of the teacher;

(2) the grade or subject taught; and

(3) the fact of the teacher's visual impairment.

(h) Large type instructional materials shall meet or exceed the Manufacturing Standards and Specifications for Textbooks approved by the national Advisory Commission of Textbook Specifications and any additional specifications that may be prescribed.

(i) Copies of adopted instructional materials in Braille, large type, or an electronic file that are requested by a parent who is blind or visually impaired shall be furnished without cost by the state. Materials in the medium needed by the parent may be requisitioned by an instructional materials coordinator. Requests for electronic files will be filled by the TEA after the parent signs and the TEA receives a statement, through the appropriate school district, promising that the parent will safeguard the security of the files and observe all current copyright laws, including those that forbid reproduction of the files and their transfer to other parties. All Braille and large type instructional materials and electronic files with educational content that have been provided to parents who are blind or visually impaired must be returned to the local school district at the end of the school year for reuse.

§66.1315. Title and Custody.

(a) Each instructional material and technological equipment purchased through the instructional materials allotment is the property of the school district or an open-enrollment charter school.

(b) Each instructional material that was previously adopted by the State Board of Education or commissioner of education is the property of the school district or an open-enrollment charter school.

(c) Ownership of electronic or online instructional materials applies only to the extent of any applicable licensing agreement.

(d) The instructional materials allotment allocated to a school district or an open-enrollment charter school is considered revenue and must be coded by the district or charter business office in a manner required by the Texas Education Agency.

(e) Current instructional materials in a district's or charter's inventory are considered assets and a value must be determined by the district or charter.

(f) The board of trustees of a school district or the governing body of an open-enrollment charter school shall distribute or provide access to instructional materials to students in the manner that the board or governing body determines is most effective and economical.

§66.1317. Sale or Disposal of Instructional Materials and Technological Equipment.

The board of trustees of a school district or governing body of an open-enrollment charter school must notify the Texas Education Agency of its intent to sell or dispose of instructional materials or technological equipment by a process established by the commissioner of education.

(1) Sale of instructional materials and technological equipment.

(A) The board of trustees or governing body may sell any printed or electronic instructional materials purchased with the district's or charter's instructional materials allotment on the date the instructional material is discontinued for use in the public schools.

(B) The ability of the board of trustees or governing body to sell or dispose of online or electronic instructional materials is conditional on the terms of any applicable licensing agreement.

(C) The board of trustees or governing body may sell technological equipment owned by the district or charter that was purchased with the district's or charter's instructional materials allotment.

(D) The board of trustees or governing body must report to the commissioner the amount of funds to be received from the sale of the instructional materials and technological equipment, identify the purchaser, and identify the instructional materials and/or technological equipment to be sold.

(E) Funds received by a district or charter from a sale of instructional materials or technological equipment purchased with the instructional materials allotment must be used to purchase instructional materials and technological equipment allowed under the Texas Education Code, §31.0211.

(F) The board of trustees or governing body must certify to the commissioner that the new instructional materials acquired from the sale of discontinued instructional materials will cover the Texas essential knowledge and skills and be made available to students and/or teachers.

(2) Disposal of instructional materials and technological equipment.

(A) The board of trustees or governing body may dispose of printed instructional material before the date the instructional material is discontinued for use in the public schools by the State Board of Education if the board of trustees or governing body determines that the instructional material is not needed by the district or charter and the board of trustees or governing body does not reasonably expect that the instructional material will be needed.

(B) The board of trustees or governing body shall determine how the district or charter will dispose of discontinued printed instructional materials and technological equipment.

(C) The board of trustees or governing body must notify the commissioner prior to the disposal of any instructional materials. The notice must identify the instructional materials to be disposed and the method of disposal.

(D) A regional education service center (ESC) may dispose of instructional materials one year after adoption by the State Board of Education or the commissioner as determined by the ESC executive director.

§66.1319. Local Accountability.

(a) Each school district or open-enrollment charter school shall conduct an annual inventory of:

(1) all currently adopted instructional materials delivered to the district;

(2) all non-adopted instructional materials purchased with funds from the instructional materials allotment; and

(3) all technological equipment purchased with funds from the instructional materials allotment.

(b) The results of the annual inventory shall be recorded in the district's or charter's files and in the EMAT system.

(c) All instructional materials owned by the district or charter and in the physical possession of the student must be returned by the student to the district or charter at the end of the school year or when the student withdraws from school.

(d) The board of trustees of a school district or governing board of an open-enrollment charter school may not require an employee of the district or charter to pay for instructional materials or technological equipment that is stolen, misplaced, or not returned by a student.

(e) Non-adopted instructional materials purchased by the district or charter shall be made available and provided in the specified format needed to students who are blind and visually impaired at the district's or charter's expense.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Education Agency
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For further information, please call: (512) 475-1497

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TITLE 28. INSURANCE

PART 1. TEXAS DEPARTMENT OF INSURANCE

CHAPTER 34. STATE FIRE MARSHAL

The commissioner of insurance adopts the repeal of 28 TAC §34.726 and §34.831, concerning the fire sprinkler and fireworks advisory councils. The repeal of the sections is adopted without changes to the proposal as published in the April 27, 2012, issue of the *Texas Register* (37 TexReg 2987).

REASONED JUSTIFICATION. The repeal of §34.726, concerning the fire sprinkler advisory council, is necessary because House Bill (HB) 1951, 82nd Legislature, 2011, repealed Insurance Code Chapter 6003, Subchapter C and abolished the fire sprinkler advisory council. The repeal of §34.831, concerning the fireworks advisory council, is necessary because HB 1951 repealed Occupations Code §2154.055(c) and abolished the fireworks advisory council.

HOW THE SECTIONS WILL FUNCTION. The adoption of the repeal will result in the repeal of sections establishing two advisory councils that the legislature abolished in HB 1951.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

The department did not receive any comments on the proposed repeal.

SUBCHAPTER G. FIRE SPRINKLER RULES

28 TAC §34.726

STATUTORY AUTHORITY. The repeal of §34.726 is adopted pursuant to HB 1951, 82nd Legislature, 2011. Section 2.008 of HB 1951 repealed Insurance Code Chapter 6003, Subchapter C, and Occupations Code Chapter 2154, Subchapter B. Section 2.009 of HB 1951 abolished the fire sprinkler advisory council and the fireworks advisory council. Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Government Code §417.004 specifies that the commissioner of insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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Texas Department of Insurance
Effective date: July 22, 2012
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SUBCHAPTER H. STORAGE AND SALE OF FIREWORKS

28 TAC §34.831

STATUTORY AUTHORITY. The repeal of §34.831 is adopted pursuant to HB 1951, 82nd Legislature, 2011. Section 2.008 of HB 1951 repealed Insurance Code Chapter 6003, Subchapter C, and Occupations Code Chapter 2154, Subchapter B. Section 2.009 of HB 1951 abolished the fire sprinkler advisory council and the fireworks advisory council. Insurance Code §36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state. Government Code §417.004 specifies that the commissioner of insurance shall perform the rulemaking functions previously performed by the Texas Commission on Fire Protection.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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PART 2. TEXAS DEPARTMENT OF INSURANCE, DIVISION OF WORKERS' COMPENSATION

CHAPTER 127. DESIGNATED DOCTOR PROCEDURES AND REQUIREMENTS

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §§127.1, 127.5, 127.10, 127.20, and 127.25 under Subchapter A, Chapter 127 of this title (relating to Designated Doctor Scheduling and Examinations), and adopts new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 under new Subchapters B and C, Chapter 127 of this title (relating to Designated Doctor Certification, Recertification, and Qualifications and Designated Doctor Duties and Responsibilities, respectively). These sections are adopted with changes to the proposed text as published in the February 24, 2012, issue of the *Texas Register* (37 TexReg 1140) and will be republished. These new and amended sections primarily implement the amendments made to Labor Code §408.0041 and §408.1225 made by House Bill 2605, 82nd Legislature, Regular Session, effective September 1, 2011 (HB 2605). Additionally, these new and amended sections also recodify the provisions of repealed §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings) and repealed §180.21 of this title (relating to Division Designated Doctor List). The repeals of §130.6 of this title and §180.21 of this title are published elsewhere in this issue of the *Texas Register.* Lastly, these new and amended sections also clarify or improve a number of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling, certification, and examination process.

In accordance with Government Code §2001.033(a)(1), the Division's reasoned justification for these rules is set out in this order, which includes the preamble and rules. The preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, the reasons why the Division agrees or disagrees with some of the comments and recommendations, and all other Division responses to the comments.

An informal draft of these new and amended sections was published on the Division's website from October 14, 2011 to November 4, 2011, and the Division received 78 informal comments on the draft. Additionally, the Division posted an informal draft of proposed new §127.130(b) on its website from December 17, 2011 to January 11, 2012, and the Division received 29 comments on this draft. Subsequent changes were made to the drafts based on the informal comments received on these drafts, and these new and amended sections were formally proposed in the *Texas Register* on February 24, 2012. A public hearing for this formal proposal was held on March 26, 2012. The public comment period closed on March 26, 2012, and the Division received 34 public comments.

HB 2605 added several amendments to §408.0041 and §408.1225 of the Labor Code that will substantially affect the Division's regulation of designated doctors in the workers' compensation system. First, HB 2605 amended Labor Code §408.1225(a-1) - (a-5) and §408.1225(b-2) to specifically require the Division to develop a certification and recertification process for designated doctors, including adopting eligibility requirements specific to designated doctor duties under Labor Code §408.0041 and adopting standardized training and testing for designated doctors. Second, HB 2605 amended Labor Code §408.1225(f) to require designated doctors to continue providing services related to a claim assigned to the designated doctor, including performing subsequent examinations and acting as a resource for Division disputes, unless the Division authorizes the designated doctor to stop providing services on the claim. Lastly, HB 2605 amended Labor Code §408.0041(b) and (b-1): (1) to require that, except as provided by Labor Code §408.1225(f), a medical examination under Labor Code §408.0041 shall be performed by the next designated doctor on the Division's list of certified designated doctors whose credentials are appropriate for the area of the body affected by the injury and the injured employee's diagnosis; and (2) to provide that if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. The Division has adopted these amended and new sections primarily in response to these amendments as described below.

The Division has also recodified portions of §130.6 of this title and §180.21 of this title, in part, to implement the amendments made by HB 2605 described above. The Division has also elected to recodify these two sections to ensure that substantially all rules applicable to designated doctors and designated doctor examinations can be found in Chapter 127. This recodification enhances the usability and logical structure of the Division's framework for designated doctor regulation, and, furthermore, it harmonizes with the rationale of the Division's similar recodification of former §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures) into §§127.1, 127.5, 127.10, 127.15, 127.20, and 127.25 of this title published in the December 17, 2010, issue of the *Texas Register* (35 TexReg 11324). A description of the recodified provisions of §130.6 and §180.21 of this title is provided below, and the repeals of these sections are published elsewhere in this issue of the *Texas Register.*

The Division has also adopted new and amended sections that will clarify or improve a number of the Division's existing designated doctor procedures in order to facilitate a more efficient designated doctor scheduling, certification, and examination process. These new or amended sections are described throughout this proposal and include, but are not limited to, a clarification of Division requirements for all designated doctor examination narrative reports, a new Designated Doctor Examination Data Report to be filed after certain examinations, and limitations on the availability of designated doctor examinations for claims on which the insurance carrier has denied compensability or otherwise denied liability. A complete description of these changes and other new or amended sections is provided below.

Additionally, there have also been nonsubstantive amendments made to these sections to conform to current nomenclature, re-

formatting, consistency, clarity, editorial reasons, and to correct typographical and/or grammatical errors in respect to the recodified language from proposed repeals of §130.6 and §180.21 of this title.

The Division also adopts these new and amended sections with several changes, all made in response to public comment, from the amendments and new sections formally proposed on February 24, 2012. First, in response to multiple comments, the Division has also deleted "or claimed to be compensable by the injured employee and not disputed by the insurance carrier" from §127.1(b)(4) and from §127.220(c)(2), because this phrase is vague and would likely create administrative confusion for the Division and system participants.

The Division, in response to comment, has also replaced the §127.1(b)(8) requirement that requestors report the dates and names of the examining designated doctors for all previous designated doctor examinations on an injured employee's claim with a requirement that requestors provide "the date of the most recent examination and the name of the examining designated doctor." The Division believes this change strikes an equitable balance, because information regarding the most recent designated doctor examination assists the Division in determining if the presently requested examination would occur within 60 days of the previous examination. The Division agrees, however, that information regarding examinations before the most recent examination is unnecessary and has, therefore, made this change.

The Division has also, in response to comment, chosen not to delete "below" from §127.1(b)(11) of this title. The deletion of "below" was intended to be a non-substantive change, but, in light of the commenter's request, the Division will leave the preposition in this subsection for clarity.

The Division has also, in response to comment, deleted "or an examination regarding the causation of the claimed injury" from §127.1(b)(11(C). This clarifying change is necessary because causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

The Division has also, in response to comment, amended §127.1(d) of this title to provide "[t]he division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor." This amendment simply codifies the Division's current practice of sending requestors written denials of their requests for designated doctor examination that explain the reasons for the denial.

The Division has also, in response to multiple comments, deleted proposed §127.1(d)(4) and adopts new §127.1(d)(4) that states that the Division will deny a request for a designated doctor examination "if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved." Additionally, the Division has deleted §127.1(d)(5), because its requirements became redundant in light of the adopted change to §127.1(d)(4). The Division has also added a new §127.1(e) and recodified former §127.1(e) as §127.1(f) of this title. New §127.1(e) provides that "If a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue." The Division believes that these changes to §127.1(d)(4) and new §127.1(e) create the optimal balance between limiting the costs imposed upon insurance carriers to pay for unnecessary examination and delays in the dispute resolution process imposed by these unnecessary examinations and the need to ensure that the Division has access to sufficient expert medical opinions to properly resolve the issue of medical causation in a compensability dispute.

The Division has also, in response to comment, made a change to §127.1(f) of this title (formerly codified as §127.1(e) of this title). Specifically, the Division has modified the deadline for parties seeking expedited proceedings and the stay of an ordered examination to file their request for expedited proceedings with the division from "within three days" to "within three working days" of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). The Division believes this change is necessary to ensure that parties will not be unduly burdened by being required to submit these requests on weekends or national holidays.

The Division has also, in response to comment, changed §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations). Specifically, the Division has deleted "shall not conduct the examination" and added "If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records." These changes are necessary to prevent unnecessary cancellations by ensuring designated doctors and injured employees still have the flexibility and discretion to perform the originally scheduled examination if the designated doctor receives the missing medical records promptly while also providing designated doctors the option to cancel that examination and reschedule if the medical records arrive too late for the designated doctor to review them.

The Division has also, in response to comment, changed §127.10(h) of this title to provide that if a designated doctor provides multiple certifications of maximum medical improvement (MMI) and/or impairment ratings (IR) under §127.10(d) "because the designated doctor was also ordered to address the extent of the injured employee's compensable injury," the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. This change is necessary to clarify that this language only applies if multiple certifications were provided when required under §127.10(d), specifically when the designated doctor is ordered by the Division to address extent of injury as well as MMI/IR.

The Division has also, in response to multiple comments, made a change to §127.20(a) of this title (relating to Requesting a Letter of Clarification Regarding Designated Doctor Reports). Specifically, the Division has deleted the proposed language that stated "The division will not approve a request that asks a designated doctor to reconsider the doctor's decision or to issue a new or amended decision unless the designated doctor failed to address an issue the designated doctor was ordered to address. Additionally, a designated doctor shall not reconsider the doctor's decision or issue a new or amended decision in response to a request for clarification unless the designated doctor failed

to address an issue the designated doctor was ordered to address." The Division has replaced this deleted language with the following provision: "Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision." The Division believes that this change is necessary because the Division acknowledges and agrees that in some cases permitting a designated doctor to correct an error in the doctor's report would expedite the dispute resolution process or curtail unnecessary litigation costs. Still, the Division also believes that designated doctors should only make these changes when the request for clarification submitted to them by the Division asks or permits them to do so. The Division, therefore, has elected to adopt this standard, currently implemented by the Division, to ensure that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution while still providing the Division the necessary discretion to monitor the quality and appropriateness of the requests and the authority to limit a designated doctor's responses to the request for clarification submitted to the doctor.

The Division has also, in response to comment, made two changes to §127.25 of this title (relating to Failure to Attend a Designated Doctor Examination). Specifically, the Division has deleted "after the insurance carrier suspends TIBs pursuant to this section" from both §127.25(c) and §127.25(d), because this phrase is unnecessary in these provisions and imposes an undue burden on designated doctors who will not know if an injured employee's temporary income benefits have been suspended or not.

The Division has also, in response to multiple comments, made a change to §127.100(a)(4) of this title (relating to Designated Doctor Certification). Specifically, the Division has elected to retain its current standard that a doctor applying for certification as a designated doctor must "have maintained an active practice for at least three years during the doctor's career." The Division believes this requirement sufficiently ensures that the doctor will have appropriate clinical knowledge to perform a physical examination while the Division's new training, testing, and certification standards will suffice to ensure that an applicant for certification has the necessary aptitude to address all issues that may be presented to a designated doctor.

The Division has also, in response to comment, made a change to §127.110(a)(3). Specifically, the Division has deleted the requirement that designated doctors who fail to inform the Division that they do not wish to remain certified as designated doctors prior the expiration of their current certification commit an administrative violation. The Division has replaced this requirement with the requirement that "a designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status." These changes are necessary to ensure that designated doctors voluntarily exiting the designated doctor program may do so with minimal administrative burden while still ensuring that designated doctors who seek recertification must do so in a timely fashion.

The Division has also, in response to comment, made a change to §127.110(c) of this title (relating to Designated Doctor Recertification). Specifically, the Division has changed §127.110(c) to provide that though the Division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the division fails to receive the required information in §127.110(b)(1) - (3) from the designated doctor before that time, "the designated doctor may still provide services on claims to which the designated doctor had been previously assigned." The Division believes this change is appropriate to ensure that even though a designated doctor is delinquent in filing the doctor's application for recertification, the doctor is still available to perform services on claims to which the designated doctor had already been assigned, such as responding to requests for clarification or performing reexaminations. The Division has further changed this section, in response to comment, by deleting the requirement that designated doctor inform the Division that they will not be seeking recertification as a designated doctor at least 45 days prior to the expiration of the designated doctor's certification. The Division has clarified the remaining language to provide "A designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation." These changes are necessary to ensure that designated doctors voluntarily exiting the designated doctor program may do so with minimal administrative burden while still ensuring that designated doctors who seek recertification must do so in a timely fashion. The Division notes that it has also changed §127.220(a)(5) in response to the same comment to clarify that only a designated doctor who wishes to stop practicing as designated doctor before the doctor's current certification as a designated doctor expires must provide the Division with written notice in advance of their voluntary exit from the designated doctor program. This change is necessary to clarify that this requirement does not apply to designated doctor who will simply not be renewing their certification as a designated doctor but intends to practice as a designated doctor for the duration of doctor's current certification.

The Division has also, in response to multiple comments, made a change to §127.110(e). Specifically, the Division has added "requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing" as an express reason for possible denial of a designated doctor's recertification. The Division believes that this clarifying change is appropriate, because while the Division could have already denied a designated doctor application for recertification for this reason under §127.110(e)(5), adding this reason as an express provision provides better notice to system participants of the emphasis the Division will place on this factor.

The Division has also, in response to multiple comments, made a change to §127.130(b)(7) and §127.130(b)(8)(E) of this title (relating to Qualification Standards for Designated Doctor Examinations). Specifically, the Division has moved the diagnosis "tendon lacerations" and the diagnosis "dislocations" from §127.130(b)(8)(E) to §127.130(b)(7). The Division has made this change because it has determined that board certification is not required to examine these issues, because these diagnoses are frequently treated and evaluated by all physicians in the workers' compensation system and, therefore, any licensed medical doctor or doctor of osteopathy appropriately trained as a designated doctor should be able to evaluate these diagnoses.

The Division has also, in response to comment, made a change to §127.130(b)(8)(A). Specifically, the Division has included physicians board certified in physical medicine and rehabilitation in the list of qualified providers under this subsection, because the Division has determined that these physicians would also be appropriately trained and qualified to evaluate traumatic brain injuries under this subsection. Doctors board certified in physical medicine and rehabilitation are frequently in charge of treating patients with traumatic brain injuries in the subacute and chronic phase of these injuries and also have extensive neurological training.

The Division has also, in response to comment, made a change to §127.130(b)(8)(C). Specifically, the Division has included physicians who are board certified in surgery in the list of qualified providers under subsection, because the Division has determined that these physicians would also be appropriately trained and qualified to evaluate severe burns under this subsection.

The Division has also, in response multiple comments, made a change to §127.200(a)(14) of this title (relating to Duties of Designated Doctor). Specifically, the Division has removed the requirement that designated doctors must present photo identification to an injured employee upon request because of concerns raised by commenters that this practice would unnecessarily reveal personal information regarding the designated doctor to the injured employee.

The Division has also, in response to comment, made a change to §127.210(a)(3) of this title (relating to Designated Doctor Administrative Violations). Specifically, the Division has clarified that a designated doctor is only prohibited from refusing to accept or perform a Division offered appointment or ordered appointment that relates to claim on which the designated doctor has previously performed an examination, not simply been assigned. This change clarifies that designated doctors are only considered bound to claims if the designated doctor actually performs an examination on the claim. If a designated doctor is simply assigned but the initial examination fails to occur that designated doctor is not bound to the claim for purposes of this subsection.

The Division has also, in response to comment, made a change to §127.220(a)(5) of this title (relating to Designated Doctor Reports). Specifically, the Division has deleted the requirement that designated doctor include "the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable" in their narrative reports. The Division has deleted this requirement because for most examinations this information will either be reported on the DWC-032, the DWC-068, or both, and, therefore, is not necessary in a designated doctor's narrative report.

The Division has also, in response to comment, deleted the requirement that designated doctors include the time the examination began from §127.220(a)(6) of this title. The Division believes that this information is unnecessary, particularly in light of the timing requirement of §127.220(a)(8).

Lastly, the Division has added a delayed effective date of September 1, 2012 to each adopted rule. The Division believes this delayed effective date is necessary to ensure that system participants receive sufficient time to prepare for the extensive changes adopted by this rule that will become effective before January 1, 2013. The extended effective date is incorporated into the following adopted sections: §§127.1(g), 127.5(f), 127.10(k), 127.20(f), 127.25(g), 127.100(h), 127.110(h), 127.120(b), 127.130(i), 127.140(g), 127.200(c), 127.210(d), and 127.220(d).

Amended §127.1.

Amended subsection (b)(3) replaces "medical condition and type of health care the injured employee is currently receiving" with "diagnosis or diagnoses and part of the body affected by the injury." This change is necessary to comply with the similar amendment made by HB 2605 to Labor Code §408.0041(b) described above. The Division has also deleted "or claimed to be compensable by the injured employee and not disputed by the insurance carrier" from amended §127.1(b)(4) because this phrase is vague and would likely create administrative confusion for the Division and system participants.

Amended subsection (b)(5) deletes the requirement that a person requesting a designated doctor examination include the injured employee's statutory date of maximum medical improvement (MMI) in every request for a designated doctor examination; instead, requestors will only need to include this information when requesting an MMI examination under amended subsection (b)(11)(A). New subsection (b)(6) and (7) require requestors to, respectively, identify the workers' compensation health care network certified under Chapter 1305, Insurance Code through which the injured employee is receiving treatment, if applicable, or to identify whether the claim involves medical benefits provided through a political subdivision under Labor Code §504.053(b)(2) and the name of the health plan, if applicable. These new paragraphs are necessary to assist the Division, designated doctors, and all other parties in determining whether a designated doctor has any disqualifying associations relevant to the injured employee's claim.

Amended subsection (b)(8) provides that requestors must also state whether the injured employee has attended any other designated doctor examinations on this claim and, if so, the date of the most recent examination and the name of the examining designated doctor. The Division believes this amendment strikes an equitable balance, because information regarding the most recent designated doctor examination assists the Division in determining if the requested examination would occur within 60 days of the previous examination. But the Division agrees, however, that information regarding examination before the most recent examination is unnecessary and has therefore made this change.

New subsection (b)(10) requires a person requesting a designated doctor examination to submit the request to the Division and a copy of the request to each other party listed in subsection (a) of this section. This new subsection is necessary to provide non-requesting parties increased opportunity and information to dispute the examination or selected designated doctor should the Division approve the request.

Amended subsection (b)(11)(A) requires requestors to submit the injured employee's statutory date of MMI when requesting an MMI examination and deletes the requirement that requestors submit the dates of MMI, if any, other than statutory MMI date; the date of certification of MMI, if any; the name of the certifying doctor, if any, and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor. Amended subsection (b)(11)(B) requires a person who requests

an impairment rating (IR) examination to provide the date of MMI that has been determined to be valid by a final decision of Division or court or by agreement of the parties, if any, and deletes the requirement that requestors submit the date of certification of MMI and prior assigned impairment rating, if any, and the name of the certifying doctor, if any; and whether the certifying doctor was a treating doctor, required medical examination doctor, or referral doctor. These amendments are necessary to ensure that designated doctors receive only necessary information that is not in dispute when accepting and performing a designated doctor examination.

Amended subsection (b)(11)(C) deletes "or an examination regarding the causation of the claimed injury." This clarifying change is necessary because causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

Amended subsection (b)(11)(E) provides that if requestors seek an examination regarding the injured employee's ability to return to work in any capacity and what activities the injured employee can perform, the requestors only need to include the beginning and ending dates for the periods to be addressed if the requestor is requesting the designated doctor to examine the injured employee's work status at a time other than the present. Amended subsection (b)(11)(E) also deletes the requirement that requestors submit a job description for job offers the employer intends to offer the injured employee. These amendments are necessary to minimize costs and administrative processes by only requiring information to be submitted in a request that a designated doctor needs to complete the doctor's examination.

Amended subsection (b)(11)(F) clarifies that if a requestor seeks an examination to determine whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, the requestor must include in the request the beginning and ending dates for the qualifying periods to be addressed. Previously, this provision did not state that only "qualifying" periods were to be addressed by the designated doctor, and this clarification is necessary to ensure designated doctors only making return-to-work determinations under this subsection for "qualifying periods" as that term is defined by §130.101(4) of this title (relating to Definitions).

Amended subsection (d) provides that "[t]he division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor" This amendment simply codifies the Division's current practice of sending requestors written denials of their requests for designated doctor examination that explain the reasons for the denial.

Amended subsection (d)(4) provides that the Division will deny a request for a designated doctor examination "if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved." Additionally, amended subsection (e) provides that "If a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue." The Division believes that these changes to §127.1(d)(4) and new §127.1(e) create the optimal balance between limiting costs imposed upon insurance carriers and delays in the dispute resolution process and the need to ensure that the Division has access to sufficient expert medical opinions to properly resolve the issue of causation in a compensability dispute.

New subsection (f) provides that parties may not dispute a designated doctor examination request or any information on the request until the Division has either approved or denied the request. This amendment clarifies that though pursuant to amended subsection (b)(10) requestors will submit their designated doctor requests to all other parties in addition to the Division, the Division only intends for parties to use these exchanged requests to inform their disputes regarding Division action on the request. The Division will not, therefore, hear disputes regarding the information provided on a request until it has either approved or denied the request, because such a dispute is not ripe for adjudication before the Division.

New subsection (f) also provides that parties may request an expedited contested case hearing for denied requests for a designated doctor examination in addition to approved requests. This amendment clarifies requestors' preexisting right to dispute these denials in an expedited contested case hearing under Chapter 410, Labor Code and Chapter 140 of this title (relating to Dispute Resolution--General Provisions). Additionally, new subsection (f) provides that the Division will only automatically stay a designated doctor examination if a request for the stay and expedited proceedings is timely received and approved.

Lastly, new subsection (f) has modified the deadline for parties seeking expedited proceedings and the stay of an ordered examination to file their request for expedited proceedings with the division from "within three days" to "within three working days" of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). The Division believes this change is necessary to ensure that parties will not be unduly burdened by being required to submit these requests on weekends or national holidays.

Amended §127.5.

Amended subsection (c)(2) deletes the current provision that states that a designated doctor is available to perform an initial examination on a claim if the designated doctor has credentials appropriate to the issue in question, the injured employee's medical condition, and as required by Labor Code §§408.0043, 408.0044, 408.0045, and applicable rules. Amended subsection (c)(2) replaces this language with "is appropriately qualified to perform the examination in accordance with §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations)." This change is necessary to correspond with new §127.130, which addresses the appropriate qualifications for designated doctors performing examinations.

Amended subsection (c)(3) provides that the Division will only select a designated doctor to perform an initial examination of an injured employee if, among other factors, the designated doctor has not failed to timely file for recertification under new §127.110, if applicable. This amendment is necessary to correspond with new §127.110(a) - (c), which provide that the Division shall not offer any new examinations to a designated doctor who fails to file materials required for recertification within the timeframes required by those subsections.

Amended subsection (d) provides that if the Division has previously assigned a designated doctor to the claim at the time a

request is made, the Division shall use that doctor again unless the Division has authorized or required the doctor to stop providing services on the claim in accordance with new §127.130. This amendment is necessary to correspond with new §127.130(e) - (g), which provide the circumstances under which the Division may authorize or compel a designated doctor to stop providing services on a claim to which the designated doctor had been previously assigned.

Amended subsection (e) provides that if both the designated doctor and the injured employee agree to reschedule the examination, the rescheduled examination shall be set to occur no later than 21 days after the date of the originally scheduled examination and may not be rescheduled to occur before the originally scheduled examination. This amendment is necessary to clarify that designated doctor examination dates or times may only be rescheduled through an agreement between the designated doctor and the injured employee and also to ensure that examinations are not rescheduled to occur before the originally ordered examination. Permitting parties to reschedule examinations to occur before the date of the originally scheduled designated doctor examination can, in some cases, interfere with the ability of the insurance carrier and the treating doctor to timely submit medical records and analyses to the designated doctor.

Amended subsection (e) also provides that within one working day of rescheduling, the designated doctor shall contact the injured employee's treating doctor with the time and date of the rescheduled examination in addition to the Division and the insurance carrier. Furthermore, this amendment to subsection (e) deletes the requirement that a designated doctor must inform the injured employee and injured employee's representative of the rescheduled examination. These amendments are necessary both to ensure that treating doctors are informed of rescheduled examinations and, therefore, of the appropriate deadlines for submitting medical records and to remove the redundant requirement that designated doctors inform the injured employee of a rescheduled examination the injured employee agreed to reschedule.

Lastly, amended subsection (e) provides that if an examination cannot be rescheduled to occur on a date no later than 21 days after the scheduled date of the originally scheduled examination or if the injured employee fails to attend the rescheduled examination, the designated doctor shall notify the Division as soon as possible but not later than 21 days after the date of the originally scheduled examination. This amendment simply clarifies that if neither the originally scheduled examination nor a rescheduled examination can timely occur, the designated doctor must inform the Division as soon as possible but no later than 21 days after the date of the originally scheduled examination. This deadline to notify the Division extends to 21 days because, in some circumstances, the designated doctor may not know that an examination cannot occur until the date of the rescheduled examination.

Amended §127.10.

Amended subsection (a)(3) provides that if the designated doctor does not timely receive medical records from either the insurance carrier or the treating doctor, the designated doctor shall report this violation to the Division within one working day of not timely receiving the records. It further provides that, once notified, the Division shall take action necessary to ensure that the designated doctor receives the records, and the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records if the originally scheduled examination cannot occur. It also provides that "If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records." These amendments are necessary to reduce the likelihood that a designated doctor will perform an examination without all necessary medical records, which was an outcome sometimes permitted under the Division's previous rule.

Amended subsection (b) contains two clarifying amendments. First, subsection (b) provides that designated doctors must review submitted medical records, analyses, and materials submitted by the Division before the designated doctor examination. This amendment is necessary in order to ensure that not only the report but also the examination is informed by those documents. Second, amended subsection (b) also provides that designated doctors shall accept medical records provided by injured employees. This amendment is consistent with both current Division policy and expectations and is necessary to ensure that a designated doctor receives full and current information the medical condition of the injured employee.

Amended subsection (c) clarifies that designated doctors shall, not may, refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. This amendment is necessary both to conform to the corresponding standard for designated doctor referrals for testing and to ensure that designated doctors do not perform examinations for which they are not qualified but are still able to obtain all necessary information to answer the question(s) at issue. Amended subsection (c) also clarifies any additional testing or examinations requested by the designated doctor shall not be denied retrospectively based on medical necessity, extent of injury, or compensability. This amendment is necessary to clarify that though insurance carriers may not deny designated doctor requested testing or examinations for the listed reasons, the bills submitted for these referrals must still comply with Division billing and fee requirements, and insurance carriers may still retrospectively review these bills for those purposes.

Amended subsection (c) also provides that any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives Division approval for additional time before the expiration of the 15 working days. This amendment is necessary to ensure that designated doctors have sufficient time to provide their reports in situations in which testing or appropriate referral examinations cannot be scheduled promptly. Lastly, amended subsection (c) provides that if the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the Division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report. This amendment is necessary to ensure that designated doctors have clear instruction on how to complete their reports when an injured employee refuses or fails to attend the designated doctor's requested testing or referral examination.

Amended subsection (d) provides that any evaluation relating to MMI, an IR, or both, shall be conducted in accordance with §130.1 of this title. This amendment simply recodifies §130.6(a) of this title, which is adopted to be repealed elsewhere in this issue of the *Texas Register.* Amended subsection (d) further provides that if a designated doctor is simultaneously requested to address MMI and/or IR and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and IRs that take into account each possible outcome for the extent of the injury. This amendment updates a previous requirement of repealed §130.6(b)(4) of this title in light of the 2005 amendment to Labor Code §408.0041(a) that provided a designated doctor the ability to examine the extent of an injured employee's compensable injury. To correspond with this amendment, the Division has also amended subsection (d) to state that if the designated doctor provides multiple certifications of MMI and IR, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each IR assigned and a Designated Doctor Examination Data Report pursuant to new §127.220 of this title for the doctor's extent of injury determination. The designated doctor, however, shall only submit one narrative report required by §130.1(d)(1)(B) of this title for all IRs assigned and extent of injury findings. Lastly, amended subsection (d) also clarifies that all designated doctor narrative reports submitted under this subsection shall also comply with the requirements of new §127.220(a), which primarily recodifies all Division required elements for designated doctor narrative reports included in current §127.10(f) and also expands upon those requirements. The Division has also adopted a parallel requirement for any narrative report submitted by a designated doctor under amended subsection (e), which governs reports filed by a designated doctor who examines an injured employee pursuant to any question relating to return-to-work. The Division has added these parallel requirement to clarify how these amended subsection apply in conjunction with new §127.220(a) of this title.

Amended subsection (f) deletes the current requirements for reports filed by designated doctors on issues other than those listed in §127.10(d) - (e). As discussed above, the Division has recodified and expanded upon these requirements in new §127.220(a). Amended subsection (f) also provides that designated doctors who file narrative reports under this subsection must also file a Designated Doctor Examination Data Report as described by new §127.220(c). This amendment is necessary to conform to the Division's new requirements for this form under that section and is further described below in relation to that new section.

Amended subsection (h) requires that if the designated doctor provides multiple certifications of MMI/IR under subsection (d) because the designated doctor was also ordered to address the extent of the injured employee's compensable injury, the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. This amendment corresponds with the Division's amendments to amended subsection (d) and also updates the requirement of repealed §130.6(f) of this title. Specifically, this amendment takes into account the fact that, pursuant to Labor Code §408.0041(f), an insurance carrier must pay benefits in accordance with the designated doctor's report, which under this circumstance would also include the designated doctor finding on the extent of the injured employee's compensable injury.

Amended subsection (i)(2) provides that a designated doctor must maintain documentation of the agreement of the designated doctor and the injured employee to reschedule the examination and the notice that the designated doctor provided to the injured employee's treating doctor within one working day of rescheduling the examination. These amendments are necessary to ensure compliance with the Division's other amendments to §127.5(e).

Amended §127.20.

Amended subsection (a) provides that "Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision." This amendment is necessary to ensure that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution while still providing the Division the necessary discretion to monitor the quality and appropriateness of the requests and the authority to limit a designated doctor's responses to the request for clarification submitted to the doctor. The Division also notes that this standard is changed from the Division's proposed standard, and the Division has made this change for the reasons discussed in the "Reasoned Justification" section.

Amended §127.25.

Amended subsection (c) provides that if the injured employee who failed to attend a designated doctor examination contacts the designated doctor within 21 days of the scheduled date of the missed examination to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor. Amended subsection (d) provides that if the injured employee fails to contact the designated doctor within 21 days of the scheduled date of the missed examination but wishes to reschedule the examination, the injured employee must request a new examination under §127.1. These two amendments are necessary to ensure that a rescheduled designated doctor examination of an injured employee who failed to attend an examination does not occur at a time so distant from the originally scheduled examination that injured employee's condition or other dispositive circumstances may have changed.

New §127.100.

New subsection (a) provides the requirements a doctor who is not a designated doctor must meet in order to become certified as a designated doctor. This subsection, in part, recodifies provisions of repealed §180.21(d)(1) - (4) of this title, which addressed the minimum requirements for admission to the Division's designated doctor list on or after September 1, 2007. New subsection (a) also expands upon these recodified sections by including new requirements for a doctor applying to become certified as a designated doctor. Specifically, new subsection (a) provides that a doctor is considered having maintained an "active practice" if the doctor maintains or has maintained routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients. This standard is consistent with the definition of active practice under Texas Medical Board rule 22 Texas Administrative Code §163.11 (relating to the Active Practice of Medicine).

New subsection (a) also requires a doctor applying for certification as a designated doctor to own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the edi-

tion of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the Division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the Division. This new subsection is necessary to ensure that a doctor applying to become certified as a designated doctor has the ability to perform the specific designated doctor duties described by Labor Code §408.0041 as required by Labor Code §408.1225(a-2).

New subsection (b) provides elements of a complete application for designated doctor certification and that the application must be submitted on the Division's required form. This subsection primarily recodifies the elements of a complete application for admission to the Division's designated doctor list under repealed §180.21(g) of this title and is necessary to ensure the Division has sufficient information to review an applicant for designated doctor certification.

New subsection (b) also requires doctors applying for certification to disclose any affiliations the doctor has with a workers' compensation health care network certified under Chapter 1305, Insurance Code or political subdivision under Labor Code §504.053(b)(2). This information is necessary for the Division to monitor possible disqualifying associations related to the doctor and a particular claim if the Division certifies the doctor.

New subsection (b) also requires applicants for certification as a designated doctor to provide the identities of any person(s) with whom the doctor has contracted to assist in performance or administration of the doctor's designated doctor duties. This information is necessary for the Division to monitor and enforce other proposed or current regulations, including monitoring disqualifying associations of a designated doctor.

Lastly, new subsection (b) requires applicants to attest not only to the accuracy of the information submitted but also that the information is and will be updated as required by new §127.200(a)(8). Furthermore, subsection (b) requires applicants to attest that the doctor shall consent to any on-site visits, as provided by new §127.200(a)(15), by the Division at facilities used or intended to be used by the designated doctor to perform designated doctor examinations for the duration of the doctor's certification, regardless of whether the Division is alleging a violation has occurred. This new provision is necessary to ensure that the Division has sufficient means to monitor the quality of facilities used by designated doctors for designated doctor examinations and to otherwise ensure that designated doctors comply with all required duties imposed upon them by the Act or other applicable Division rules. Furthermore, it is necessary to correspond with the related requirement of the Division's new §127.200(a)(15).

New subsection (c) primarily recodifies the provisions of repealed §180.21(j) of this title. Additionally, new subsection (c) also provides that approvals of certification by the Division shall also include the effective and expiration dates of the certification and that a designated doctor's certification shall only be for a term of two years. This amendment is necessary to implement the recertification process for designated doctors required by Labor Code §408.1225(b)(2). The Division fully provides for this process, however, in new §127.110, which is described below.

New subsection (d) recodifies the provisions of repealed §180.21(i) of this title; however, while these standards for denial previously applied to admission to the Division's designated doctor list, they now apply to the denial of a doctor's application for certification as a designated doctor. This subsection is necessary to inform possible applicants of the possible reasons for denial of an application for certification.

New subsection (e) recodifies the majority of repealed §180.21(j) of this title and describes the written appeal process through which a doctor whose application for certification as a designated doctor is denied may dispute that denial. This subsection is necessary to ensure applicants are notified of their remedies if their applications for certification as a designated doctor are denied.

New subsection (f) provides that a designated doctor whose application for certification is approved but wishes to dispute the examination qualification criteria under §127.130 that the Division assigned to the doctor may do so through the procedures described in new subsection (e). Designated doctors must include in their response to the Division the specific criteria they believe should be modified and documentation to justify the requested change. This new provision is necessary to ensure that designated doctor whose applications for certification are approved still have the opportunity to dispute the terms of that approval, if necessary.

New subsection (g) provides that designated doctors who are designated doctors on the effective date of new §127.100 shall be considered certified for the duration of the designated doctor's current certification. New subsection (g) further provides that before the expiration of the designated doctor's current certification, the designated doctor must timely apply for recertification under the applicable requirements of §127.110. This provision is necessary to permit the Division to phase in its proposed new certification requirements over a two year period and to prevent any sudden gaps in designated doctor availability after January 1, 2013. This phase-in period is also necessary to comply with §41(b) of HB 2605, which provides that a designated doctor is not required to obtain designated doctor certification until January 1, 2013. Lastly, the Division clarifies that, for the purposes of this subsection, a designated doctor's "current certification" expires on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title.

New §127.110.

New subsection (a) describes the process through a designated doctor may apply for recertification as a designated doctor if the doctor's certification expires before January 1, 2013. This subsection is necessary to clarify the appropriate recertification procedure for designated doctors who, before January 1, 2013, would have been required to renew their application under repealed §180.21(e) of this title. The Division also clarifies that for the purposes of new subsection (a) a designated doctor's certification is considered to have expired on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title.

New subsection (a)(1) primarily recodifies the application renewal provision of repealed §180.21(e) of this title. Specifically, it provides that designated doctors must renew their application status by submitting to the Division verification that the doctor has completed a minimum of 12 additional hours of Division required training. New subsection (a)(1), however, expands upon this requirement to also require designated doctors to pass all Division required examinations under §127.100 and to submit to the Division an application for certification under new §127.100(b). The Division clarifies that the substance of this required information will not be used to approve or deny a designated doctor seeking recertification under new subsection

(a); instead, the Division is only requiring this information to ensure its background information on each designated doctor is fully updated, and the Division has the designated doctor's consent to perform on-site inspections in accordance with new §127.200 of this title in order to ensure compliance with the Act and applicable Division rules. Lastly, new subsection (a)(1) provides that designated doctors who submit the materials required by this subsection will only be recertified as designated doctors under this subsection if the materials are submitted before January 1, 2013.

New subsection (a)(2) provides the process through which the Division will notify a designated doctor of its receipt of the required information in new subsection (a)(1) and of the effective and expiration dates of the designated doctor's new certification. This subsection is necessary to inform applicants for recertification of how they will receive notice of the Division's action on their application.

New subsection (a)(3) provides that "a designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status." This requirement is necessary to ensure that designated doctors maintain current training and testing and are still qualified to perform all designated doctor duties under Labor Code §408.0041 and other applicable statutes and Division rules.

Lastly, new subsection (a)(4) provides that designated doctors who fail to renew their application status before January 1, 2013 must instead apply for recertification under the procedures described under subsection (b) of this section. This requirement is necessary to comply with §41(b) of HB 2605, which provides that a designated doctor is not required to obtain designated doctor certification until January 1, 2013.

New subsection (b) provides the requirements for a designated doctor to be recertified as a designated doctor if the designated doctor's certification expires on or after January 1, 2013. The requirements under this new subsection do not substantially differ from the requirements for a doctor applying for certification under new §127.100(a) and are required for the same reasons as described above in reference to that subsection. The Division further clarifies that for the purposes of this subsection a designated doctor's "certification" expires either on the date by which the designated doctor would have been required to renew the doctor's application pursuant to repealed §180.21(e) of this title or on the expiration date specified by the Division under new subsection (d) of this section.

New subsection (c) provides that the Division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the Division fails to receive the required information in subsection (b)(1) - (3) from the designated doctor before that time though the designated doctor may still provide services on claims to which the designated doctor had been previously assigned. New subsection (c) further provides that "a designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation. A designated doctor who fails to apply for recertification under this section within 30 days after the expiration of the designated doctor's certification may no longer apply for recertification and must instead apply for certification under §127.100." These new requirements parallel the analogous requirements in new subsection (a)(3) for designated doctors whose certifications expire before January 1, 2013, and these requirements are necessary for the same reasons described above in reference to that new subsection. Specifically, they are necessary to ensure timely compliance with the Division's recertification requirements and to ensure that designated doctors maintain current training and testing and are still qualified to perform all designated doctor duties under Labor Code §408.0041 and other applicable statutes and Division rules.

New subsection (d) provides the process through which the Division will notify a designated doctor of approval or denial of the designated doctor's application for recertification, the effective and expiration dates of the designated doctor's new certification, and the designated doctor's examination qualification criteria under new §127.130 that the Division has assigned to the doctor as part of the doctor's recertification. The Division emphasizes that new subsection (d) differs from the notification process provided in new subsection (a)(2), because under new subsection (d) the Division will either approve or deny a designated doctor's application for recertification based on several different factors, including the quality of the designated doctor's decisions and reviews during the previous two years, and a denial of recertification will lead to a designated doctor's removal from the Division's designated doctor list. This process differs from the recertification process under new subsection (a)(2), because the recertification process under that subsection entitles a designated doctor to recertification if all required information is timely submitted to the Division. The recertification process under new subsection (d), however, implements Labor Code §408.1225(b), which requires the Division to actively monitor designated doctors and permits the Division to deny renewal of a designated doctor's certification to ensure the quality of designated doctor decisions and reviews. Furthermore, this enhanced recertification process is necessary, because of the Division's required phase-in of the certification requirements of Labor Code §408.1225(a-1) - (a-4) and new §127.100 over the next two years. This recertification process will ensure that a designated doctor approved for recertification meets all those required certification standards.

New subsection (e) provides the reasons for which the Division may deny a designated doctor's application for recertification under new subsection (b). These reasons include all the reasons for which the Division would deny a doctor's application for certification as a designated doctor under new §127.100 of this title. New subsection (e)(4) - (5), however, expand upon those denial reasons with several other performance-based factors that the Division will review when deciding whether to deny or approve a designated doctor's application for recertification. This expansion is necessary, because a complete biannual review of a designated doctor's performance, both from an administrative and quality of review perspective, provides the Division with the critical information that can help determine whether a particular designated doctor can still meet the duties of a designated doctor under Labor Code §408.0041 and other applicable provisions of the Act and Division rules. Additionally, this review meets the Division's obligation to have a recertification process that ensures the quality of designated doctor decisions and reviews under Labor Code §408.1225(b)(2).

New subsection (f) describes the process through which a designated doctor may dispute the Division's denial of the doctor's application for recertification. This subsection provides a des-

ignated doctor with two options. First, the designated doctor may provide a written response to a denial under new subsection (f)(2). This process parallels the written response process under new §127.100(e) for denials of an application for certification as a designated doctor. Alternatively, however, a designated doctor whose application for recertification was denied may also seek reconsideration of this denial through an informal hearing before a panel of Commissioner of Workers' Compensation (Commissioner) designated representatives, and new subsection (f)(3) describes the process for this informal hearing, which includes the right for a designated doctor to have an attorney present at the informal hearing. These informal processes are necessary to ensure that designated doctors have a fair opportunity to dispute a denied application for recertification and to ensure the quality and accuracy of the Division's determinations in its proposed recertification process after January 1, 2013, which often may involve detailed or complex facts and analysis.

New subsection (g) provides that a designated doctor whose application for recertification under subsection (b) is approved but wishes to dispute the examination qualification criteria under new §127.130 that the Division assigned to the doctor may do so through the written appeal procedures described in subsection (f)(2) of this section. Designated doctors must include in their response to the Division the specific criteria they wish to be modified and documentation to justify the requested change. This new provision is necessary to ensure that a designated doctor whose application for recertification is approved still has the opportunity to dispute the terms of that approval, if necessary.

New §127.120.

New §127.120 recodifies repealed §180.21(k) of this title and provides that when necessary because the injured employee is temporarily located or is residing out-of-state, the Division may waive any of the requirements as specified in this chapter for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute or perform a particular examination. This recodification is necessary to ensure the availability of designated doctor examinations for out-of-state employees who may not be able to locate or travel to a certified designated doctor in Texas or another state.

New §127.130.

New subsection (a) provides that for examinations that will occur before January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor has credentials that are appropriate to the issue in question and the injured employee's medical condition and that meet the requirements of Labor Code §408.0043 and §408.0045, and applicable Division rules, and the designated doctor has no applicable disqualifying associations under new §127.140. This new subsection is necessary to codify the Division's current policy for assigning designated doctors to approved examinations, and this policy will remain in effect until January 1, 2013. This new subsection creates no substantive change in the Division's current practices and ensures that the Division's designated doctor selection process will continue to comply with Labor Code §§408.0041, 408.0043, 408.0045, and 408.1225 and other applicable Division rules until January 1, 2013.

New subsection (b) provides the qualification standard for selecting a designated doctor for an examination that will occur on or after January 1, 2013. The selection criteria under this new qualification standard will create a substantive change in the Division's designated doctor selection process, but this substantive change is necessary to comply with two amendments to Labor Code §408.0041 made by HB 2605 that will apply to all designated doctor examinations on or after January 1, 2013. Specifically, HB 2605, as discussed above, amended §408.0041(b) to provide that a medical examination under Labor Code §408.0041 shall be performed by the next designated doctor on the Division's list of certified designated doctors whose credentials are appropriate for "the area of the body affected by the injury and the injured employee's diagnosis" and deletes the requirement that a designated doctor's credentials must be appropriate for the "issue in question" and the injured employee's "medical condition."

Additionally, however, HB 2605 also amended §408.0041(b-1) to provide that while Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. This conflict provision will substantially limit the application of Labor Code §408.0043 and §408.0045 to a designated doctor selected to perform an examination under Labor Code §408.0041 on or after January 1, 2013. Specifically, though both Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, Labor Code §408.0041 requires designated doctor examinations to be performed by the next available designated doctor who meets the Labor Code §408.0041 criteria.

To implement these amendments, the Division has adopted new subsection (b)(1) - (8). New subsection (b)(1) - (7) provide the substantive core of the Division's new qualification standard. Each of these new paragraphs governs injuries and diagnoses relating to a different area of the body (such as hand and upper extremity or feet, including the toes and heel) and matches that area of the body to particular doctor license types the Division has determined to be qualified and appropriate to examine the injuries and diagnoses of that area of the body. Generally, the Division's based its rationale for these determinations on the fact that for the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

The Division recognizes that the broad categories of new subsection (b)(1) - (7) could potentially in some circumstances permit a designated doctor to evaluate a particular injury or diagnosis that would exceed the scope of the doctor's license or require the doctor to examine an uncommon, complex diagnosis that may require a higher level of expertise in a particular medical specialty; therefore, the Division has adopted new subsection (b)(8)(A) - (H) and, in part, new subsection (f)(5) and new §127.200(a)(12) of this title (relating to Duties of a Designated Doctor) to prevent these outcomes.

New subsection (b)(8)(A) - (H) address the necessary qualifications of designated doctors to examine certain complex diagnoses less frequently seen in the workers' compensation system. The Division has determined that nearly 90% of designated doctor examinations will be requested to evaluate injuries and diagnoses addressed by new subsection (b)(1) - (7); however, the Division has determined that there also exists a relatively infrequently seen but nonetheless sufficiently impactful subset of

diagnoses or injuries in the workers' compensation system that because of their infrequency and complexity require additional qualification criteria. The Division, therefore, has in new subsection (b)(8)(A) - (H) divided these diagnoses or injuries (such as traumatic brain injuries or chemical exposures) into eight subcategories and for each subcategory determined which medical doctors or doctors of osteopathy who are board certified by either the American Board of Medical Specialties or American Osteopathic Association Bureau of Osteopathic Specialists would be appropriate to evaluate that subcategory of diagnoses or injuries. These new subparagraphs thus ensure that these subcategories of diagnoses and injuries are evaluated by optimally qualified individuals with objectively demonstrable expertise while also preventing designated doctors who could not evaluate these conditions within the scope of their license or who may not have the appropriate training and specialty from examining these conditions by separating these conditions from new subsection (b)(1) - (7).

New subsection (c) provides that "[t]o be qualified to perform an initial examination on an injured employee, a designated doctor, other than a chiropractor, must be qualified under Labor Code §408.0043. A designated doctor who is a chiropractor must be qualified to perform an initial designated doctor examination under Labor Code §408.0045. If, however, the requirements of this subsection would disqualify a designated doctor otherwise qualified under subsection (b), this subsection, pursuant to Labor Code §408.0041(b-1), does not apply." This new subsection is necessary to both clarify and reiterate the impact of the HB 2605 amendment to Labor Code §408.0041(b-1) discussed above.

New subsection (d) provides that "For any particular designated doctor examination, the division may exempt a designated doctor from the applicable qualification standard if no other designated doctor is qualified and available to perform the examination." This provision is necessary because the Division must have such an exception as a safeguard for instances in which no doctor qualified under this subsection is available to perform the examination. In these instances, the Division will rely on other designated doctors who, though not optimally qualified, can use both referrals for specialist consultations and their training as designated doctors to incorporate these referrals into their reports to still produce a designated doctor report of high quality. New subsection (d) also provides that the Division may not offer a qualified designated doctor an examination if it is reasonably probable that the designated doctor will not be qualified on the date of the examination. This provision is necessary to ensure the Division has the discretion to select an appropriate designated doctor in uncommon circumstances, such as when a qualified doctor may not be qualified on the date of the examination because a disciplinary action by the doctor's licensing board will come into effect before that date.

New subsection (e) provides that a designated doctor who performs an initial designated doctor examination of an injured employee and had the appropriate selection criteria to perform that examination under either subsection (a) or (b) of this section, as applicable, shall remain assigned to that claim and perform all subsequent examinations of that injured employee unless the Division authorizes or requires the designated doctor to discontinue providing services on that claim. This new subsection simply codifies the requirements of the HB 2605 amendment to Labor Code §408.1225(f).

New subsection (f) provides the reasons for which the Division would authorize a designated doctor to leave a claim to which the designated doctor had been previously assigned. These reasons include, but are not limited to, a decision by the doctor to leave the workers' compensation system or a determination by the doctor that examining the injured employee would require the designated doctor to exceed the scope of the doctor's license. The Division notes that this last reason serves as an additional precaution to ensure that a designated doctor does not perform examinations on an injured employee the doctor previously examined if the injured employee's medical condition has developed in such a manner during the life of the claim that it now exceeds the scope of the designated doctor's license.

New subsection (g) provides the reasons for which the Division would compel a designated doctor to leave a claim to which the designated doctor had been previously assigned. The reasons include the following uncommon circumstances: the doctor has failed to become recertified as a designated doctor under either subsection (a) or (b) of §127.110; the doctor no longer has the appropriate qualification criteria under either subsection (a) or (b) of this section, as applicable, to perform examinations on the claim; the doctor has a disqualifying association, as specified in new §127.140, relevant to the claim; the doctor has repeatedly failed to respond to Division appointment, clarification, or document requests regarding the claim; or the doctor's continued service on the claim could endanger the health, safety, or welfare of either the injured employee or doctor. This new subsection is necessary, because these circumstances either would violate other provisions of the Labor Code or other law or would create administratively unworkable outcomes.

New subsection (h) provides that the Division will prohibit a designated doctor from performing examinations on all new or existing claims if the designated doctor has had the doctor's license revoked or suspended and the suspension has not been probated by an appropriate licensing authority. This amendment is necessary to clarify that no other circumstances will permit a doctor to perform a designated doctor examination if the doctor is wholly unable to practice within the scope of the doctor's license.

New §127.140.

New subsection (a) relates to designated doctor disqualifying associations and primarily recodifies repealed §180.21(a)(2) of this title. Additionally, however, it also adds that a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for the provision of medical benefits to the injured employee may also constitute a disqualifying association.

New subsection (b) provides that, for an examination performed on or after January 1, 2013, a designated doctor shall also have a disqualifying association relevant to a claim if an agent of the designated doctor has an association relevant to the claim that would constitute a disqualifying association under subsection (a) of this section. This amendment is necessary as a logical extension of the Division's current standard of prohibiting any association by a designated doctor with the injured employee, the employer, or insurance carrier that may give the appearance of preventing the designated doctor from rendering an unbiased opinion and to implement the requirement of Labor Code §408.1225(d) that requires the Division to develop rules that ensure a designated doctor has no conflicts of interest relevant to a claim for which the designated doctor will perform an examination. For without this new subsection, the Division would have no express prohibition of certain potentially inappropriate system practices, such as when the same third party is both requesting a

designated doctor examination on behalf of an insurance carrier while also on the same claim accepting and scheduling designated doctor examinations on behalf of a designated doctor. The Division emphasizes, however, that these potential disqualifying associations must still be examined on a case by case basis in order to determine whether or not the association could reasonably be perceived as having the potential to influence the conduct or decision of a designated doctor. Lastly, the Division has elected to delay implementation of this requirement until January 1, 2013, so that system participants may have time to prepare for its effect on their business practices and so that it may be implemented simultaneously with the Division's other designated doctor selection changes.

New subsection (c) substantially recodifies repealed §180.21(m)(9) of this title but also adds that a designated doctor commits an administrative violation if the designated doctor performs an examination when the designated doctor has a disqualifying association relevant to that claim. This amendment is necessary to ensure diligence on the part of the designated doctor in review of both offered appointments and other documents relating to accepted examination for any possible disqualifying association.

New subsection (d) provides that insurance carriers shall notify the Division of any disqualifying associations between the designated doctor and injured employee because of the network affiliations described under subsection (a)(6) of this section within five days of receiving the Division's order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments). This new subsection is necessary to help ensure that injured employees are not subject to nor insurance carriers liable for designated doctor examinations for which the selected designated doctor has a disqualifying association because of an affiliation with a Chapter 1305, Insurance Code workers' compensation health care network or a contract with a political subdivision or political subdivision health plan under Labor Code §504.053(b)(2).

New subsection (e) provides that if the Division determines that a designated doctor with a disqualifying association performed a designated doctor examination, all reports produced by that designated doctor as a result of that examination shall be stripped of their presumptive weight. This new subsection is necessary to harmonize this new section with current §127.10(g), which provides that the report of the designated doctor is given presumptive weight regarding the issue(s) in question the designated doctor was properly appointed to address.

New subsection (f) provides that a party that seeks to dispute the selection of a designated doctor for a particular examination based on a disqualifying association or to dispute the presumptive weight of a designated doctor's report based on a disqualifying association must do so through the Division's dispute resolution processes in Chapter 410, Labor Code and Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures). This new subsection is necessary to clarify that only the Division may make a final determination regarding the existence of a designated doctor's disqualifying association related to a claim, and parties wishing to raise this issue must do so through the Division's dispute resolution processes.

New §127.200.

New subsection (a) lists certain duties of designated doctors. New subsection (a)(1) provides that a designated doctor must perform designated doctor examinations in a facility currently used and properly equipped for medical examinations or other similar health care services and that ensures safety, privacy, and accessibility for injured employees and injured employee medical records and other records containing confidential claim information. This new subsection is necessary to clarify that designated doctor examination facilities meet basic standards of medical appropriateness and to be consistent with the general system goal expressed in Labor Code §402.021(a) that injured employees shall have access to high-quality medical care under the Act.

New subsection (a)(2) provides that designated doctors must ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor in the doctor's capacity as a designated doctor for the duration of the retention period specified in §127.10(i) and ensure the destruction of these medical records after both this retention period expires and the designated doctor determines the information is no longer needed. This new subsection is necessary to clarify and ensure that designated doctors must comply with confidentially provisions of the Act, including, but not limited to, Labor Code §402.083.

New subsection (a)(3) provides that designated doctors must ensure that all agreements with a person or persons that permit those parties to perform designated doctor administrative duties, including but not limited to billing and scheduling duties, on the designated doctor's behalf are in writing and signed by the designated doctor and the person(s) with whom the designated doctor is contracting; define the administrative duties that the person may perform on behalf of the designated doctor; require the person or persons to comply with all confidentiality provisions of the Act and other applicable laws; comply with all medical billing and payment requirements under Chapter 133 of this title (relating to Medical Benefits); do not constitute an improper inducement relating to the delivery of benefits to and injured employee under Labor Code §415.0036 and §180.25 of this title (relating to Improper Inducements, Influence and Threats); and are made available to the Division upon request. This new subsection is necessary to ensure that the agents of a designated doctor are authorized to perform administrative duties on the designated doctor's behalf, that those person(s) comply with the confidentiality provisions of the Act, and to assist the Division in monitoring the disqualifying associations imputed to designated doctors by these third parties.

New subsection (a)(4) provides that designated doctors must notify the Division in writing and in advance if the designated doctor voluntarily decides to defer the designated doctor's availability to receive any offers of examinations for personal or other reasons and specify the duration of and reason for the deferral. This new subsection is necessary for the Division to be able to administratively prepare for these deferrals. The Division also notes that while the Division has elected to leave the frequency and extent of these deferrals to the discretion of the designated doctor, excessive or unnecessary deferrals will be a factor considered if the designated doctor applies for recertification under new §127.110(b).

New subsection (a)(5) provides that a designated doctor must notify the Division in writing and in advance if the designated doctor no longer wishes to practice as a designated doctor before the doctor's current certification as a designated doctor expires; a designated doctor who no longer wishes to practice as a designated doctor before the doctor's current certification expires must expressly surrender the designated doctor's certifica-

tion in a signed, written statement to the Division. This amendment is necessary to ensure the Division is fully aware and can document that a designated doctor has elected to withdraw from practice a designated doctor before the expiration of the doctor's certification as a designated doctor.

New subsection (a)(6) provides that designated doctors must be physically present in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee that is not referred to another health care provider under §127.10(c). The new subsection is necessary to ensure that designated doctors either perform or directly supervise all elements of a designated doctor examination that are not referred to another health care provider under §127.10(c).

New subsection (a)(7) provides that designated doctors must apply the appropriate edition of the *American Medical Association Guides to the Evaluation of Permanent Impairment* and Division-adopted return-to-work guidelines and consider Division-adopted treatment guidelines or other evidence-based medicine when appropriate. This new subsection is necessary to clarify that designated doctors must use these guidelines as required by the Act and other Division rules.

New subsection (a)(8) requires that all designated doctors must provide the Division with updated information within 10 working days of a change in any of the information provided to the Division on the doctor's application for certification or recertification as a designated doctor. This new subsection primarily recodifies repealed §180.21(l) of this title but also reduces the timeframe for submitting these updates from 30 days to 10 working days in order to limit the administrative errors caused by inaccurate designated doctor profile information.

New subsection (a)(9) requires that designated doctors must maintain a professional and courteous demeanor when performing the duties of a designated doctor, including, but not limited to, explaining the purpose of a designated doctor examination to an injured employee at the beginning of the examination and using non-inflammatory, appropriate language in all reports and documents produced by the designated doctor. This new subsection is necessary to ensure that designated doctor examinations meet the express system goal of Labor Code §402.021(a) that all injured employees shall be treated with dignity and respect when injured on the job and to maintain the objectivity of the designated doctor process.

New subsection (a)(10) provides that designated doctors must bill for designated doctor examinations and receive payment in accordance with Chapter 133 of this title and Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments). This new subsection is necessary simply to reiterate and clarify the application of those chapters to designated doctor billing. New subsection (a)(11) is similarly for clarification purposes.

New subsection (a)(12) provides that designated doctors must notify the Division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would required the doctor to exceed the scope of practice authorized by the doctor's license. This new subsection is necessary to conform with the requirements of new §127.130 and to ensure that designated doctors do not perform examinations that are not permitted within the scope of their license.

New subsection (a)(13) provides that designated doctors must not perform required medical examinations, utilization reviews, or peer reviews on a claim to which the designated doctor has been assigned as a designated doctor. This new subsection is necessary to ensure that designated doctors do not intentionally or negligently disqualify themselves from claims to which they have already been assigned.

New subsection (a)(14) provides that designated doctors must identify themselves at the beginning of every designated doctor examination. This requirement is necessary to assist injured employees in verifying that the designated doctor performing examination is the designated doctor that was ordered to perform the examination.

New subsection (a)(15) provides that designated doctors must consent to and cooperate during any on-site visits by the Division pursuant to §180.4 of this title (relating to On-Site Visits); notwithstanding §180.4(e)(2) of this title, the Division's purpose for these visits will be to ensure the designated doctor's compliance with the Act and applicable Division rules, and the notice provided to the designated doctor in accordance with §180.4(e) of this title, either in advance of or at the time of the on-site visit, will specify the duties being investigated by the Division during that visit. This amendment is necessary to ensure that the Division has sufficient means to monitor the quality of facilities used by designated doctors for designated doctor examinations and to otherwise ensure that designated doctors comply with all required duties imposed upon them by the Act or other applicable Division rules and is adopted in tandem with the requirement that designated doctors provide this consent as a requirement of the certification or recertification as a designated doctor under §127.100 and §127.110 of this title, respectively. The Division notes that though these on-site visits generally shall comply with the requirements of §180.4 of this title, the Division will not necessarily be alleging a specific violation at the time of the on-site visit; instead, the Division may, in some cases, simply be inspecting a designated doctor on a random basis to ensure compliance with the Act and applicable Division rules. The Division will, however, provide the designated doctor notice of the specific duties being investigated during the on-site visit at the time of the visit (for unannounced on-site visits) or in advance of the visit (for announced on-site visits).

New subsection (b) provides that for the purposes of Chapter 127 and Chapter 180 of this title (relating to Monitoring and Enforcement), and all other applicable laws and Division rules, any person with whom a designated doctor contracts or otherwise permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the doctor's "agent" as defined under §180.1 of this title (relating to Definitions). This new subsection is necessary to harmonize this new section with the Division's rules regarding agents in Chapter 180 of this title.

New §127.210.

New subsection (a) primarily recodifies repealed §180.21(m) of this title and provides a non-exhaustive list of designated doctor administrative violations that are not necessarily expressed in any other Division rule. New subsection (a)(3) also clarifies that any refusal to accept or perform a Division offered appointment or ordered appointment that relates to a claim on which the doctor has previously performed an examination is an administrative violation. This new violation is necessary to implement the HB 2605 amendment to Labor Code §408.1225(f) described above.

New subsection (a)(6) provides that it is an administrative violation for a designated doctor to order or perform unnecessary testing of an injured employee as part of a designated doctor's

examination. This new subsection is necessary to clarify that testing should only be performed when necessary to resolve the issue(s) in question and to conform to the analogous standard for health care provider referrals in new subsection (a)(5), which recodifies current §180.21(m)(3).

Additionally, new subsection (a)(12) provides that it is an administrative violation for a designated doctor to behave in an abusive or assaultive manner toward an injured employee. This new subsection is necessary to correspond with the Division's professionalism standard under new §127.200(a)(8) and to ensure injured employee safety and dignity during designated doctor examinations.

Lastly, new subsection (a)(14) provides that designated doctors may not perform examinations that the designated doctor was not ordered to perform. This amendment is necessary to highlight that only the designated doctor assigned to the claim may perform the designated doctor examination of the injured employee.

New subsection (b) provides that designated doctors are liable for all administrative violations committed by their agents on the designated doctor's behalf under this section, other Division rules, or any other applicable law. This amendment is necessary to harmonize this new section with the definition of "agent" in §180.1 of this title and to remind designated doctors of the existing and applicable requirements of that section.

New subsection (c) recodifies repealed §180.21(n) of this title.

New §127.220.

New subsection (a) primarily recodifies repealed §127.10(f)(1) - (8) and also expands upon those subsections in order to both ensure medical and legal sufficiency of designated doctor narrative reports and to provide the Division with information necessary for the monitoring of designated doctor reviews and administrative functions. The majority of these required provisions are either recodified provisions or are necessary in order for the designated doctor to document compliance with other Division rules. The Division also notes that the new proposed requirement that designated doctors must document the time the designated doctor began taking the medical history of the injured employee, physically examining the employee, and engaging in medical decision making and the time the designated doctor completed these tasks is primarily necessary for informational purposes and to assist in the investigation of complaints of injured employee maltreatment or possible fraud. The Division recognizes, however, that the time spent performing these tasks may not necessarily have any bearing on the quality of a designated doctor's review and intends to make no definitive implication of that nature by imposing this requirement.

The Division notes that it has also made two changes, in response to comment, to subsection (a) from the formal proposal. The Division has deleted the requirement that designated doctor include "the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable" in their narrative reports. The Division has deleted this requirement because for most examinations this information will either be reported on the DWC-032, the DWC-068, or both and, therefore, is not necessary in a designated doctor's narrative report. The Division has also deleted the requirement that designated doctor include the time the examination began from §127.220(a)(6) of this title. The Division believes that this information is unnecessary, particularly in light of the timing requirement of §127.220(a)(8).

New subsection (b) provides that designated doctors who perform examinations under §127.10(d) or (e) shall also complete and file the Division forms required by those subsections with their narrative reports. Designated doctors shall complete and file these forms in manner required by applicable Division rules

New subsection (c) provides that designated doctors who perform examinations under §127.10(f) must, in addition to filing a narrative report that complies with new subsection (a) of this section, also file a Designated Doctor Examination Data Report in the form and manner required by the Division. New subsection (c) then further provides for the required elements of a Designated Doctor Examination Data Report. The purpose of this report is intended to be analogous to the purpose of the Division's DWC-069 form for MMI/IR examinations and is necessary to ensure that the Division has uniform report format for these examination suitable for data harvesting. The elements of this report do not substantially differ from the requirements of designated doctor narrative reports except that they do not require a designated doctor to include any of the narrative elements on the form. The designated doctor's rationale and other narrative elements are only to be included in the designated doctor's narrative report as described by new subsection (a) of this section.

Additionally, however, new subsection (c)(2) also requires that Designated Doctor Examination Data Reports list all injuries determined to be compensable by the Division or accepted as compensable by the insurance carrier. Designated doctors must obtain this information from the Division's DWC-032. Furthermore, designated doctors must also assign a single or multiple diagnosis codes for each listed injury or medical condition. The Division emphasizes, however, that this translation to a diagnosis code does not constitute a finding of the designated doctor for the purposes benefit payments or presumptive weight under the Act or §127.10(g) or (h). Instead, the Division only requires these codes for informational purposes, because they are necessary for mass data collection. New subsection (c) also provides a similar requirement for the disputed conditions examined by a designated doctor to determine the extent of the compensable injury, and, similarly, the diagnosis code requirement is only for informational purposes and has no other effect.

SUMMARY OF COMMENTS AND AGENCY RESPONSES

General: One commenter states that Division's new requirements for designated doctors are too high and too complex. Designated doctors will be overburdened and these rules will not increase quality. An agency cannot legislate quality.

Agency Response: The Division disagrees. These adopted sections are necessary to ensure the quality and availability of designated doctor examinations for reasons stated above and are necessary to comply with the Texas Workers' Compensation Act (Act).

General: One commenter states that the Division's cost note did not take into account the hotel, travel, food, etc. required to attend the training. The commenter states that the real cost is closer to $1000-$1500 every two years. Also, the *Official Disability Guidelines and Medical Disability Advisor* will cost approximately $800 a year.

Agency Response: The Division clarifies that travel and lodging expenses are not the result of the rule but are the result of an individual stakeholder's personal decisions. The Division also

notes that there are several designated doctor training sessions offered in Texas each year and that doctors are free to choose which training session meets their personal needs in terms of travel and scheduling. Moreover, even if the costs were the result of the rule, the Division would have no viable means of estimating these costs, because travel costs vary significantly from doctor to doctor depending on a variety of factors, including but not limited to the location of the doctor's primary practice, the training location selected by the doctor, the time of year chosen for the training, and the type of accommodations selected by the doctor. Lastly, the Division has determined that the *Official Disability Guidelines and Medical Disability Advisor* can be acquired from $390-$780 a year, and designated doctors may contact the Division for further information on acquiring the materials.

General: One commenter states that these rules impose more regulations, costs, and forms on designated doctors but offer no additional compensation to designated doctors. Designated doctor fees should be increased, and they should be paid for no shows.

Agency Response: The Division notes that designated doctor fees and reimbursement procedures are addressed in Chapter 134 of this title and are, therefore, outside the scope of these rules.

General: One commenter states that there are several bad ideas in these rules. They will drive designated doctors out of the system and lead to a shortage of quality examiners.

Agency Response: The Division disagrees. These adopted sections are necessary to ensure the quality and availability of designated doctor examinations for reasons stated above and are necessary to comply with the Texas Workers' Compensation Act (Act). Additionally, the Division will continue to monitor the availability and quality of designated doctor examinations after the adoption of these rules and will make future changes to these rules, if necessary.

§127.1(a): One commenter states that Office of the Injured Employee Counsel's (OIEC) ombudsmen should be added to the list of parties who may request an examination of the injured employee. An injured employee's representative, including a lay representative, is included and ombudsmen need to be listed for the same reasons they do.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.1(b): One commenter states the Division should require that any injuries in dispute be required to be resolved by an extent of injury examination.

Agency Response: The Division disagrees. The Division cannot compel system participants to request a designated doctor examination on the extent of a compensable injury even if that issue is in dispute. Disputing parties are free to request a benefit review conference on the issue, to request a designated doctor examination to address the issue, or to take no action at all despite the dispute if they so choose.

§127.1(b)(1) - (2): One commenter asks that the Division confirm that a prospective date of maximum medical improvement rendered by a previous designated doctor examination is sufficient grounds to approve a new request.

Agency Response: The Division declines to make an absolute confirmation that this circumstance would merit a reexamination, because of a number of possible, though unusual, intervening factors that would make the examination unmerited, such as a possible error in approving the first examination.

§127.1(b)(3): One commenter appreciates the inclusion of "diagnosis and part of the body affected" in this subsection.

Agency Response: The Division appreciates the support.

§127.1(b)(4): One commenter states that the Division should delete the requirement that parties must list all injuries determined to be compensable by the Division. The Division should already have this information and parties may not be aware of injuries deemed to be compensable by the Division in the Division's internal files. Also, requiring requesting parties to include injuries claimed by the injured employees but not disputed does not make sense and could have the unintended effect of allowing injured employees to raise new injuries before the carrier has a chance to investigate these claims. Subsection (b)(4) should be deleted.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that parties should not include injuries determined to be compensable by the Division. The Division does not make internal determinations of compensability; the Division makes determinations of compensability through its dispute resolution processes, and parties are aware of the outcomes of these disputes. Requestors, therefore, do have full access to this information. The Division agrees, however, that "injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier" is vague and would likely create confusion in the administration of claims. The Division, therefore, has deleted this provision.

§127.1(b)(4): One commenter states that the proposed rule is contradictory. It requires listing of injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier. But there is no point of listing areas claimed to be compensable if they are being disputed by the carrier, and the designated doctor is not being requested to examine extent.

Agency Response: The Division has deleted the requirement that parties list injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier from its adopted rule for other reasons stated above.

§127.1(b)(4): One commenter states that this section in its entirety is too vague, untenable, and repetitive. Without a specific diagnosis, as required in §127.1(b)(3) of this section, the analysis letter under §127.10(a)(2) of this title (relating to General Procedures for Designated Doctor Examinations) is obliterated and creates an avenue for unnecessary disputes and attacks on the designated doctor report. If an injured worker asserts a claim injury or condition, is it compensable?

Agency Response: The Division agrees and disagrees and has made a change. The Division disagrees that the requirement that parties list all injuries determined to be compensable by the Division or accepted as compensable by the insurance carrier

is too vague or untenable. The Division notes that this requirement has been in place since February 2011 and has not caused any of the problems suggested by the commenter. The Division agrees, however, that "injuries claimed to be compensable by the injured employee and not disputed by the insurance carrier" is vague and would likely create confusion in the administration of claims. The Division, therefore, has deleted this proposed provision.

§127.1(b)(8): Multiple commenters state that the Division should already have this information in its own claims management system. Also, this information is irrelevant given that most subsequent designated doctor examinations are on new issues. The Division should be able to screen whether the designated doctor has addressed the same issue based on its own internal files. This requirement is not necessary to determine the appropriateness of a request and is an unnecessary burden on the party requesting the examination. Each designated doctor examination should stand alone as intended.

Agency Response: The Division agrees in part and has made a change. The Division disagrees that this information is wholly irrelevant because information regarding the most recent designated doctor examination assists the Division in determining if the requested examination would occur within 60 days of the previous examination. The Division agrees, however, that information regarding examinations before the most recent examination is unnecessary and has therefore made a change. Specifically, adopted §127.1(b)(8) now only requires requestors to state whether a previous examination has occurred and, if so, to provide information regarding the most recent previous examination.

§127.1(b)(9): One commenter states that OIEC ombudsmen should also receive a copy of the DWC-032. Though injured employees receive a copy of the request often they do not understand the request or appreciate the importance of promptly providing this document to their ombudsmen. The Division recognizes this when it requires these notices to be sent to the injured employee's representative. Ombudsmen function similarly to lay representative and should be treated the same.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope of this rule.

§127.1(b)(11): One commenter requests that the Division include the modifier "below." Some of us need that clarity of direction to avoid automatically searching backward.

Agency Response: The Division agrees and has kept "below" in the adopted rule.

§127.1(b)(11)(C): One commenter requests that the Division replace the word "injuries" with either "diagnoses" or "conditions" in question.

Agency Response: The Division disagrees. This change is unnecessary because "injuries" includes diagnoses or conditions.

§127.1(b)(11)(C): A commenter requests that the Division remove the language permitting a person to request an examination to determine the "causation of the claimed injury" under this subsection.

Agency Response: The Division agrees to make this change. Causation is an element of extent of injury and, therefore, it is unnecessary to separate it from the authority to request an extent of injury examination.

§127.1(d): One commenter agrees that the Division needs a specific basis to deny a designated doctor examination request but also requests that the rule provide that the Division state with specificity the grounds for denial with statutory basis, if possible. This request is not to elicit information to which the parties are not or should not be entitled but to ensure that the basis is both objectively justified and understood by the parties. It is unclear why stating the basis for a determination affecting legal rights should not be afforded basic due process.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that its current rule denies "basic due process" and notes that the Division already does provide reasons for its denials of designated doctor requests in those denials. Nonetheless, the Division agrees that this practice is helpful and consistent with the Division's current procedures and, therefore, has made a change. Specifically, adopted §127.1(d) has been amended to state that the division will provide a written explanation for the denial to the requestor if the Division denies a request for a designated doctor examination.

§127.1(d)(4): Multiple commenters state that this subsection does not implement any portion of Senate Bill 1, House Bill 7, or House Bill 2605, and there is no authority for a designated doctor to resolve compensability disputes. The commenters further state that there is no legislative history to indicate that the designated doctor system was to be used to assist the Division in resolving disputes over the compensability of the claim. The designated doctor system was intended to assist the Division in resolving medical issues on compensable claims, and this is an issue unique and separate from the scope of a designated doctor authority.

Another commenter states that the Texas Workers' Compensation Act does not grant the Division the authority to appoint a designated doctor to address compensability, because it specifically provides this power to a hearing officer as a finder of fact. If the Legislature intended designated doctors to review compensability, it would have stated so. Because it did not, this exclusion is meaningful.

Agency Response: The Division disagrees with this comment but notes that, for other reasons, it has made a change. First, proposed §127.1(d)(4) (and now adopted §127.1(e)) does not authorize a designated doctor to resolve a compensability dispute or to address compensability. It permits a designated doctor to opine on medical causation (whether a claimed incident caused a claimed injury). Causation is not synonymous with compensability and alone is insufficient to determine the compensability of a claim as a whole. Other required determinations include, but are not limited to, whether the injured employee was an employee of the employer, whether the claimed incident actually occurred as described to the designated doctor, and whether the claimed incident occurred within the course and scope of employment. These determinations may only be made by the Division's Hearing's staff and have not been delegated to des-

ignated doctors. Thus, the commenter's concerns regarding a designated doctor's authority to resolve a compensability dispute or address compensability are unfounded, because proposed §127.1(d)(4) does not authorize designated doctors to address compensability.

Additionally, designated doctors cannot resolve a dispute regarding medical causation under proposed §127.1(d)(4) any more than a designated doctor can resolve a dispute regarding any issue under Labor Code §408.0041. Designated doctors never resolve disputes regarding issues addressed by them in a designated doctor examination. At most, they resolve or answer questions regarding issues under Labor Code §408.0041, but answering questions falls short of actually resolving a dispute and finally determining the liability of an insurance carrier on a particular claim as the Division does through its dispute resolution process. In fact, Labor Code §401.011(15) plainly states that a designated doctor can only "recommend a resolution of a dispute as to the medical condition of an injured employee." Recommending resolution and resolving are not synonymous actions. Thus, the report of a designated doctor only has presumptive weight, and a party may overcome this presumption through the Division's dispute resolution process by providing competing evidence and demonstrating that the preponderance of the evidence is contrary to the designated doctor's report. Permitting a designated doctor, therefore, to address medical causation in an examination no more conflicts with the Act or the duties of the Division and Division hearing officers to resolve disputes than permitting a designated doctor to address maximum medical improvement or extent of injury does.

Additionally, the Division does have the statutory authority to permit designated doctors to address medical causation in a designated doctor examination. Specifically, Labor Code §408.0041(a)(6) authorizes a designated doctor to perform examinations in order to resolve any question on issues similar to those described in Labor Code §408.0041(a)(1) - (5). The medical causation analysis a designated doctor provides under §127.1(d)(4) is, in many cases, substantially identical to the analysis a designated doctor provides when evaluating the extent of a compensable injury. Thus, designated doctors may appropriately address this issue under Labor Code §408.0041(a)(6).

Nonetheless, the Division acknowledges that in some cases the issue of medical causation may not be in dispute, may not be necessary to resolve a dispute regarding compensability of a claim, or the claimed injury may not require an expert medical opinion on causation; therefore, a designated doctor examination in these cases would create an unnecessary expenditure of system resources and unnecessary delay of the dispute. Additionally, however, determining whether a medical causation dispute exists and whether that dispute would require an expert medical opinion to be resolved at a contested case hearing is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carriers and delays in the dispute resolution process and the Division's need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): Multiple commenters state that there is no authority in the Act for a designated doctor to examine a claimant to either resolve or express an opinion regarding or create a presumption regarding the issue of compensability or causation of the initial injury as opposed to extent of injury. One commenter states that this rule, in tandem with §127.1(a)(6) and §127.1(b), allows the inference that a designated doctor may properly opine on compensability and further confuses the already weakened distinction between causation/extent of injury analysis and compensability analysis. Another commenter states that the issue of whether an employee suffered a compensable injury is not a "similar issue." All issues listed in Labor Code §408.0041(a) involve compensable claims, which is consistent with a carrier's liability under the Act. Permitting a designated doctor to determine compensability is not a "similar issue" because the carrier has denied all liability in these claims.

Agency Response: The Division disagrees with this comment but notes that for other reasons it has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Additionally, the Division disagrees that designated doctors are not authorized to opine on causation of the initial injury or that medical causation is not a "similar issue" under Labor Code §408.0041(a)(6), because the analysis of medical causation as it presents in a compensability dispute is often substantially identical to the analysis of extent of injury performed by a designated doctor. Extent of injury disputes do not address the compensability of a claim as whole but instead pertain to the dispute of the compensability of a particular aspect of the claim, such as which body areas/systems, injuries, conditions, or symptoms. *See State Office of Risk Management v. Lawton, 295 S.W.3d 646, 649 (Tex. 2009).* Furthermore, these disputes can essentially present in two varieties. First, an extent of injury dispute can involve an insurance carrier disputing that a later developing condition or diagnosis, such as clinical depression, is not causally tied to the injured employee's initial injury and thus should not be included as part of the compensable injury. One could characterize this form of extent of injury dispute as a consequential extent of injury dispute in which the injured employee is not claiming that the condition in dispute was caused by original mechanism of injury or incident but instead naturally resulted from the initial injury or harm. Alternatively, many other extent of injury disputes involve the insurance carrier disputing an injured employee's claim that a particular condition or diagnosis resulted from the initial mechanism of

injury. Put another way, the issue in dispute in this form of extent of injury dispute (which one could characterize as a concurrent extent of injury dispute) is whether a disc herniation an injured employee complains of months into a claim also resulted from the accident at work in addition to the broken kneecap and ankle injury, which the insurance carrier had already accepted as compensable. In fact, this fact scenario mirrors the facts presented in the notable extent of injury case *City of Laredo v. Garza,* 293 S.W.3d 625 (Tex. App.-- San Antonio 2009, no pet.), in which the Fourth Court was asked to determine whether the injured employee could establish through lay testimony a strong, logically traceable connection between his on-the-job accident and his injuries or if expert medical testimony was necessary to establish medical causation. Even though the injured employee in this case claimed that the disputed condition was caused by the original mechanism of injury and the dispute itself centered around this fact, the dispute appropriately presented as an extent of injury dispute not a compensability dispute because the insurance carrier was only disputing the compensability of particular aspects of the claim not the compensability of the claim as a whole.

This form of concurrent extent of injury analysis qualifies designated doctors to opine on medical causation in a dispute of compensability of an entire claim, because in fact this form of extent of injury analysis is substantially identical to the medical causation question presented to the designated doctor under proposed §127.1(d)(4). Specifically, both issues require a designated doctor to determine whether the claimed incident caused the claimed injury. Therefore, this form of medical causation is a "similar issue" to determining the extent of a compensable injury under Labor Code §408.0041(a)(6) and appropriate for a designated doctor to evaluate.

Nonetheless, the Division has changed this subsection for other reasons stated above.

§127.1(d)(4): One commenter states that appointing designated doctors to address the compensability of a denied claim conflicts with the purpose of the designated doctor and exceeds their expertise. Designated doctors address disputes with a medical component that arises in a compensable claim. Compensability issues deal with factual and legal concerns related to whether a claimant sustained an injury in the course and scope of employment. The use of designated doctors to determine compensability exceeds their authority to resolve medical disputes.

Agency Response: The Division disagrees for multiple reasons, but for other reasons has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Additionally, the Division disagrees that designated doctors do not have the authority to address medical causation because, as described above, it is a "similar issue" under Labor Code §408.0041. Lastly, the Division disagrees with the commenter's contention that designated doctors do not have the expertise to address the medical causation element of a compensability dispute. As described above the analysis a designated doctor must undertake when addressing the extent of a compensable injury is often substantially identical to the analysis the designated doctor must undertake when addressing whether or not a claimed incident caused a claimed injury during a compensability dispute. Thus, designated doctors are trained to address this issue and frequently do so in their capacity as designated doctors.

Nonetheless, the Division notes that for other reasons stated above it has made a change to this subsection.

§127.1(d)(4): A commenter states the Division's changes to this section do not resolve the fundamental problem that designated doctors do not review a complete record regarding the "claimed incident" nor the testimony of other witnesses. The Division does review this record and, therefore, has the responsibility to resolve these disputes.

Another commenter states that the proposed rule shifts the fact-finding responsibility onto the designated doctor. The Division, by assigning designated doctors to determine whether there was an injury resulting from the claimed incident, is creating a presumption that an injury occurred in the course and scope of employment and requiring the carrier to present evidence to overcome the designated doctor's opinion.

Agency Response: The Division agrees in part and disagrees in part. The Division acknowledges that it has primary, exclusive jurisdiction to determine the compensability of a particular claim. Furthermore, the Division acknowledges that a designated doctor cannot opine as to whether a claimed incident actually occurred, how the incident occurred, or whether that incident occurred within the course and scope of employment. The Division disagrees, however, that these facts are relevant to proposed §127.1(d)(4) because proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve disputes on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

The Division also clarifies that a designated doctor opining on medical causation does not preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenters, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that implied or direct delegation by the agency to the designated doctor is an abrogation of the Division's duties and ultra vires, specifically because the Legislature has otherwise given the designated doctor presumptive weight. Therefore, the ability of a designated doctor to opine on causation should be removed.

Agency Response: The Division disagrees. Permitting designated doctors to opine on medical causation in a claim on which the insurance carrier has denied compensability does not improperly delegate any specific Division duty. As described above, designated doctors may properly opine on this issue as a "similar issue" under Labor Code §408.0041(a)(6) because of its substantial analytic similarity to many extent of injury issues already addressed by designated doctors. The Division acknowledges that a designated doctor's report on this issue will have presumptive weight but only on the issue of medical causation. Additionally, the Division notes that designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters state that Labor Code §408.0041 does not permit designated doctors to determine the compensability of an injury. Instead, Labor Code §410.002 specifically grants the Division, through dispute resolution, the responsibility to determine liability of an insurance carrier for compensation under the Act. The Division cannot delegate or abdicate this authority.

Agency Response: The Division disagrees with this comment for multiple reasons but notes that for other reasons it has made a change. First, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. More specifically, the commenter's rationale would also imply that permitting designated doctors to address the extent of a compensable injury is also an abdication of authority, because this issue will also ultimately affect an insurance carrier's liability on a claim.

Lastly, the Division notes that though it disagrees with the commenters, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that this rule attempts to separate compensability into medical and legal components. This is an erroneous interpretation of law that creates a situation in which a designated doctor is not making a medical evaluation but instead acting as an adjudicator of compensation liability. The statute does not permit or contemplate this role. Designated doctors were created in House Bill 2600 and this legislation included no discussion or consideration of designated doctors replacing or superseding the authority of a hearing officer.

Agency Response: The Division disagrees. First, the Division clarifies that designated doctors have been in the Texas Workers' Compensation Act since its creation in 1989. House Bill 2600 and then subsequently House Bill 7 each expanded the role of a designated doctor, but neither bill created this role in the Act. Second, the Division clarifies that proposed §127.1(d)(4) does not try to separate compensability into medical and legal components. Compensability is necessarily a legal finding. Causation, however, is a required element of determining compensability. *See Transcontinental Insurance Company v. Crump,* 330 S.W.3d 211, 221-222 (Tex. 2010). Furthermore, Texas courts have also made clear that expert medical testimony is necessary to establish causation as to medical conditions outside the common knowledge and experience of a layperson. *See City of Laredo v. Garza;* and *Guevara v. Ferrer,* 247 S.W.3d 662 (Tex. 2007). Thus, while compensability is a legal issue, in many cases an expert medical opinion will be required to establish compensability if causation is in dispute. Designated doctors can properly provide an expert medical opinion on medical causation as a "similar issue" under Labor Code §408.0041(a)(6), because this form of medical causation analysis is substantially identical to the extent of injury analysis already performed by designated doctors in many cases as described above.

Additionally, the Division clarifies that, as stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue or supersede a hearing officer's authority to do so any more than they can resolve a dispute on any other issue under Labor Code §408.0041 or supersede a hearing officer's authority to do so because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that designated doctors cannot address whether an injury resulted from a claimed incident until a hearing officer determines whether the incident actually took place as claimed. A designated doctor is not aware of all relevant testimony and evidence that is needed to determine whether or not an injury is compensable. At best, a designated doctor could opine that an injury could have happened but that opinion is still without benefit of legal analysis and consideration of all proper evidence. By statute, hearings officers are the sole judge of the relevance and materiality of the evidence offered and the evidence's weight and credibility.

Agency Response: The Division disagrees in part and agrees in part. The Division agrees that hearings officers are the sole judge of the relevance and materiality of the evidence offered and the evidence's weight and credibility. The Division disagrees, however, that a designated doctor may not opine on medical causation until a hearings officer determines that the incident actually took place, because designated doctors are not being asked to resolve a compensability dispute. Compensability of a claim as whole is a question of law that the Division agrees a designated doctor cannot address. Des-

ignated doctors, however, are being asked a far narrower question regarding medical causation, and the designated doctor's report addressing this issue would have no bearing or weight on the finding as to whether the incident took place as claimed. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter asks that when determining whether a designated doctor examination should be scheduled because it would "help a finder of fact resolve an element of that dispute" we are unsure who is the finder of fact and how the designated doctor's opinion would help resolve compensability? The commenter further asks would not the designated doctor now, in effect, be assigned as the de facto trier of fact?

Agency Response: The Division disagrees. First, the Division clarifies that the language quoted by the commenter was only in the informal draft of proposed §127.1(d)(4) and was removed from the Division's formally proposed amendment to that rule and is not adopted in either amended §127.1(d)(4) or §127.1(e). That portion of the comment, therefore, is outside the scope of this proposal.

Second, the Division notes that, as explained above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Third, the Division also clarifies that a designated doctor opining on medical causation does make a designated doctor a de facto trier of fact or preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the commenter, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter argues permitting a designated doctor to resolve compensability violates due process. Designated doctors base their opinions upon unsworn representations and incomplete records that parties cannot challenge prior to the issuance of the report.

Agency Response: The Division disagrees. First, the Division notes that, as explained above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation.

Second, no due process violation can occur as a result of the designated doctor examination under §127.1(d)(4) because, as stated above, designated doctors can only recommend the resolution of a dispute not resolve the dispute; designated doctors, therefore, cannot resolve a dispute on medical causation any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence.

Additionally, a designated doctor opining on medical causation fact or preclude a party from challenging other related issues, such as whether the claimed incident actually occurred or how the incident occurred, through the Division's dispute resolution process. The Division also clarifies that a designated doctor's report would have no presumptive weight on these underlying factual issues because the Division does not order the designated doctor to provide an opinion on these questions of fact. The designated doctor's report is based on a party's assertion that the claimed incident occurred as described and inasmuch as this assertion is proven to be erroneous, the designated doctor's report may be diminished in credibility on medical causation because it is based on an improper factual basis. Furthermore, the Division notes that the Division's proposed changes to proposed §127.1(d)(4) and new §127.1(e) should largely address these concerns, because a hearings officer or benefit review officer could consider or resolve these issues before requesting a designated doctor examination, if appropriate.

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): A commenter states permitting designated doctors to resolve compensability allows the presumptive weight of a designated doctor's report to apply to this dispute, which effectively shifts the burden of proof to the insurance carrier. This is not authorized by statute or Texas jurisprudence and violates due process.

Agency Response: The Division disagrees. First, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Additionally, as stated above, because designated doctors can only address medical causation under proposed §127.1(d)(4), they only have presumptive weight on this issue.

Additionally, the Division also clarifies that a designated doctor's report does not shift the burden of proof in dispute resolution; the designated doctor's report simply has presumptive weight on issues the designated doctor was properly appointed to address unless the preponderance of the evidence is to the contrary. Furthermore, even if a designated doctor's report did shift the burden of proof in a dispute over medical causation and, therefore, violate due process under the commenter's rationale, then a designated doctor's report would also shift the burden of proof on all other issues under Labor Code §408.0041(a), meaning all designated doctor examinations under that section, or at least all examinations that resulted in reports favorable to burdened parties, would violate due process. The Division disagrees with this interpretation.

Lastly, the Division notes that though it disagrees with the relevance of the commenters' concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that assigning a designated doctor to a dispute claim violates a insurance carrier's due process rights. Insurance carriers have a property interest in their liability for a claim. To assign a designated doctor in a completely denied claim would result in a carrier paying the expenses associated with a designated doctor examination in a claim where compensability has been disputed and benefits are not owed. This conflicts with Labor Code §409.021 and other provisions of the Act, because an insurance carrier is only liable for benefits if it does not timely dispute compensability. This rule lacks fundamental fairness, resulting in a denial of a carrier's substantive due process. It is also not equitable to require an insurance carrier to pay the costs of a designated doctor exam on a disputed claim.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division disagrees that proposed §127.1(d)(4) of this title violates an insurance carrier's due process rights, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Thus, no benefits would be due under Labor Code §409.021 or Labor Code §408.0041, because a designated doctor does not resolve compensability or make any other finding that would, alone, entitle an injured employee to benefits under proposed §127.1(d)(4).

The Division agrees, however, that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or if the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): Multiple commenters states that the Act requires that the carrier must pay benefits in accordance with the designated doctor report. One commenter additionally states that the Division has previously stated that designated doctor examinations cannot be nonbinding. The proposed rule, therefore, requires carriers to pay benefits on a denied claim until the dispute resolution process is complete. The commenters state it is clear the statute would create this obligation and require payment on dubious claims before a carrier is able to have evidence heard and able to question witnesses. Furthermore, because designated doctor opinions have presumptive weight, this would effectively shift the burden of proof to carriers that the injured employee did not suffer a compensable injury. One commenter also state that this rule also requires carrier to incur expenses as a result of reimbursing the designated doctor on a denied claim.

Agency Response: The Division disagrees in part and agrees in part. First, the Division agrees that designated doctor examinations may not be nonbinding. Pursuant to Labor Code §408.0041(e) - (f), a designated doctor's report has presumptive weight unless the preponderance of the evidence is to the contrary, and insurance carriers must pay benefits in accordance with a designated doctor's report during the pendency of any dispute. The Division disagrees that these requirements reverse the burden of proof or require payment on dubious claims, however. As stated above, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Thus, no benefits would be due under Labor Code §409.021 or Labor Code §408.0041 or any other provision of the Act, because a determining that a claimed incident did cause a claimed injury does not alone entitle an injured employee to benefits.

Second, the Division also clarifies that the Division also clarifies that a designated doctor's report does not shift the burden of proof in dispute resolution; the designated doctor's report simply has presumptive weight on issues the designated doctor was properly appointed to address unless the preponderance of the evidence is to the contrary.

The Division agrees, however, that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a

contested claim if that issue is not in dispute or if the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that it is fallacious to divide compensability into medical and legal components. Neither the definition of "compensable injury" nor "injury" make this division. Furthermore, this distinction allows designated doctors to examine only one side, the "medical" side, of a single and independent issue, which is not authorized by the Act. Under this logic, all issues under Labor Code §408.0041 should be able to be parsed into elements for examination but each of those issues are whole issues that cannot separated into medical and legal issues. For example, one could parse maximum medical improvement (MMI) into a legal (statutory MMI) and a medical (clinical MMI) component. Additionally, under the Act, the only language regarding the medical aspect of a claim relates to medical benefits from a compensable injury; therefore, there must be a compensable injury before medical aspects of a claim are available for a doctor to examine. Any interpretation allowing designated doctors to examine the medical aspect of a disputed claim conflict with the Act and are invalid. Hearing officers do not and cannot rule on only one element of an issue when issuing decisions, and a designated doctor cannot limit his opinion to only part of the issue either. Appeals Panel decision No. 043168 states that the designated doctor must address the entirety of the compensable injury.

Agency Response: The Division disagrees. As explained above, Texas law is clear that causation is a required element of establishing compensability, and Texas law is equally clear that, in many cases, causation can only be established through an expert medical opinion. To state, therefore, that there are no medical aspects of a claim until compensability is established would prevent parties from offering required evidence. The Division disagrees with this outcome and, furthermore, clarifies that designated doctors may address medical causation because, as explained above, it is a "similar issue" under Labor Code §408.0041 and because Texas courts have held that expert medical opinions are required in many cases to establish causation.

Additionally, the Division disagrees with the commenter's statement that if designated doctors may opine medical causation in a compensability dispute, parties must also be able to impermissibly parse the other "whole issues" under Labor Code §408.0041 into separate issues. The Division disagrees, because it does not believe these issues are all "whole issues." Impairment rating necessarily includes a finding of the extent of a compensable injury, but designated doctors are not required to address both issues simultaneously. Determining whether disability is the direct result of a work-related injury implies the existence of disability and a defined extent of the compensable injury yet a designated doctor is not required to determine these issues in addition to direct result. Thus, the Division disagrees with this portion of the comment because it essentially argues that all DD opinions are flawed and impermissible because they rely on facts or findings that can be disputed.

Even if one assumes the issues under Labor Code §408.0041(a)(1) - (5) are "whole issues," however, it is still not clear why this fact would prohibit a designated doctor from addressing medical causation under Labor Code §408.0041(a)(6) as a similar issue when it is a substantially identical issue to many issues already addressed by a designated doctor when examining the extent of a compensable injury. The commenter's logic appears to imply for an issue to be "similar" to the issues in Labor Code §408.0041(a)(1) - (5), it must be identical to those issues or at least similar to them in one particular way (be a "whole issue"). Labor Code §408.0041 imposes no such requirements, however, and the general likeness between extent of injury analysis and the medical causation analysis performed under proposed §127.1(d)(4) and adopted §127.1(e) is sufficient to establish similarity between the two issues.

Furthermore, the Division is unclear as to the relevance of Appeals Panel Decision No. 043168. This appeals panel decision held that a designated doctor must rate the entirety of the compensable injury when assigning an impairment rating to an injured employee's compensable injury. The Division is unclear as to why requiring a designated doctor to comply with the legal definition of "impairment rating" would result in the conclusion that a designated doctor cannot limit the doctor's opinion to only part of an issue, specifically medical causation in the context of compensability. The comment appears to reason that a designated doctor must not only address all the issues Division ordered the designated doctor to address, but the designated doctor must also address all issues associated with the issue the doctor was ordered to address even if the Division did not order the designated doctor to address those issues. The Division disagrees with this reasoning.

Lastly, the Division notes that though it disagrees the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters state that this rule will unnecessarily increase system costs. One commenter emphasizes that this rule conflicts with the system goal of reducing costs by requiring carriers to pay for these examinations. Another commenter states that allowing parties to increase costs and prolong the dispute resolution process should not be allowed simply because a party styles their request under a catch all provision.

Agency Response: The Division agrees in part and has made a change. Specifically, the Division agrees that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that a designated doctor examination should never be assigned to a denied claim prior to adjudication of the denial. In any claim, a treating doctor is on the scene preceding the investigation of a claim or filing of a compensability dispute and has initiated treatment for a condition asserted as work-related by a claimant. This treatment has technically established a medical premise that an injury or work-related condition has occurred. Why would this medical opinion carry any less weight than the opinion of a designated doctor and what specialized training would a designated doctor possess in order to determine this issue with any more medical certainty? It is not clear, therefore, what need there would be for a designated doctor examination.

Agency Response: The Division disagrees. First, while a treating doctor's diagnosis may suffice to establish that an injury exists, a diagnosis without further analysis will not always suffice to establish that the work-related incident was a producing cause of that diagnosis, which is a necessary element for an injured employee to prove the compensability of the employee's claim. Specifically, as discussed above, in many cases causation requires an expert medical opinion, and expert medical opinions must be based upon a reliable foundation. *See Transcontinental Insurance Company v. Crump,* 330 S.W.3d 211, 221-222 (Tex. 2010). Thus, in most cases, unless the treating doctor has additionally provided analysis based upon a reliable foundation to demonstrate that the work-related injury was a producing cause of the injured employee's diagnosis, then the treating doctor's participation in the claim will not meet the required standards for an injured employee to prove this element of the employee's claim.

A designated doctor's report, however, will fully address this issue, and because medical causation analysis is substantially identical to many of the issues a designated doctor will analyze when addressing the extent of the compensable injury, the designated doctor will be uniquely trained and experienced to address this issue.

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): One commenter states that assigning designated doctors on disputed claims also unfairly obligates public funds, which are already scarce for Texas school districts, without due process, and a finding of non-compensability does not release that obligation. This obligation is compounded by possible designated doctor referrals or testing, which cannot be reviewed.

Agency Response: The Division agrees in part and has made a change. Specifically, the Division agrees that in some cases it would be inequitable to require an insurance carrier to pay the costs of a designated doctor exam addressing medical causation on a contested claim if that issue is not in dispute or the claimed injury does not require an expert medical opinion on causation. Moreover, the Division believes that these medical causation examinations would in some cases unnecessarily delay the dispute resolution process if the insurance carrier is not contesting this issue as part of its denial of compensability or if the injured employee has not contested that denial. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(4): One commenter states that the Division may order an injured employee to attend a required medical examination on compensability if the Division determines that it needs further medical evidence on a claim in which the insurance carrier has disputed compensability. The commenter reasons that this remedy would be more appropriate than a designated doctor examination, because it would not compel an insurance carrier to pay benefits pursuant to the report.

Agency Response: The Division disagrees for several reasons. Most importantly, the Division does not have the statutory authority to order an injured employee to attend a required medical examination under Labor Code §408.0041 on the Division's own motion; therefore, the commenter's suggested remedy is not possible. Furthermore, the Division disagrees that benefits would be due based on a report of a designated doctor asked to determine whether a claimed incident caused a claimed injury under proposed §127.1(d)(4). Specifically, proposed §127.1(d)(4) of this title does not authorize a designated doctor to resolve a compensability dispute, because proposed §127.1(d)(4) only authorizes designated doctors to address medical causation. Furthermore, as explained above, designated doctors only recommend the resolution of a dispute and, therefore, cannot resolve a dispute on this issue any more than they can resolve a dispute on any other issue under Labor Code §408.0041 because parties may challenge designated doctors reports through the Division's dispute resolution processes with competing, contrary evidence. Thus, no benefits would be due under Labor Code §409.021 or Labor Code §408.0041 or any other provision of the Act, because a designated doctor does not resolve compensability under proposed §127.1(d)(4).

Lastly, the Division notes that though it disagrees with the relevance of the commenter's concerns, the Division has nonetheless made a change to proposed §127.1(d)(4) for other reasons described above.

§127.1(d)(4): Multiple commenters support this rule because of an injured employee's difficulty in obtaining a medical causation opinion, which is even more pronounced on network claims. One commenter states that, in addition, the Division's Appeals Panel continues to expand the number of cases where medical evidence of causation is necessary. Moreover, this cost is properly borne by insurance carriers, because insurance carriers are entitled to subsequent injury fund reimbursement. Another commenter states that this rule is consistent with the stated intent of the Act in Labor Code §402.021. Specifically, this proposed amendment ensures Injured employees have access to medical evidence. Also, this comports with the general principle that the Act shall be liberally construed in favor of the injured employee and the *quid pro quo* principle of *Texas Workers' Compensation Commission v. Garcia,* 893 S.W.2d 504 (Tex. 1995).

Agency Response: The Division agrees in part and disagrees in part and has made a change. Specifically, the Division agrees that designated doctor can and, in some cases, should address medical causation. The Division believes that the authority for these examinations is within the Act and necessary for many of the policy reasons proposed by the commenters. The Division disagrees, however, that insurance carriers should be required to pay for these examination in all cases in which compensability has been denied, particularly those in which medical causation is not at issue. The Division also acknowledges that in some cases it would be appropriate to require an insurance carrier to pay the costs of a designated doctor exam on a disputed claim. However, determining whether a medical causation dispute is present in a particular dispute or if a medical expert opinion is necessary for a hearings officer to resolve the issue is, in most cases, administratively infeasible for the Division to determine based solely on its internal files and a request for a designated doctor examination by a party. The Division, therefore, has made a change that remedies these issues. It has deleted proposed §127.1(d)(5) and adopted §127.1(d)(4) to state that the Division will deny all designated doctor examination requests in which the compensability of the claim as a whole is in dispute. The Division has also added new §127.1(e) that provides that "if a Division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue."

The Division believes that this change creates the optimal balance between limiting costs imposed upon insurance carrier and delays in the dispute resolution process and the need for sufficient expert medical opinions on the issue of medical causation in certain compensability disputes where such an opinion is necessary for the Division to properly resolve that issue.

§127.1(d)(5): Multiple commenters support this rule. One commenter states expresses agreement with the denial of a designated doctor request for these reasons. Medical evidence is not generally required to overcome a denial based on these sections of the Labor Code.

Agency Response: The Division appreciates the support but notes that it has deleted this proposed provision for reasons described above.

§127.1(e): One commenter states that the Division should impose a 10 day deadline upon itself to respond to requests for expedited contested case hearings. As stated in §127.1, parties requesting expedited contested case hearings must do so within 3 days of receiving the order. Section 142.6 states that the Division shall set an expedited contested case hearing no later than 30 days after receipt of the request. But the necessity of an expedited hearing respecting a designated doctor setting is to prevent inappropriate examinations prior to threshold issues being addressed. Failure to timely respond to a request for hearing and stay the examination may result in irreparable harm. The commenter states that it makes this request under Labor Code §408.0041(f-3).

Agency Response: The Division disagrees. While the Division intends to respond to all requests for expedited contested case hearings as quickly as possible, the Division sees no reason to impose an arbitrary deadline on its administrative discretion. Moreover, the Division notes that if the requestor has timely requested a stay of the designated doctor examination, the irreparable harm described by the commenter would not occur because the examination would have been stayed. Lastly, the Division notes that Labor Code §408.0041(f-3) is not relevant to this subsection or the dispute of approved designated doctor examinations. Labor Code §408.0041(f-3) applies to post-designated doctor examination required medical examinations or treating doctor examinations. Therefore, a designated doctor examination must have already occurred for Labor Code §408.004(f-3) to apply.

§127.1(e): One commenter states that under current §127.1(e), failure to meet the three calendar day deadline has been determined to not be a waiver of the right to dispute the setting of the designated doctor examination. The currently proposed §127.1(e) adds the word "timely." The commenter is concerned that "timely" provides the DWC with the justification to refuse to set an expedited hearing and stay the designated doctor evaluation for failure to timely file. The Division has previously acknowledged in prior rule preamble that a three calendar day timeframe is untenable and unreasonable, and a proposed a three to five working day deadline or five calendar day deadline. The com-

menter requests these timelines be used for requesting a stay of a designated doctor examination.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division's previous statement regarding waiver of the ability to dispute the approval of a designated doctor examination request is not applicable to the staying of an approved designated doctor examination. Specifically, in its December 17, 2010 adoption order for §127.1, the Division stated:

Comment: One commenter states that it should be clarified that failure to request expedited proceedings or any other hearing under §127.1(e) in order to dispute an ordered designated doctor examination does not waive a party's right to dispute the appointment of a designated doctor at a later time.

Response: The Division agrees and disagrees. The Division agrees that parties do not waive their right to contest the appointment of a designated doctor or approval of an examination if they fail to do so under §127.1(e). The Division disagrees that any clarification is necessary, however, as nothing in the rule would imply this outcome. Moreover, the rule states no deadline for non-expedited disputes, thus it is not clear how a party could lose the ability to seek dispute resolution under this rule provided the subject of dispute had not already been adjudicated through the Division's dispute resolution process. *(35 TexReg 11330)*

The commenter's requested clarification and the Division's response concerned the authority of parties to still dispute an approved designated doctor examination under other provisions of the Division's rule and the Act if the party fails to request expedited proceedings under §127.1(e). The Division did not, however, state that untimely requests for a stay would be approved. The Division, therefore, has added "timely" to adopted subsection (e) to further clarify that requests for a stay must be timely received. If the Division were required to stay examinations at any time, it would lead to undue hardship on designated doctors and injured employees who had already made preparations for the examination. But the Division does agree that in some instances a three calendar day deadline for the request of a stay would be unduly burdensome on requesting parties, such as in instances that would require parties to submit the party's request on a weekend or national holiday. The Division, therefore, has modified this deadline to extend to three working days in adopted §127.1(e).

§127.1(e): One commenter supports prohibiting parties from disputing a DWC-032 until the Division has approved or denied the request.

Agency Response: The Division appreciates the support.

§127.5(a): Multiple commenters request the Division impose a 10 day or other similar deadline upon itself to approve or deny a designated doctor examination request.

Agency Response: The Division disagrees. Though the Division will strive in all cases to process these requests as timely as possible, imposing an arbitrary and extra-statutory deadline upon approving these requests would unnecessarily restrict the Division's administrative flexibility.

§127.5(a): Multiple commenters state that injured employees should be required to call and write the designated doctor that they will attend the designated doctor examination or otherwise confirm their intention to attend the examination to the designated doctor when they receive the Division's order. The commenters reason that the majority of DWC-032s have inaccurate injured employee contact information. This change, therefore, would help coordinate and confirm the examinations and reduce missed examinations by injured employees. Additionally, if this information is inaccurate the designated doctor cannot contact the injured employee if the designated doctor needs to reschedule. Also, if the Division expects designated doctors to review the medical records before the examination, this change makes missed examinations even more costly. Designated doctors often travel several hours to the examination site, and rescheduled examinations can require significant travel obligations for all parties.

Agency Response: The Division disagrees, because such a requirement is unnecessary. Once a Division order has been issued, all parties subject to that order must comply. If a designated doctor is unable to contact an injured employee, the designated doctor should contact the Division for assistance. The Division further clarifies that injured employees are not required to contact a designated doctor before an examination, and a designated doctor's failure to contact an injured employee does not alleviate that designated doctor of the duty to attend the ordered examination.

§127.5(a): One commenter requests that OIEC ombudsmen receive the order for designated doctor examinations under this section.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.5(b): One commenter states that injured employees and designated doctors should be able to change locations without Division approval if both parties agree and that agreement is documented. These types of location changes are often to the mutual convenience of the parties. Alternatively, a designated doctor should be able to offer alternative locations for the examinations within 50 miles of the original county.

Agency Response: The Division disagrees. Permitting location changes without the knowledge of the Division would permit examinations to be held at potentially non-approved examination locations, thus preventing the Division from monitoring the suitability of the new location. Moreover, the Division selects designated doctors, in part, based on their stated available practice locations. Allowing these locations to change without Division approval thwarts this process.

§127.5(c)(3): One commenter states that this subsection should change "offered" to "performed." If the designated doctor is not certified on the date of the examination, the examination is not valid.

Agency Response: The Division disagrees. The Division can only verify if a designated doctor is certified the day the examination is offered, because certain extraordinary circumstances could lead to a designated doctor no longer being certified or otherwise available on the day the examination takes place, such as the issuance of an emergency cease and desist order by the Division. The Division emphasizes, however, that these instances

are rare and in almost all cases a designated doctor certified on the day the examination is offered will be certified on the day the examination takes place. Furthermore, a doctor must be certified as a designated doctor to perform a designated doctor examination, and a doctor who violates this requirement commits an administrative violation.

§127.5(c)(4): One commenter states that if a designated doctor has ever treated an injured employee in a non-designated doctor capacity, this should be a disqualifying association. This follows the rationale that if the treating doctor is in the same network as the injured employee it has a disqualifying association.

Agency Response: The Division disagrees. The Division clarifies that §127.5(c)(4) does not exempt any doctor/patient relationships from its disqualifying association requirements. Specifically, as the Division previously stated in its December 17, 2010 adoption order for §127.5:

Comment: One commenter states that §127.5(c)(4) improperly operates as a special exception to the disqualifying associations described in 28 TAC §180.21. The commenter explains that this exception is improper because a designated doctor who had a doctor/patient relationship with an injured employee regarding another medical condition thirteen months before the designated doctor examination certainly creates a sufficient appearance of influence to preclude the designated doctor from being the designated doctor on the claim under 28 TAC §180.21.

Response: The Division disagrees. Section 127.5(c)(4) does not qualify any designated doctor to perform an examination, exempt any designated doctor from the disqualifying association provisions of 28 TAC §180.21, or otherwise operate as a special exception; instead, §127.5(c)(4) simply disqualifies two particular classes of designated doctors: those who have treated the injured employee on an unrelated medical condition within the past 12 months and those who have treated the injured employee on the medical condition at issue at any time. Thus, §127.5(c)(4) does not disqualify or qualify the designated doctor described in the commenter's example, because that designated doctor does not fit in either class addressed by §127.5(c)(4). Pursuant to §127.5(c)(1), however, the disqualifying association provisions of 28 TAC §180.21 would apply to the designated doctor described in the commenter's example just as it would apply to any other designated doctor. If the commenter, therefore, believes the application of 28 TAC §180.21 to such a designated doctor should disqualify that doctor from the claim at issue, the commenter may pursue that argument through the Division's dispute resolution process. *(35 TexReg 11331)*

The Division, therefore, declines to make the commenter's suggested change because whether or not the commenter's described scenario constitutes a disqualifying association may still be determined under the requirements of §127.140 of this title (relating to Disqualifying Associations).

§127.5(d): One commenter agrees with the use of the mandatory "shall" in this subsection.

Agency Response: The Division appreciates the support.

§127.5(e): A commenter suggests that if the designated doctor and injured employee agree and all medical records have been received, examinations should be able to be rescheduled before the originally scheduled examination. Another commenter suggests rescheduled examinations before the originally scheduled appointment should be permitted if the injured employee requests it, all other parties agree, and the Division approves.

Agency Response: The Division disagrees. Incorporating the commenter's suggested change into this subsection would require the Division to confirm the agreement of the insurance carrier, treating doctor, designated doctor, and injured employee and to verify receipt of medical records, and this practice would be too administratively burdensome for the Division. Additionally, there appears to be little advantage to these recommendations, because if the medical records have not been received, it is not appropriate to reschedule the examination before the original examination; and, if the records have been received, it is unlikely that there will still be sufficient time for the designated doctor to both fully review the records and to schedule the examination at an earlier date.

§127.5(e): One commenter states that designated doctors can only fulfill the obligation of informing parties of rescheduling if they receive all appropriate information.

Agency Response: The Division agrees, though the Division notes that inaccurate information does not relieve the designated doctor of the doctor's duty to contact the insurance carrier and treating doctor. If the designated doctor believes the information received is inaccurate, the designated doctor should contact the Division for assistance.

§127.5(e): One commenter requests clarification as to whether a new designated doctor appointed under §127.5(e) for failure to reschedule within 21 days will be retained and kept on as the designated doctor for all future examinations.

Agency Response: The Division clarifies that this determination will be made on a case-by-case basis and depend largely on the reasons for which the examination could not originally occur. In some cases, the selection of a new designated doctor may be necessary for the examination to occur, and, because the previously selected designated doctor never examined the injured employee, there should be no disadvantage to this new selection. The Division further clarifies, however, that if the originally selected designated doctor had previously examined the injured employee, the Division would not select a new designated doctor unless the original designated doctor had been authorized or compelled by the Division to stop providing services on the claim under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations).

§127.10(a)(2): One commenter states that OIEC ombudsmen should also receive the analysis as representatives do under this subsection.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay representatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.10(a)(2): One commenter states that the Division should specify that analyses under subsection must be neutral.

Agency Response: The Division disagrees. The requirements for these analyses are statutorily prescribed and the Division declines to expand upon that prescription.

§127.10(a)(3): A commenter asks the Division to clarify whether the examination must still take place if the medical records are not timely received.

Agency Response: The Division clarifies the examination shall still take place and be performed by the selected designated doctor at the originally scheduled or at a rescheduled date, because adopted §127.10(a)(3) provides that "the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records."

§127.10(a)(3): One commenter states that this subsection is unclear as to when a physician should receive medical records from the division in order to comply with the regulation.

Agency Response: The Division clarifies that adopted §127.10(a)(3) requires a designated doctor to receive the medical records within three working days of the scheduled examination in all cases. It is only in cases where this requirement is not met that the Division shall intervene to ensure that the medical records are received by the designated doctor.

§127.10(a)(3): One commenter notes that though the Division should be notified within 3 working days of the examination, the examination should not be cancelled until within one working day of the examination. Cancelling 3 working days out before the Division and parties can attempt to resolve the records issue may cause undue hardship on traveling parties.

Agency Response: The Division agrees in part and has made a change. The Division agrees that requiring cancellation in all cases in which a designated doctor notifies the Division that medical records have not been timely received may be an overly broad requirement. The Division, however, notes that, in many cases, prompt cancellation may be necessary to prevent unnecessary travel by the injured employee or designated doctor. In light of these determinations, the Division has changed adopted §127.10(a)(3). Specifically, the Division has deleted "shall not conduct the examination" and added "If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records."

§127.10(a)(3): One commenter states that the "shall" in this subsection should be a "may" given the number of participants in the process, the complexity of the process, and the fact there is so much room for error. Carriers are frequently at the mercy of vendors who habitually state that no records have been received, and there will, at times, be circumstances beyond the carrier's control.

Agency Response: The Division disagrees. "Shall" is correct because the Division will, in all cases, take some form of action in order to ensure that the designated doctor receives the necessary medical records. The Division clarifies that the action in any given case will vary upon the factors described by the commenter and other concerns, which may make an order to produce appropriate in some cases and a simple, clarifying phone call appropriate in others. The Division further clarifies that any action taken to ensure the designated doctor receives the medical records is separate from any enforcement action the Division may take if either the treating doctor or insurance carrier did, in fact, fail to timely submit the medical records.

§127.10(a)(3): One commenter states that records should be required to arrive five working days prior in light of the requirement to review the records before the examination.

Agency Response: The Division disagrees. Three working days is sufficient time for a designated doctor to review the records, especially because the designated doctor may still review and refer to those records after the examination of the injured employee.

§127.10(a)(3): One commenter states that designated doctors should report the violation within three working days of not receiving the records not one working day, so the complaint is made on the day of the violation.

Agency Response: The Division disagrees. The violation occurs on the day the designated doctor fails to timely receive the medical records. If the designated doctor waits three working days from the date the doctor fails to receive the records, the designated doctor would be reporting the violation three working days after the violation and would not provide the Division with sufficient time to rectify the situation and possibly allow the scheduled examination to proceed.

§127.10(a)(3): One commenter states that treating doctors and insurance carriers should be required to send records by verifiable means. There is currently no rule in place to enforce or monitor record submission, and the commenter states that the Division never takes action on these complaints.

Agency Response: The Division disagrees. Section 127.10(a)(3) plainly requires insurance carriers and treating doctors to submit these medical records to the designated doctor within 3 working days of the designated doctor examination; therefore, there is an enforceable standard for this duty and a verifiable means requirement is not necessary for this standard to be enforced.

§127.10(b): One commenter states that records provided by injured employees should be subject to the same timeframe as other system participants' medical records.

Agency Response: The Division disagrees. Unlike insurance carriers and treating doctors, the injured employee will be attending the examination, and, therefore, imposing an additional cost upon the injured employee to mail or fax their records to the designated doctor creates an unnecessary burden. Furthermore, unlike insurance carriers or treating doctors, injured employees are not required to submit medical records to the designated doctor.

§127.10(c): One commenter states that the Division should return to the 17 working days total time period for designated doctor reports that include testing or referrals. This extended period would ensure all necessary time for diagnostic testing.

Agency Response: The Division disagrees. First, the Division clarifies that its rules never contained a uniform 17 working days after the date of the examination deadline for designated doctors to submit their reports after a referral for testing or examination by another health care provider. Instead, the former Division rule §126.7 of this title (relating to Designated Doctor Examinations: Requests and General Procedures) provided up to 17 working days for reports submitted after the date of an MMI/IR examination and up to 7 calendar days plus up 10 working days to submit the report after the date of all other examinations. Un-

der current §127.10(c) of this title, designated doctors have 15 working days after the date of all examinations to submit their reports. Thus, designated doctors have never uniformly been entitled to the deadline recommended by the commenter. Moreover, the Division finds the deadline requested by the commenter unnecessary in light of the Division's newly included exception to adopted §127.10(c) that permits a designated doctor to request that the Division grant the doctor additional time to submit the doctor's report, if necessary.

§127.10(c): Multiple commenters state that this proposed language lacks safeguards to ensure that the referrals are medically necessary and reasonable, and that the Division has the statutory duty to ensure that the workers' compensation system is cost effective. Designated doctors often order diagnostic testing that has been recently performed for the sake of generating revenue. This rule provision needs to be amended to clarify that a designated doctor may not order diagnostic testing when the testing is not medically necessary, not appropriate as related to the diagnosis, has previously been performed, exceeds the standard of care or is not required to complete the examination. Designated doctor testing should be the subject of a medical quality review panel audit and considered as a performance measure for designated doctor performance based oversight. Furthermore, the Division should take action on any complaints submitted by carriers to the MQRP and sanction violating doctors and order refunds to the carrier under Labor Code §413.016.

Agency Response: The Division agrees in part and disagrees in part and has made a change. The Division fully agrees it has the responsibility of the Division to monitor this particular practice carefully, because of its unique exception from insurance carrier review. In light of this responsibility, the Division has added "requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing" to adopted §127.110(e)(4) of this title (relating to Designated Doctor Recertification) as a factor the Division will consider when determining whether to deny a designated doctor's application for recertification. Additionally, the Division notes that unnecessary referrals may constitute an administrative violation under adopted §127.210(a) of this title. Furthermore, the Division encourages system participants to submit complaints regarding any possible unnecessary testing, and the Division will investigate those complaints and take all appropriate actions, including, if merited, the ordering of refunds.

The Divisions disagrees, however, that any amendments to §127.10(c) are necessary because this subsection already contains sufficient standards for the Division to monitor and regulate the necessity and merits of designated doctor referrals for examinations and additional testing.

§127.10(c): One commenter states that if the Division is going to require referrals for testing, it needs to assist designated doctors in finding these referral doctors. Many physicians will always decline workers' compensation referrals.

Agency Response: The Division disagrees. While Division will make efforts to assist designated doctors in finding the appropriate referral providers, the Division reminds designated doctors that the ultimate duty to obtain all necessary testing and referrals falls upon the designated doctor. Furthermore, the Division reminds designated doctors that this standard simply returns to the previous standard for referral examinations under repealed §126.7 of this title, which was in effect from 2006 until February 2011.

§127.10(c): One commenter agrees with designated doctor testing and referrals not being subject to retrospective review.

Agency Response: The Division appreciates the support.

§127.10(c): One commenter states this rule blurs the lines between treating doctor and designated doctor, which will decrease the objectivity of the designated doctor opinion. Treating doctors should be required to perform or request the necessary testing if it was suggested by the doctor.

Agency Response: The Division disagrees. Designated doctors must answer all questions submitted to them to a reasonable degree of medical certainty and if additional testing is necessary to achieve this certainty then the designated doctor must request it.

§127.10(d): One commenter agrees with this rule but disagrees with the repeal of §130.6. The commenter states that this change leaves injured employees no avenue to have injured areas claimed to be compensable examined by a designated doctor if those areas are disputed by a carrier. This matter should be addressed by designated doctors regardless of whether the injured employee or insurance carrier requested extent. House Bill 2605 did not require the repeal of §130.6 and by repealing this rule you have required injured employees to have direct knowledge of the designated doctors administrative system and to understand their diagnoses. This rule prevents designated doctors from examining disputed areas and denies due process to injured employees.

Agency Response: The Division appreciates the commenter's support on this subsection. The Division disagrees, however, with the commenter's concerns regarding the repeal of §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings) published elsewhere in this issue of the *Texas Register.* Though the Division also expresses its rationale for this disagreement in response to the commenter's comments on the repeal of §130.6 of this title, the Division reiterates here that the repeal of §130.6 was necessary for several reasons. Most relevantly, the majority of the rule's provisions were unnecessary because they were redundant with other rules related to designated doctor examinations found in Chapter 127 of this title. Additionally, the requirement that designated doctors issue multiple impairment ratings if the designated doctors determines that the extent of the injured employee's compensable injury is in dispute is no longer necessary because designated doctors can now be requested to opine on the extent of a compensable injury. When the multiple impairment rating requirement of §130.6 of this title was adopted in 2001, designated doctors could not opine on that issue. Therefore, because parties can now request that designated doctors provide an opinion on extent of injury in addition to MMI/IR, it is no longer appropriate to permit designated doctors to consider the extent of the injured employee's injury if the parties have not requested the designated doctor to do so.

The Division does clarify, however, that if a designated doctor is requested to address MMI/IR and not extent, the designated doctor should base the doctor's rating upon the medical records and other documentation provided to the doctor.

§127.10(e) - (f): One commenter requests that designated doctors be required to send copies of reports under these subsections to OIEC ombudsmen as well.

Agency Response: The Division disagrees. This subsection properly limits the parties to representatives because lay rep-

resentatives, pursuant to §150.3 of this title (relating to Representatives: Written Authorization Required), must submit written verification to the Division that the person is representing an injured employee. The Division may not have notice, however, of when an OIEC ombudsman is participating on the claim, making it difficult to determine if a particular ombudsman is appropriately included in this subsection for a particular claim. Additionally, whether OIEC ombudsmen should qualify as lay representatives under §150.3 of this title is outside the scope this rule.

§127.10(f): One commenter states that designated doctors cannot fill out the DWC-068 if the information is not given. The Division should not accept a designated doctor examination request unless all information needed to complete the form required by this subsection is provided. Designated doctors should not be put into situation in which that information is not available.

Agency Response: The Division agrees and disagrees. The Division denies designated doctor examination requests based on the reasons provided in §127.1 of this title (relating to Requesting Designated Doctor Examinations) and declines to modify those reasons to address each individual field required by the DWC-068. That said, the Division agrees that a designated doctor may have difficulty providing information not supplied on the DWC-032, and the designated doctor should contact the Division if this should occur. Moreover, the Division clarifies that if the designated doctor was not provided information on a DWC-032 that should have been provided on that form, the Division will consider this factor heavily when evaluating the designated doctor's compliance with §127.220 of this title.

§127.10(g): Multiple commenters state that this rule does not clarify what weight should be given to a designated doctor's opinion on a question the designated doctor was not appointed to address. The Division's appeals panel has been inconsistent on this issue. There is no statutory authority to give these opinions presumptive weight or to ignore them. Instead, it appears the proper remedy is to give those opinions appropriate weight based on credibility and the record as a whole.

Agency Response: The Division agrees and disagrees. The Division agrees that if a designated doctor opines on issues the designated doctor was not ordered to address, the designated doctor's report will not receive presumptive weight regarding those issues; instead, the report would be weighed as any other medical report on those issues that the designated doctor was not ordered to address. The Division disagrees, however, that §127.10(g) of this title is unclear on this issue. Under §127.10(g), a designated doctor's report is only given presumptive weight on issues in question the designated doctor was properly appointed to address. If a designated doctor was not ordered to address an issue, the issue is not in question and the designated doctor was not appointed to address it; therefore, the doctor's report has no presumptive weight on those issues.

§127.10(h): One commenter states that this subsection should state that a carrier must only pay benefits for multiple maximum medical improvement examinations if the designated doctor was asked to address extent.

Agency Response: The Division agrees with this clarification, because it matches the intent of the Division's proposed amendment to this subsection and has made a change to the adopted subsection.

§127.20: One commenter requests that the Division require parties to resubmit a DWC-032 with requests for clarification, so that the designated doctor will have updated information on the injured employee's condition, particularly in circumstances in which the request is received long after the original examination.

Agency Response: The Division disagrees. If a designated doctor does not feel that the doctor has sufficient or sufficiently current information on an injured employee to respond to the request for clarification, the designated doctor should request that the Division order a reexamination. If, in fact, the request for clarification has come after dispositive and substantial changes have occurred on an injured employee's claim, a reexamination would likely be appropriate in most cases.

§127.20(a): Multiple commenters state that the Division should remove its proposed amendments to this rule. Some commenters state that this rule protects bad doctors at the expense of the rights of system participants. Most requests for clarification ask designated doctors to reconsider their decision or issue a new decision based on submitted evidence or legal considerations. This rule effectively eliminates this possibility and will require parties to go to benefit review conferences or contested case hearings, which goes against the system goals of workers' compensation. Other commenters state that to approve requests for clarification for only one reason (the doctor failed to address an ordered issue) is extremely limiting and makes the process largely futile. Requests for clarification are the most efficient way of correcting an error. Otherwise, these errors can only be corrected through litigation. For instance, requests for clarification can address instances in which multiple dates of maximum medical improvement and impairment ratings were required; when the impairment rating was calculated in error; or the report is incomplete and the ordered issue was not fully addressed. Also, designated doctors often do not meet the Division's Appeals Panel's standards for medical probability when addressing causation or extent questions. Letters of clarification provided by designated doctors can remedy these defects.

Agency Response: The Division agrees in part and disagrees in part and has made a change. Specifically, the Division disagrees that prohibiting designated doctors from amending their reports would make the letter of clarification process futile. This prohibition would not have prevented doctors from resolving ambiguity in their reports or from further explaining their reasoning.

Nonetheless, the Division acknowledges and agrees, however, that in some cases permitting a designated doctor to correct an error in the doctor's report would expedite the dispute resolution process and curtail unnecessary litigation costs. Still, the Division also believes that designated doctors should only make these changes when the request for clarification submitted to them by the Division asks or permits them to do so. The Division, therefore, has made a change to this subsection. Specifically, the Division has removed its proposed limitations on requests for clarification and replaced them with this standard that clarifies the Division's current procedure when reviewing requests for clarification: "Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision." This standard, currently implemented by the Division, ensures that system participants may still have simple errors corrected or other changes made by a designated doctor, when appropriate, without requiring the system participant to pursue dispute resolution. Additionally, this standard also provides the Division the necessary discretion to monitor the quality and ap-

propriateness of the requests and clarifies its authority to limit a designated doctor's responses to the request for clarification submitted to the doctor.

§127.20(a): One commenter agrees that the introduction of new or additional medical records through the request for clarification process should be disallowed.

Agency Response: The Division generally agrees that most requests which ask the designated doctors to review new or additional medical would most properly be denied and resubmitted as new examination requests; however, the Division declines to bar this practice entirely, as in some cases it may be appropriate.

The Division also notes that it has made a change to this subsection for other reasons as described above.

§127.20(a): One commenter states that this rule proposal is internally inconsistent in permitting parties to "request clarification on issues already addressed by the designated doctor's report" yet affirmatively limiting reconsideration or new decisions only to instances when the designated doctor failed to address an issue the designated doctor was ordered to address.

Agency Response: The Division disagrees with this alleged inconsistency. The commenter's alleged inconsistency only exists if clarification can only be achieved if the designated doctor reconsiders the doctor's decision or issues a new decision. Because the Division does not agree with this interpretation, the Division fails to see the alleged inconsistency in its proposed rule.

The Division also notes, however, that it has made a change to this subsection for other reasons as described above.

§127.20(a): One commenter states that this rule change is illogical, arbitrary, and capricious, and wholly ignores the purpose of clarification process utilized by injured workers and insurers to resolve observed vagueness, ambiguity, or problems in a received opinion as early in the process as possible. The commenter strongly recommends the Division remove this arbitrary limitation on designated doctors to correct errors.

Agency Response: The Division disagrees in part and agrees in part and has made a change. The Division disagrees that its proposal was "illogical, arbitrary, and capricious." The Division provided a rational basis for its proposed amendment. Specifically, the Division stated:

"This amendment is necessary to prevent overlapping determinations by a designated doctor that can both muddle the presumptive weight given to a designated doctor's initial report and confuse an insurance carrier's entitlement to reimbursement from the subsequent injury fund for benefits paid by the insurance carrier pursuant to an overturned designated doctor report. Furthermore, the Division also notes that this new standard for appropriate requests for clarification of a designated doctor parallels the standard for requests for clarification of an independent review organization's decision under §133.308(t)(B)(iv) of this title (relating to MDR by Independent Review Organizations).

The Division fails to see how this constitutes arbitrary and capricious reasoning, particularly because this standard has been successfully implemented in the medical necessity dispute context.

These factors notwithstanding, the Division acknowledges and agrees, however, that in some cases permitting a designated doctor to correct an error in the doctor's report would expedite the dispute resolution process and curtail unnecessary litigation costs and has, therefore, made a change to this subsection as described above.

§127.20(b)(3): One commenter states that leading questions are not always inflammatory and are often an essential means of reaching the truth. A party who believes that a designated doctor has misapplied the AMA guides must ask leading questions to inquire as to whether the designated doctor did comply with those guides.

Agency Response: The Division disagrees. Leading questions are not necessary to elicit truth nor determine compliance with the AMA Guides. For example, if a party needs to ask a designated doctor whether the designated doctor complied with a particular provision of the AMA Guides, the party may simply ask the designated doctor if the doctor did so. The party does not need to suggest the preferred answer through the question or otherwise attempt to influence the designated doctor's response with the party's questions. The designated doctor is neither hostile nor adverse to any party and, therefore, direct questions are more than appropriate for the purposes of a request for clarification.

§127.25: Multiple commenters support this rule.

Agency Response: The Division appreciates the support.

§127.25: One commenter asks why an injured employee must request a new examination if the injured worker failed to contact he designated doctor within 21 days of the missed examination.

Agency Response: The Division clarifies that an injured employee must request a new designated doctor examination at that time in order to ensure that a rescheduled designated doctor examination of an injured employee who failed to attend an examination does not occur at a time so distant from the originally scheduled examination that the injured employee's medical condition or other dispositive circumstances may have changed. The submission of a new DWC-032 will prevent these outcomes.

§127.25(c): One commenter states that the rule should be amended to remove "if, after the insurance carrier suspends temporary income benefits" because designated doctors will not know if temporary income benefits have been suspended or ever received.

Agency Response: The Division agrees and has made the change.

§127.100: One commenter states that the Division should implement a pre-approval process as well as a timeline for the certification process to temper the out-of-pocket expenses of designated doctors who apply but are not approved for certification. The commenter states that these expenses could be up to $2200.

Agency Response: The Division disagrees. Completing all required Division training and testing is a threshold requirement for a doctor to even be considered a candidate to become a designated doctor. The time and other Division resources that would be expended by the Division reviewing physicians who may not even be able to pass all required testing would result in a waste of state resources.

§127.100(a): One commenter states that Division should replace its new active practice requirements with standards based on specific performance and adherence to the applicable aspects of regulation. Designated doctors all have active licenses and attend continuing medical education, and even the Division's

own medical advisor could not meet the Division's proposed active practice standard.

Agency Response: The Division disagrees but has made a change for other reasons. The Division cannot base its original certification determination on the specific performance of a doctor, because, in almost all cases, a doctor applying for certification, as opposed to recertification, has never been a designated doctor before and, therefore, there is no performance to evaluate. Nonetheless, the Division has, for other reasons described below, modified this requirement to provide that a designated doctor must have had three years of active practice in their career and not within the past ten years.

§127.100(a) and §127.110(c): A commenter asks if the Division could simply e-mail copies of its treatment and return-to-work guidelines to designated doctors instead of requiring designated doctors to purchase the documents.

Agency Response: The Division declines to e-mail copies of its treatment guidelines and return-to-work guidelines to designated doctors. These guidelines are copyrighted material and the unlicensed distribution to designated doctors described by commenter would be inappropriate.

§127.100(a)(2): One commenter asks what are the required tests under this subsection and when will they be offered? The commenter also asks how often will designated doctors have to take these tests?

Agency Response: The Division will clarify the specific requirements of its new designated doctor certification and recertification tests later this year when it completes development of these tests. The Division does clarify, however, that pursuant to §127.110 of this title (relating to Designated Doctor Recertification), testing will be required bi-annually before a designated doctor can become recertified as a designated doctor.

§127.100(a)(4): Multiple commenters suggest that the Division remove its proposed active practice requirements. One commenter states that the proposed active practice requirements will put an undue burden on the workers' compensation system. Another commenter states that no changes in HB 2605 require this new requirement. Additionally, the Division's new designated doctor qualification criteria under proposed §127.130 does not involve the doctors current clinical practices but on the testing and training qualifications and the diagnosis and body part affected and doctor license type. Therefore, it is not clear why the active practice requirement is necessary. It should be replaced with a requirement to have an active medical license and current continuing medical education.

Agency Response: The Division agrees in part and disagrees in part. The Division agrees that its proposed active practice requirement may be unnecessarily burdensome and could prevent some qualified doctors from becoming certified designated doctors. The Division, therefore, has elected to retain its current standard for active practice that requires designated doctors to have engaged in active practice for at least three years in their career not within the past ten years and has included this standard in adopted §127.100(a)(4). The Division believes this requirement sufficiently ensures that the doctor will have appropriate clinical knowledge to perform a physical examination while the Division's new, more rigorous training, testing, and certification standards will suffice to ensure that an applicant for certification has the necessary aptitude to address all issues that may be presented to a designated doctor.

The Division disagrees, however, with the commenter's suggested standard for certification, because it would not meet the necessary standards described above even in conjunction with the Division's other increased standards for certification as a designated doctor.

§127.100(a)(4): One commenter states that though this section certainly attempts to address the problem of doctors with limited recent clinical experience, this provision does not go far enough. It would still allow doctors out of practice for seven years to become designated doctors. The rule should require that within the past five years the doctor must have earned as much treating patients as providing expert opinions.

Agency Response: The Division disagrees with the commenter's suggested standard for designated doctor certification because it would be nearly impossible for the Division to verify unless the Division fully audited an applicant's income from practice over a five year period, which is not administratively feasible. Moreover, the Division has also determined, for reasons stated above, that its current standard for active practice will continue to suffice for the purposes of designated doctor certification and has, therefore, elected to retain this standard.

§127.100(a)(5): One commenter asks how the Division will verify compliance with this requirement.

Agency Response: The Division will verify this compliance through required attestations by the designated doctor in a conjunction with its normal investigation and monitoring of designated doctor compliance.

§127.100(c): One commenter states that if a designated doctor takes the certification test early, that designated doctor's certification should be extended to compensate for the early training in light of the few trainings offered by Division.

Agency Response: The Division disagrees. Designated doctor certifications in all cases, unless revoked or suspended, last for two years and this duration can neither be shortened nor extended by the date the designated doctor completes the Division's required testing.

§127.100(d)(3): One commenter states that the term "relevant restriction" is vague and should be detailed because it is a reason for denial. This requirement as proposed may be subject to too much interpretation.

Agency Response: The Division disagrees. The Act provides the Division with the discretion to determine the appropriate standards for certification as a designated doctor, and, therefore, the Division declines to limit this discretion with unnecessary specification. The Division has successfully implemented this standard for certification since 2006 and believes it will continue to suffice for this purpose. The Division does clarify, however, that, pursuant to §127.100 of this title (relating to Designated Doctor Certification) the Division will inform a doctor of the reason for its denial of the doctor's application for certification and the doctor will have the opportunity to respond to that reason in writing.

§127.100(d)(4): One commenter states that "other activities" is unclear and vague and should be detailed because it is a reason for denial.

Agency Response: The Division disagrees. The Act provides the Division with the discretion to determine the appropriate standards for certification as a designated doctor, and, therefore, the Division declines to limit this discretion with unnecessary specification. The Division has successfully implemented this stan-

dard for certification since 2006 and believes it will continue to suffice for this purpose. The Division does clarify, however, that, pursuant to §127.100 of this title (relating to Designated Doctor Certification) the Division will inform a doctor of the reason for its denial of the doctor's application for certification and the doctor will have the opportunity to respond to that reason in writing.

§127.110(a) and (c): One commenter states that designated doctors should not have to take recertification examinations if they maintain their continuing medical education. It is unnecessary and financially burdensome.

Agency Response: The Division disagrees. Continuing medical education will not address the workers' compensation specific issues regularly presented to a designated doctor and, therefore, will be insufficient for the purposes of designated doctor recertification. The Division tailors its training and testing to ensure that designated doctors are prepared for and sufficiently competent to address questions posed to them. The Division further clarifies that any financial burden imposed on a designated doctor are voluntary as no doctor is required to be a designated doctor.

§127.110(a)(2): One commenter states that designated doctor recertifications should be effective on the date approved and not on the date the training was completed. If it is on the training date, the certification time period should compensate for early training.

Agency Response: The Division disagrees. Certifications will generally be effective on the day after the last effective day of the designated doctor's previous certification to prevent a lapse in certification. The Division notes, however, that late filing of applications for recertification could cause a lapse in certification. In all cases, barring a suspension or revocation of certification, the designated doctor's certification will only be effective for two years.

§127.110(b)(2): One commenter asks how the Division will verify compliance with this requirement?

Agency Response: The Division will verify this compliance through required attestations by the designated doctor in a conjunction with its normal investigation and monitoring of designated doctor compliance, including the investigation of complaints and auditing of designated doctors.

§127.110(b)(3): One commenter states that the application to become a designated doctor asks about a designated doctor's active practice requirements. Does this imply that they have to meet this requirement for recertification? Do designated doctors have to complete MMI/IR testing?

Agency Response: The Division clarifies that its active practice requirements only apply to doctors applying for their initial certification as a designated doctor and not to designated doctors applying for recertification. Additionally, the Division clarifies that designated doctors will be required to complete all Division required testing in order to be approved for recertification and that, for designated doctors, testing required to assign impairment ratings is simply one element of the required testing to maintain designated doctor certification.

§127.110(c): One commenter recommends that the rule be amended to permit expiring designated doctors to still be able to perform reexaminations and respond to letters of clarification during the 45 day pre-expiration period. Assigning a new designated doctor in these situations would be a great system cost.

Agency Response: The Division agrees and has made a change. The 45 day pre-expiration period is only intended to prevent designated doctors from receiving offers of new examinations and not to prevent the designated doctor from providing all services on claims to which the designated doctor was previously assigned and the Division has made a change to clarify this point.

§127.110(c): One commenter states that this rule will be impossible to impose because the Division only offers its training four times a year. Also, the grace period of thirty days after expiration is not sufficient time for a doctor to apply for recertification based on current designated doctor training availability.

Agency Response: The Division disagrees. First, the Division clarifies that the Division currently does and will continue to offer more frequent training than claimed by the commenter. Even if the commenter's statement were correct, however, quarterly training would still be sufficient for a designated doctor to meet the certification requirements. Moreover, the thirty day grace period is more than sufficient considering that a designated doctor had eighteen months to meet all applicable requirements. The thirty day grace period is intended simply to help designated doctors adjust to the implementation of these new recertification requirements.

§127.110(c): One commenter states that the affirmative opt-out of this rule and §127.110(a)(3) of this section should be removed. This penalty seems excessive. A doctor who fails to inform that the doctor no longer wishes to be a designated doctor the Division should simply expire.

Agency Response: The Division agrees and has made a change. Specifically, the Division has deleted the requirements that doctors who no longer wish to be certified as designated doctors must notify the Division of this fact or commit an administrative violation from both §127.110(a)(3) and §127.110(c). The Division has further clarified under these subsections that only designated doctors who seek to remain certified as designated doctors and fail to timely renew their application status under §127.110(a)(3) or timely apply for recertification under §127.110(c) commit an administrative violation. The Division believes these changes remove the possibly excessive penalty discussed by the commenter while also ensuring that designated doctors who no longer wish to be designated doctor after their current certification expires are not included in the timely filing requirements.

The Division notes that it has also changed §127.200(a)(5) in response to this comment to clarify that only designated doctor who wishes to stop practicing as a designated doctor before the doctor's current certification as a designated doctor expires must provide the Division with written notice in advance of the doctor's voluntary exit from the designated doctor program. This change is necessary to clarity that this requirement does not apply to a designated doctor who will simply not be renewing the doctor's certification as a designated doctor but intends to practice as a designated doctor for the duration of the doctor's current certification.

§127.110(d): One commenter states that this section should be changed from two years to two years from the date of approved.

Agency Response: The Division disagrees. The Division will, in all possible cases, choose the date that both ensures no lapse of certification while also preventing an overlap of certifications. In cases of delinquent application for recertification, however, there may be a lapse in certification and the Division will determine an

appropriate effective date for the certification on a case-by-case basis. The Division also notes that a designated doctor's initial certification under §127.100 of this title will become effective on the date the doctor's application for certification is approved by the Division.

§127.110(e)(4)(E): One commenter states that this requirement appears very subjective and it is unclear who will decide whether the criterion is met.

Agency Response: The Division clarifies that the Division's Medical Advisor, Medical Quality Review Panel, and other medical staff will review for compliance with this standard. The Division disagrees with the alleged "very subjective" nature of this requirement, because this form of medical case review is a common practice for the Division and compliance with it can be determined with a reasonable degree of medical certainty through expert reviews and dialogue with the subject of the review.

§127.120: One commenter generally supports the rule but seeks that the rule provide that the doctor shall be paid the same reimbursement amount as a doctor located in Texas. The commenter states that the fee for Texas doctors is more than adequate.

Agency Response: The Division disagrees. For out-of-state injured employees, the Division must have the authority to take whatever steps necessary to ensure that a designated doctor examination can be performed. Furthermore, the Division reminds system participants that, pursuant to §413.011(d-4), an insurance carrier may contract with a health care provider for fees in excess of the Division's fee guidelines if necessary to secure health care for an injured employee. Lastly, the Division notes that reimbursement rates for designated doctors are governed by §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services) and is currently outside the scope of these rules.

§127.120: One commenter asks if the Division will provide all parties with written notice of any waived requirements prior to the exam in order to avoid complaints from the parties.

Agency Response: The Division clarifies that it will make all possible efforts to inform parties and Division staff involved in any subsequent dispute resolution processes of any exceptions made to its designated doctor certification requirements.

§127.130: One commenter states that the Division maintains the sole responsibility to determine the qualification of a designated doctor for a particular claim based on previously provided information and matrix completion. The responsibility should be on Division to confirm the designated doctor's matrix matches the particular claims.

Agency Response: The Division agrees. The Division agrees that it will assign all doctors to claims based on the information it has regarding the claim and the information it has on the doctor. The Division reminds designated doctors, however, of their duty under §127.200(a)(12) of this title (relating to Duties of a Designated Doctor) to notify the Division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would required the doctor to exceed the scope of practice authorized by the doctor's license.

§127.130: One commenter states that the commenter generally supports this section but also thinks designated doctors should be required to refer to specialists if the designated doctor is not qualified completely for the claim.

Agency Response: The Division agrees but notes that §127.10(c) of this title already requires a designated doctor to refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question.

§127.130(b): One commenter states that this subsection will be extremely problematic to all system participants and will ultimately increase costs and promote unnecessary delays in resolving disputes. The specialist requirements of §127.130(b)(5) - (8) will make it harder for the Division to find qualified physicians who will accept the appointment. Moreover, the exception in subsection (d), which actually undermines this rule, will only delay disputes and increase costs.

Agency Response: The Division disagrees. The Division believes this subsection will decrease system costs and expand access to care. The Division anticipates that very few designated doctor examinations will fail to have a qualified designated doctor because of the "specialist requirements" of this subsection. Moreover, the Division emphasizes that Labor Code §408.0041 requires the Division to account for specific diagnoses, among other factors, when determining the credentials appropriate for a particular designated doctor examination.

Additionally, the Division disagrees that §127.130(d) of this title undermines this subsection, because the Division must have such an exception as a safeguard for instances in which no doctor qualified under this subsection is available to perform the examination. In these instances, the Division will rely on other designated doctors who through the use of referrals for specialist consultations and their training as designated doctors to incorporate these referrals into their reports can still produce a designated doctor report of high quality.

§127.130(b): One commenter states that the human body cannot, in all cases, be separated into different parts. Frequently, one part will affect another and the pathology spreads. Only a doctor with proper training and experience can appreciate the "wholeness" of the human body. Compensable body parts are not a decision to be made by an insurance carrier.

Agency Response: The Division clarifies that any dispute by an insurance carrier regarding the compensability of a claim or the extent of a compensable injury must ultimately be resolved by the Division if the injured employee disagrees with the insurance carrier's determination. Regarding the commenter's statement on the wholeness of the human body, Labor Code §408.0041 requires the Division to select designated doctors for examinations based, in part, on the injured employee's diagnosis and body party affected by the injury.

§127.130(b): One commenter is concerned about the subsequent review of a patient who has undergone or been referred for surgical intervention. The commenter states that the rules should reflect that when a surgical intervention has been proposed or performed, a surgeon with the same or similar licensure and certification should perform the designated doctor examination.

Agency Response: The Division disagrees. While the Division acknowledges that surgical intervention may create unique clinical circumstances in a particular claim, the Division notes that the statutory factors the Division must consider when assigning a designated doctor to a claim are the injured employee's diagnosis and the body part(s) affected by the injury. The Division also notes, however, that designated doctors are required to refer in-

jured employees for evaluations by other health care providers if the designated doctor is not qualified to perform the evaluation and the evaluation is necessary to answer the issue in question.

§127.130(b): One commenter states that a designated doctor's background, education, training, or board certification have no bearing on the quality of a designated doctor's report. The quality of a report is contingent on the effort of the designated doctor and on the designated doctor's education regarding the AMA Guides, 4th Edition and how to address the issues on the DWC-032. There needs to be a test to reflect these skills. The commenter states that nothing in the training of a medical doctor or doctor of osteopathy prepares the doctor to perform designated doctor examinations except for the actual patient examinations. Designated doctor practice should be treated like a specialty with substantial maintenance requirements.

Agency Response: The Division disagrees. While the Division agrees that a designated doctor's personal effort and specific education regarding the applicable version of the AMA Guides and other workers' compensation issues are critical to a designated doctor's ability to produce quality reports, the Division strongly disagrees that a designated doctor's background, education, training, or board certification have no bearing on this quality as well. Furthermore, the Division notes that a system that attempted to assign designated doctors through standards based on personal effort and knowledge and application of the AMA Guides would lead to subjective doctor selections on an unacceptable number of examination requests and, therefore, inconsistent assignments of designated doctor examinations. One strength of the Division's adopted selection criteria for examinations that occur on or after January 1, 2013 is the objective standards it uses in its selection process and, therefore, the transparency in the selection of a designated doctor it provides to system participants.

§127.130(b): One commenter states that physicians certified in emergency medicine are not qualified to perform any designated doctor evaluations. Emergency medicine physicians only have training in acute conditions.

Agency Response: The Division disagrees. First and foremost, the Division disagrees that physicians board certified in emergency medicine are not qualified to perform any examinations, because the Division has determined that for the vast majority of diagnoses seen in the Texas workers' compensation system, specifically those covered by §127.130(b)(1) - (7) of this title, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

Furthermore, the Division also believes that designated doctors who are board certified in emergency medicine are among those physicians specially qualified to perform examinations on certain complex diagnoses that are uncommon in the workers' compensation system. Specifically, the Division believes that board certification in emergency medicine will especially qualify a designated doctor to examine multiple bone fractures, certain chemical exposures, and heart and cardiovascular conditions because these conditions most frequently present in the emergency room context and are, therefore, frequently seen by these physicians, especially multiple bone fractures. And though the Division acknowledges that the long-term outpatient treatment of these conditions would likely not be performed by a doctor board certified in emergency medicine, their frequent experience with those conditions is rare and applicable and, moreover, their experience with these conditions as acute conditions will be particularly helpful when examining injured employees for extent of injury or medical causation issues.

§127.130(b): One commenter states that physicians who are board certified in Occupational/Preventive Medicine are not qualified to perform designated doctor examinations.

Agency Response: The Division disagrees. First and foremost, the Division disagrees that physicians board certified in occupational/preventive medicine (occupational medicine doctors) are not qualified to perform any examinations, because the Division has determined that for the vast majority of diagnoses seen in the Texas workers' compensation system, specifically those covered by §127.130(b)(1) - (7) of this title, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

Additionally, the Division believes that occupational medicine doctors are among those physicians specially qualified to perform designated doctor examinations on several complex diagnoses infrequently seen in the workers' compensation system. These diagnoses include spinal cord injuries, severe burns, and multiple bone fractures under §127.130(b)(8)(B), (C) and (E) because occupational medicine doctors are familiar with and trained to evaluate these injuries in the chronic phase for return-to-work and extent of injury issues and are generally trained to assess post-trauma patients for fitness for duty and functional ability. The Division has also determined that occupational medicine doctors are qualified to evaluate CRPS under §127.130(b)(8)(D) because occupational medicine doctors are trained in their residency to evaluate and diagnose this condition that is most frequently related to work-related injuries. The Division has also determined that occupational medicine doctors are qualified to evaluate complicated infectious diseases under §127.130(b)(8)(F) because occupational medicine doctors frequently provide post-exposure prophylaxis for blood borne pathogen exposures, are involved in the care of patients who contract infectious diseases from their work, and are trained in travel medicine for that purpose. The Division has also determined that occupational medicine doctors are qualified to evaluate chemical exposures under §127.130(b)(8)(G) because occupational medicine doctors are trained in toxicology and routinely assess patients for possible chemical exposures at work and also provide medical surveillance to prevent these exposures. Finally, the Division has determined that occupational medicine doctors are qualified to evaluate cardiovascular conditions under §127.130(b)(8)(H) because occupational medicine doctors must routinely perform cardiovascular assessments for fitness for duty examinations, medical surveillance, driver examinations for other agencies, and, in many instances, as Aviation Medical Examiners for pilots.

§127.130(b): One commenter states that this subsection will substantially decrease the qualifications for a designated doctor and will result in the substantial decrease in the quality of designated doctor evaluations, increase costs to injured employees and insurance carriers, and adversely affect injured employee care. Essentially, the proposed rules seem to indicate that any physician who takes a two day course for evaluating maximum medical improvement and has a copy of the appropriate AMA guides has sufficient training to act as a designated doctor. The

commenter concludes musculoskeletal injuries, other than the most minor injuries, should be treated by either an orthopedic surgeon or a specialist in physical medicine and rehabilitation.

Agency Response: The Division disagrees. The Division believes the commenter's characterization of the Division's current training is inaccurate. The Division's training has changed in recent years and expanded its coverage of all issues a designated doctor must address and not simply MMI. Furthermore, the Division, in light of the HB 2605 amendments to §408.1225, is currently in the process of developing new tests and training required for designated doctor certification that will further ensure that designated doctors certified or recertified by the Division will be more than adequately trained to evaluate the vast majority of injuries presented to that doctor provided those injuries can be evaluated by that doctor within the scope of the doctor's license. Thus, the Division believes that this subsection, in addition to the other rules adopted with this subsection, will increase the quality of designated doctor examinations and reports. Lastly, the Division notes that qualification standard recommended by the commenter would likely lead to drastic access to care issues because it would reduce the number of qualified designated doctors by approximately 75% and, therefore, appears largely administrative infeasible.

§127.130(b): One commenter states that this subsection subverts the legislative intent of Labor Code §408.0041 and §408.0043. If the legislature meant "professional licensure" it would have not stated "professional certification." While the conflict provision included in this subsection may match the letter of law, it overrides this legislative intent of these sections.

Agency Response: The Division disagrees. The Division must comply with the Act and declines to ignore the plain language of its provisions, including the conflict provision in Labor Code §408.0041(b-1) mentioned by the commenter. Additionally, the Division notes that the legislative intent behind amendments made by HB 2605 to §408.0041, including amendments governing the criteria to be used by the Division in selecting a designated doctor, can be found in the Sunset Advisory Commission's final decisions regarding the Texas Department of Insurance, Division of Workers' Compensation. A copy of the Sunset Advisory Commission's report can be found here: http://www.sunset.state.tx.us/82ndreports/wcd/wcd_fr.pdf.

§127.130(b)(1): One commenter states that the qualified designated doctors under this subsection should be limited to orthopedic and hand surgeons and physicians certified in physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph and §127.130(b)(2) - (7).

§127.130(b)(1) - (7): One commenter states that these categories are broad and could let a doctor practice outside the scope of their license. The commenter states that though the Division's new scope of license requirements should prevent most of these outcomes, §127.130(b)(4) is still concerning, specifically regarding the definition of "foot." The Division should expressly exclude the "ankle" from this subsection pursuant to *Texas Orthopaedic Ass'n v. Texas State Bd. of Podiatric Medical Examiners,* 254 S.W.3d 714 (Tex. App.--Austin 2008, pet. denied). Also, "relating to" is too broad and implies inclusion of the ankle because the ankle is related to the foot.

Agency Response: The Division disagrees. Though the Division acknowledges that it may be possible that in some exceptional circumstances its qualification criteria under §127.130(b) could permit a designated doctor to exceed the scope of their license, the Division believes the duty that this section and §127.200 of this title (relating to Designated Doctor Duties) imposes on designated doctors to notify the Division if the doctor's participation on a claim would cause the designated doctor to exceed the scope of the doctor's license suffices to remedy these exceptional circumstances and, moreover, presents the most administratively feasible means of addressing this issue. Regarding the commenter's concerns regarding §127.130(b)(4), the Division declines to make the recommended exclusion or amendment. These scope of license determinations are best made by practitioners subject to the applicable laws and licensing boards, and the Division expects its designated doctors to be vigilant and forthcoming in informing the Division if they feel a claim would require the designated doctor to exceed their scope of practice.

§127.130(b)(2): One commenter states that the qualified designated doctors under this subsection should be limited to orthopedic surgeons and doctors board certified in physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1), and §127.130(b)(3) - (7).

§127.130(b)(3): One commenter states that the qualified designated doctors under this subsection should be limited to doctors board certified in orthopedic surgery, neurosurgery, physical medicine and rehabilitation, and chiropractic for injuries to the spine. The commenter also states that for torso injuries, general surgeons would be preferred.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1) and (2), and §127.130(b)(4)- (7).

§127.130(b)(4): One commenter states that the qualified designated doctors under this subsection should be limited to doctors board certified in orthopedic surgery and physical medicine and rehabilitation.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph, §127.130(b)(1) - (3), and §127.130(b)(5) - (7).

§127.130(b)(5): One commenter states that the designated doctors qualified under this subsection should be limited to licensed dentists or doctors board certified in plastic surgery.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

§127.130(b)(6): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in ophthalmology or licensed in optometry.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body.

§127.130(b)(7): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in family medicine, ear, nose, and throat, or plastic surgery, except for mental and behavioral conditions. Those conditions should be evaluated by a psychiatrist or psychologist.

Agency Response: The Division disagrees. For the vast majority of diagnoses seen in the Texas workers' compensation system, any doctor who is trained to be a designated doctor and who can evaluate the area of the body at issue within the scope of the doctor's license will be appropriately qualified for the purposes of Labor Code §408.0041 to perform a designated doctor examination of any injury or diagnosis relating to that area of the body. Additionally, the Division notes that the qualification standards recommended by commenter would likely create tremendous access to care problems for the workers' compensation system, particularly in rural areas, because of the frequency of examinations that fall under this paragraph and §127.130(b)(1) - (6). The Division also notes that psychologists cannot become designated doctors, because they are not "doctors" as that term is defined in the Act.

§127.130(b)(8): One commenter states that board certified providers will not produce better reports. While they may provide better treatment, designated doctors perform evaluations not treatment and the State-approved training makes distinctions based on certification. The assignment of designated doctor examinations should be equal among all designated doctors based on their scope of practice. This would comply with the intent of Labor Code §§408.0041, 408.0043, and 408.0045.

Agency Response: The Division disagrees. The Division believes that for the certain complex and uncommon diagnoses, physicians with more extensive clinical expertise and appropriate designated doctor training will be optimally qualified to produce the most high quality reports in the most expedient fashion. The Division agrees that designated doctors do not provide treatment but this fact does not make clinical experience irrelevant, particularly for the complex diagnoses selected by the Division that many practitioners may have no or little experience in treating or evaluating. Lastly, the Division notes that Labor Code §408.0041 requires the Division to take specific diagnoses into account when determining the credentials appropriate for a doctor selected to perform designated doctor examination.

§127.130(b)(8): One commenter states that "board certification" implies an assumption that board certified doctors know what they're doing, particularly in regard to pain management doctors and the diagnosis of RSD.

Agency Response: The Division agrees that "board certification" implies that board certified doctors "know what they're doing" and the Division agrees with this implication. Furthermore, the Division also believes that physicians board certified in anesthesiology with a subspecialty in pain management are among those physicians specially qualified to evaluate complex regional pain syndrome or RSD.

§127.130(b)(8): One commenter states that board certification is not necessary to address dislocations or tendon lacerations. These issues are thoroughly addressed by the Official Disability Guidelines and American Medical Association's Guidelines to the Evaluation of Permanent Impairment. A designated doctor's reports are the best gauge of their competence.

Agency Response: The Division agrees that board certification is not required to examine these issues, because these diagnoses are frequently treated and evaluated by all physicians in the workers' compensation system and, therefore, any licensed medical doctor or doctor of osteopathy appropriately trained as a designated doctor should be able to evaluate these diagnoses. The Division, therefore, has moved these diagnoses to §127.130(b)(7) of this title.

§127.130(b)(8): Multiple commenters state that it is not clear why chiropractors are excluded from this subsection when the use of the "SP" modifier has always been in place for exactly this reason i.e., in order to reach out to a specialist for a consultation. Is use of the "SP" modifier being removed?

Agency Response: The Division clarifies that neither this subsection nor any other rule adopted in this order remove the authority for a designated doctor to request the consultation of a specialist if necessary and appropriate under §127.10(c) of this title. The Division, however, also clarifies that the Division does not believe that the diagnoses in this subsection would generally fall within the scope of a chiropractor's license and, therefore, excludes them from this subsection.

§127.130(b)(8): One commenter states that a better solution to the criteria in this subsection is simply to allow designated doctors to use referrals under §127.10(c) of this title.

Agency Response: The Division disagrees that permitting designated doctors to use referrals under §127.10(c) of this title would produce better qualification outcomes than the criteria the Division has currently adopted, because the Division believes that the clinical background and training of the physicians selected in this subsection provides them with greater experience and familiarity in evaluating the uncommon and complex diagnoses under this subsection. Moreover, the Division notes that though most designated doctors could also produce reports of sufficient quality on these diagnoses with the proper use of referral consultations, the physicians selected under this subsection are optimally qualified because they would not require referrals, leading to more expedient outcomes and high-quality reports. Additionally, Labor Code §408.0041 requires the Division to consider the diagnoses of a injured employee when establishing the appropriate qualification criteria for designated doctor selection and simply requiring the use of referrals would not meet this requirement.

§127.130(b)(8): One commenter states that it is not clear that the Division is properly applying Labor Code §408.0043. The Division's listed certifications do not appear to match the requirements of this section. Specifically, it is not clear whether occupational medicine certification is appropriate to treat traumatic brain and spinal cord injuries, complicated infectious diseases, or cardiovascular conditions. The commenter doubts that this certification would be appropriate and recommends the Division review this section to make it more closely conform with Labor Code §408.0043.

Agency Response: The Division disagrees that it is not properly applying Labor Code §408.0043 in this subsection. As the Division explained in its proposal of these amendments and earlier in this adoption order, the new conflict provision in Labor Code §408.0041(b-1) is dispositive in determining the proper application of Labor Code §408.0043 to designated doctor selection. Specifically, HB 2605 amended §408.0041(b-1) to provide that while Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing an examination, if either Labor Code §408.0043 or §408.0045 conflict with Labor Code §408.0041, Labor Code §408.0041 controls. Thus, though both Labor Code §408.0043 and §408.0045 still apply to a designated doctor performing a designated doctor examination, Labor Code §408.0041 also requires designated doctor examinations to be performed by the next available designated doctor who meets the Labor Code §408.0041(b) criteria.

§127.130(b)(8): One commenter states that doctors should be able to be board certified by "any equivalent board" not simply the ABMS or AOABOS. The Division had this provision in its informal draft but has excluded it from this proposal.

Agency Response: The Division disagrees. The ABMS and the AOABOS are the standard certifying boards approved by the Texas Medical Board for the specialties included in this subsection, and the Division has, therefore, elected to limit its definition of board certification to certifications granted by the member boards of the ABMS and the AOABOS. *See* 22 Texas Administrative Code §164.4. The Division acknowledges that the Texas Medical Board also approves board certifications by other certifying boards on a case-by-case basis, but the Division has no procedures or standards to perform these evaluations and, therefore, this exception is administratively infeasible for the Division to implement. Furthermore, the Division notes, as discussed above in the preamble description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

§127.130(b)(8): One commenter states that finding board certified doctors is more difficult, particularly in rural areas where the doctors are also likely to have a disqualifying association.

Agency Response: The Division disagrees. As discussed above in the Division's description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

The Division does acknowledge, however, that this data cannot fully anticipate the effects of disqualifying associations and changes in designated doctor travel patterns; therefore, the Division assures system participants that the Division will closely monitor access to care outcomes throughout 2013 and beyond to ensure that the Division's new qualification standards have anticipated successful impact.

§127.130(b)(8): One commenter states that appointments under this subsection will increase burdens on the Division. These types of cases are rare, and, therefore, designated doctors will be less likely to accept these single appointments because of the additional costs of travel. Also, designated doctors who are board certified will decrease their traveling locations to avoid these cases, because the state average "no-show" rate is estimated to be around 20% to 25% and that rate will likely be higher in uniquely burdensome cases such as these.

Agency Response: The Division disagrees that this subsection will increase burdens on the Division. As discussed above in the Division's description of this subsection, the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements. Thus, the Division anticipates a relatively manageable implementation of this new standard beginning on January 1, 2013. The Division also notes that a consistent pattern of turning down examinations by a designated doctor, even if the doctor never exceeds the 4 declined appointment offers in a given 90 day period, will likely be a factor the Division will consider when examining the designated doctor's application for recertification. Additionally, the Division notes that based on its internal data less than 9% of examinations involve a "no-show" by an injured employee.

Lastly, the Division does acknowledge, however, that this data cannot fully anticipate the effects of disqualifying associations and changes in designated doctor travel patterns; therefore, the Division assures system participants that the Division will closely monitor access to care outcomes throughout 2013 and beyond

to ensure that the Division's new qualification standards have anticipated successful impact.

§127.130(b)(8): One commenter states that the Division does not have enough designated doctors board certified in neurosurgery or neurology to meet the demands of this subsection. Fortunately, the Division has included its exception under §127.130(d) of this title.

Agency Response: The Division disagrees it has insufficient numbers of qualified doctors to perform examinations under this subsection for reasons stated above but appreciates the support regarding its safeguard availability provision in §127.130(d) of this title.

§127.130(b)(8)(A): One commenter states that the designated doctors qualified under this subsection should be limited to doctors board certified in neurosurgery, neurology, and physical medicine and rehabilitation. The commenter's excludes physicians board certified in psychiatry from this subsection.

Agency Response: The Division agrees and disagrees. The Division disagrees that physicians board certified in psychiatry are not qualified to examine traumatic brain injuries, because physicians board certified in psychiatry have training and background through their residency in neurological testing and evaluations and, furthermore, are qualified to test and evaluate the cognitive function of an injured employee who has suffered a traumatic brain injury.

The Division agrees, however, that physicians board certified in neurology or neurosurgery are appropriately qualified and, therefore, did and continues to include them in this subsection. Lastly, the Division also agrees with the commenter that designated doctors board certified physical medicine and rehabilitation are qualified and sufficiently trained to perform evaluations under this subsection and has added them to this subsection. Doctors board certified in physical medicine and rehabilitation are frequently in charge of treating patients with traumatic brain injuries in the subacute and chronic phase of these injuries and also have extensive neurological training.

§127.130(b)(8)(B): Multiple commenters state that the phrase "profound peripheral neuropathy" is broad and vague. The commenters ask what range of neurological involvement will this phrase cover? It seems that any and all motor or sensory complaints could meet this description and peripheral neuropathy is within the scope of license of a chiropractor. The commenters ask for more specific ICD-9 codes that could be used.

Agency Response: The Division agrees that this term is unacceptably vague and has removed it from this subsection. The Division has determined that the severe neuropathies intended to be captured by the deleted term will still be captured under the chemical exposure diagnoses found in §127.130(b)(8)(G) of this title and, therefore, the deletion of the term will also not permit non-qualified designated doctors to evaluate these diagnoses.

§127.130(b)(8)(B): Multiple commenters state that "spinal cord injuries" is vague. The commenters ask, for instance, would it cover a multiple level disc bulge causing stenosis or does it include disc injuries causing nerve root impingement. More specific language would be helpful.

Agency Response: The Division disagrees that "spinal cord injuries" is vague. A spinal cord injury is a diagnosis based upon objective clinical signs, acute and chronic characteristics, and historical and physical findings of spinal cord damage. Furthermore, neither diagnosis mentioned by the commenter would necessarily qualify as a spinal cord injury. A multiple level disc bulge causing spinal stenosis is a radiological diagnosis that does not imply spinal cord damage but may affect spinal cord function. Additionally, disc injuries causing nerve root impingement do not qualify as spinal cord injuries because they affect nerve fibers outside the spinal cord.

§127.130(b)(8)(C): One commenter states that general surgeons should be able to examine severe burns. The head of the "burn department" at Texas Tech is a general surgeon. The commenter states that the only certification that the Division has included under this subsection that is relevant to burns is plastic surgery.

Agency Response: The Division agrees that physicians certified in general surgery would be appropriately qualified to examine injured employees with diagnoses with under this subsection and has made a change.

§127.130(b)(8)(D) - (H): One commenter states that the Division has removed doctors board certified in family medicine from these subsections, but the commenter believes they are appropriate in these subsections. The commenter states that the exclusion of doctors board certified in family medicine from this subsection may create access to care issues in rural areas.

Agency Response: The Division disagrees. First, the Division clarifies that the Division's adopted qualification standard will suffice to ensure the qualified designated doctors will be available to perform the vast majority of examinations. Specifically, the Division's internal data estimates that very few approved designated doctor examination requests that involve the diagnoses listed in this subsection would lack a qualified doctor because of the Division's adopted board certification requirements.

Additionally, however, the Division also does not believe that physicians board certified in family medicine (family medicine doctor) will meet the optimally qualified standards of these subsections. Specifically, the Division does not agree family medicine doctors would be optimally qualified to evaluate complex regional pain syndrome (CRPS), because their training in the complexities of anatomy, pathophysiology, and treatment of peripheral nerve, spinal nerve root, and spinal cord ailments is limited. Additionally, CRPS is very uncommon and controversial diagnosis and family practice doctors may not be familiar with current developments regarding this diagnosis because they typically refer the patient to specialists who diagnose and manage the care short and long term. Furthermore, the Division also disagrees family medicine doctors should be included in §127.130(b)(8)(E), because family medicine doctors would not typically see multiple bone fractures in their office practice.

Additionally, the Division declines to include family medicine doctors under §127.130(b)(8)(F) of this title because family medicine doctors typically do not admit patients to hospitals to care for infectious processes requiring intravenous antibiotics, so do not have the requisite residency training to evaluate patients hospitalized for prolonged antibiotic treatment. Lastly, the Division declines to include family medicine doctors under §127.130(b)(8)(G), because though family medicine physicians are trained to diagnose and treat cutaneous and ingested forms of exposure, inhalation exposure is more complex in its causation and evaluation and family doctors typically would not treat these conditions.

§127.130(b)(8)(E): Multiple commenters state that this subsection does not explain whether "multiple bone fractures" must be

displaced or nondisplaced. Doctors of chiropractic can see injured employees with healed nondisplaced fractures.

Agency Response: The Division clarifies that this subsection applies to either displaced or nondisplaced fractures and while chiropractors may be able to evaluate some of these injuries within scope of their license, the Division has determined that the optimally qualified doctors to examine this diagnosis are the doctors with the board certifications listed in this subsection.

§127.130(b)(8)(E): One commenter states that the designated doctors qualified under this subsection should not include physicians board certified in occupational/preventive medicine, plastic surgery, or emergency medicine.

Agency Response: The Division disagrees. Occupational/preventive medicine physicians and emergency medicine physicians are appropriately included under this subsection for reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection. Similarly, physicians board certified in emergency medicine are also appropriately qualified for the reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection. Physicians board certified in plastic surgery are appropriately qualified in this subsection because plastic surgery training requires training with a wide range of acute and chronic conditions involving multiple bone fractures, particularly open fractures, and plastic surgeons also have training and experience regarding extremity functional assessment and in dealing with patients with multiple injuries.

§127.130(b)(8)(F): One commenter states that designated doctor qualified under this subsection should include physicians board certified in the specialty of infectious diseases.

Agency Response: The Division disagrees that any change to the rule is necessary. The Division notes that this subsection already includes physicians board certified in internal medicine and infectious diseases is a subspecialty of internal medicine.

§127.130(b)(8)(F) - (H): One commenter states that the designated doctors qualified under these subsections should be limited to doctors board certified in internal medicine or family medicine.

Agency Response: The Division disagrees. Family medicine doctors are not properly included in these subsections for the reasons stated above, except for in §127.130(b)(8)(H) which already includes family medicine doctors. Occupational/preventive medicine physicians and emergency medicine physicians are appropriately included under this subsection for reasons stated above regarding their general qualifications to perform designated doctor evaluations under this subsection.

§127.130(b)(8)(H): One commenter states that the designated doctor qualified under this subsection should include physicians board certified in cardiovascular disease and interventional cardiology.

Agency Response: The Division disagrees that a change is necessary. The Division notes that this subsection already includes physicians board certified in internal medicine and cardiovascular disease and interventional cardiology are subspecialties of internal medicine.

§127.130(f): One commenter generally supports the rule but asks that this section be amended to state that designated doctors may still respond to requests for clarification even if they seek not to pursue recertification.

Agency Response: The Division agrees and disagrees. The Division agrees that in many cases it would be appropriate for a designated doctor to continue to provide certain services on claims, such as responding to requests for clarification; in others, however, such as if the designated doctor entirely leaves the workers' compensation system, this requirement would not be appropriate. The Division, therefore, clarifies that it will make these determinations on a case-by-case basis depending on the designated doctor's reasons for being authorized to leave a claim or being compelled to do so.

§127.130(h): One commenter also recommends that the Division also include felony convictions or guilty pleas. Felons should be disqualified from performing designated doctor examinations.

Agency Response: The Division disagrees. A doctor who has had the doctor's licensed revoked or suspended can legally not perform an examination of an injured employee; therefore, the Division includes this reason as the sole basis for the extraordinary remedy under §127.130(h). On the other hand under the commenter's facts, if the doctor still has an active license, it is at least possible the doctor could still be appropriately qualified to perform an examination (the Division also notes that if the doctor's license was suspended or revoked because of a felony conviction, §127.130(h) as proposed would already suffice). The Division notes, however, that any criminal conviction is an appropriate basis for a sanction, including possible revocation of the designated doctor's certification, and, furthermore, the Division may pursue an emergency cease and desist order if the Division believes the health, safety, or welfare of a person is possibly subject to imminent harm.

§127.140: One commenter states that designated doctors are neither influenced nor affected by third parties; designated doctors treat each assignment on a case-by-case basis. Furthermore, the Division chooses the doctor for the claim, so the third party's role should not present a concern.

Agency Response: The Division disagrees but clarifies except for network or political subdivision health plan affiliations under §127.140(a)(6), no other circumstance under §127.140 automatically creates a disqualifying association in all cases. The Division will make these determinations on a case-by-case basis to establish whether the association at issue may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor.

§127.140: One commenter states that the Division emphasizes in its preamble that disqualifying associations are determined on a case-by-case basis but does not include this language in the rule. It should include it in the rule.

Agency Response: The Division disagrees that any change to the rule is necessary. Section 127.140(a) plainly states that the listed circumstances "may," not "shall," constitute a disqualifying association, and, therefore, that determination must be made on a case-by-case basis by the Division. The Division also notes that the "receipt of income, compensation or payment of any kind not related to health care provided by the doctor" has been a disqualifying association for designated doctors for several years and has not caused any of the problems identified by the commenters.

§127.140(a)(1): Multiple commenters state that these sections as written are so broad that they would potentially disqualify all current designated doctors and all Texas doctors from serving as a designated doctor. It is also important to note that treat-

ing doctors provide health care. Designated doctors do not provide health care. As drafted, this subsection makes the receipt of income, compensation or payment of any kind not related to health care provided by the doctor a disqualifying association regardless of whether or not the association may be reasonably perceived as having the potential to influence the conduct or decision of a designated doctor.

Agency Response: The Division disagrees. Section 127.140(a) plainly states that the listed circumstances "may," not "shall," constitute a disqualifying association, and, therefore, that determination must be made on a case-by-case basis by the Division. The Division also notes that the "receipt of income, compensation or payment of any kind not related to health care provided by the doctor" has been a disqualifying association for designated doctors for several years and has not caused any of the problems identified by the commenters.

§127.140(a)(8): One commenter states that injured employee's representative should be included in this disqualifying association as well.

Agency Response: The Division disagrees, because it has not listed the representative of any party in this subsection, such as the employer's representative or the insurance carrier's representative. The Division also clarifies, however, that any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor may constitute a disqualifying association and this standard is sufficiently broad to include associations with the agent or representative of any system participant, if appropriate.

§127.140(c): One commenter states that the Division should also notify the injured employee and all other parties if the Division is notified about a disqualifying association.

Agency Response: The Division acknowledges it will make all possible efforts to notify all relevant parties of the disqualifying association promptly.

§127.140(c) and §127.220: One commenter states that designated doctors are not credentialing services for the Division. Designated doctors will not know all a treating doctors or referral doctors or network affiliations or the affiliations of an injured employee. Presumably, all designated doctor regulations apply equally to referral doctors and the burden should be on them. Also, designated doctors can certainly not know this information all over the state. This is the duty of the Division not designated doctors.

Agency Response: The Division disagrees. The duty of investigating whether or not a designated doctor may have a disqualifying association relevant to a claim requires vigilance on the part of all parties, because no single party will have in all cases sufficient information to determine the existence of all possible disqualifying associations. However, the Division also notes that the designated doctor has had the duty to notify the Division of disqualifying associations for several years, including the network affiliations of an injured employee. The Division further clarifies that though a designated doctor who performs an examination with a disqualifying association commits a violation, whether or how the Division pursues enforcement action against that doctor will be heavily influenced by the extent to which the designated doctor could have been aware of the disqualifying association. The Division also clarifies that the disqualifying association provision of this section do not apply to referral doctors, because those doctors are neither the designated doctor on the claim nor agents of the designated doctor on the claim. The Division reminds designated doctors, however, the financial disclosure requirements of §180.24 of this title (relating to Financial Disclosure) do apply to all referrals made by designated doctors under §127.10(c) of this title.

§127.140(e): Multiple commenters state that though a designated doctor's report is stripped of presumptive weight, it may nonetheless serve as a basis for ordering benefits or denying benefits in spite of the disqualifying association. This is insufficient. The designated doctor report should not be admitted into evidence at all or held as void if a disqualifying association is found, and it should not be used for any purposes.

Agency Response: The Division disagrees. Labor Code §410.165 requires that a hearing officer accept into evidence all written reports signed by a health care provider; the Division, therefore, cannot legally exclude a designated doctor report from evidence. The Division clarifies, however, that hearing officers will certainly take the existence of a disqualifying association into account when judging the credibility of the designated doctor's report.

§127.200(a)(6): Multiple commenters disagree with this subsection. One commenter states that it is an insurmountable logistical problem to be in the same room as the employee for all testing, such as a functional capacity examination. It also affords the designated doctor no privacy and quiet to conduct consultations or to complete reports. Also, if employee can't complete testing that day, the designated doctor would have to return to be in the same room. Another commenter states that designated doctors should not have to be in the same room if a medical assistant or technician providing the same service has attended the same certification training as the designated doctor. If the medical assistant or technician is certified, the general practice of physician supervision should apply here which would require that the designated doctor be in the same office or suite and available.

Agency Response: The Division disagrees. The Division's designated doctors are uniquely trained to perform examinations assigned to them by the Division, and permitting designated doctors to delegate large portions of the examination that the doctor is already qualified to perform or permitting designated doctors to participate in an examination only through on-site supervision thwarts the purpose of assigning the designated doctor to the claim originally. The Division clarifies, however, that designated doctor does not need to be in the same room as the injured employee when the designated doctor completes the report nor does a designated doctor need to be physically present for any appropriately requested testing or referral examinations under §127.10(c) of this title.

§127.200(a)(7): One commenter states that designated doctors should be made aware that the Division's return-to-work guidelines presuppose optimal treatment and cannot be mechanically applied.

Agency Response: The Division clarifies that all designated doctors are trained in proper application of the Division's treatment and return-to-work guidelines.

§127.200(a)(9): One commenter states that the subjective nature of this requirement could provide too much leeway for injured employee who is dissatisfied with a report to use this requirement against the designated doctor.

Agency Response: The Division disagrees. This subsection outlines the Division's reasonable expectations for designated doctors to be professional and courteous when performing desig-

nated doctor examinations on the Division's behalf. In keeping with the existing rules regarding complaints and the Division's current complaint handling procedures, the Division will investigate complaints filed with the Division to determine its merits on a case-by-case basis and then take appropriate action as needed.

§127.200(a)(14): Multiple commenters state that this requirement raises privacy concerns. Designated doctors may not wish to show their driver's license or other forms of identification because it would reveal their personal information. This could be a problem if the injured employee becomes disgruntled.

Agency Response: The Division agrees and has made a change. Specifically, §127.200(a)(14) now requires designated doctors to identify themselves to injured employees but does not require the presentation of photographic identification upon the request of an injured employee.

§127.210(a)(3): A commenter states that this subsection appears to subject a designated doctor to sanctions if he or she declines a designated doctor examination even if the medical records or injured employee fail to arrive or attend the examination.

Agency Response: The Division agrees this subsection is ambiguous and has made a change. This subsection only applies if the designated doctor has previously examined the injured employee. If a designated doctor has never examined the injured employee, and the injured employee fails to attend the examination or the medical records fail to arrive, the Division may redesignate if appropriate. If, however, the designated doctor has previously examined the injured employee designated doctors must accept and perform all subsequent examinations unless the Division authorizes or compels the designated doctor to leave the claim. Furthermore, if the injured employee fails to attend the examination or the medical records fail to timely arrive, the Division and other parties shall take necessary steps to ensure that the examination occurs at a later date as appropriate under §127.10(c) or §127.25 of this title as appropriate.

§127.210(a)(3): One commenter states that the Division should permit designated doctors one refusal of an offered designated doctor examination in a 90 day period even if the designated doctor has already been assigned to the claim. During the summer when doctors are on vacation or are covering vacation time for other doctors, it can be difficult to get time off to see one injured employees, especially in outlying areas.

Agency Response: The Division disagrees. Labor Code §408.1225(f) requires that a designated doctor continue providing all services on a claim to which the designated doctor has been previously assigned unless the Division has authorized or compelled the designated doctor to discontinue providing services on the claim. The Division notes, however, that a designated doctor may reschedule an assigned examination under §127.5(e) of this title with the agreement of the injured employee, and this provision should provide designated doctors sufficient flexibility in most cases to meet the demand of their personal schedules.

§127.220(a): One commenter states that the Division fails to state what happens if a designated doctor fails to include a required element.

Agency Response: The Division clarifies that failure to meet these requirements constitutes an administrative violation. The narrative report maintains its presumptive weight, though failure to meet these requirements may also affect credibility a Division hearing officer or the Division Appeals Panel assigns to the narrative report or constitute evidence to overcome the presumptive weight. But a narrative report's failure to comply with this section will not invalidate or otherwise require exclusion of the narrative report from dispute resolution proceedings.

§127.220(a)(5): One commenter states that designated doctor narrative reports do not need to include information regarding whether the injured employee is being treated through a workers' compensation health care network under Chapter 1305, Insurance Code or a network under Chapter 504, Labor Code. It is not relevant to a designated doctor narrative report, and most designated doctors will not know this information. Furthermore, the Division is now requiring this information to be in all designated doctor requests.

Agency Response: The Division agrees and has removed this requirement from this subsection, but the Division notes that for data collection purposes designated doctors must still provide this information pursuant to §127.220(c) of this title on the new DWC-068 form when a designated doctor conducts an examination under §127.10(f) of this title.

§127.220(a)(6): One commenter states that the Division should remove the requirement that a designated doctor include the time the examination began. There are several factors to consider when determining this time including when it is scheduled and time spent filling out necessary paperwork by injured employees. This rule is not clear regarding these concerns and should be removed.

Agency Response: The Division agrees and has made a change.

§127.220(a)(6): One commenter supports this provision.

Agency Response: The Division appreciates the support.

§127.220(a)(7): One commenter states that a designated doctor may not know the dates of the additional testing at the time the designated doctor's report is submitted.

Agency Response: The Division disagrees. If the designated doctor has received the reports of the referral doctors, those reports should contain the dates of the testing or examination. If the reports do not contain these dates, the reports should have sufficient information for the designated doctor to contact the referral provider and find out the appropriate dates.

§127.220(a)(8): Multiple commenters state that this requirement should be removed. The commenters state that it is unduly burdensome and inefficient for designated doctors to track the time the physician spends taking medical history, examining, and engaging in medical decision making. Moreover, this rule demonstrates a lack of understanding of realistic designated doctor/patient relationships and punishes good designated doctors. One commenter states that if Division knows which designated doctors are the problem, the Division should simply take action against those doctors, not punish other good designated doctors. Another commenter asks if the Division makes no definitive implication of the nature of the quality of the examination through this requirement, then why have it at all? One commenter also notes that the DWC is not raising reimbursement to compensate for the time spent performing these tasks. Another commenter states that the purpose of this requirement is unclear because each examination presents a unique situation. One commenter also states that the Division has no standard time that is desired, and it is not required for billing; therefore, considering the differences between cases, it

is impossible for the Division to determine the appropriate time or to enforce this requirement.

Agency Response: The Division disagrees. This requirement is necessary for informational purposes and to assist in the investigation of complaints of injured employee mistreatment or possible fraud. Furthermore, though the Division recognizes that the time spent performing these tasks may not necessarily have any direct bearing on the quality of a designated doctor's review and intends to make no definitive implication of that nature by imposing this requirement, this recognition does not mean that this information could never be factor in a determination by the Division. Additionally, the Division notes that this requirement is not unduly burdensome as it ultimately amounts only to the transcription of two numbers (the time these activities began and the time they were completed) in a designated doctor's report and is ultimately analogous to the billing procedures designated doctors use in other health care contexts. Finally, the Division notes that designated doctor reimbursement is outside the scope of this rule project.

§127.220(a)(8): One commenter states that the Division's clarification regarding the effect this timing requirement implies on a designated doctor's quality of examination should be included in the rule.

Agency Response: The Division disagrees. It is unnecessary to include this language in the rule because nothing in the rule precludes this application of the rule nor does any provision require a different interpretation.

§127.220(a)(8): One commenter supports this timing requirement but states that segmenting these practices is not possible. It should only be the time spent from start to finish on all of these tasks.

Agency Response: The Division clarifies that this subsection only requires designated doctors to record the time spent perform all of these tasks in aggregate, not individually.

§127.220(b): One commenter states that if much of the information on the DWC-068 is on the DWC-032, then the Division does not need the DWC-068. The commenter states that this only creates more unnecessary work without more additional compensation for designated doctors.

Agency Response: The Division disagrees. The DWC-068 is necessary to ensure that the Division has information regarding the outcome of extent of injury examinations and other examinations performed under §127.10(f) of this title so that the Division can effectively monitor the quality of these examinations the same way it does for examinations on impairment rating, maximum medical improvement, and an injured employee's ability to return-to-work. The information the Division is collecting on extent of injury examinations and other examinations under §127.10(f) of this title through the DWC-068 form is similar to the information the Division already collects on designated doctor examinations regarding impairment rating, maximum medical improvement, and return-to-work issues through the DWC-069 and DWC-073 forms.

NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS

For: None.

For, with changes: American Insurance Association; Insurance Council of Texas; Texas Medical Association.

Against: Texas Independent Evaluators, LLC.

Neither for nor against, with changes: Examworks; Genesis Medical Management Solutions; IWP; Office of the Injured Employee Counsel; Property Casualty Insurers Association of America; RMJ Evaluations; State Office of Risk Management; Texas Association of School Boards Risk Management Fund.

SUBCHAPTER A. DESIGNATED DOCTOR SCHEDULING AND EXAMINATIONS

28 TAC §§127.1, 127.5, 127.10, 127.20, 127.25

The amendments are adopted under the Labor Code §408.0041 and §408.1225 and under the general authority of Labor Code §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. Section 408.1225 provides, in relevant part, that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for Division disputes, unless the Division authorizes the designated doctor to discontinue providing services.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

§127.1. Requesting Designated Doctor Examinations.

(a) At the request of the insurance carrier, an injured employee, the injured employee's representative, or on its own motion, the division may order a medical examination by a designated doctor to resolve questions about the following:

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

(2) the attainment of maximum medical improvement (MMI);

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

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

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

(6) issues similar to those described by paragraphs (1) - (5) of this subsection.

(b) To request a designated doctor examination a requestor must:

(1) provide a specific reason for the examination;

(2) explain any change of condition if the requestor indicates that the injured employee's medical condition has changed since a previous designated doctor examination on the same claim;

(3) report the injured employee's current diagnosis or diagnoses and part of the body affected by the injury;

(4) provide a list of all injuries determined to be compensable by the division or accepted as compensable by the insurance carrier;

(5) provide general information regarding the identity of the requestor, injured employee, employer, treating doctor, insurance carrier;

(6) identify the workers' compensation health care network certified under Chapter 1305, Insurance Code through which the injured employee is receiving treatment, if applicable;

(7) identify whether the claim involves medical benefits provided through a political subdivision under Labor Code §504.053(b)(2) and the name of the health plan, if applicable;

(8) state whether the injured employee has attended any other designated doctor examinations on this claim and, if so, provide the date of the most recent examination and the name of the examining designated doctor;

(9) submit the request on the form prescribed by the division under this section. A copy of the prescribed form can be obtained from:

(A) the division's website at www.tdi.texas.gov/wc/indexwc.html; or

(B) the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744 or any local division field office location;

(10) submit the request to the division and a copy of the request to each party listed in subsection (a) of this section who did not request the designated doctor examination;

(11) provide all information listed in subparagraphs (A) - (G) of this paragraph below applicable to the type of examination the requestor seeks:

(A) if the requestor seeks an examination on the attainment of MMI, include the statutory date of maximum medical improvement, if any;

(B) if the requestor seeks an examination on the impairment rating of the injured employee, include the date of MMI that has been determined to be valid by a final decision of division or court or by agreement of the parties, if any;

(C) if the requestor seeks an examination on the extent of the compensable injury, include a description of the accident or incident that caused the claimed injury and a list of all injuries in question;

(D) if the requestor seeks an examination on whether the injured employee's disability is a direct result of the work-related injury, include the beginning and ending dates for the claimed periods of disability; state if the injured employee is either not working or is earning less than pre-injury wages as defined by Labor Code §401.011(16);

(E) if the requestor seeks an examination regarding the injured employee's ability to return to work in any capacity and what activities the injured employee can perform, include the beginning and ending dates for the periods to be addressed if the requestor is requesting for the designated doctor to examine the injured employee's work status during a period other than the current period;

(F) if the requestor seeks an examination to determine whether or not an injured employee entitled to supplemental income benefits may return to work in any capacity for the identified period, include the beginning and ending dates for the qualifying periods to be addressed and whether or not this period involves the ninth quarter or a subsequent quarter of supplemental income benefits;

(G) if the requestor seeks an examination on topics under subsection (a)(6) of this section, specify the issue in sufficient detail for the doctor to answer the question(s); and

(12) provide a signature to attest that every reasonable effort has been made to ensure the accuracy and completeness of the information provided in the request.

(c) If a party submits a request for a designated doctor examination under subsection (b) of this section that would require the division to schedule an examination within 60 days of a previous examination of the injured employee that party must provide good cause for scheduling that designated doctor examination in order for the division to approve the party's request. For the purposes of this subsection, the commissioner or the commissioner's designee shall determine good cause on a case by case basis and will require at a minimum:

(1) if that requestor also requested the previous examination, a showing by the requestor that the submitted questions could not have reasonably been included in the prior examination and a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits; or

(2) if that requestor did not request the previous examination, a showing by the requestor a designated doctor examination is reasonably necessary to resolve the submitted question(s) and will affect entitlement to benefits.

(d) The division shall deny a request for a designated doctor examination and provide a written explanation for the denial to the requestor:

(1) if the request does not comply with any of the requirements of subsection (b) or (c) of this section;

(2) if the request would require the division to schedule an examination in violation of Labor Code §§408.0041, 408.123, or 408.151;

(3) if the commissioner or the commissioner's designee determines the request to be frivolous because it lacks either any legal or any factual basis that would merit approval; or

(4) if the insurance carrier has denied the compensability of the claim or otherwise denied liability for the claim as a whole and reported the denial to the division in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements) and the dispute is not yet resolved.

(e) If a division hearing officer or benefit review officer determines during a dispute regarding the compensability of a claim as a whole that an expert medical opinion would be necessary to resolve a dispute as to whether the claimed injury resulted from the claimed incident, the hearing officer or benefit review officer may order the injured employee to attend a designated doctor examination to address that issue.

(f) A party may dispute the division's approval or denial of a designated doctor request through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures). Parties may not dispute a designated doctor examination request or any information on the request until the division has either approved or denied the request. Additionally, a party is entitled to seek an expedited contested case hearing under §140.3 of this title (relating to Expedited Proceedings) to dispute an approved or denied request for a designated doctor examination. The division, upon timely receipt and approval of the request for expedited proceedings, shall stay the disputed examination pending the decision and order of the expedited contested case hearing. Parties seeking expedited proceedings and the stay of an ordered examination must file their request for expedited proceedings with the division within three working days of receiving the order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

(g) This section will become effective on September 1, 2012.

§127.5. Scheduling Designated Doctor Appointments.

(a) The division, within 10 days after approval of a valid request, shall issue an order that assigns a designated doctor and shall notify the designated doctor, the treating doctor, the injured employee,

the injured employee's representative, if any, and the insurance carrier that the designated doctor will be directed to examine the injured employee. The order shall:

(1) indicate the designated doctor's name, license number, examination address and telephone number, and the date and time of the examination or the date range for the examination to be conducted;

(2) explain the purpose of the designated doctor examination;

(3) require the injured employee to submit to an examination by the designated doctor;

(4) require the designated doctor to perform the examination at the indicated examination address; and

(5) require the treating doctor, if any, and insurance carrier to forward all medical records in compliance with §127.10(a)(3) of this title (relating to General Procedures for Designated Doctor Examinations).

(b) The examination address indicated on the order in subsection (a)(4) of this section may not be changed by any party or by an agreement of any parties without good cause and the approval of the division.

(c) Except as provided in subsection (d) of this section, the division shall select the next available doctor on the designated doctor list for a medical examination requested under §127.1 of this title (relating to Requesting Designated Doctor Examinations). A designated doctor is available to perform an examination at any address the doctor has filed with the division if the doctor:

(1) does not have any disqualifying associations as described in §127.140 of this title (relating to Disqualifying Associations);

(2) is appropriately qualified to perform the examination in accordance with §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations);

(3) is a certified designated doctor on the day the examination is offered and has not failed to timely file for recertification under §127.110 of this title (relating to Designated Doctor Recertification), if applicable; and

(4) has not treated or examined the injured employee in a non-designated doctor capacity within the past 12 months and has not examined or treated the injured employee in a non-designated doctor capacity with regard to a medical condition being evaluated in the designated doctor examination.

(d) If the division has previously assigned a designated doctor to the claim at the time a request is made, the division shall use that doctor again unless the division has authorized or required the doctor to stop providing services on the claim in accordance with §127.130 of this title. Examinations under this subsection must be conducted at the same examination address as the designated doctor's previous examination of the injured employee or at another examination address approved by the division.

(e) The designated doctor's office and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least one working day prior to the appointment. The one working day requirement will be waived in an emergency situation. If both the designated doctor and the injured employee agree to reschedule the examination, the rescheduled examination shall be set to occur no later than 21 days after the scheduled date of the originally scheduled examination and may not be rescheduled to occur before the originally scheduled examination. Within one working day of rescheduling, the designated doctor shall contact the division, the injured employee or the injured employee's representative, if any, the injured employee's treating doctor, and the insurance carrier with the time and date of the rescheduled examination. If the examination cannot be rescheduled no later than 21 days after the scheduled date of the originally scheduled examination or if the injured employee fails to attend the rescheduled examination, the designated doctor shall notify the division as soon as possible but not later than 21 days after the scheduled date of the originally scheduled examination After receiving this notice, the division may select a new designated doctor.

(f) This section will become effective on September 1, 2012.

§127.10. General Procedures for Designated Doctor Examinations.

(a) The designated doctor is authorized to receive the injured employee's confidential medical records and analyses of the injured employee's medical condition, functional abilities, and return-to-work opportunities to assist in the resolution of a dispute under this subchapter without a signed release from the injured employee. The following requirements apply to the receipt of medical records and analyses by the designated doctor:

(1) The treating doctor and insurance carrier shall provide to the designated doctor copies of all the injured employee's medical records in their possession relating to the medical condition to be evaluated by the designated doctor. For subsequent examinations with the same designated doctor, only those medical records not previously sent must be provided. The cost of copying shall be reimbursed in accordance with §134.120 of this title (relating to Reimbursement for Medical Documentation).

(2) The treating doctor and insurance carrier may also send the designated doctor an analysis of the injured employee's medical condition, functional abilities, and return-to-work opportunities. The analysis may include supporting information such as videotaped activities of the injured employee, as well as marked copies of medical records. If the insurance carrier sends an analysis to the designated doctor, the insurance carrier shall send a copy to the treating doctor, the injured employee, and the injured employee's representative, if any. If the treating doctor sends an analysis to the designated doctor, the treating doctor shall send a copy to the insurance carrier, the injured employee, and the injured employee's representative, if any. The analysis sent by any party may only cover the injured employee's medical condition, functional abilities, and return-to-work opportunities as provided in Labor Code §408.0041.

(3) The treating doctor and insurance carrier shall ensure that the required records and analyses (if any) are received by the designated doctor no later than three working days prior to the date of the designated doctor examination. If the designated doctor has not received the medical records or any part thereof at least three working days prior to the examination, the designated doctor shall report this violation to the division within one working day of not timely receiving the records. Once notified, the division shall take action necessary to ensure that the designated doctor receives the records. If the designated doctor does not receive the medical records within one working day of the examination or if designated doctor does not have sufficient time to review the late medical records before the examination, the designated doctor shall reschedule the examination to occur no later than 21 days after receipt of the records.

(b) Before examining an injured employee, the designated doctor shall review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities and return to work opportunities provided by the insurance

carrier and treating doctor in accordance with subsection (a) of this section, and any materials submitted to the doctor by the division. The designated doctor shall also review the injured employee's medical condition and history as provided by the injured employee, any medical records provided by the injured employee, and shall perform a complete physical examination of the injured employee. The designated doctor shall give the medical records reviewed the weight the designated doctor determines to be appropriate.

(c) The designated doctor shall perform additional testing when necessary to resolve the issue in question. The designated doctor shall also refer an injured employee to other health care providers when the referral is necessary to resolve the issue in question and the designated doctor is not qualified to fully resolve the issue in question. Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title (relating to Workers' Compensation Health Care Networks, Agents' Licensing, General Medical Provisions, and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively) but is subject to the requirements of §180.24 of this title (relating to Financial Disclosure). Any additional testing or referral examination and the designated doctor's report must be completed within 15 working days of the designated doctor's physical examination of the injured employee unless the designated doctor receives division approval for additional time before the expiration of the 15 working days. If the injured employee fails or refuses to attend the designated doctor's requested additional testing or referral examination within 15 working days or within the additional time approved by the division, the designated doctor shall complete the doctor's report based on the designated doctor's examination of the injured employee, the medical records received, and other information available to the doctor and indicate the injured employee's failure or refusal to attend the testing or referral examination in the report.

(d) Any evaluation relating to either maximum medical improvement (MMI), an impairment rating, or both, shall be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). If a designated doctor is simultaneously requested to address maximum medical improvement (MMI) and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury. A designated doctor who determines the injured employee has reached maximum medical improvement (MMI) or who assigns an impairment rating, or who determines the injured employee has not reached MMI, shall complete and file a report as required by §130.1 of this title and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor). If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor extent of injury determination. The designated doctor, however, shall only submit one narrative report required by §130.1(d)(1)(B) of this title for all impairment ratings assigned and extent of injury findings. All designated doctor narrative reports submitted under this subsection shall also comply with the requirements of §127.220(a) of this title.

(e) A designated doctor who examines an injured employee pursuant to any question relating to return to work is required to file a Work Status Report that meets the required elements of these reports described in §129.5 of this title (relating to Work Status Reports) and a narrative report that complies with the requirements of §127.220(a) of this title within seven working days of the date of the examination of the injured employee. This report shall be filed with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall file the reports with the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the report by other verifiable means.

(f) A designated doctor who resolves questions on issues other than those listed in subsections (d) and (e) of this section, shall file a Designated Doctor Examination Data Report that complies with §127.220(c) of this title and a narrative report that complies with §127.220(a) of this title within seven working days of the date of the examination of the injured employee. These reports shall be filed with the treating doctor, the division, and the insurance carrier by facsimile or electronic transmission. In addition, the designated doctor shall provide these reports to the injured employee and the injured employee's representative (if any) by facsimile or by electronic transmission if the designated doctor has been provided with a facsimile number or email address for the recipient, otherwise, the designated doctor shall send the reports by other verifiable means.

(g) The report of the designated doctor is given presumptive weight regarding the issue(s) in question the designated doctor was properly appointed to address, unless the preponderance of the evidence is to the contrary.

(h) The insurance carrier shall pay all benefits, including medical benefits, in accordance with the designated doctor's report for the issue(s) in dispute. If the designated doctor provides multiple certifications of MMI/impairment ratings under subsection (d) of this section because the designated doctor was also ordered to address the extent of the injured employee's compensable injury, the insurance carrier shall pay benefits based on the conditions to which the designated doctor determines the compensable injury extends. For medical benefits, the insurance carrier shall have 21 days from receipt of the designated doctor's report to reprocess all medical bills previously denied for reasons inconsistent with the findings of the designated doctor's report. By the end of this period, insurance carriers shall tender payment on these medical bills in accordance with the Act and Chapters 133 and 134 of this title. For all other benefits, the insurance carrier shall tender payment no later than five days after receipt of the report.

(i) The designated doctor shall maintain accurate records for, at a minimum, five years from the anniversary date of the date of the designated doctor's last examination of the injured employee. This requirement does not reduce or replace any other record retention requirements imposed upon a designated doctor by an appropriate licensing board. These records shall include the injured employee's medical records, any analysis submitted by the insurance carrier or treating doctor (including supporting information), reports generated by the designated doctor as a result of the examination, and narratives provided by the insurance carrier and treating doctor, to reflect:

(1) the date and time of any designated doctor appointments scheduled with an injured employee;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled and, if applicable, documentation of the agreement of the designated doctor and the injured employee to reschedule the examination and the notice that the doctor provided to the division, the

injured employee's treating doctor, and the insurance carrier within 24 hours of rescheduling an appointment;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person;

(5) the date reports described in subsections (d), (e) and (f) of this section were submitted to all required parties and documentation that these reports were submitted to the division, treating doctor, and insurance carrier by facsimile or electronic transmission and to other required parties by verifiable means;

(6) the name(s) of any referral health care providers used by the designated doctor, if any; the date of appointments by referral health care providers; and the reason for referral by the designated doctor; and

(7) the date, if any, the doctor contacted the division for assistance in obtaining medical records from the insurance carrier or treating doctor.

(j) Parties may dispute any entitlement to benefits affected by a designated doctor's report through the dispute resolution processes outlined in Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures).

(k) This section will become effective on September 1, 2012.

§127.20. Requesting a Letter of Clarification Regarding Designated Doctor Reports.

(a) Parties may file a request with the division for clarification of the designated doctor's report. A copy of the request must be provided to the opposing party. The division may contact the designated doctor if it determines that clarification is necessary to resolve an issue regarding the designated doctor's report. Parties may only request clarification on issues already addressed by the designated doctor's report or on issues that the designated doctor was ordered to address but did not address. Additionally, a designated doctor shall only respond to the questions or requests submitted to the designated doctor in the request for clarification and shall not otherwise reconsider the doctor's previous decision, issue a new or amended decision, or provide clarification on the doctor's previous decision.

(b) Requests for clarification must:

(1) include the name of the designated doctor, the reason for the designated doctor's examination, the date of the examination, and the name and signature of the requestor;

(2) explain why clarification of the designated doctor's report is necessary and appropriate to resolve a future or pending dispute;

(3) include questions for the designated doctor to answer that are neither inflammatory nor leading; and

(4) provide any medical records that were not previously provided to the designated doctor and explain why these records are necessary for the designated doctor to respond to the request for clarification.

(c) The division, at its discretion, may also request clarification from the designated doctor on issues the division deems appropriate.

(d) To respond to the request for clarification, the designated doctor must be on the division's designated doctor list at the time the request is received by the division. The designated doctor shall respond, in writing, to the request for clarification within five working days of receipt and send copies of the response to the parties listed in §127.10(f) of this title (relating to General Procedures for Designated Doctor Examinations). If, in order to respond to the request for clarification, the designated doctor has to reexamine the injured employee, the doctor shall:

(1) respond, in writing, to the request for clarification advising of the need for an additional examination within five working days of receipt of the request and provide copies of the response to the parties specified in §127.10(f) of this title;

(2) if the division orders the reexamination, conduct the reexamination within 21 days from the date the order is issued by the division at the same examination address as the original examination; and

(3) respond, in writing, to the request for clarification based on the additional examination within seven working days of the examination and provide copies of the response to the parties specified in §127.10(f) of this title.

(e) Any refusal or failure by a designated doctor to conduct a reexamination that is necessary to respond to a request for clarification is an administrative violation.

(f) This section will become effective September 1, 2012.

§127.25. Failure to Attend a Designated Doctor Examination.

(a) An insurance carrier may suspend temporary income benefits (TIBs) if an injured employee, without good cause, fails to attend a designated doctor examination.

(b) In the absence of a finding by the division to the contrary, an insurance carrier may presume that the injured employee did not have good cause to fail to attend the examination if by the day the examination was originally scheduled to occur the injured employee has both:

(1) failed to submit to the examination; and

(2) failed to contact the designated doctor's office to reschedule the examination.

(c) If the injured employee contacts the designated doctor within 21 days of the scheduled date of the missed examination to reschedule the examination, the designated doctor shall schedule the examination to occur as soon as possible, but not later than the 21st day after the injured employee contacted the doctor.

(d) If the injured employee fails to contact the designated doctor within 21 days of the scheduled date of the missed examination but wishes to reschedule the examination, the injured employee must request a new examination under §127.1 of this title (relating to Requesting a Designated Doctor Examination).

(e) The insurance carrier shall reinstate TIBs effective as of the date the injured employee submitted to the rescheduled examination under subsection (c) of this section or the examination scheduled pursuant to the injured employee's request under subsection (d) of this section unless the report of the designated doctor indicates that the injured employee has reached MMI or is otherwise not eligible for income benefits. The re-initiation of TIBs shall occur no later than the seventh day following:

(1) the date the insurance carrier was notified that the injured employee submitted to the examination; or

(2) the date that the insurance carrier was notified that the division found that the injured employee had good cause for not attending the examination.

(f) An injured employee is not entitled to TIBs for a period during which the insurance carrier suspended benefits pursuant to this section unless the injured employee later submits to the examination

and the division finds or the insurance carrier determines that the injured employee had good cause for failure to attend the examination.

(g) This section will become effective September 1, 2012.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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SUBCHAPTER B. DESIGNATED DOCTOR CERTIFICATION, RECERTIFICATION, AND QUALIFICATIONS

28 TAC §§127.100, 127.110, 127.120, 127.130, 127.140

The new sections are adopted under the Labor Code §§408.0041, 408.0043, 408.0045, and 408.1225 and under the general authority of Labor Code §402.00128 and §402.061. Section 408.0041 provides the general requirements and procedures for designated doctor examinations. In relevant part, Section 408.0043 requires designated doctors, other than dentists and chiropractors, who review a specific workers' compensation case to meet certain professional specialty requirements. Section 408.0045 provides, in relevant part, that a designated doctor who reviews a chiropractic service in conjunction with a specific workers' compensation case must be licensed to engage in the practice of chiropractic. Section 408.1225 provides that the Commissioner by rule shall develop a process for the certification of a designated doctor and that the Division may deny renewal of a designated doctor's certification. Section 408.1225 also provides that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for division disputes, unless the division authorizes the designated doctor to discontinue providing services.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

§127.100. Designated Doctor Certification.

(a) In order to serve as a designated doctor, a doctor who is not a designated doctor must be certified as a designated doctor. To be certified as a designated doctor, a doctor who is not a designated doctor must:

(1) submit a complete designated doctor certification application as described by subsection (b) of this section;

(2) submit a certificate or certificates certifying that the doctor has successfully completed all division required trainings and passed all division required testing on the specific duties of a designated doctor under the Act and division rules, including demonstrated proficient knowledge of the currently adopted edition of the American Medical Association Guides to Evaluation of Permanent Impairment and the division's adopted treatment and return-to-work guidelines;

(3) be licensed in Texas;

(4) have maintained an active practice for at least three years during the doctor's career. For the purposes of this subsection, a doctor has an active practice if the doctor maintains or has maintained routine office hours of at least 20 hours per week for 40 weeks per year for the treatment of patients; and

(5) own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the current edition of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division.

(b) For the purposes of subsection (a) of this section, a complete designated doctor certification application must be completed on the division's required form for certification applications and must include:

(1) contact information for the doctor;

(2) information on the doctor's education;

(3) a description of the doctor's license(s), certifications, and professional specialty, if any;

(4) a description of the doctor's work history and hospital or other health care provider affiliations;

(5) a description of any affiliations the doctor has with a workers' compensation health care network certified under Chapter 1305, Insurance Code or political subdivision under Labor Code §504.053(b)(2);

(6) information regarding the doctor's current practice locations;

(7) disclosure questions regarding the doctor's professional background, education, training, and fitness to perform the duties of a designated doctor, including disclosure and summary of any disciplinary actions taken against the doctor by any state licensing board or other appropriate state or federal agency;

(8) the identities of any person(s) with whom the doctor has contracted to assist in performance or administration of the doctor's designated doctor duties;

(9) an attestation that:

(A) all information provided in the application is accurate and complete to the best of the doctor's knowledge;

(B) the doctor will inform the division of any changes to this information as required by §127.200(a)(8) of this title (relating to Duties of a Designated Doctor); and

(C) the doctor shall consent to any on-site visits, as provided by §127.200(a)(15) of this title, by the division at facilities used or intended to be used by the designated doctor to perform designated doctor examinations for the duration of the doctor's certification.

(c) The division shall notify a doctor of the commissioner's approval or denial of the doctor's application to be certified as a designated doctor in writing. Denials will include the reason(s) for the denial. Approvals only certify a doctor for a term of two years and will include the effective date and expiration date of the certification. Approvals will also include the examination qualification criteria under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations) that the division has assigned to the designated doctor as part of the doctor's certification.

(d) Doctors shall be denied certification as a designated doctor:

(1) if the doctor did not submit the information required by subsection (a) of this section, including having completed all division required training and passed all division required examinations;

(2) if the doctor did not submit a complete application for certification as required by subsection (b) of this section;

(3) for having a relevant restriction on their practice imposed by a state licensing board, certification authority, or other appropriate state or federal agency, including the division; or

(4) for other activities that warrant denial of a doctor's application for certification as a designated doctor, such as grounds that would allow the division to sanction a health care provider under the Act or division rules.

(e) Within 15 working days after receiving a denial, a doctor may file a written response with the division, which addresses the reasons given to the doctor for denial.

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

(2) If a written response which disagrees with the denial is timely received, the division shall review the response and shall notify the doctor of the commissioner's final decision. If the final decision is still a denial, the division's final notice shall provide the reason(s) why the doctor's response did not change the commissioner's decision to deny the doctor's application for certification as a designated doctor. The denial will be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(f) Designated doctors whose application for certification is approved but wish to dispute the examination qualification criteria under §127.130 of this title that the division assigned to the doctor may do so through the procedures described in subsection (e) of this section. Designated doctors must include in their response to the division the specific criteria they believe should be modified and documentation to justify the requested change.

(g) Designated doctors who are designated doctors on the effective date of this section shall be considered certified for the duration of the designated doctor's current certification. Before the expiration of the designated doctor's current certification, the designated doctor timely must apply for recertification under the applicable requirements of §127.110 of this title (relating to Designated Doctor Recertification).

(h) This section will become effective on September 1, 2012.

§127.110. Designated Doctor Recertification.

(a) If a designated doctor's certification expires before January 1, 2013:

(1) A doctor previously admitted to the division's designated doctor list who seeks to remain on the list must renew the doctor's application status by submitting to division verification that the doctor has completed a minimum of 12 additional hours of division required training and passed all division required testing described under §127.100(a) of this title (relating to Designated Doctor Certification) since the effective date of the designated doctor's last certification or recertification. Designated doctors must also submit a complete application that meets the requirements of §127.100(b) of this title. Designated doctors who submit the materials required by this subsection will be recertified as designated doctors if the materials are submitted before January 1, 2013.

(2) The division shall notify a designated doctor of its receipt of this submitted information in writing, and this notice will renew the designated doctor's certification for a period of two years. The notice will also include the effective and expiration dates of that certification.

(3) A designated doctor who seeks to be recertified as a designated doctor and fails to renew the doctor's application status under paragraph (1) of this subsection prior to the expiration of the designated doctor's certification commits an administrative violation and will be prohibited from performing designated doctor examinations until the doctor renews the doctor's application status.

(4) Designated doctors who fail to renew their application status before January 1, 2013 must instead apply for recertification under the procedures described under subsection (b) of this section.

(b) If a designated doctor's certification expires on or after January 1, 2013, the designated doctor must apply for recertification. Designated doctor seeking recertification after this date must:

(1) submit to the division certificate(s) evidencing that the doctor has, within the past 18 months, successfully completed all division required trainings and passed all division required testing on the specific duties of a designated doctor under the Act and division rules, including demonstrated proficient knowledge of the current division adopted edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and the division's adopted treatment and return-to-work guidelines;

(2) own or subscribe to, for the duration of the doctor's term as a certified designated doctor, the current edition of the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division; and

(3) submit to the division a complete application for recertification that meets the requirements of §127.100(b) of this title.

(c) The division will not assign examinations to a designated doctor during the 45 days prior to the expiration of the designated doctor's certification if the division fails to receive the required information in subsection (b)(1) - (3) of this section from the designated doctor before that time though the designated doctor may still provide services on claims to which the designated doctor had been previously assigned during this period. A designated doctor who seeks to be recertified as a designated doctor and who fails to apply for recertification under subsection (b)(1) - (3) of this section at least 45 days prior to the expiration of the designated doctor's certification commits an administrative violation. A designated doctor who fails to apply for recertification under this section within 30 days after the expiration of the designated doctor's certification may no longer apply for recertification and must instead apply for certification of §127.100 of this title.

(d) The division will notify a doctor in writing of the commissioner's approval or denial of the doctor's application to be recertified as a designated doctor under subsection (b) of this section. Denials will include the reason(s) for the denial. Approvals recertify a doctor for a term of two years and will include the effective date and expiration date of the certification. Approvals will also include the designated doctor's examination qualification criteria under §127.130 of this title (relating to Qualification Standards for Designated Doctor Examinations) that the division has assigned to the doctor as part of the doctor's recertification.

(e) The division may deny an application for recertification under subsection (b) of this section for the following reasons:

(1) the doctor did not submit the information required by subsection (b) of this section, including verification of having timely

completed all division-required training and passed all division-required examinations;

(2) if the doctor failed to properly update the doctor's initial application for certification under §127.100(b) of this title;

(3) for having a relevant restriction on their practice imposed on the doctor by a state licensing board, certification authority, or other appropriate state or federal agency, including the division;

(4) for requesting unnecessary referral examinations or testing or failure to comply with requirements of §180.24 of this title (relating to Financial Disclosure) when requesting referral examinations or additional testing; or

(5) for other activities that warrant denial of a doctor's application for recertification as a designated doctor, including but not limited to:

(A) the quality of the designated doctor's past reports;

(B) the designated doctor's history of complaints;

(C) excess requests for deferral from the designated doctor list by the doctor;

(D) a pattern of overturned reports by the division and/or a court;

(E) a demonstrated lack of ability to apply or properly consider the American Medical Association Guides to Evaluation of Permanent Impairment adopted by the division for the assignment of impairment ratings and all return-to-work and treatment guidelines adopted by the division;

(F) a demonstrated lack of ability to consistently perform designated doctor examinations in a timely manner;

(G) a demonstrated failure to identify disqualifying associations;

(H) a demonstrated lack of ability to ensure the confidentiality of injured employee medical records and claim information provided to or generated by the designated doctor; or

(I) any other grounds that would allow the division to sanction a health care provider under the Act or division rules.

(f) Within 15 working days after receiving a denial, a doctor may file a written response with the division that addresses the reasons given to the doctor for denial or may submit a written request an informal hearing before the division to address the reasons given for the denial.

(1) If neither a response nor a written request for informal hearing is received by the 15th working day after the date the doctor received the notice, the denial will be final effective the following day. No further notice will be sent.

(2) If a written response which disagrees with the denial is timely received, the division will review the response and will notify the doctor of the commissioner's final decision in writing. If the final decision is still a denial, the division's final notice shall provide the reason(s) why the doctor's response did not change the commissioner's decision to deny the doctor's application for recertification as a designated doctor. The denial will be effective the day following the date the doctor receives notice of the denial unless otherwise specified in the notice.

(3) If a written request for informal hearing is timely received, the division will set the informal hearing to occur no later than 31 days after the request is received. At the informal hearing, the designated doctor may present evidence that addresses the reasons the doctor was denied recertification to the commissioner's designated representatives. The designated doctor may have an attorney present. At the conclusion of the informal hearing, the designated representatives will provide the designated doctor with their final recommendation regarding the doctor's recertification. If the final recommendation is still a denial, the designated representatives will provide the reason(s) why they decided not to recertify the doctor as a designated doctor. After the informal hearing, the designated representatives will forward their recommendation to the commissioner who will review the final recommendation and all evidence presented at the informal hearing and make a final decision. The division shall notify the designated doctor of the commissioner's final decision in writing. The decision will be effective the day following the date the doctor receives notice of the decision unless otherwise specified in the notice.

(g) Designated doctors whose application for recertification under subsection (b) of this section is approved but wish to dispute the examination qualification criteria under §127.130 of this title that the division assigned to the doctor may do so through the procedures described in subsection (f) of this section. Designated doctors must include in their response to the division or present at the informal hearing the specific criteria they wish to be modified and documentation to justify the requested change.

(h) This section will become effective on September 1, 2012.

§127.120. Exception to Certification as a Designated Doctor for Out-of-State Doctors.

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

(b) This section will become effective on September 1, 2012.

§127.130. Qualification Standards for Designated Doctor Examinations.

(a) For examinations performed before January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor has credentials that are appropriate to the issue in question, the injured employee's medical condition, that meet the requirements of Labor Code §408.0043, §408.0045, and applicable division rules, and the designated doctor has no applicable disqualifying associations under §127.140 of this title (relating to Disqualifying Associations).

(b) For examinations performed on or after January 1, 2013, a designated doctor is qualified to perform a designated doctor examination on an injured employee if the designated doctor meets the appropriate qualification criteria for the area of the body affected by the injury and the injured employee's diagnosis and has no disqualifying associations under §127.140 of this title. A designated doctor's qualification criteria are determined as follows:

(1) To examine injuries and diagnoses relating to the hand and upper extremities, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(2) To examine injuries and diagnoses relating to the lower extremities excluding feet, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(3) To examine injuries and diagnoses relating to the spine and torso, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of chiropractic.

(4) To examine injuries and diagnoses relating to the feet, including the toes and heel, a designated doctor must be a licensed

medical doctor, doctor of osteopathy, doctor of chiropractic, or doctor of podiatric medicine.

(5) To examine injuries and diagnoses relating to the teeth and jaws, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of dental surgery.

(6) To examine injuries and diagnoses relating to the eyes, including the eye and adnexal structures of the eye, a designated doctor must be a licensed medical doctor, doctor of osteopathy, or doctor of optometry.

(7) To examine injuries and diagnoses relating to other body areas or systems, including but not limited to internal systems; ear, nose, and throat; head and face; skin; mental and behavioral disorders; tendon lacerations; and dislocations, a designated doctor must be a licensed medical doctor or doctor of osteopathy.

(8) Notwithstanding paragraphs (1) - (7) of this subsection, a designated doctor must be a licensed medical doctor or doctor of osteopathy who has the required board certification to examine any of the following diagnoses. For purposes of this section, a designated doctor is "board certified" in a required specialty or subspecialty, as applicable, if the designated doctor holds a general certificate in the required specialty or a subspecialty certificate in the required subspecialty from the American Board of Medical Specialties (ABMS) or if the designated doctor holds a primary certificate in the required specialty and a certificate of special qualifications or certificate of added qualifications in the required subspecialty from the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

(A) To examine traumatic brain injuries, a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, or psychiatry by the ABMS or board certified in neurological surgery, neurology, physical medicine or rehabilitation, or psychiatry by the AOABOS.

(B) To examine spinal cord injuries, including spinal fractures with documented neurological deficit, a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopaedic surgery, or occupational medicine by the ABMS or board certified in neurological surgery, neurology, physical medicine and rehabilitation, orthopedic surgery, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(C) To examine severe burns, including chemical burns, defined as 3rd or 4th degree burns over 9 percent or greater of the body, a designated doctor must be board certified in dermatology, physical medicine and rehabilitation, plastic surgery, orthopaedic surgery, surgery, or occupational medicine by the ABMS or board certified in dermatology, physical medicine and rehabilitation, plastic and reconstructive surgery, orthopedic surgery, surgery (general), preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(D) To examine complex regional pain syndrome (reflex sympathetic dystrophy), a designated doctor must be board certified in neurological surgery, neurology, orthopaedic surgery, anesthesiology with a subspecialty in pain medicine, occupational medicine, or physical medicine and rehabilitation by the ABMS or board certified in neurological surgery, neurology, orthopedic surgery, preventive medicine/occupational-environmental medicine, preventive medicine/occupational, anesthesiology with certificate of added qualifications in pain management, or physical medicine and rehabilitation by the AOABOS.

(E) To examine multiple bone fractures, excluding spinal fractures, a designated doctor must be board certified in emergency medicine, orthopaedic surgery, plastic surgery, physical medicine and rehabilitation, or occupational medicine by the ABMS or board certified in emergency medicine, orthopedic surgery, plastic surgery, physical medicine and rehabilitation, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(F) To examine complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, including blood borne pathogens, a designated doctor must be board certified in internal medicine or occupational medicine by the ABMS or board certified in internal medicine, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(G) To examine chemical exposure, excluding chemical exposure limited to skin exposure, a designated doctor must be board certified in internal medicine, emergency medicine, or occupational medicine by the ABMS or board certified in internal medicine, emergency medicine, preventive medicine/occupational-environmental medicine, or preventive medicine/occupational by the AOABOS.

(H) To examine heart or cardiovascular conditions, a designated doctor must be board certified in internal medicine, emergency medicine, occupational medicine, thoracic and cardiac surgery, or family medicine by the ABMS or board certified in internal medicine, emergency medicine, preventive medicine/occupational-environmental medicine, preventive medicine/occupational, thoracic and cardiovascular surgery or family practice and osteopathic manipulative treatment by the AOABOS.

(c) To be qualified to perform an initial examination on an injured employee, a designated doctor, other than a chiropractor, must be qualified under Labor Code §408.0043. A designated doctor who is a chiropractor must be qualified to perform an initial designated doctor examination under Labor Code §408.0045. If, however, the requirements of this subsection would disqualify a designated doctor otherwise qualified under subsection (b) of this section, pursuant to Labor Code §408.0041(b-1), does not apply.

(d) For any particular designated doctor examination, the division may exempt a designated doctor from the applicable qualification standard if no other designated doctor is qualified and available to perform the examination. Additionally, the division may not offer a qualified designated doctor an examination if it is reasonably probable that the designated doctor will not be qualified on the date of the examination.

(e) A designated doctor who performs an initial designated doctor examination of an injured employee and had the appropriate selection criteria to perform that examination under either subsection (a) or (b) of this section, as applicable, shall remain assigned to that claim and perform all subsequent examinations of that injured employee unless the division authorizes or requires the designated doctor to discontinue providing services on that claim.

(f) The division may authorize a designated doctor to stop providing services on a claim if the doctor:

(1) decides to stop practicing in the workers' compensation system;

(2) decides to stop practicing as a designated doctor in the workers' compensation system;

(3) relocates the doctor's residence or practice;

(4) has asked the division to indefinitely defer the doctor's availability on the designated doctor list;

(5) determines that examining the injured employee would require the designated doctor to exceed the scope of practice authorized by the doctor's license; or

(6) can otherwise demonstrate to the division that the doctor's continued service on the claim would be impracticable or could impair the quality of examinations performed on the claim.

(g) The division will prohibit a designated doctor from providing services on a claim if:

(1) the doctor has failed to become recertified as a designated doctor under §127.110(a) or (b) of this title (relating to Designated Doctor Recertification);

(2) the doctor no longer has the appropriate qualification criteria under either subsection (a) or (b) of this section, as applicable, to perform examinations on the claim;

(3) the doctor has a disqualifying association, as specified in §127.140 of this title, relevant the claim;

(4) the doctor has repeatedly failed to respond to division appointment, clarification, or document requests, or other division inquiries regarding the claim;

(5) the doctor's continued service on the claim could endanger the health, safety, or welfare of either the injured employee or doctor; or

(6) the division has revoked or suspended the designated doctor's certification.

(h) The division will prohibit a designated doctor from performing examinations on all new or existing claims if the designated doctor has had the doctor's license revoked or suspended and the suspension has not been probated by an appropriate licensing authority.

(i) This section will become effective on September 1, 2012.

§127.140. Disqualifying Associations.

(a) A disqualifying association is any association that may reasonably be perceived as having potential to influence the conduct or decision of a designated doctor. Disqualifying associations may include:

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

(2) shared investment or ownership interest;

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

(4) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, billing services agents, documentation management or storage services or warranties, or any other services related to the management or operation of the doctor's practice;

(5) personal or family relationships;

(6) a contract with the same workers' compensation health care network certified under Chapter 1305, Insurance Code or a contract with the same political subdivision or political subdivision health plan under Labor Code §504.053(b)(2) that is responsible for the provision of medical benefits to the injured employee; or

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

(b) For examination performed after January 1, 2013, a designated doctor shall also have a disqualifying association relevant to an examination or claim if an agent of the designated doctor has an association relevant to the claim that would constitute a disqualifying association under subsection (a) of this section.

(c) A designated doctor shall not perform an examination if that doctor has a disqualifying association relevant to that claim. If a designated doctor learns of a disqualifying association relevant to a claim after accepting the examination, the designated doctor must notify the division of that disqualifying association within two working days of learning of the disqualifying association. A designated doctor who performs an examination even though the doctor has a disqualifying association relevant to that claim commits an administrative violation.

(d) Insurance carriers shall notify the division of any disqualifying associations between the designated doctor and injured employee because of the network affiliations described under subsection (a)(6) of this section within five days of receiving the division's order of designated doctor examination under §127.5(a) of this title (relating to Scheduling Designated Doctor Appointments).

(e) If the division determines that a designated doctor with a disqualifying association performed a designated doctor examination, all reports produced by that designated doctor as a result of that examination shall be stripped of their presumptive weight.

(f) A party that seeks to dispute the selection of a designated doctor for a particular examination based on a disqualifying association or to dispute the presumptive weight of a designated doctor's report based on a disqualifying association must do so through the division's dispute resolution processes in Chapter 410, Labor Code and Chapters 140 - 144 and 147 of this title (relating to Dispute Resolution processes, proceedings, and procedures).

(g) This section will become effective on September 1, 2012.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 9, 2012.

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Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

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SUBCHAPTER C. DESIGNATED DOCTOR DUTIES AND RESPONSIBILITIES

28 TAC §§127.200, 127.210, 127.220

The new sections are adopted under the Labor Code §§402.083, 408.0041, 408.1225, and 415.021 and under the general authority of Labor Code §§402.00128, 402.021 and 402.061. Section 402.083 provides that Information in or derived from a claim file regarding an employee is confidential and may not be disclosed by the division except as provided by Title 5, Subtitle A of the Labor Code or other law. Section 408.0041 provides the gen-

eral requirements and procedures for designated doctor examinations. Section 408.1225 provides that the Commissioner by rule shall develop a process for the certification of a designated doctor and that the Division may deny renewal of a designated doctor's certification. Section 408.1225 also provides that a designated doctor shall continue providing services related to a case assigned to the designated doctor, including performing subsequent examinations or acting as a resource for division disputes, unless the division authorizes the designated doctor to discontinue providing services. Section 415.021 provides that a person commits an administrative violation if the person violates, fails to comply with, or refuses to comply with this subtitle or a rule, order, or decision of the Commissioner.

Section 402.00128 lists the general powers of the Commissioner, including the power to hold hearings. Section 402.021 provides the basic goals of the workers' compensation system of this state, including that each employee shall be treated with dignity and respect when injured on the job and that each injured employee shall have access to prompt, high-quality medical care within the framework established by this subtitle. Section 402.061 provides that the Commissioner shall adopt rules as necessary for the implementation and enforcement of this subtitle.

§127.200. Duties of a Designated Doctor.

(a) All designated doctors shall:

(1) perform designated doctor examinations in a facility currently used and properly equipped for medical examinations or other similar health care services and that ensures safety, privacy, and accessibility for injured employees and injured employee medical records and other records containing confidential claim information;

(2) ensure the confidentiality of medical records, analyses, and forms provided to or generated by the designated doctor in the doctor's capacity as a designated doctor for the duration of the retention period specified in §127.10(i) of this title (relating to General Procedures for Designated Doctor Examinations) and ensure the destruction of these medical records after both this retention period expires and the designated doctor determines the information is no longer needed;

(3) ensure that all agreements with person(s) that permit those parties to perform designated doctor administrative duties, including but not limited to billing and scheduling duties, on the designated doctor's behalf:

(A) are in writing and signed by the designated doctor and the person(s) with whom the designated doctor is contracting;

(B) define the administrative duties that the person may perform on behalf of the designated doctor;

(C) require the person or persons to comply with all confidentiality provisions of the Act and other applicable laws;

(D) comply with all medical billing and payment requirements under Chapter 133 of this title (relating to General Medical Benefits);

(E) do not constitute an improper inducement relating to the delivery of benefits to and injured employee under Labor Code §415.0036 and §180.25 of this title (relating to Improper Inducements, Influence and Threats); and

(F) made available to the division upon request;

(4) notify the division in writing and in advance if the designated doctor voluntarily decides to defer the designated doctor's availability to receive any offers of examinations for personal or other reasons and the notice must specify the duration of and reason for the deferral;

(5) notify the division in writing and in advance if the designated doctor no longer wishes to practice as a designated doctor before the doctor's current certification as a designated doctor expires; a designated doctor who no longer wishes to practice as a designated doctor before the doctor's current certification expires must expressly surrender the designated doctor's certification in a signed, written statement to the division;

(6) be physically present in the same room as the injured employee for the designated doctor examination or any other health care service provided to the injured employee that is not referred to another health care provider under §127.10(c) of this title;

(7) apply the appropriate edition of the American Medical Association Guides to the Evaluation of Permanent Impairment and division-adopted return-to-work guidelines and consider division-adopted treatment guidelines or other evidence-based medicine when appropriate;

(8) provide the division with updated information within 10 working days of a change in any of the information provided to the division on the doctor's application for certification or recertification as a designated doctor;

(9) maintain a professional and courteous demeanor when performing the duties of a designated doctor, including, but not limited to, explaining the purpose of a designated doctor examination to an injured employee at the beginning of the examination and using non-inflammatory, appropriate language in all reports and documents produced by the designated doctor;

(10) bill for designated doctor examinations and receive payment for those examinations in accordance with Chapter 133 of this title and Chapter 134 of this title (relating to Benefits--Guidelines for Medical Services, Charges, and Payments);

(11) respond timely to all division appointment, clarification, document requests, or other division inquiries;

(12) notify the division if a designated doctor's continued participation on a claim to which the designated doctor has already been assigned would required the doctor to exceed the scope of practice authorized by the doctor's license;

(13) not perform required medical examinations, utilization reviews, or peer reviews on a claim to which the designated doctor has been assigned as a designated doctor;

(14) identify themselves at the beginning of every designated doctor examination;

(15) consent to and cooperate during any on-site visits by the division pursuant to §180.4 of this title (relating to On-Site Visits); notwithstanding §180.4(e)(2) of this title, the division's purpose for these visits will be to ensure the designated doctor's compliance with the Act and applicable division rules, and the notice provided to the designated doctor in accordance with §180.4 of this title, either in advance of or at the time of the on-site visit, will specify the duties being investigated by the division during that visit;

(16) cooperate with all division compliance audits, quality reviews; and

(17) otherwise comply with all applicable laws and rules.

(b) For the purposes of this chapter, Chapter 180 of this title (relating to Monitoring and Enforcement), and all other applicable laws and division rules, any person with whom a designated doctor contracts

or otherwise permits to perform designated doctor administrative duties on behalf of the designated doctor qualifies as the doctor's "agent" as defined under §180.1 of this title (relating to Definitions).

(c) This section will become effective on September 1, 2012.

§127.210. Designated Doctor Administrative Violations.

(a) In addition to the grounds for issuing sanctions against a doctor under §180.26 of this title (relating to Criteria for Imposing, Recommending, and Determining Sanctions; Other Remedies), other division rules, or the Texas Workers' Compensation Act, the commissioner may revoke or suspend a designated doctor's certification as a designated doctor or otherwise sanction a designated doctor for noncompliance with requirements of this chapter or for any of the following:

(1) four refusals within a 90-day period to accept or perform a division offered appointment or ordered appointment for which the doctor is qualified and that relates to a claim to which the doctor has not been previously assigned;

(2) four consecutive refusals to perform within the required time frames a division ordered appointment for which the doctor is qualified and that relates to a claim to which the doctor has not been previously assigned;

(3) any refusal to accept or perform a division offered appointment or ordered appointment that relates to a claim on which the doctor has previously performed an examination;

(4) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;

(5) submitting unnecessary referrals to other health care providers for the answering of any question submitted to the designated doctor by the division;

(6) ordering or performing unnecessary testing of an injured employee as part of a designated doctor's examination;

(7) submission of inaccurate or inappropriate reports due to insufficient medical history or physical examination and analysis of medical records;

(8) submission of designated doctor reports that fail to include all elements required by §127.220 of this title (relating to Designated Doctor Reports), §127.10 of this title (relating to General Procedures for Designated Doctor Examinations), and other division rules;

(9) failure to timely respond to a request for clarification from the division regarding an examination or any other information request by the division;

(10) failure to successfully complete training and testing requirements as specified in §127.110 of this title (relating to Designated Doctor Recertification);

(11) self-referring, including referral to another health care provider with whom the designated doctor has a disqualifying association, for treatment or becoming the employee's treating doctor for the medical condition evaluated by the designated doctor;

(12) behaving in an abusive or assaultive manner toward an injured employee, the division, or other system participant;

(13) failing to maintain the confidentiality of patient medical and claim file information;

(14) performing a designated doctor examination which the designated doctor was not ordered by the division to perform; or

(15) other violations of applicable statutes or rules while serving as a designated doctor.

(b) Designated doctors are liable for all administrative violations committed by their agents on the designated doctor's behalf under this section, other division rules, or any other applicable law.

(c) The process for notification and opportunity for appeal of a sanction is governed by §180.27 of this title (relating to Restoration) except that suspension, revocation, or other sanction relating to a designated doctor's certification will be in effect during the pendency of any appeal.

(d) This section will become effective on September 1, 2012.

§127.220. Designated Doctor Reports.

(a) Designated doctor narrative reports must be filed in the form and manner required by the division and at a minimum:

(1) identify the question(s) the division ordered to be addressed by the designated doctor examination;

(2) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions;

(3) sufficiently explain how the designated doctor determined the answer to each question within a reasonable degree of medical probability;

(4) demonstrate, as appropriate, application or consideration of the American Medical Association Guides to the Evaluation of Permanent Impairment, division-adopted return-to-work and treatment guidelines, and other evidence-based medicine, if available;

(5) include general information regarding the identity of the designated doctor, injured employee, employer, treating doctor, insurance carrier;

(6) state the date of the examination and the address where the examination took place;

(7) summarize any additional testing conducted or referrals made as part of the evaluation, including the identity of any health care providers to which the designated doctor referred the injured employee under §127.10(c) of this title (relating to General Procedures for Designated Doctor Examinations), the types of tests conducted or referrals made and the dates the testing or referral examinations occurred, and explain why the testing or referral was necessary to resolve a question at issue in the examination;

(8) include a narrative description of the medical history, physical examination, and medical decision making performed by the designated doctor, including the time the designated doctor began taking the medical history of the injured employee, physically examining the employee, and engaging in medical decision making and the time the designated doctor completed these tasks;

(9) list the specific medical records or other documents the designated doctor reviewed as part of the evaluation, including the dates of those documents and which, if any, medical records were provided by the injured employee;

(10) be signed by the designated doctor who performed the examination;

(11) include a statement that there is no known disqualifying association as described in §127.140 of this title (relating to Disqualifying Associations) between the designated doctor and the injured employee, the injured employee's treating doctor, the insurance carrier, the insurance carrier's certified workers' compensation health care network, or a network established under Chapter 504, Labor Code;

(12) certify the date that the report was sent to all recipients required by and in the manner required by §127.10 of this title; and

(13) indicate on the report that the designated doctor reviewed and approved the final version of the report.

(b) Designated doctors who perform examinations under §127.10(d) or (e) of this title shall also complete and file the division forms required by those subsections with their narrative reports. Designated doctors shall complete and file these forms in the manner required by applicable division rules.

(c) Designated doctors who perform examinations under §127.10(f) of this title must, in addition to filing a narrative report that complies with subsection (a) of this section, also file a Designated Doctor Examination Data Report in the form and manner required by the Division. A Designated Doctor Examination Data Report must:

(1) include general information regarding the identity of the designated doctor, injured employee, insurance carrier, as well as the identity of the certified workers' compensation health care network under Chapter 1305, Insurance Code, if applicable, or whether the injured employee is receiving medical benefits through a political subdivision health care plan under Labor Code §504.053(b)(2) and the identity of that plan, if applicable;

(2) list all injuries included on the examination request as:

(A) determined to be compensable by the division;

(B) accepted as compensable by the insurance carrier; or

(C) for informational purposes only, the diagnosis code for each injury;

(3) identify the question(s) the division ordered to be addressed by the designated doctor examination;

(4) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions. For extent of injury examinations, the designated doctor should also provide, for informational purposes only, a diagnosis code for each disputed injury;

(5) state the date of the examination, the time the examination began, and the address where the examination took place;

(6) list any additional testing conducted or referrals made as part of the evaluation, including the identity of any health care providers to which the designated doctor referred the injured employee under §127.10(c) of this title, the types of tests conducted or referrals made and the dates the testing or referral examinations occurred;

(7) be signed by the designated doctor who performed the examination.

(d) This section will become effective on September 1, 2012.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 9, 2012.

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Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

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CHAPTER 130. IMPAIRMENT AND SUPPLEMENTAL INCOME BENEFITS

SUBCHAPTER A. IMPAIRMENT INCOME BENEFITS

28 TAC §130.6

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts the repeal of §130.6, concerning Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings. The repeal is adopted without changes to the proposal as published in the February 24, 2012, issue of the *Texas Register* (37 TexReg 1165) and will become effective September 1, 2012.

This repeal is necessary to ensure clarity and efficiency in designated doctor regulation and is adopted simultaneously with the adoption of amended §127.10 of this title (relating to General Procedures for Designated Doctor Examinations), which is published elsewhere in this issue of the *Texas Register.* Amended §127.10 of this title recodifies subsections (a), (b)(5), and (f) of repealed §130.6. The remaining subsections of §130.6 are repealed without recodification, because the provisions are either no longer applicable or redundant with other Division rules.

This repeal was formally proposed, together with proposed amended §§127.1, 127.5, 127.10, 127.20, 127.25, and 180.23 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §180.21 of this title, in the February 24, 2012, issue of the *Texas Register,* and the Division received three formal comments on the proposal.

This repeal will take effect on September 1, 2012. This effective date for the repeal is necessary to coincide with the effective dates for amended §§127.1, 127.5, 127.10, 127.20, 127.25, and 180.23 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §180.21 of this title.

SUMMARY OF COMMENTS AND AGENCY RESPONSES.

General: One commenter supports the Division's repeal of this section.

Agency Response: The Division appreciates the support.

General: Multiple commenters disagree with this repeal and the Division's amendment to §127.10(d), because these changes no longer permit designated doctors to provide multiple impairment ratings if the designated doctor determines a dispute regarding the extent of the compensable injury exists. The commenters state that these changes leave injured employees no means to have injured areas claimed to be compensable examined by a designated doctor if those areas are disputed by a carrier. This matter should be addressed by designated doctors regardless of whether the injured employee or insurance carrier requested an extent of injury examination. House Bill 2605 did not require the repeal of §130.6 and by repealing this rule, the Division has required injured employees to have direct knowledge of the Division's designated doctor request procedure and to understand their diagnoses. The repeal of this rule prevents designated doctors from examining disputed areas and denies due process to injured employees.

Agency Response: The Division disagrees. The requirement that designated doctors issue multiple impairment ratings if the designated doctors determines that the extent of the injured em-

ployee's compensable injury is in dispute is no longer necessary because parties can now request designated doctors to provide an opinion on the extent of an injured employee's compensable injury. When the multiple impairment rating requirement of §130.6 was adopted in 2001, designated doctors could not address that issue. Therefore, because parties can now request that designated doctors opine on extent of injury in addition to issues regarding an injured employee's date of maximum medical improvement and/or impairment rating, it is no longer appropriate to require designated doctors to consider the extent of the injured employee's injury if the parties have not requested the designated doctor to do so.

COMMENTING FOR AND AGAINST THE SECTION.

For: Insurance Council of Texas.

Against: Genesis Medical Management Solutions.

The repeal is adopted under the broad general authority granted to the Commissioner of Workers' Compensation by Labor Code §402.00111 and §402.061. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under the Labor Code. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Labor Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 9, 2012.

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Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

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CHAPTER 180. MONITORING AND ENFORCEMENT

SUBCHAPTER B. MEDICAL BENEFIT REGULATION

28 TAC §180.21

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts the repeal of §180.21, concerning the Division Designated Doctor List. The repeal is adopted without changes to the proposal as published in the February 24, 2012, issue of the *Texas Register* (37 TexReg 1170) and will become effective September 1, 2012.

This repeal is necessary to ensure clarity and efficiency in designated doctor regulation and is adopted simultaneously with the adoption of amended §§127.1, 127.5, 127.10, 127.20, and 127.25 and new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title (relating to Designated Doctor Procedures and Requirements), which are published elsewhere in this issue of the *Texas Register.* These adopted amended and new sections recodify the majority of the provisions of §180.21 of this title (relating to Division Designated Doctor List). The remaining provisions of §180.21 are repealed without recodification because the provisions are either no longer applicable or redundant with other Division rules.

This repeal was formally proposed, together with proposed amended §§127.1, 127.5, 127.10, 127.20, 127.25, and 180.23 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §130.6 of this title, in the February 24, 2012, issue of the *Texas Register,* and the Division received one formal comment on the proposal.

This repeal will take effect on September 1, 2012. This effective date for the repeal is necessary to coincide with the effective dates for amended §§127.1, 127.5, 127.10, 127.20, 127.25, and 180.23 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §130.6 of this title.

SUMMARY OF COMMENTS AND AGENCY RESPONSES

General: One commenter supports the Division's repeal of this section.

Agency Response: The Division appreciates the support.

COMMENTING FOR AND AGAINST THE SECTION.

For: Insurance Council of Texas.

Against: None.

This repeal is adopted under the broad general authority granted to the Commissioner of Workers' Compensation by Labor Code §402.00111 and §402.061. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under the Labor Code. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Labor Code.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 804-4703

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28 TAC §180.23

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) adopts amendments to §180.23, concerning Division Required Training for Doctors. These amendments are adopted with changes to the proposed text as published in the February 24, 2012, issue of the *Texas Register* (37 TexReg 1171) and shall take effect on September 1, 2012.

These amendments primarily delete provisions of §180.23 that have become outdated because of the expiration of Labor Code §408.023(a) - (g) and (i) on September 1, 2007 and the Division's subsequent repeal of §180.20 of this title (relating to the

Commission Approved Doctor List) on January 9, 2011. These amendments, however, retain certain provisions relating to impairment rating training and testing for doctors who do not seek to become certified as Division designated doctors in order to the fulfill the requirements of Labor Code §408.023(n), which requires the Division to adopt such requirements by rule. The amendments to §180.23 also clarify how the training and testing under this section interplays with the testing and training requirements for designated doctors under adopted new §127.100 and §127.110 of this title (relating to Designated Doctor Certification and Designated Doctor Recertification, respectively), which are published elsewhere in this issue of the *Texas Register.* A brief description of the amendments to §180.23 is provided below.

These amendments were formally proposed, together with amended §§127.1, 127.5, 127.10, 127.20, 127.25 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §130.6 and §180.21 of this title, in the February 24, 2012, issue of the *Texas Register,* and the Division received one formal comment on the proposal.

The Division has also changed the text of §180.23 as proposed. Specifically, the Division has changed the title of the rule to remove "Commission" and replace it with "Division" and added a new subsection (e) to the adopted rule. The title change is necessary to remove outdated references to the former Texas Workers' Compensation Commission and replace it with the updated reference to the Division of Workers' Compensation. This change is nonsubstantive and does not impose any new requirements on system stakeholders. New subsection (e) provides that this section shall become effective on September 1, 2012. This effective date is necessary to coincide with the effective dates of amended §§127.1, 127.5, 127.10, 127.20, 127.25 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §130.6 and §180.21 of this title.

Amended §180.23(a) - (h).

The deletions of current subsections (a) - (h) are adopted, because these subsections pertain, primarily, to required certification levels for the performance of various health care functions that are no longer applicable after the expiration of Labor Code §408.023(a) - (g) and (i) and the repeal of §180.20 of this title.

Amended §180.23(i).

Adopted amended §180.23(i) is recodified as new §180.23(a) - (d). New §180.23(a), addresses the scope of the amended section, specifically that this section now only governs authorization relating to certification of maximum medical improvement (MMI), determination of permanent impairment, and assignment of impairment ratings in the event that a doctor finds permanent impairment exists.

New §180.23(b) provides that full authorization to assign an impairment rating and certify MMI in an instance where the injured employee is found to have permanent impairment requires a doctor to obtain Division certification by successfully completing the Division-prescribed impairment rating training and passing the test or meeting the training and testing requirements for designated doctor certification or recertification under §127.100 and §127.110 of this title (relating to Designated Doctor Certification and Designated Doctor Recertification, respectively). Furthermore, this adopted subsection provides that for a doctor to remain certified the doctor must successfully complete follow-up training and testing at least every two years. Previously, doctors were only required to retrain and retest every four years, but this amendment is necessary to harmonize with the biannual recertification requirement for designated doctors in adopted new §127.110 of this title, so that all doctors assigning impairment rating in the workers' compensation system are equally current in training and testing.

New §180.23(c) provides that a doctor who has not completed the required training under subsection (b) of this section but who has had similar training in the *American Medical Association Guides* from a Division-approved vendor within the prior two years may submit the syllabus and training materials from that course to the Division for review. If the Division determines that the training is substantially the same as the Division-required training and the doctor passes the Division-required test, the doctor is fully authorized under this subsection. The ability to substitute training only applies to the initial training requirement, not the follow-up training. This subsection maintains the Division's current policy regarding alternative first time training for doctors seeking authorization under this section.

New §180.23(d) provides that notwithstanding any other provision of this section, a doctor who has not successfully completed training and testing required by this subsection for authorization to assign impairment ratings and certify MMI when there is permanent impairment may receive permission by exception to do so from the Division on a specific case-by-case basis. This subsection maintains the Division's current policy regarding exceptions to the authorization requirements necessary to certify MMI and assign impairment ratings.

New subsection (e) provides that "This section is effective September 1, 2012." This effective date is necessary to coincide with the effective dates of amended §§127.1, 127.5, 127.10, 127.20, 127.25 of this title; new §§127.100, 127.110, 127.120, 127.130, 127.140, 127.200, 127.210, and 127.220 of this title; and repealed §130.6 and §180.21 of this title.

SUMMARY OF COMMENTS AND AGENCY RESPONSES

General: One commenter supports the Division's amendments to this section.

Agency Response: The Division appreciates the support.

General: One commenter recommends that the Division require doctors to obtain the Division's adopted impairment rating, treatment, and return-to-work guidelines as part of the training and testing under this section.

Agency Response: The Division disagrees. Treating doctors and referral doctors are already required to comply with these guidelines under the Labor Code §408.124 and §137.10 and §137.100 of this title (relating to Return-to-Work Guidelines and Treatment Guidelines, respectively), and the training and testing under this section will ensure that doctors who seek to assign impairment ratings and certify MMI will have sufficient training and knowledge to perform these functions. Thus, whether a doctor needs to acquire a personal copy of each guide is best left to the discretion of that doctor in order to avoid imposing unnecessary costs on doctors who have developed other means of complying with these guidelines (such as sharing a single copy in an office practice). The Division further clarifies, however, that this increased burden is appropriately imposed upon designated doctors in the workers' compensation system (to whom this rule does not apply), because of the increased level of expertise required to become a designated doctor and because of the presumptive weight and binding effects of designated doctor

opinions. The Division has, therefore, imposed this requirement upon designated doctors as a requirement for certification and recertification as a designated doctor under new §127.100 and §127.110 of this title (relating to Designated Doctor Certification and Designated Doctor Recertification, respectively).

COMMENTING FOR AND AGAINST THE SECTION

For, with changes: Insurance Council of Texas.

Against: None.

The amendments are adopted under Labor Code §408.023 and the broad general authority granted to the Commissioner of Workers' Compensation by Labor Code §402.00111 and §402.061. Labor Code §408.023(n) provides, in relevant part, that the Commissioner shall by rule establish reasonable requirements for doctors regarding training and impairment rating test. Section 402.00111 provides that the Commissioner of Workers' Compensation shall exercise all executive authority, including rulemaking authority under the Labor Code. Section 402.061 provides that the Commissioner of Workers' Compensation shall adopt rules as necessary for the implementation and enforcement of the Labor Code.

§180.23. Division Required Training for Doctors.

(a) This section governs authorization relating to certification of maximum medical improvement (MMI), determination of permanent impairment, and assignment of impairment ratings in the event that a doctor finds permanent impairment exists.

(b) Full authorization to assign an impairment rating and certify MMI in an instance where the injured employee is found to have permanent impairment requires a doctor to obtain division certification by successfully completing the division-prescribed impairment rating training and passing the test or meeting the training and testing requirements for designated doctor certification or recertification under §127.100 and §127.110 of this title (relating to Designated Doctor Certification and Designated Doctor Recertification, respectively). To remain certified, a doctor is required to successfully complete follow-up training and testing at least every two years.

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

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

(e) This section is effective September 1, 2012.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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TITLE 31. NATURAL RESOURCES AND CONSERVATION

PART 2. TEXAS PARKS AND WILDLIFE DEPARTMENT

CHAPTER 65. WILDLIFE

SUBCHAPTER A. STATEWIDE HUNTING PROCLAMATION

The Texas Parks and Wildlife Commission in a duly noticed meeting on March 29, 2012, adopted amendments to §§65.7, 65.8, 65.11, 65.25, 65.42, and 65.60, concerning the Statewide Hunting Proclamation, without changes to the proposed text as published in the February 17, 2012, issue of the *Texas Register* (37 TexReg 880).

The amendments to §65.7, concerning Harvest Log, and §65.8, concerning Alternative Licensing System, remove references to tarpon and red drum. In 2010 the department restructured hunting and fishing regulations to separate hunting rules from fishing rules. In the process, the department overlooked references to tarpon and red drum in regulations addressing the license log and the alternative licensing system. Those references are not germane to hunting. The amendment corrects that oversight.

The amendment to §65.11, concerning Lawful Means, allows the use of firearm silencers to hunt alligators, game animals and game birds. Under current rule, the use of sound-suppressing devices to hunt alligators, game animals or game birds is unlawful. The department has determined that there is no resource- or enforcement-related reason to prohibit the use of firearm silencers for the take of alligators, game animals or game birds, and is therefore eliminating the current prohibition. The term "silencer" is used in the regulation to be consistent with federal law regarding firearm silencers. See, 18 U.S.C. §921(a)(24), 27 C.F.R. §478.11. The rule also specifically states that the rule does not relieve any person of the obligation to comply with any applicable state, federal, or local law governing the possession or use of firearm silencers.

The amendment also alters §65.11(3) to include additional counties to the applicability of the provisions governing the use of crossbows and eliminates references to specific season dates. This change is necessary to ensure consistency with the changes to §65.42 discussed elsewhere in this preamble.

The amendment to §65.25, concerning Wildlife Management Plan (WMP), removes provisions concerning WMP issuance for the hunting of lesser prairie chicken. The lesser prairie chicken is a ground nesting bird that is native to the mixed grass prairies of the Texas Panhandle, Colorado, Kansas, New Mexico and Oklahoma. Two distinct populations have historically occurred in the Panhandle, one in the sand hills country of the High Plains west of Lubbock and the other in the Rolling Plains region in the northeast. Although once common,

its numbers have steadily declined across its range due to alteration of habitat. In response to declines in lesser prairie chicken populations, the department in 2005 prohibited the take of lesser prairie chicken except on properties managed under a WMP for lesser prairie chicken. In response to continuing population declines the department in 2009 amended §65.56 to completely close the season on lesser prairie chicken statewide. The provisions of §65.25(b) were retained at that time with the intent that if lesser prairie chicken populations recovered within the near future, the department would be able to reinstitute limited hunting opportunity on managed lands; however, the department has determined that population recovery is now a long-term conservation goal and the presence of the regulations is confusing to the public, since it would appear that there is hunting opportunity available, in spite of the closed season. The department therefore concludes that is prudent to remove the subsection in question.

The amendment to §65.42, concerning Deer, alters the current season structure in Grayson County by allowing full-season, either-sex harvest, implementing the Grayson County deer season structure in Dallas, Collin, and Rockwall counties, and implementing the Harris County season structure in Galveston County.

In 2010 the department received a petition for rulemaking requesting the implementation of a full-length open season for white-tailed deer in Collin and Rockwall counties, during which the lawful means would be restricted to archery equipment. The deer season in Collin and Rockwall counties has been closed since 1976. The original tallgrass prairie ecosystem in the area was virtually eliminated by agricultural development in the early part of the 20th century, resulting in the near-obliteration of white-tailed deer habitat, primarily in wooded bottomlands that were ideal for crop cultivation and timber exploitation. Since that time, agriculture has been gradually displaced by the extensive urban, suburban, and exurban growth of the Metroplex, which has resulted in highly fragmented habitat and minimal populations of white-tailed deer, mostly in riparian areas surrounding lakes and streams. The department believes that there is no biological reason to prohibit hunting and this is an opportunity to increase hunting opportunity. Opening a season also provides an additional method for addressing nuisance deer issues. Given the continued urbanization of these counties, the sparse deer habitat that currently exists is expected to continue to decline in the future. Although areas such as residential landscapes in subdivisions may artificially support deer within these counties, it is not biologically responsible to encourage the growth of deer herds within these non-native habitats. Supporting deer populations beyond what native habitat is able to support will lead to further habitat degradation, ultimately affecting habitat quantity and quality for all wildlife species that utilize those native habitats. Since the counties in question, along with Dallas County, are ecologically similar to Grayson County, where there is an archery season (during which crossbows are lawful only by hunters with an upper-limb disability) and a general season restricted to archery equipment including crossbows, the department chooses to implement the Grayson County season structure (with adopted changes noted as follows) in Collin, Dallas, and Rockwall counties, primarily to establish identical harvest regulations in the contiguous counties to reduce potential hunter confusion and differential enforcement issues.

Under current regulations in Grayson County, the take of antlerless deer is by permit only. The department has determined that because harvest in Grayson County is restricted to archery equipment only, the implementation of full-season, either-sex hunting will not result in depletion or waste of the resource because of the comparatively low hunter success rate of archery equipment compared to firearms. The amendment therefore implements full-season, either-sex hunting in Grayson County.

Under current regulations there is no open deer season in Galveston County. The season has been closed in Galveston County for many years. The department has determined that much like Collin, Dallas, and Rockwall counties, Galveston County contains fragmented native habitat that supports small deer populations. Currently, all surrounding counties including Harris County have an open general season for deer. These counties have characteristics similar to Galveston in that Fort Bend, Harris, and Brazoria counties have isolated pockets of suitable deer habitat and small but huntable deer populations. By implementing harvest regulations in Galveston County that are identical to those in adjoining counties, the department will be able to more accurately assess the impacts of the regulations on the population. The department has determined that additional hunting opportunity can be provided under the regulatory structure currently in effect in adjoining counties. The department has determined that there is no biological reason to prohibit hunting and the regulation will provide a tool to help manage deer populations. The hunting opportunity consists of an archery-only season, a general season, and a special late muzzleloader season, with an aggregate annual bag limit of four deer (no more than two bucks and two antlerless deer), with antlerless harvest by permit only after Thanksgiving.

The amendment to §65.60, concerning Pheasant: Open Seasons, Bag, and Possession Limits, closes the season for pheasant in Chambers, Jefferson, and Liberty counties. In 1976 the department stocked pheasant in seven counties along the upper Texas coast in an effort to create hunting opportunity. By 2002, surveys indicated no pheasant populations in four of those counties, and the seasons in those counties were closed. Surveys now indicate that there are no pheasants remaining in Chambers, Jefferson, or Liberty counties, either. Therefore, the department closes the season in those counties because there are no birds left to hunt.

The department received 33 comments opposing adoption of the proposed amendments to §65.7 and §65.8, concerning nonsubstantive administrative changes to rules affecting alternative licensing and the use of the license log. Of the 33 comments, two offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the log should be retained for the Super Combo license. The department agrees with the comment and responds that the rule as proposed did not alter the current requirements for completing the license log. See, 31 TAC §65.7. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department should offer a standard hunting license that allows the harvest of two deer and a premium license that allows the harvest of four deer in a four-deer county. The department disagrees with the comment and responds that the rule is a nonsubstantive administrative transfer of regulatory provisions and does not contemplate the elimination, alteration, or creation of any license types. Therefore, the comment is beyond the scope of the rulemaking. No changes were made as a result of the comment.

The department received 1,241 comments supporting adoption of the proposed amendment to §65.7 and §65.8, concerning nonsubstantive administrative changes to rules affecting alternative licensing and the use of the license log.

The department received 350 comments opposing adoption of the proposed amendment to §65.11 that would legalize the use of firearm silencers for the take of game animals, game birds, and alligators. Of the 350 comments, 144 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Thirty-five commenters opposed adoption and stated that allowing the use of silencers will create a threat to human health and safety because people will not know when other people are discharging firearms nearby. The department disagrees with the comment and responds that the Parks and Wildlife Code does not authorize the department to promulgate hunting regulations on the basis of public safety. See, e.g., Op. Tex. Att'y Gen. Nos. H-558 (1975), M-953 (1971). No changes were made as a result of the comments.

Seventy-one commenters opposed adoption and stated that allowing the use of silencers will encourage poaching/trespassing and hinder law enforcement. Similarly, three commenters opposed adoption and stated that allowing the use of silencers would enable unethical hunters to hide mistakes and evade tagging or minimum antler requirements. The department disagrees with the comments and responds that the department's Law Enforcement Division has determined that the legalization of silencers for lawful hunting activities will not present additional enforcement problems to the department's game wardens and will not offer any particular advantage to the person who intends to evade the law. The department also notes that other lawful means for hunting game animals, such as lawful archery equipment, emit a sound that is less discernible than a firearm. No changes were made as a result of the comments.

Twenty commenters opposed adoption and stated that allowing the use of silencers is unethical because it violates the "fair chase" doctrine. In addition, one commenter opposed adoption and stated that allowing the use of silencers to hunt any wildlife resource would encourage the undesirable habits of poor hunters, but the commenter did not elaborate on the type of undesirable habits. The department disagrees with the comments and responds that the rule as adopted will not offer any particular advantage to the person who intends to evade the law or engage in unethical behavior. Although the department encourages ethical hunting through hunter education and other programs (see, e.g., www.tpwd.state.tx.us/learning/hunter_education/homestudy/ethics/), hunting ethics are beyond the scope of this rulemaking. No changes were made as a result of the comments.

One commenter opposed adoption and stated that silencers should be lawful only on public hunting lands. Conversely, one commenter opposed adoption and stated that silencers should be lawful on private property but not on public hunting lands. The department disagrees with both comments and responds that there is no fundamental difference between hunting activities on public lands and private lands that would justify limiting the effect of the rule to hunting activities on public lands. No changes were made as a result of the comments.

One commenter opposed adoption and stated that allowing the use of silencers to hunt game animals furnishes anti-hunting advocates with material to oppose hunting. The department disagrees with the comment and responds that although the department received a number of comments opposing the rule, which are summarized herein, those comments did not include objections based on an opposition to hunting. The theoretical use of the rule to support or oppose a particular argument was not a consideration in the rulemaking. In adopting the rule, the department determined that the rule as adopted would not negatively impact the wildlife resources the department is charged with protecting. The department also determined that enforcement of game laws would not be hindered by allowing the use of firearm silencers. No changes were made as a result of the comment.

One commenter opposed adoption and stated that silencers should not be lawful to hunt game birds. The department disagrees with the comment and responds that there is no biological or enforcement reason to exclude game birds from the rule. No changes were made as a result of the comment.

One commenter opposed adoption and stated that silencers should be allowed for the take of feral hogs and predators. Likewise, one commenter opposed adoption and stated that the rule does not address the use of silencers to take feral hogs or predators. The department agrees with the comments and responds that the use of silencers to take feral hogs and nongame wildlife is currently lawful. The rule, as adopted, does not alter the legality of using a firearm equipped with a silencer to take feral hogs and nongame wildlife. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the rule will be used by the federal government to identify gun owners. Similarly, one commenter opposed adoption and stated that misuse of silencers will give the federal government a justification for further regulation of guns and ammunition. The department disagrees with the comments and responds that the rule as adopted does not alter the authority of the federal government regarding firearms. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule's provisions governing the applicability of other law makes the rule moot. The department disagrees with the comment and responds that while other law may impose restrictions on the possession and/or use of firearm silencers, the rule as adopted does allow persons who comply with those laws to use firearm silencers when engaged in lawful hunting activities. The rule does not absolve anyone of the responsibility to comply with any other law relating to the possession or use of silencers. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule should specifically exempt all persons from any obligation to comply with federal laws governing possession or use of firearms and firearm silencers. The department disagrees with the comment and responds that the Texas Parks and Wildlife Commission does not have the authority to preempt the applicability of federal firearm laws. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule should include enhanced penalties for taking game unlawfully by use of a silencer. The department disagrees with the comment and responds that the penalties for violations are prescribed by statute and are not within the powers of the Texas Parks and Wildlife Commission to alter. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that ear protection can be accomplished by other methods such as earplugs.

The department interprets this comment as referring to the fact that some have asserted that the use of firearm silencers would reduce hearing impairments. The department disagrees with the comment and responds that although the department encourages hunting safety and use of protective gear, the Parks and Wildlife Code does not authorize the department to promulgate hunting regulations on the basis of public safety. No changes were made as a result of the comment.

The department received 4,165 comments supporting adoption of the proposed amendment.

The department received 70 comments opposing adoption of the proposed amendment to §65.25 that eliminated provisions for the hunting of lesser prairie chicken on managed lands. Of the 70 comments, 12 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the department should improve the population before restricting hunting. The department disagrees with the comment and responds that there has been no open season for lesser prairie chicken since 2009. See, 31 TAC §65.56 (34 TexReg 5701). Therefore, the rule as adopted does not impose additional hunting restrictions, but merely eliminates a provision that could be confusing. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department should wait an additional two seasons to see if populations increase. The department disagrees with the comment and responds that there has been no open season on lesser prairie chicken since 2009. See, 31 TAC §65.56 (34 TexReg 5701). Therefore, the rule as adopted does not impose additional hunting restrictions, but merely eliminates a provision that could be confusing. In addition, current population trends and data suggest that it is unlikely that lesser prairie chicken populations will sufficiently increase within the next two years to support huntable populations. No changes were made as a result of the comment.

One commenter opposed adoption and stated that game species should not be endlessly regulated. The department disagrees with the commenter and responds that the rule as adopted does not impose any additional regulations regarding lesser prairie chicken. The rule as adopted removes a regulation that is no longer necessary. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should be reopened. The department disagrees with the comment and responds that season closure is a reasonable component of a long-term recovery strategy. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the opportunity to hunt lesser prairie chicken should not be eliminated. The department disagrees with the comment and responds that the opportunity to hunt lesser prairie chicken was eliminated when the season was closed in 2009 in response to significant long-term population declines. See, 31 TAC §65.56 (34 TexReg 5701). Therefore, the rule as adopted merely eliminates a provision that could be confusing. In addition, given current population trends, continuing to allow hunting of lesser prairie chicken cannot be biologically justified. The lesser prairie chicken retains game bird status and the season can be restored if and when population recovery is achieved. No changes were made as a result of the comment.

One commenter opposed adoption and stated that hunting should be allowed where "populations can be seen as average." The department disagrees with the comment and responds that the season for lesser prairie chicken was closed in 2009 in response to significant population declines throughout its historic range. See, 31 TAC §65.56 (34 TexReg 5701). Therefore, the rule as adopted does not alter the status of lesser prairie chicken or impose additional hunting restrictions, but merely eliminates a provision that could be confusing. In addition, given current population trends, continuing to allow hunting of lesser prairie chicken cannot be biologically justified. The lesser prairie chicken retains game bird status and the season can be restored if and when population recovery is achieved. No changes were made as a result of the comment.

One commenter opposed adoption and stated that properties should be able to control lesser prairie chicken populations by limiting the number that could be taken. The department disagrees with the comment and responds that the season for lesser prairie chicken was closed in 2009 in response significant population declines, a status which continues. Given current population trends, continuing to allow hunting of lesser prairie chicken cannot be biologically justified. No changes were made as a result of the comment.

One commenter opposed adoption and stated that removing incentives for land managers will cause habitat to suffer. The department disagrees with the comment and responds that the rule as adopted does not eliminate the ability of a private landowner to manage his or her land for lesser prairie chicken. In 2009, when the season on lesser prairie chicken was closed, the hunting of lesser prairie chicken was prohibited on any land, regardless of whether the land was subject to a WMP. The rule as adopted does not alter that prohibition, but merely removes language that could be confusing. The department is currently working cooperatively with landowners in the Panhandle to restore habitat and recover the species to the point where hunting can be resumed. No changes were made as a result of the comment.

One commenter opposed adoption and stated that anti-hunting activists will make it too difficult to reopen the season. The department disagrees with the comment and responds that in the event that populations recover to the extent that an open season can be biologically justified, the Texas Parks and Wildlife Commission can make the determination of whether to adopt an open season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that language should be retained to the effect that it is the goal of the department to return lesser prairie chicken to huntable numbers. The department disagrees with the comment and responds that although it is the goal of the department to recover lesser prairie chicken populations and again provide hunter opportunity, the rule as adopted, does not impact the achievement of that goal. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be an option to reinstate hunting when populations recover. The department disagrees with the comment and responds that in the event that populations recover to the extent that an open season can be biologically justified, the Texas Parks and Wildlife Commission is authorized to open the season at that time. No changes were made as a result of the comment.

One commenter opposed adoption and stated that "if there is an over population and it effects farming, then there should be no

prohibition." The department disagrees with the comment and responds that currently there is not an over population of lesser prairie chicken. No changes were made as a result of the comment.

The department received 1,281 comments supporting adoption of the proposed amendment.

The department received 68 comments opposing adoption of the proposed amendment to §65.42, concerning Deer, that implement seasons for white-tailed deer in Collin, Dallas, and Rockwall counties. Of the 68 comments, 23 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the deer should be left alone. The department disagrees with the comment and responds that there are no biological reasons that deer in Collin, Dallas, and Rockwall counties should not be subject to lawful harvest. No changes were made as a result of the comment.

One commenter opposed adoption and stated that prohibiting the use of crossbows discriminates against the very young and the very old. The department disagrees with the comment and responds that crossbow use is restricted during the archery-only season based on a statutory requirement of Parks and Wildlife Code, §43.201(a), which stipulates that in a county that does not permit hunting with a firearm, a hunter may use a crossbow only if the hunter is a person with upper limb disabilities and has an archery hunting stamp. No changes were made as a result of the comment.

One commenter opposed adoption and stated that problem animals should be relocated. The department disagrees with the comment and responds that there are few areas of the state where white-tailed deer can be relocated without causing habitat problems. In addition, the cost of relocating deer from urban areas can be prohibitively expensive. The ability to lawfully hunt such animals is another tool for the control of those animals. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that a gun season should be provided. The department disagrees with the comment and responds that restrictions on lawful means were specifically requested in two petitions for rulemaking received by the department. In addition, given the continued urbanization of these counties and the sparse deer habitat that currently exists, the use of lawful archery equipment is believed to be the most appropriate means for hunting deer in these counties. No changes were made as a result of the comments.

One commenter opposed adoption and stated that there are other ways to address nuisance deer issues. The department agrees with the comment but responds that the usefulness of hunting as a tool to address nuisance deer issues is an additional, rather than primary benefit. The primary intent of the rule is to provide additional hunting opportunity. No changes were made as a result of the comment.

One commenter opposed adoption and stated that "if there is an over population and it effects farming, then there should be no prohibition." The department disagrees with the comment and responds that the primary goal of the rule is to provide additional hunting opportunity, although there is an additional benefit in the form of providing an additional tool for the control of nuisance deer. In addition, given the continued urbanization of these counties and the sparse deer habitat that currently exists, the restriction to lawful archery equipment is believed to be the most appropriate means for hunting deer in these counties. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the department should develop ways to conserve natural habitat in Dallas, Collin, and Rockwall counties. The department agrees with the commenter that the conservation of natural habitat is important, but responds that so little natural habitat is left in the three counties that it is incapable of sustaining anything other than fragments of a population. No changes were made as a result of the comment.

Five commenters opposed adoption and stated that anyone should be allowed to use a crossbow during the archery-only season. Similarly, two commenters opposed adoption and stated that crossbow use should be permitted. The department disagrees with the comments and responds that under Parks and Wildlife Code, §43.201(a), in a county that does not permit hunting with a firearm, a hunter may use a crossbow only if the hunter is a person with upper limb disabilities and has an archery hunting stamp. No changes were made as a result of the comments.

One commenter opposed adoption and stated that deer hunting should be prohibited. The department disagrees with the comment and responds that there is no biological reason not to provide an open season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be a lottery for hunting opportunity because allowing anyone to hunt would cause more poaching. The department disagrees with the comment and responds that while a lottery-style method of allocating hunting opportunity may be appropriate on public hunting lands, decisions concerning the allocation of hunting opportunity on private lands covered by the rule are best left to landowners. The department is aware of no evidence indicating that allowing an open season on deer would result in increased poaching. No changes were made as a result of the comment.

One commenter opposed adoption and stated that in a suburban area it only takes one crossbow arrow to hit a child riding a bicycle. The department, although sympathetic to the commenter's concerns, disagrees and responds that the Parks and Wildlife Code does not authorize the department to promulgate hunting regulations on the basis of public safety. See, e.g., Op. Tex. Att'y Gen. Nos. H-558 (1975), M-953 (1971). In addition, the archery hunting authorized under the rule as adopted is far more likely to take place in the few remaining pockets of natural habitat than in suburban neighborhoods. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the rule should be implemented only if there are public hunting opportunities. The department disagrees with the comment and responds that public hunting opportunities are better provided on lands that contain less fragmented habitat and support greater populations of white-tailed deer. No changes were made as a result of the comment.

One commenter opposed adoption and stated that Dallas County is too highly populated and built up to allow hunting. The department disagrees with the comment and responds that although the majority of the landscape in Dallas County is heavily developed, there are isolated pockets of natural habitat that contain deer, and there is no biological reason for there not

to be an opportunity to harvest them. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the bag limit should be smaller in order to prevent the population from being wiped out. The department disagrees with the commenter and responds that the deer populations in Dallas, Collin, and Rockwall counties will likely continue to decline because of habitat elimination. However, white-tailed deer populations throughout the state continue to thrive and should not be impacted by the rule as adopted. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that urban white-tailed deer populations in certain parts of New Jersey are not problematic. The department neither agrees nor disagrees with the comment and responds that the primary intent of the rule is to provide additional hunting opportunity, not to address nuisance deer issues. No changes were made as a result of the comments.

The department received 1,621 comments supporting adoption of the rule as proposed.

The department received 53 comments opposing adoption of the proposed amendment to §65.42 that eliminates the permit requirement for harvest of antlerless deer in Grayson County. Of the 53 comments, 10 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that Grayson County should remain archery only. The department agrees with the comment and responds that the rule as adopted will not change the archery-only status of Grayson County. The objective of the rule is to eliminate the permit requirement for the harvest of antlerless deer. The rule does not and was not intended to alter the lawful means that may be used to hunt deer in Grayson County. No changes were made as a result of the comment.

One commenter opposed adoption and stated that "if there is an over population and it effects farming, then there should be no prohibition." The department disagrees with the comment and responds that the rule as adopted liberalizes provisions governing the harvest of antlerless deer. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that Grayson County should have a gun season. The department disagrees with the comments and responds that the intent of the rule was to remove permit restrictions for the harvest of antlerless deer and did not contemplate changes to lawful means. Therefore, a change in lawful means was beyond the scope of the rulemaking. No changes were made as a result of the comments.

One commenter opposed adoption and stated that shotguns should be a lawful means for deer in Grayson County and that there should be a ten-day buck-only season with a bag limit of one buck with a minimum of 10 points and 20-inch spread. The department disagrees with the comment and responds that the objective of the rule is to eliminate the permit requirement for the harvest of antlerless deer. The rule does not and was not intended to address season lengths, bag limits, antler restrictions, or the lawful means that may be used to hunt deer in Grayson County. Therefore, a change in lawful means was beyond the scope of the rulemaking. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the amendment will allow success rates on does to go up substantially because hunters are very selective about bucks, which will negatively impact populations over the long term. The department disagrees with the comment and responds that since Grayson County will continue to allow archery only, harvest impact on reproductive potential is expected to be minimal. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that crossbows should be lawful in Grayson County. The department disagrees with the comment and responds that the objective of the rule is to eliminate the permit requirement for the harvest of antlerless deer. The rule does not and was not intended to address the lawful means that may be used to hunt deer in Grayson County. Therefore, the comment is beyond the scope of this rulemaking. In addition, the crossbow use restriction during the archery-only season is based on a statutory requirement of Parks and Wildlife Code, §43.201(a), which stipulates that in a county that does not permit hunting with a firearm, a hunter may use a crossbow only if the hunter is a person with upper limb disabilities and has an archery hunting stamp. No changes were made as a result of the comment.

One commenter opposed adoption and stated that rules in Grayson County should remain as they currently are because archers already have an advantage over gun hunters. The department disagrees with the commenter and responds that the goal of the rule is not to redistribute hunting opportunity among user groups but to liberalize harvest regulations. The department also notes that there is no gun season in Grayson County. No changes were made as a result of the comment.

One commenter opposed adoption and stated that wounding loss is a problem with archery hunting. The department disagrees with the comment and responds that the objective of the rule is to eliminate the permit requirement for the harvest of antlerless deer. The rule does not and was not intended to address the efficacy of lawful means that may be used to hunt deer in Grayson County. Therefore, a change in lawful means is beyond the scope of this rulemaking. No changes were made as a result of the comment.

The department received 1,510 comments supporting adoption of the proposed rule.

The department received 59 comments opposing adoption of the proposed amendment to §65.42 that implements a season for white-tailed deer in Galveston County. Of the 59 comments, 20 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Six commenters opposed adoption and stated that lawful means should be restricted to archery equipment. Similarly, three commenters opposed adoption and stated that lawful means should be restricted to archery equipment and muzzleloaders. The department disagrees with the comment and responds that the regulatory scheme implemented in Galveston County is the same as that in surrounding counties, which is necessary to allow the department to effectively evaluate the impact of hunting regulations on deer populations. If the regulations in Galveston County were different from adjoining counties it would be a regulatory "island" and could also cause potential confusion with respect to enforcement and compliance. No changes were made as a result of the comments.

One commenter opposed adoption and stated that "if there are no reason to prohibit hunting why limit total count, let the county choose annually what will work the best pending deer populous." The department disagrees with the comment and responds that under Parks and Wildlife Code, Chapter 61, only the Texas Parks and Wildlife Commission has the authority to establish seasons and bag limits for wildlife resources. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that anterless deer permits should not be required after Thanksgiving. The department disagrees with the comment and responds that based on consideration of various data such as population, sex ratios, and hunting pressure, the department has determined that the antlerless harvest in Galveston County should be buffered in order to protect reproductive potential. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the muzzleloader season should either be during the general season or the archery season. The department disagrees with the comment and responds that muzzleloaders are lawful during the general season. In addition, although advances in propellants and projectiles have made muzzleloader more accurate than in the past, the extremely low numbers of hunters who participate in late muzzleloader seasons makes harvest impacts negligible. As a result, there is no biological reason to not also allow a special late muzzleloader season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the four-deer bag limit is not realistic because of low populations, habitat loss, and uncontrolled predators. The department disagrees with the comment and responds that in neighboring counties that have similar deer population characteristics as well as shared soil and vegetative types, the same harvest regulations have not resulted in depletion or waste. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be no muzzleloader season because modern muzzleloaders are as effective as modern rifles. The department disagrees with the commenter and responds that although advances in propellants and projectiles have made muzzleloader more accurate than in the past, the extremely low numbers of hunters who participate in late muzzleloader seasons makes harvest impacts negligible. No changes were made as a result of the comment.

One commenter opposed adoption and stated that deer hunting should be prohibited in Galveston County. The department disagrees with the comment and responds that the department has determined that there are areas of suitable habitat containing huntable numbers of deer in Galveston County, and that hunting is sustainable under the harvest regulations as adopted. No changes were made as a result of the comment.

One commenter opposed adoption and stated that shotguns should be a lawful means of taking deer in Galveston County. The department agrees with the comment and responds that the rule as adopted does not prohibit the use of shotguns to take deer. No changes were made as a result of the comment.

One commenter opposed adoption and stated that Galveston County should be a one-buck county. The department disagrees with the comment and responds that a two-buck bag limit is biologically appropriate in Galveston County, and that habitat loss will have a greater impact on populations than hunting pressure. The department also notes that the implementation of a deer season in Galveston that is identical to surrounding counties will allow the department to more accurately assess the effects of hunting regulations on the population. No changes were made as a result of the comment.

One commenter opposed adoption and stated that hunting in Galveston County should be by archery only and that the bag limit was too high for such a small population. The department disagrees with the comment and responds that the rules as adopted create the same season structure in Galveston County as in surrounding counties in the same RMU, including Harris County. The bag limits and lawful means are biologically appropriate, and the department notes that habitat loss will have a greater impact on populations that hunting pressure. No changes were made as a result of the comment.

One commenter opposed adoption and stated that allowing the use of rifles creates a safety issue. The department disagrees with the comment and responds that the Parks and Wildlife Code does not authorize the department to promulgate hunting regulations on the basis of public safety. See, e.g., Op. Tex. Att'y Gen. Nos. H-558 (1975), M-953 (1971). No changes were made as a result of the comment.

The department received 1,500 comments supporting adoption of the proposed amendment.

The department received 99 comments opposing adoption of the proposed amendment to §65.60 that eliminated the open season for pheasant in four coastal counties. Of the 99 comments, 19 offered a specific reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Six commenters opposed adoption and stated in various ways that closing the season is unnecessary if there are no birds left. The department disagrees with the comment and responds that providing an open season for a resource that does not exist causes confusion. The season is therefore being eliminated. No changes were made as a result of the comments.

Eight commenters opposed adoption and stated that the department should restock pheasants in the affected counties. The department disagrees with the comment and responds that although pheasant were stocked in coastal counties in the 1970s, biologists now have a better understanding of the ecological significance of managing native habitat for indigenous species. As a result, the department does not plan to use department resources to stock pheasant in coastal counties where pheasant are not indigenous and there is a lack of native habitat. On that basis there is no reason for the department to consider restocking pheasant on the coast. No changes were made as a result of the comment.

Three commenters opposed adoption and stated that the season should be left open so that any remaining pheasants can be harvested lawfully. The department disagrees with the comment and responds that the season is being eliminated because a viable pheasant population ceased to exist. No changes were made as a result of the comments.

Three commenters opposed adoption and stated that the season should be kept open so that hunters can pursue pen-reared pheasants. The department disagrees with the comment and responds that the rule as adopted does not affect licensed private bird hunting areas. No changes were made as a result of the comments.

One commenter opposed adoption and stated that pheasant are an exotic species and should not be regulated. The department disagrees with the comment and responds that under Parks and Wildlife Code, §64.001, pheasant are a game bird and may be regulated as such. No changes were made as a result of the comment.

One commenter opposed adoption and stated that stocking efforts utilizing pen-raised birds are a waste of time. The department agrees that department resources should not be used to stock pheasant in coastal counties, where pheasant are not indigenous and there is a lack of native habitat.. No changes were made as a result of the comment.

One commenter opposed adoption and stated that landowners should be allowed to raise and release birds on their own land without interference from the government. The department disagrees with the comment and responds that under Parks and Wildlife Code, §64.001, pheasant are a game bird. Under Parks and Wildlife Code, §62.010, no person may hunt any game bird except during an open season. However, a person may raise and release birds for hunting if the person has been issued a private bird hunting area license. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there are pheasants in Liberty County. The department agrees that there may be one or two pheasant still alive in this area of the state, but that viable populations have ceased to exist. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there are pheasants in Chambers and Jefferson counties. The department agrees that there may be a few pheasant still alive in this area of the state outside private hunting areas, but viable populations have ceased to exist. No changes were made as a result of the comment.

The department received 1,383 comments supporting adoption of the proposed amendment.

DIVISION 1. GENERAL PROVISIONS

31 TAC §§65.7, 65.8, 65.11, 65.25

The amendments are adopted under the authority of Parks and Wildlife Code, Chapter 42, which allows the department to issue tags for animals during each year or season and to prescribe the form and issuance of licenses and tags; and Chapter 61, which requires the commission to regulate the periods of time when it is lawful to hunt, take, or possess game animals, game birds, or aquatic animal life in this state; the means, methods, and places in which it is lawful to hunt, take, or possess game animals, game birds, or aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the game animals, game birds, or aquatic animal life authorized to be hunted, taken, or possessed; and the region, county, area, body of water, or portion of a county where game animals, game birds, or aquatic animal life may be hunted, taken, or possessed.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 6, 2012.

TRD-201203515
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Effective date: September 1, 2012
Proposal publication date: February 17, 2012
For further information, please call: (512) 389-4775

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DIVISION 2. OPEN SEASONS AND BAG LIMITS

31 TAC §65.42, §65.60

The amendments are adopted under the authority of Parks and Wildlife Code, Chapter 61, which requires the commission to regulate the periods of time when it is lawful to hunt, take, or possess game animals, game birds, or aquatic animal life in this state; the means, methods, and places in which it is lawful to hunt, take, or possess game animals, game birds, or aquatic animal life in this state; the species, quantity, age or size, and, to the extent possible, the sex of the game animals, game birds, or aquatic animal life authorized to be hunted, taken, or possessed; and the region, county, area, body of water, or portion of a county where game animals, game birds, or aquatic animal life may be hunted, taken, or possessed.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 389-4775

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SUBCHAPTER N. MIGRATORY GAME BIRD PROCLAMATION

31 TAC §65.315, §65.319

The Texas Parks and Wildlife Department (the department) adopts amendments to §65.315 and §65.319, concerning the Migratory Game Bird Proclamation, without changes to the proposed text as published in the May 18, 2012, issue of the *Texas Register* (37 TexReg 3673).

The United States Fish and Wildlife Service (Service) issues annual frameworks for the hunting of migratory game birds in the United States. Regulations adopted by individual states may be more restrictive than the federal frameworks, but may not be less restrictive. Responsibility for establishing seasons, bag limits, means, methods, and devices for harvesting migratory game birds within Service frameworks is delegated to the Texas Parks and Wildlife Commission (Commission) under Parks and Wildlife Code, Chapter 64, Subchapter C. Parks and Wildlife Code, §64.022, authorizes the Executive Director, after notification of the Chairman of the Commission, to engage in rulemaking.

Typically, the Service issues the preliminary early-season (dove, teal, snipe, rails, gallinules) frameworks in late June and the preliminary late-season (ducks, geese, cranes) frameworks in early August. Because there is no Commission meeting between May and late August, the 2012-2013 migratory game bird regulations are being adopted in two separate actions under the authority of the Executive Director.

The proposed amendments to the migratory game regulations published in the May 18, 2012, issue of the *Texas Register* also included amendments to §§65.318, 65.320, and 65.321, which affect late-season species of migratory game birds. The proposed amendments to §§65.318, 65.320, and 65.321 will be considered for adoption by the Executive Director or Commission following the release of the late-season frameworks by the Service in early August, after which the department will file notice of adoption.

The amendment to §65.315, concerning Open Seasons and Bag and Possession Limits--Early Season, retains the season structure and bag limits from last year and adjusts the season dates for early-season species of migratory game birds other than dove to account for calendar shift (i.e., to ensure that seasons open on the desired day of the week, since dates from a previous year do not fall on the same days in following years). The amendment implements a structure for dove seasons in the North and Central zones that is slightly different from years past, ending the first segment on a weekday and the second segment on a Sunday. The change is intended to offer an additional weekend of hunting in January.

The amendment to §65.315 also implements a 16-day statewide teal season to run from September 15 - 30, 2012 and a 16-day early Canada goose season in the Eastern Goose Zone to run from September 15 - 30, 2012.

The amendment to §65.319, concerning Extended Falconry Season--Early Season Species, adjusts season dates to reflect calendar shift and clarifies that white-tipped doves can be taken.

The amendments are generally necessary to implement Commission policy to provide the greatest hunter opportunity possible, consistent with hunter and landowner preference for starting dates and segment lengths, under frameworks issued by the Service. The policy of the Commission is to adopt the most liberal provisions possible, consistent with hunter preference, under the Service frameworks in order to provide maximum hunter opportunity.

The amendment to §65.315, concerning Open Seasons and Bag and Possession Limits--Early Season, will function by establishing the season dates for the hunting of early-season species of migratory game birds.

The amendment to §65.319, concerning Extended Falconry Season--Early Season Species, will function by establishing the season dates for the hunting of early-season species of migratory game birds by means of falconry.

The department received 15 comments opposing adoption of the portion of the proposed amendment to §65.315 governing the hunting of doves. Of the 15 comments, 13 articulated a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the South Zone should open one week after the North and Central zones, which would be September 8. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone cannot open earlier than September 17. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the winter segment in the North and South zones should begin the first week in November. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the Christmas break, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, starting the winter segment in November would not leave enough days to cover the Christmas/New Year holiday season. No changes were made as a result of the comment

One commenter opposed adoption and stated that the first segment in the Central Zone should extend through a weekend. The department disagrees with the comment and responds that as adopted, the first segment in the Central Zone ends on a Wednesday, which essentially means that it extends through a weekend. Extending the segment through an additional weekend would reduce opportunity during the winter segment, when the department believes it is important to provide hunting opportunity that includes the Christmas/New Year holiday season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that Brazoria County should be in the Central Zone. The department disagrees with the comment and responds that such a change is not possible at this time because changes to zone boundaries must be approved in advance by the Service. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the season should start on a weekend. The department disagrees with the comment and responds that hunter preference is for the season to open on a Friday. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the first segment in the Central Zone should remain open into November. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the Christmas break, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, running the first segment into November would not leave enough days to cover the Christmas/New Year holiday season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the winter segment in the South Zone should begin December 26th. The commenter stated that people are too busy with the holidays to go hunting before Christmas Day. The department disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the Christmas break, when more people, especially youth, are able to take advantage of opportunity.

One commenter opposed adoption and stated that because there are fewer white-wing doves in Rio Grande valley than there are farther north, the special white-wing dove season should be eliminated and the four days added to the regular dove season. The department disagrees with the comment and responds that hunter and landowner surveys indicate that the

special white-wing dove season is popular because it occurs in early September, which would not be possible if the four days were added to the regular South Zone season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that dove hunters on public lands in the South Zone have little opportunity during the late season split since most annual public hunting permit property leases are for the first part of the split only. The department neither agrees nor disagrees with the comment and responds that the department cannot dictate the terms of lease agreements to private landowners who participate in the short-term dove hunting program. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the special white-wing season regulations should be in effect for the entire South Zone. The department disagrees with the comment and responds that the special white-wing dove zone and season are allowed by a special provision of the federal frameworks, which cannot be altered without the prior approval of the Service. No charges were made as a result of the comment.

One commenter opposed adoption and stated that the South Zone should open on September 15. The department disagrees with the comment and responds that under the federal frameworks, the season in the South Zone can open no earlier than September 17.

One commenter opposed adoption and stated that the opening segment ends too early. The commenter did not indicate to which zone the comment referred, but the department nevertheless disagrees with the comment and responds that season structures have historically been set in such a fashion as to allow greater hunting opportunity during the Christmas break, when more people, especially youth, are able to take advantage of opportunity, and that hunter preference is to have a late segment that is roughly 15 days in length. Given that the Service allows a maximum of 70 days of hunting opportunity, extending the length of the first segment in any of the three dove zones would not leave enough days to cover the Christmas/New Year holiday season. No changes were made as a result of the comment.

One commenter opposed adoption and stated that either the South Zone should start sooner or another zone should be created. The department disagrees with the comment and responds that the season as adopted contains the earliest possible opening day under the federal frameworks, and that Texas currently has the maximum number of zones allowable under federal law. No changes were made as a result of the comment.

The department received 32 comments supporting adoption of the proposed amendments governing dove hunting.

The department received eight comments opposing adoption of the portion of the proposed amendment to §65.315 governing the hunting of teal. All eight comments articulated a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

Two commenters opposed adoption and stated that the daily bag should be increased to six birds. The department disagrees with the comment and responds that the bag limit as adopted is the maximum allowed under the federal frameworks. No changes were made as a result of the comments.

One commenter opposed adoption and stated dissatisfaction with a nine-day season. The department neither agrees nor disagrees with the comment and responds that Commission policy is to adopt the most liberal harvest rules possible under the federal frameworks, which this year will result in a 16-day teal season.

One commenter opposed adoption and stated that the department should adopt a seven-day teal season rather than a 16-day season and shift the remaining nine days to the regular duck season. The department disagrees with the comment and responds that days cannot be taken from the September teal season and added to duck season because the duck season in Texas is already at the maximum number of days allowed by federal law. No changes were made as a result of the comment.

Two commenters opposed adoption and stated that the department should select the full number of days available for the regular duck season and eliminate the early teal season. The department disagrees with the comments and responds that days cannot be taken from the September teal season and added to duck season because the duck season in Texas is already at the maximum number of days allowed by federal law. No changes were made as a result of the comments.

One commenter opposed adoption and stated that the season should open earlier. The department disagrees with the comment and responds that dates selected for the early teal season are intended to capture the time period when teal migration makes the most birds available in the greatest part of the state. No changes were made as a result of the comment.

One commenter opposed adoption and stated that there should be a split season for teal. The department disagrees with the comment and responds that the federal frameworks do not allow the option of a split season for teal. No changes were made as a result of the comment.

The department received 28 comments supporting adoption of the proposed amendment.

The department received five comments opposing adoption of the portion of the proposed amendment to §65.315 governing the hunting of rails, gallinules, woodcock, and snipe. Of the seven comments, three articulated a reason or rationale for opposing adoption. Those comments, accompanied by the department's response to each, follow.

One commenter opposed adoption and stated that the snipe season should open earlier. The department disagrees with the comment and responds that snipe seasons are set to overlap as much of the goose, duck, crane, rail, and gallinule seasons as possible, in order to allow concurrent hunting for multiple species. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the snipe season should run concurrently with the dove season. The department disagrees with the comment and responds that snipe seasons are set to overlap as much of the goose, duck, crane, rail, and gallinule seasons as possible, in order to allow concurrent hunting for multiple species. No changes were made as a result of the comment.

One commenter opposed adoption and stated that the woodcock season should run concurrently with the duck season. The department disagrees with the comment and responds that surveys indicate that hunter preference for the woodcock season, which under federal frameworks cannot exceed 45 days in length or end later than January 31, is for a season that runs as late as

possible in the framework. No changes were made as a result of the comment.

The department received 16 comments supporting adoption of the proposed amendment.

The department received one comment opposing adoption of the portion of the proposed amendment to §65.319, which governs the hunting of early-season species of migratory game birds by means of falconry. The commenter did not articulate a reason or rationale for opposing adoption. No changes were made as a result of the comment.

The department received six comments supporting adoption of the proposed amendment.

No groups or associations commented in favor of or opposition to adoption of the proposed amendments.

The amendments are adopted under Parks and Wildlife Code, Chapter 64, which authorizes the Commission and the Executive Director to provide the open season and means, methods, and devices for the hunting and possessing of migratory game birds.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 6, 2012.

TRD-201203517
Ann Bright
General Counsel
Texas Parks and Wildlife Department
Effective date: September 1, 2012
Proposal publication date: May 18, 2012
For further information, please call: (512) 389-4775

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TITLE 34. PUBLIC FINANCE

PART 5. TEXAS COUNTY AND DISTRICT RETIREMENT SYSTEM

CHAPTER 103. CALCULATIONS OR TYPES OF BENEFITS

34 TAC §103.3

The Texas County and District Retirement System (TCDRS) adopts the amendment to §103.3, concerning the validity of spousal consents. The amendment is adopted without changes to the proposed text as published in the May 25, 2012, issue of the *Texas Register* (37 TexReg 3781) and will not be republished.

The adopted amendment deletes the notarization requirement from the rule which requires that spousal consent must be in writing and either witnessed by an officer or employee of the system or acknowledged by a notary. Incidents of a forged spousal signature are extremely rare. Given the extreme rarity of forged signatures, the requirement to have a signature notarized merely operates as an additional administrative burden upon the vast and overwhelming majority of retiring members who are not intent upon circumventing the spousal consent requirement, without the benefit of otherwise ensuring full and complete compliance with the requirement by those members who do intend to circumvent it.

No comments were received regarding the adoption of this amendment.

The amendment is adopted under the Government Code, §244.010(d), which authorizes the board of trustees of TCDRS to adopt rules concerning the designation and validity of beneficiaries under the TCDRS Act.

The Government Code, §844.010(b), is affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 6, 2012.

TRD-201203514
Tom Harrison
General Counsel
Texas County and District Retirement System
Effective date: July 26, 2012
Proposal publication date: May 25, 2012
For further information, please call: (512) 637-3247

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CHAPTER 107. MISCELLANEOUS RULES

34 TAC §107.3

The Texas County and District Retirement System (TCDRS) adopts the amendment to §107.3, concerning direct rollovers and trustee-to-trustee transfers. The amendment is adopted without changes to the proposed text as published in the May 25, 2012, issue of the *Texas Register* (37 TexReg 3782) and will not be republished.

The adopted amendment incorporates changes mandated by the Pension Protection Act of 2006 and the Worker, Retiree, and Employer Recovery Act of 2008. In accordance with those federal laws, the required amendment reflects the expanded list of plans eligible to receive direct rollovers and trustee-to-trustee transfers and the expanded group of distributees eligible to elect such rollovers and trustee-to-trustee transfers. These federal laws enlarge the opportunities of all living distributees of benefits payable under TCDRS to preserve and protect the tax advantages associated with benefits payable as lump sums under qualified plans. There now is a mechanism for every living distributee of benefits payable in that form to continue the tax advantaged status of the distribution.

No comments were received regarding the adoption of this amendment.

The amendment is adopted under the Government Code, §842.108(d), which requires the board of trustees of TCDRS to adopt rules that are necessary to maintain the retirement system as a qualified plan under §401(a) of the Internal Revenue Code of 1986.

The Government Code, §842.108(c), is affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 6, 2012.

TRD-201203512
Tom Harrison
General Counsel
Texas County and District Retirement System
Effective date: July 26, 2012
Proposal publication date: May 25, 2012
For further information, please call: (512) 637-3247

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34 TAC §107.4

The Texas County and District Retirement System (TCDRS) adopts new §107.4, concerning the definition and description of a bona fide termination of employment. The new rule is adopted without changes to the proposed text as published in the May 25, 2012, issue of the *Texas Register* (37 TexReg 3783) and will not be republished.

The adopted new rule clarifies that under the TCDRS Act, for purposes of determining whether the termination is bona fide, the term "employment" includes service in a public elective or appointive office that is compensated by the employer, as well as service as a common law employee. Under the rules and regulations of the Internal Revenue Service, a distribution of benefits from a defined benefit plan before there has been a bona fide termination of employment is considered to be an impermissible in-service distribution. An in-service distribution jeopardizes the qualification of the employer's plan, may cause the loss of the tax-deferred status of the contributions to the plan and may result in the assessment of back taxes, interest and penalties on those contributions. Recognizing the serious implications of a disqualification caused by an in-service distribution, Government Code, §842.110, requires that a benefit distribution must be based on a bona fide termination of employment from the subdivision and a break in service of at least one calendar month before the person may resume employment with the same subdivision. A member receiving a distribution of benefits, but who does not satisfy both requirements before returning to employment with the same subdivision, is considered to have been ineligible for a refund or retirement distribution and must return any amounts distributed and payments received. The adopted new rule sets out these dual requirements and provides guidance as to factors that could cause the termination to not be a bona fide termination.

No comments were received regarding the adoption of the new rule.

The new rule is adopted under the Government Code, §845.507, which authorizes the board of trustees of TCDRS to adopt rules that are necessary for the retirement system to be considered a qualified plan under §401(a) of the Internal Revenue Code of 1986, and under Texas Government Code, §845.102, authorizing the board of trustees to establish system-wide standards.

The Government Code, §842.110, is affected by this adoption.

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on July 6, 2012.

TRD-201203513
Tom Harrison
General Counsel
Texas County and District Retirement System
Effective date: July 26, 2012
Proposal publication date: May 25, 2012
For further information, please call: (512) 637-3247

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REVIEW OF AGENCY RULES

This section contains notices of state agency rules review as directed by the Texas Government Code, §2001.039. Included here are (1) notices of *plan to review;* (2) notices of *intention to review,* which invite public comment to specified rules; and (3) notices of *readoption,* which summarize public comment to specified rules. The complete text of an agency's *plan to review* is available after it is filed with the Secretary of State on the Secretary of State's web site (http://www.sos.state.tx.us/texreg). The complete text of an agency's rule being reviewed and considered for *readoption* is available in the *Texas Administrative* Code on the web site (http://www.sos.state.tx.us/tac).

For questions about the content and subject matter of rules, please contact the state agency that is reviewing the rules. Questions about the web site and printed copies of these notices may be directed to the *Texas Register* office.

Adopted Rule Reviews

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Texas Department of Insurance, Division of Workers' Compensation

Title 28, Part 2

The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) has completed its review required by the Texas Government Code §2001.039 of the following chapter of the Texas Administrative Code, Title 28, Part 2: Chapter 147, Dispute Resolution--Agreements, Settlements, Commutations. The reviewed sections in this chapter are subsequently referred to collectively in this Notice of Adopted Review as "the sections."

The notice of proposed rule review was published in the February 17, 2012, issue of the *Texas Register* (37 TexReg 946). As provided in this notice, the Division reviewed and considered the sections for readoption, revision, or repeal.

The Division considered whether the reasons for adoption of the sections continue to exist. The Division received no written comments regarding the review of the sections.

The Division has determined that the reasons for adopting the sections continue to exist and the sections are retained. Any revisions in the future will be accomplished in accordance with the Administrative Procedure Act.

This concludes and completes the Division's review of Chapter 147; the chapter will be reviewed again in the future in accordance with Texas Government Code §2001.039.

TRD-201203575
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: July 11, 2012

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The Texas Department of Insurance (Department), Division of Workers' Compensation (Division) has completed its review required by the Texas Government Code §2001.039 of the following chapter of the Texas Administrative Code, Title 28, Part 2: Chapter 152, Attorney Fees. The reviewed sections in this chapter are subsequently referred to collectively in this Notice of Adopted Review as "the sections."

The notice of proposed rule review was published in the April 27, 2012, issue of the *Texas Register* (37 TexReg 3197). As provided in this notice, the Division reviewed and considered the sections for readoption, revision, or repeal.

The Division considered whether the reasons for adoption of the sections continue to exist. The Division received no written comments regarding the review of the sections.

As a result of the review, the Division has determined that the reason for adoption of the sections continues to exist. The Division readopts the sections.

This concludes and completes the Division's review of Chapter 152; the chapter will be reviewed again in the future in accordance with Texas Government Code §2001.039.

TRD-201203576
Dirk Johnson
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Filed: July 11, 2012

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The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of the Attorney General

Notice of Settlement of a Texas Clean Water Act Enforcement Action

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Clean Water Act. Before the State may settle a judicial enforcement action, pursuant to the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Acts.

Case Title and Court: *Settlement Agreement in Kerr County, Texas, and Texas Commission on Environmental Quality v. The Estate of L. De Juan Abel, et al.,* Cause No. 07-456A, 216th Judicial District of Kerr County, Texas.

Background: This suit alleges violations of the Texas Clean Water Act at an on-site sewage facility in Kerr County, Texas. The defendant is Castlecomb Trust. The suit seeks injunctive relief, civil penalties, attorney's fees and court costs. The Clean Water Act violations are for unauthorized use of an on-site sewage facility.

Nature of Settlement: The settlement awards injunctive relief designed to bring the on-site sewage facility into compliance with State law.

For a complete description of the proposed settlement, the proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgments and written comments on the proposed settlement should be directed to Mary Smith, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0052. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201203519
Katherine Cary
General Counsel
Office of the Attorney General
Filed: July 6, 2012

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Notice of Settlement of a Texas Water Code Enforcement Action

The State of Texas gives notice of the following proposed resolution of an environmental enforcement action under the Texas Water Code. Before the State may enter into a voluntary settlement agreement, pursuant to §7.110 of the Texas Water Code the State shall permit the public to comment in writing. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreement if the comments disclose facts or considerations indicating that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the law.

Case Title: *Rheem Manufacturing Co. v. Texas Natural Resource Conservation Commission;* No. D-1-GN-02-002163; in the 345th District Court, Travis County, Texas.

Background: This case involves a 12.4 acre tract at 1025 Lockwood Drive in Houston, Harris County, Texas ("the Site"), formerly owned or operated by Rheem Manufacturing Company. In 2002 the Texas Natural Resource Conservation Commission ("TNRCC") issued an administrative order styled "AN ORDER Assessing Administrative Penalties and Requiring Certain Actions of Rheem Manufacturing Company"; TNRCC Docket No. 1999-0432-IHW-E; SOAH Docket No. 582-00-2100 (May 13, 2002) ("the Order"). The Order found that the Site was contaminated with various chemicals, found that Rheem had violated the solid waste regulations, assessed administrative penalties, and ordered a cleanup. The current lawsuit arose when Rheem filed a petition for judicial review of the Order.

Nature of the Settlement: The lawsuit will be settled by an agreed final judgment in the district court.

Proposed Settlement: The proposed judgment notes that Rheem has substantially complied with the cleanup requirements of the Order and that the Texas Commission on Environmental Quality, successor to the TNRCC, has approved the cleanup. The proposed judgment provides for the recovery of administrative penalties.

The Office of the Attorney General will accept written comments relating to the proposed judgment for thirty (30) days from the date of publication of this notice. The proposed judgment may be examined at the Office of the Attorney General, 300 W. 15th Street, 10th Floor, Austin, Texas. Copies may be obtained in person or by mail for the cost of copying. Requests for copies of the judgment, and written comments on the same, should be directed to Thomas H. Edwards, Assistant Attorney General, Office of the Attorney General (MC-066), P.O. Box 12548, Austin, Texas 78711-2548; telephone (512) 463-2012, fax (512) 320-0052.

TRD-201203502
Katherine Cary
General Counsel
Office of the Attorney General
Filed: July 5, 2012

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Notice of Settlement of a Texas Water Code Enforcement Action

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Water Code. Before the State may settle a judicial enforcement action under the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Texas Water Code.

Case Title and Court: *Harris County, Texas and the State of Texas acting by and through the Texas Commission on Environmental Quality v. Phillip Eaglin, Michele Eaglin, and Krebs Utilities, Inc.,* Cause No. 2010-63283, in the 125th Judicial District Court, Harris County, Texas.

Nature of Defendants' Operations: Defendants Phillip and Michele Eaglin own the real property on which a sewage lift station is located for the use of a subdivision in Harris County. Numerous illegal discharges of sewage have occurred from the lift station. Defendant Krebs Utilities, Inc., provides water and sewage services to the subdivision. Claims settled include allegations that the Defendants caused, suffered, or allowed the discharge of wastewater without authorization.

Proposed Agreed Judgment: The Agreed Final Judgment orders Phillip Eaglin and Michele Eaglin, jointly and severally, to pay $64,845.74 in civil penalties to be divided equally between Harris County and the State of Texas. The Agreed Final Judgment also orders Krebs Utilities, Inc., to pay civil penalties of $64,845.74, to be divided equally between Harris County and the State of Texas. In addition, the Eaglins shall pay $2,500.00 in attorney's fees to Harris County and to the State of Texas respectively. Krebs Utilities, Inc., shall also pay $2,500.00 in attorney's fees to Harris County and to the State of Texas respectively. The Agreed Final Judgment further orders the Defendants to properly operate and maintain the lift station and appurtenant equipment so as to cease illegal discharges. The Agreed Final judgment allows for the deferral of all amounts awarded as long as Defendants continue proper operation and maintenance of the lift station. Defendants shall pay all court costs.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment, and written comments on the proposed settlement, should be directed to Anthony W. Benedict, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201203503
Katherine Cary
General Counsel
Office of the Attorney General
Filed: July 5, 2012

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Notice of Settlement of a Texas Water Code Enforcement Action

Notice is hereby given by the State of Texas of the following proposed resolution of an environmental enforcement lawsuit under the Texas Water Code. Before the State may settle a judicial enforcement action under the Texas Water Code, the State shall permit the public to comment in writing on the proposed judgment. The Attorney General will consider any written comments and may withdraw or withhold consent to the proposed agreed judgment if the comments disclose facts or considerations that indicate that the consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the Texas Water Code.

Case Title and Court: *Harris County, Texas and the State of Texas acting on behalf of the Texas Commission on Environmental Quality v. Arch-Con Corporation,* Cause No. 2011-37043, in the 151st Judicial District Court, Harris County, Texas.

Nature of Defendant's Operations: Defendants violated environmental laws and regulations by allowing the emission and discharge of polystyrene from a construction site in Harris County.

Proposed Agreed Judgment: The Agreed Final Judgment orders Defendant Arch-Con Corporation to pay $35,000 in civil penalties, to be divided equally between Harris County and the State of Texas. In addition, the Defendant will pay $6,000 in attorney's fees to the State of Texas.

For a complete description of the proposed settlement, the complete proposed Agreed Final Judgment should be reviewed. Requests for copies of the judgment, and written comments on the proposed settlement, should be directed to Anthony W. Benedict, Assistant Attorney General, Office of the Texas Attorney General, P.O. Box 12548, Austin, Texas 78711-2548, (512) 463-2012, facsimile (512) 320-0911. Written comments must be received within 30 days of publication of this notice to be considered.

TRD-201203532
Katherine Cary
General Counsel
Office of the Attorney General
Filed: July 9, 2012

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Camino Real Regional Mobility Authority

Notice of Issuance of Request for Qualifications for Environmental and Preliminary Engineering Services

The Camino Real Regional Mobility Authority (CRRMA), a political subdivision of the State of Texas, is soliciting qualifications from firms with professional engineering and environmental services expertise to advance the Loop 375 (Americas Avenue) Managed Lanes Project from Zaragoza Road to Pellicano Drive in El Paso, Texas (Project). All or a portion of the project will include managed toll lanes.

The CRRMA intends to issue a Request for Qualifications (RFQ) to identify a shortlist of potential teams to provide environmental and preliminary engineering services for the Project. Respondents to any Request for Proposal (RFP) issued for the Project will be limited to the teams shortlisted during this initial RFQ process.

The RFQ was made available on or about July 11, 2012. Copies may be obtained from the CRRMA website at www.crrma.org. Periodic updates, addenda, and clarifications will be posted on the CRRMA website and interested parties are responsible for monitoring the website accordingly. Final statements of qualifications (SOQs) must be received by the Camino Real Regional Mobility Authority, 2 Civic Center Plaza, 9th Floor, El Paso, Texas 79901, Attention: Mr. Raymond L. Telles, Executive Director, by 3:00 p.m., Mountain Standard Time (MST) on August 2, 2012, to be eligible for consideration. Each SOQ will be evaluated based on the criteria and process set forth in the RFQ. The final selection of the shortlisted firms, if any, will be made by the CRRMA Board of Directors.

Questions concerning this RFQ should be submitted in writing to Camino Real Regional Mobility Authority, 2 Civic Center Plaza, 9th Floor, El Paso, Texas 79901, Attn: Raymond Telles or via email to tellesrl@crrma.org. All deadlines for submission of questions are included in the RFQ.

TRD-201203587
Raymond Telles
Executive Director
Camino Real Regional Mobility Authority
Filed: July 11, 2012

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Comptroller of Public Accounts

Notice of Contract Award

The Comptroller of Public Accounts (Comptroller), on behalf of the Texas Prepaid Higher Education Tuition Board (Board), announces this notice of contract award under Request for Proposals (RFP #203e) for Actuarial Services for the Texas Prepaid Higher Education Tuition Board. The contract was awarded to Sherman Actuarial Services, LLC, located at 16 High Street, Wakefield, Massachusetts, 01880. The term of the contract is July 5, 2012, through August 31, 2015, with option to renew for up to two (2) additional one-year periods, one year at a time. The total amount of the Contract is not-to-exceed $200,000.00.

TRD-201203518
William Clay Harris
Assistant General Counsel, Contracts
Comptroller of Public Accounts
Filed: July 6, 2012

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Office of Consumer Credit Commissioner

Notice of Rate Ceilings

The Consumer Credit Commissioner of Texas has ascertained the following rate ceilings by use of the formulas and methods described in §§303.003, 303.005, and 303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 07/16/12 - 07/22/12 is 18% for Consumer[1]/Agricultural/Commercial[2] credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 07/16/12 - 07/22/12 is 18% for Commercial over $250,000.

[1] Credit for personal, family or household use.

[2] Credit for business, commercial, investment or other similar purpose.

TRD-201203538
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: July 10, 2012

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Texas Council for Developmental Disabilities

Request for Proposals

The Texas Council for Developmental Disabilities (TCDD) announces the availability of funds for up to four projects to establish and/or strengthen a network of appropriately diverse organizations and to develop a plan to build the capacity of that community to provide community-based services that will decrease the need for individuals who have disabilities to be served in an institution. Services to be enhanced through these projects should include high quality, community-based, person-centered and/or family-centered healthcare services; behavior supports; and/or respite for people with developmental disabilities. Upon completion of a plan, networks may submit funding requests to TCDD for implementation.

TCDD has approved funding up to $75,000 per project, for up to four projects, for 18 months, for each network to be established or strengthened and to develop a plan. Each network may then submit their plan to TCDD for consideration for additional funding to implement the plan. TCDD expects to make available approximately $150,000 per project, per year, for up to five years, for up to four projects, to implement plans that are accepted by TCDD. Funds available for these projects are provided to TCDD by the U.S. Department of Health and Human Services, Administration on Intellectual and Developmental Disabilities, pursuant to the Developmental Disabilities Assistance and Bill of Rights Act. Funding for the project is dependent on the results of a review process established by the Council and on the availability of funds. Non-federal matching funds of at least 10% of the total project costs are required for projects in federally designated poverty areas. Non-federal matching funds of at least 25% of total project costs are required for projects in other areas.

Additional information concerning this Request for Proposals (RFP) or more information about TCDD may be obtained through TCDD's website at **http://www.txddc.state.tx.us.** All questions pertaining to this RFP should be directed to Joanna Cordry, Planning Coordinator, at (512) 437-5410 or via e-mail **Joanna.Cordry@tcdd.state.tx.us.** Application packets must be requested in writing or downloaded from the Internet.

Deadline: One hard copy, with original signatures, and one electronic copy must be submitted. All proposals must be received by TCDD, not later than 4:00 p.m. Central Time, Wednesday, September 12, 2012, or, if mailed, postmarked prior to midnight on the date specified above. Proposals may be delivered by hand or mailed to TCDD at 6201 East Oltorf, Suite 600, Austin, Texas 78741-7509 to the attention of Jeri Barnard. Faxed proposals cannot be accepted. Electronic copies should be addressed to **Jerianne.Barnard@tcdd.state.tx.us.**

Proposals will not be accepted after the due date.

Grant Proposers' Workshops: The TCDD will conduct telephone conferences to help potential applicants understand the grant application process and this specific RFP. In addition, answers to frequently asked questions will be posted on the TCDD website. Please check the TCDD website at **http://txddc.state.tx.us/grants_projects/rfp_announcements.asp** for a schedule of conference calls for this RFP.

TRD-201203577
Roger Webb
Executive Director
Texas Council for Developmental Disabilities
Filed: July 11, 2012

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East Texas Council of Governments

Request for Proposals

As the Administrative unit for the Workforce Solutions East Texas Board, the East Texas Council of Governments (ETCOG) is soliciting proposals for the operation and management of Youth Stand Alone Projects for a period beginning November 1, 2012, and extending through September 30, 2013, with the availability of three, one-year additional extensions. Youth Stand Alone Projects are independently operated, year-round programs that provide allowable services under the Workforce Investment Act (WIA). The purpose of Youth Stand Alone Projects are to help economically disadvantaged out-of-school youth ages 14 through 21 achieve academic and employment success. Proposers have three options for project design: Option #1 - Independent Projects offering any combination of allowable activities, Option #2 - Activities which the Workforce Centers can access for Youth participants, Option #3 - "Add-on" activities that supplement other activities offered by the provider.

The mission of the Workforce Solutions East Texas Board is to improve the quality of life in this area through economic development by providing a first-class workforce for present and future businesses. Counties that comprise the East Texas Workforce Development Areas are: Anderson, Camp, Cherokee, Gregg, Harrison, Henderson, Marion, Panola, Rains, Rusk, Smith, Upshur, Van Zandt, and Wood Counties.

The Workforce Solutions East Texas Board is making approximately $152,679 available through this RFP. Proposals are limited to $80,000. The amount of funds available is subject to change. Projects must serve out-of-school youth exclusively.

Persons or organizations wanting to receive a Request for Proposals (RFP) package, should submit a request by letter, fax, or email to the East Texas Council of Governments, 3800 Stone Road, Kilgore, Texas 75662, Attn: Gary Allen (903) 984-8641 (Ext. 227). The fax number for ETCOG is (903) 983-1440 or email gary.allen@etcog.org.

The Request for Proposals package will not be released prior to July 11, 2012. The deadline for receipt of proposals is Thursday, August 16, 2012, at 5:00 p.m. CDT.

Questions concerning the RFP process should be addressed by email or fax to Gary Allen (see above). Historically Underutilized Businesses (HUBs) are encouraged to apply. All programs and employers under the auspices of the Workforce Solutions East Texas Board are in compliance with EEO. Auxiliary aids and services are available, upon request, to individuals with disabilities.

TRD-201203569
David Cleveland
Executive Director
East Texas Council of Governments
Filed: July 10, 2012

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Texas Commission on Environmental Quality

Agreed Orders

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the proposed orders and the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is August 20, 2012. TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building C, 1st Floor, Austin, Texas 78753, (512) 239-2545 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the enforcement coordinator designated for each AO at the commission's central office at P.O. Box 13087, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 20, 2012.** Written comments may also be sent by facsimile machine to the enforcement coordinator at (512) 239-2550. The commission enforcement coordinators are available to discuss the AOs and/or the comment procedure at the listed phone numbers; however, TWC, §7.075 provides that comments on the AOs shall be submitted to the commission in **writing.**

(1) COMPANY: Alice Southern Equipment Service, Incorporated; DOCKET NUMBER: 2012-0496-WR-E; IDENTIFIER: RN106224165; LOCATION: Flynn, Leon County; TYPE OF FACILITY: oil and gas mining exploration; RULE VIOLATED: TWC, §11.121, and 30 TAC §297.11, by failing to obtain authorization prior to diverting, storing, impounding, taking, or using state water; PENALTY: $1,694; ENFORCEMENT COORDINATOR: JR Cao, (512) 239-2543; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(2) COMPANY: ALL SAINTS CORPORATION dba Texas Food Store; DOCKET NUMBER: 2012-0506-PST-E; IDENTIFIER: RN101780922; LOCATION: Houston, Harris County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.10(b)(1)(B), by failing to maintain all underground storage tank records and making them immediately available for inspection upon request by agency personnel; PENALTY: $1,370; ENFORCEMENT COORDINATOR: Epifanio Villarreal, (361) 825-3425; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(3) COMPANY: ALTOGA WATER SUPPLY CORPORATION; DOCKET NUMBER: 2012-0570-PWS-E; IDENTIFIER: RN101436152; LOCATION: Princeton, Collin County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.46(d)(2)(A) and §290.110(b)(4), and Texas Health and Safety Code, §341.0315(c), by failing to maintain the disinfectant residual concentration throughout the distribution system at a minimum of 0.2 milligrams per liter free chlorine; PENALTY: $120; ENFORCEMENT COORDINATOR: James Fisher, (512) 239-2537; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(4) COMPANY: Aqua Utilities, Incorporated; DOCKET NUMBER: 2012-0480-MWD-E; IDENTIFIER: RN101519668; LOCATION: Houston, Harris County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: Texas Pollutant Discharge Elimination System Permit Number WQ0014117001, Effluent Limitations and Monitoring Requirements Number 1, 30 TAC §305.125(1) and TWC, §26.121(a), by failing to comply with permitted effluent limits; PENALTY: $30,482; ENFORCEMENT COORDINATOR: Jorge Ibarra, P.E., (817) 588-5890; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(5) COMPANY: AWSH-Q, Incorporated dba Kool Corner; DOCKET NUMBER: 2012-0551-PST-E; IDENTIFIER: RN102427762; LOCATION: Luling, Caldwell County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and (2) and TWC, §26.3475(a) and (c)(1), by failing to monitor the underground storage tanks (USTs) for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring) and by failing to provide proper release detection for the product piping associated with the UST system; PENALTY: $2,636; ENFORCEMENT COORDINATOR: David Carney, (512) 239-2583; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753-1808, (512) 339-2929.

(6) COMPANY: BASHIR PETROLEUM, INCORPORATED dba Grogans Mill Shell Car Care; DOCKET NUMBER: 2012-0724-PST-E; IDENTIFIER: RN102355088; LOCATION: The Woodlands, Montgomery County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.245(2) and Texas Health and Safety Code, §382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months and the Stage II vapor space manifolding and dynamic back pressure at least once every 36 months or upon major system replacement or modification, whichever occurs first; PENALTY: $3,838; EN-

FORCEMENT COORDINATOR: Danielle Porras, (713) 767-3682; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(7) COMPANY: BAZE CHEMICAL, INCORPORATED formerly known as INTERCHEM, INCORPORATED; DOCKET NUMBER: 2012-0837-IWD-E; IDENTIFIER: RN103114070; LOCATION: Liberty, Liberty County; TYPE OF FACILITY: organic chemical manufacturing facility with an associated wastewater treatment facility; RULE VIOLATED: 30 TAC §§305.125(17), 319.1 and 319.7(d) and Texas Pollutant Discharge Elimination System Permit Number WQ0004873000, Monitoring and Reporting Requirements Number 1, by failing to timely submit the monthly discharge monitoring reports (DMRs) for the monitoring periods ending August 31, 2011, September 30, 2011, October 31, 2011, November 30, 2011, and December 31, 2011, and the annual DMR for the monitoring period ending September 30, 2011; PENALTY: $1,590; ENFORCEMENT COORDINATOR: Stephen Thompson, (512) 239-2558; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(8) COMPANY: Bonham Concrete, Incorporated; DOCKET NUMBER: 2012-0308-PST-E; IDENTIFIER: RN102788775; LOCATION: Bonham, Fannin County; TYPE OF FACILITY: fleet refueling; RULE VIOLATED: 30 TAC §334.8(c)(4)(A)(vi)(I), by failing to submit a properly completed registration and self-certification form to obtain an underground storage tank (UST) delivery certificate; and 30 TAC §334.8(c)(5)(A)(i) and TWC, §26.3467(a), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the UST; PENALTY: $1,606; ENFORCEMENT COORDINATOR: Elvia Maske, (512) 239-0789; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(9) COMPANY: Brenda Cunningham Byrd and Cozy Lounge, LLC dba Cozy Lounge; DOCKET NUMBER: 2012-0490-PWS-E; IDENTIFIER: RN106083355; LOCATION: Eagle Lake, Colorado County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.106(e), by failing to provide the results of triennial minerals monitoring and annual nitrate sampling to the executive director; 30 TAC §290.109(c)(2)(A)(i) and §290.122(c)(2)(B), and Texas Health and Safety Code, §341.033(d), by failing to collect routine distribution water samples for coliform analysis and by failing to provide public notice of the failure to sample; and 30 TAC §290.51(a)(3) and TWC, §5.702, by failing to pay public health service fees, including late fees, for TCEQ Financial Administration Account Number 90450099; PENALTY: $2,708; ENFORCEMENT COORDINATOR: Epifanio Villarreal, (361) 825-3425; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(10) COMPANY: Cadre Material Products, LLC; DOCKET NUMBER: 2012-0206-MLM-E; IDENTIFIER: RN105978191; LOCATION: Voca, McCulloch County; TYPE OF FACILITY: sand mining operation; RULE VIOLATED: 30 TAC §321.66 and TWC, §26.121(a)(1), by failing to obtain authorization prior to discharging industrial wastewater into or adjacent to water in the state; 30 TAC §305.125(1) and Texas Pollutant Discharge Elimination System Multi-Sector General Permit (MSGP) Number TXR05AC07, Part II, Section C.4., by failing to develop and implement a storm water pollution prevention plan according to the requirements of the MSGP before submitting a Notice of Intent for permit coverage; and 30 TAC §297.11 and TWC, §11.121, by failing to obtain authorization prior to impounding, diverting, or using state water; PENALTY: $12,057; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 622 South Oakes, Suite K, San Angelo, Texas 76903-7013, (325) 655-9479.

(11) COMPANY: City of Commerce; DOCKET NUMBER: 2012-0566-MWD-E; IDENTIFIER: RN102178233; LOCATION: Commerce, Hunt County; TYPE OF FACILITY: wastewater treatment facility with an associated collection system; RULE VIOLATED: TWC, §26.121(a) and Texas Pollutant Discharge Elimination System Permit Number WQ0010555001, Permit Condition Number 2.g., by failing to prevent a discharge of untreated wastewater from the collection system; PENALTY: $12,225; Supplemental Environmental Project offset amount of $12,225 applied to Texas Association of Resource Conservation and Development Areas, Incorporated - Abandoned Tire Cleanups and Tire Collection Events; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(12) COMPANY: City of Denton; DOCKET NUMBER: 2012-0092-MLM-E; IDENTIFIER: RN102546066; LOCATION: Aubrey, Denton County; TYPE OF FACILITY: surface water treatment plant; RULE VIOLATED: 30 TAC §335.4 and TWC, §26.121(a)(1), by failing to prevent the unauthorized discharge of municipal hazardous waste into or adjacent to water in the state; and TWC, §26.039(b) and 30 TAC §327.3(b), by failing to notify the TCEQ within 24 hours after the discovery of the unauthorized discharge of approximately 5,000 gallons of caustic solution from the respondent's surface water treatment plant; PENALTY: $13,770; ENFORCEMENT COORDINATOR: Jennifer Graves, (956) 430-6023; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(13) COMPANY: City of Florence; DOCKET NUMBER: 2011-0854-MWD-E; IDENTIFIER: RN101920502; LOCATION: Florence, Williamson County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: TWC, §26.121(a), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010944001, Final Effluent Limitations and Monitoring Requirements Numbers 1 and 2, by failing to comply with permitted effluent limitations; 30 TAC §305.125(1) and (17) and §319.7(d) and TPDES Permit Number WQ0010944001, Monitoring and Reporting Requirements Number 1, by failing to submit monitoring results at the intervals specified in the permit; and 30 TAC §305.125(17) and §319.1 and TPDES Permit Number WQ0010944001, Sludge Provisions, by failing to submit a complete annual sludge report for the monitoring period ending July 31, 2010; PENALTY: $13,107; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753-1808, (512) 339-2929.

(14) COMPANY: City of Fort Worth; DOCKET NUMBER: 2012-0151-MWD-E; IDENTIFIER: RN100942259; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: wastewater treatment facility and associated collection system; RULE VIOLATED: TWC, §26.121(a) and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010494013, Permit Conditions Number 2.g, by failing to prevent a discharge of untreated wastewater from the collection system; and TWC, §26.039(b), 30 TAC §305.125(9) and TPDES Permit Number WQ0010494013, Monitoring and Reporting Requirements Number 7, by failing to report an unauthorized discharge within 24 hours of becoming aware of the noncompliance; PENALTY: $15,625; Supplemental Environmental Project offset amount of $15,625 applied to Texas Association of Resource Conservation and Development Areas, Incorporated - Water or Wastewater Treatment Assistance; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(15) COMPANY: City of Groesbeck; DOCKET NUMBER: 2012-0688-MWD-E; IDENTIFIER: RN101918944; LOCATION:

Groesbeck, Limestone County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010182001, Monitoring and Reporting Requirements Number 1 and 30 TAC §305.125(1) and §319.7(d), by failing to timely submit the monthly discharge monitoring reports for the months of July 2011 and October 2011 - December 2011 by the 20th day of the following month; and TPDES Permit Number WQ0010182001, Final Effluent Limitations and Monitoring Requirements Numbers 1 and 6, 30 TAC §305.125(1) and TWC, §26.121(a), by failing to comply with permitted effluent limits; PENALTY: $4,430; ENFORCEMENT COORDINATOR: Jorge Ibarra, P.E., (817) 588-5890; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(16) COMPANY: City of Van Alstyne; DOCKET NUMBER: 2011-0940-MWD-E; IDENTIFIER: RN102844123; LOCATION: Van Alstyne, Grayson County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: Texas Pollutant Discharge Elimination System Permit Number WQ0010502001, Effluent Limitations and Monitoring Requirements Numbers 1 and 6, 30 TAC §305.125(1) and TWC, §26.121(a), by failing to comply with permitted effluent limits; PENALTY: $31,775; Supplemental Environmental Project offset amount of $31,775 applied to Texas Association of Resource Conservation and Development Areas, Incorporated - Household Hazardous Waste; ENFORCEMENT COORDINATOR: Cheryl Thompson, (817) 588-5886; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(17) COMPANY: GATE TREE, LLC dba Patios Del Lago Felipes Restaurant; DOCKET NUMBER: 2012-0614-PWS-E; IDENTIFIER: RN105874713; LOCATION: Lakehills, Bandera County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.109(f)(3) and Texas Health and Safety Code, §341.031(a), by failing to comply with the Maximum Contaminant Level for total coliform during the month of October 2011; 30 TAC §290.109(c)(3)(A)(i), by failing to collect all repeat distribution coliform samples within 24 hours of being notified of total coliform-positive results on routine samples collected during the month of October 2011; and 30 TAC §290.109(c)(2)(F), by failing to collect at least five distribution coliform samples the month following a coliform positive sample result during the month of November 2011; PENALTY: $711; ENFORCEMENT COORDINATOR: James Fisher, (512) 239-2537; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(18) COMPANY: Gilbert Daniel Jr. and Noelle Glass dba Daniel's Chevron; DOCKET NUMBER: 2012-0461-PST-E; IDENTIFIER: RN101676153 (Facility 1) and RN101676401 (Facility 2); LOCATION: Fairfield, Freestone County; TYPE OF FACILITY: convenience stores with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the underground storage tanks for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $7,500; ENFORCEMENT COORDINATOR: Rebecca Boyett, (512) 239-2503; REGIONAL OFFICE: 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(19) COMPANY: GOLDEN SPREAD REDI-MIX, INCORPORATED; DOCKET NUMBER: 2012-0773-IWD-E; IDENTIFIER: RN100242114; LOCATION: Amarillo, Potter County; TYPE OF FACILITY: ready-mix concrete batch plant; RULE VIOLATED: 30 TAC §305.125(1), TWC, §26.121(a), and Texas Pollutant Discharge Elimination System (TPDES) General Permit Number TXG110238, Part III, Permit Requirements, by failing to comply with permitted effluent limits; and 30 TAC §305.125(1) and TPDES General Permit Number TXG110238, Part IV, Standard Permit Conditions Number 7(f), by failing to include the pH maximum data on the discharge monitoring report for the monitoring period ending October 31, 2011; PENALTY: $3,800; ENFORCEMENT COORDINATOR: Jeremy Escobar, (361) 825-3422; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(20) COMPANY: GRANITE STONEBRIDGE HEALTH CENTER LLC; DOCKET NUMBER: 2011-2158-MWD-E; IDENTIFIER: RN101520500; LOCATION: Travis County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and TCEQ Permit Number WQ0013860001, Effluent Limitations and Monitoring Requirements A, by failing to comply with permitted effluent limitations; 30 TAC §305.125(1) and TCEQ Permit Number WQ0013860001, Monitoring Requirements Number 5, by failing to accurately calibrate all automatic flow measuring or recording devices and all totalizing meters for measuring flows, at least annually unless authorized by the executive director for a longer period; 30 TAC §305.125(1) and §319.5(b), and TCEQ Permit Number WQ0013860001, Effluent Limitations and Monitoring Requirements B and Monitoring Requirements Number 1, by failing to collect weekly effluent samples; 30 TAC §305.125(1) and TCEQ Permit Number WQ0013860001, Special Provisions (SP) Number 10, by failing to collect and analyze representative soil samples taken from the root zone of the irrigated site; and TWC, §26.121(a)(1), 30 TAC §305.125(1) and (5), and TCEQ Permit Number WQ0013860001, Operational Requirements Number 1 and SP Number 3, by failing to ensure that the facility and all its systems of collection, treatment, and disposal are properly operated and maintained; PENALTY: $13,621; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 12100 Park 35 Circle, Building A, Austin, Texas 78753-1808, (512) 339-2929.

(21) COMPANY: Harcharn & Puneet Bhullar, Incorporated dba Tony's Neighborhood Groceries; DOCKET NUMBER: 2012-0617-PST-E; IDENTIFIER: RN102367414; LOCATION: Dallas, Dallas County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(1)(A) and TWC, §26.3475(c)(1), by failing to monitor the facility's underground storage tank in a manner which will detect a release at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,550; ENFORCEMENT COORDINATOR: Bridgett Lee, (512) 239-2565; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(22) COMPANY: Hunt Oil Company; DOCKET NUMBER: 2012-0383-AIR-E; IDENTIFIER: RN102563863; LOCATION: Poyner, Henderson County; TYPE OF FACILITY: gas plant; RULE VIOLATED: 30 TAC §116.115(b)(2)(F) and §122.143(4), Texas Health and Safety Code, §382.085(b), Permit Number 215, Special Conditions Number 1, and Federal Operating Permit Number O2932, General Terms and Conditions and Special Terms and Conditions Number 5, by failing to comply with the allowable hourly emissions rate; PENALTY: $13,125; ENFORCEMENT COORDINATOR: Rebecca Johnson, (361) 825-3423; REGIONAL OFFICE: 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(23) COMPANY: JOHNSON RESOURCES, INCORPORATED; DOCKET NUMBER: 2012-0509-IHW-E; IDENTIFIER: RN105683239; LOCATION: Corpus Christi, Nueces County; TYPE OF FACILITY: oil and gas waste transporter; RULE VIOLATED: 30 TAC §335.2(b), by failing to prevent the disposal of industrial waste at an unauthorized facility; PENALTY: $1,886; ENFORCEMENT COORDINATOR: Brianna Carlson, (956) 430-6021; REGIONAL OFFICE: 6300 Ocean Drive, Suite 1200, Corpus Christi, Texas 78412-5503, (361) 825-3100.

(24) COMPANY: Leona Bullock dba Blue Ridge Mobile Home Park; DOCKET NUMBER: 2012-0149-PWS-E; IDENTIFIER: RN101226538; LOCATION: Ingram, Kerr County; TYPE OF FACILITY: public water supply; RULE VIOLATED: 30 TAC §290.109(c)(2)(A)(ii) and Texas Health and Safety Code, §341.033(d), by failing to collect routine distribution water samples for coliform analysis; and 30 TAC §290.271(b) and §290.274(a) and (c), by failing to mail or directly deliver one copy of the Consumer Confidence Report (CCR) to each bill paying customer by July 1 of each year and by failing to submit a copy of the annual CCR and certification that the CCR has been distributed to the customers of the facility and that the information in the CCR is correct and consistent with compliance monitoring data to the TCEQ by July 1 of each year; PENALTY: $2,088; ENFORCEMENT COORDINATOR: Stephen Thompson, (512) 239-2558; REGIONAL OFFICE: 14250 Judson Road, San Antonio, Texas 78233-4480, (210) 490-3096.

(25) COMPANY: Marcelino Lopez, Sr. dba Lantera Lopez; DOCKET NUMBER: 2011-1625-MSW-E; IDENTIFIER: RN106164551; LOCATION: Pharr, Hidalgo County; TYPE OF FACILITY: retail tire shop; RULE VIOLATED: 30 TAC §330.15(c), by failing to prevent the unauthorized disposal of municipal solid waste; and 30 TAC §328.56(d)(2) and §328.60(a), by failing to obtain a scrap tire storage site registration for the facility prior to storing more than 500 used or scrap tires on the ground; PENALTY: $22,500; ENFORCEMENT COORDINATOR: Andrea Park, (512) 239-4575; REGIONAL OFFICE: 1804 West Jefferson Avenue, Harlingen, Texas 78550-5247, (956) 425-6010.

(26) COMPANY: Matagorda Waste Disposal and Water Supply Corporation; DOCKET NUMBER: 2012-0034-MWD-E; IDENTIFIER: RN102286747; LOCATION: Matagorda, Matagorda County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: 30 TAC §305.126(a) and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0010913001, Operational Requirements Number 8.a, by failing to initiate engineering and financial planning for expansion and/or upgrading of the wastewater treatment and/or collection facilities when flow reaches 75% of the permitted average daily or annual average flow for three consecutive months; 30 TAC §305.125(4), TWC, §26.121(a)(1), and TPDES Permit Number WQ0010913001, Permit Conditions Number 2.d, by failing to take all reasonable steps to minimize or prevent any discharge of sludge into the receiving stream; 30 TAC §305.125(9) and TPDES Permit Number WQ0010913001, Monitoring and Reporting Requirements Number 7.a, by failing to report any noncompliance which may endanger human health or safety or the environment; and TWC, §26.121(a)(1), 30 TAC §305.125(1), and TPDES Permit Number WQ0010913001, Effluent Limitations and Monitoring Requirements Number 1, by failing to comply with permitted effluent limits; PENALTY: $26,975; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(27) COMPANY: Michelle Enterprises, Incorporated dba Sam's Shell; DOCKET NUMBER: 2012-0694-PST-E; IDENTIFIER: RN100639079; LOCATION: Dallas, Dallas County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §334.50(b)(2) and TWC, §26.3475(a), by failing to provide proper release detection for the product piping associated with the underground storage tank system; PENALTY: $1,754; ENFORCEMENT COORDINATOR: Amancio R. Gutierrez, (512) 239-3921; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(28) COMPANY: New Way Quick Shopping, Incorporated; DOCKET NUMBER: 2012-0406-PST-E; IDENTIFIER: RN101557601; LOCATION: Fort Worth, Tarrant County; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULE VIOLATED: 30 TAC §115.246(7)(A) and Texas Health and Safety Code (THSC), §382.085(b), by failing to maintain all required Stage II records at the station and making them immediately available for review upon request by agency personnel; 30 TAC §115.248(1) and THSC, §382.085(b), by failing to ensure that at least one station representative received training in the operation and maintenance of the Stage II vapor recovery system, and each current employee receives in-house Stage II vapor recovery training regarding the purpose and correct operation of the Stage II equipment; 30 TAC §115.245(2) and THSC, §382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months and vapor space manifolding and dynamic back-pressure at least once every 36 months or upon major system replacement or modification, whichever occurs first; and 30 TAC §115.242(3)(A) and THSC, §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition, as specified by the manufacturer; PENALTY: $6,525; ENFORCEMENT COORDINATOR: Brianna Carlson, (956) 430-6021; REGIONAL OFFICE: 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(29) COMPANY: Northwest Harris County Municipal Utility District Number 15; DOCKET NUMBER: 2012-0256-MLM-E; IDENTIFIER: RN103123238; LOCATION: Tomball, Harris County; TYPE OF FACILITY: wastewater treatment; RULE VIOLATED: TWC, §26.121(a)(1), 30 TAC §305.125(1), and Texas Pollutant Discharge Elimination System (TPDES) Permit Number WQ0011939001, Interim Effluent Limitations and Monitoring Requirements Number 4, Permit Conditions Number 2.d, by failing to prevent the discharge of floating solids into the receiving stream; 30 TAC §305.125(1) and (5) and TPDES Permit Number WQ0011939001, Operational Requirements Number 1, by failing to ensure that the facility and all of its systems of collection, treatment, and disposal are properly operated and maintained; and 30 TAC §101.4 and Texas Health and Safety Code, §382.085(a) and (b), by failing to prevent nuisance odor conditions that interfere with the normal use and enjoyment of property; PENALTY: $11,725; ENFORCEMENT COORDINATOR: Lanae Foard, (512) 239-2554; REGIONAL OFFICE: 5425 Polk Avenue, Suite H, Houston, Texas 77023-1486, (713) 767-3500.

(30) COMPANY: Oscar Hernandez dba O J's Discount; DOCKET NUMBER: 2012-0417-PST-E; IDENTIFIER: RN101443901; LOCATION: Borger, Huchinson County; TYPE OF FACILITY: convenience store with retail gasoline sales; RULE VIOLATED: TWC, §26.3467(a) and 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to renew a previously issued underground storage tank (UST) delivery certificate by submitting a properly completed UST registration and self-certification at least 30 days before the expiration date; and TWC, §26.3467(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; PENALTY: $6,013; ENFORCEMENT COORDINATOR: Harvey Wilson, (512) 239-0321; REGIONAL OFFICE: 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

TRD-201203536
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: July 10, 2012

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Enforcement Orders

An agreed order was entered regarding First Baptist Church of Jonestown, Texas, Docket No. 2011-0765-PWS-E on June 28, 2012 assessing $2,610 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Stephen Thompson, Enforcement Coordinator at (512) 239-2558, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding TAKHAR & SON, L.L.C. dba Texas Oasis, Docket No. 2011-0875-PST-E on June 28, 2012 assessing $12,012 in administrative penalties with $2,402 deferred.

Information concerning any aspect of this order may be obtained by contacting Rajesh Acharya, Enforcement Coordinator at (512) 239-0577, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Ramon C. Gonzales, Jr. dba Warren Road Subdivision Water Supply, Docket No. 2011-1099-PWS-E on June 28, 2012 assessing $3,938 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jennifer Cook, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Rocky Wadlington and Steven Stewart dba Farrar Water Supply Corporation, Docket No. 2011-1230-PWS-E on June 28, 2012 assessing $4,313 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jeffrey Huhn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding NIGTON-WAKEFIELD WATER SUPPLY CORPORATION, Docket No. 2011-1322-PWS-E on June 28, 2012 assessing $1,564 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Stephen Thompson, Enforcement Coordinator at (512) 239-2558, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding SAO LIM CORPORATION dba Kwik Stop, Docket No. 2011-1449-PST-E on June 28, 2012 assessing $2,100 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Joel Cordero, Staff Attorney at (512) 239-0672, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding US Innovations, Inc., Docket No. 2011-1473-MSW-E on June 28, 2012 assessing $15,700 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jim Sallans, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Mages Group, LLC, Docket No. 2011-1516-WQ-E on June 28, 2012 assessing $7,875 in administrative penalties with $1,575 deferred.

Information concerning any aspect of this order may be obtained by contacting Steve Villatoro, Enforcement Coordinator at (512) 239-4930, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Sharp Investment, Inc. dba Little Buddy 2, Docket No. 2011-1558-PST-E on June 28, 2012 assessing $75,100 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Peipey Tang, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default and shutdown order was entered regarding Zohra Virani dba RZS Food Mart, Docket No. 2011-1604-PST-E on June 28, 2012 assessing $4,830 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Rudy Calderon, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Heather McD, Ltd. [Formerly CHEM-PRUF DOOR CO., LTD.] dba Chem-Pruf Door, Docket No. 2011-1648-AIR-E on June 28, 2012 assessing $10,200 in administrative penalties with $2,040 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding City of Morton, Docket No. 2011-1700-MWD-E on June 28, 2012 assessing $9,350 in administrative penalties with $1,870 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Brister, Enforcement Coordinator at (254) 761-3034, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding ALIKE INC. dba Beta C Store, Docket No. 2011-1767-PST-E on June 28, 2012 assessing $10,695 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Peipey Tang, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding INEOS USA LLC, Docket No. 2011-1788-AIR-E on June 28, 2012 assessing $10,000 in administrative penalties with $2,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Audra Benoit, Enforcement Coordinator at (409) 899-8799, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Central State Shingle Recycling LLC, Docket No. 2011-1823-MSW-E on June 28, 2012 assessing $18,375 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Jeffrey Huhn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RGV TIRE RECYCLING GROUP, LLC, Docket No. 2011-1879-MSW-E on June 28, 2012 assessing $15,000 in administrative penalties with $3,000 deferred.

Information concerning any aspect of this order may be obtained by contacting Andrea Park, Enforcement Coordinator at (512) 239-4575, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Kenneth Martin, Docket No. 2011-1889-MLM-E on June 28, 2012 assessing $9,975 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Tammy Mitchell, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Munson Point Property Owners Association, Docket No. 2011-1986-PWS-E on June 28, 2012 assessing $1,055 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Katy Schumann, Enforcement Coordinator at (512) 239-2602, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding KIRK SHEET METAL COMPANY, INC., Docket No. 2011-2135-PST-E on June 28, 2012 assessing $14,981 in administrative penalties with $2,996 deferred.

Information concerning any aspect of this order may be obtained by contacting Brianna Carlson, Enforcement Coordinator at (956) 430-6021, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Moss Bluff Hub, LLC, Docket No. 2011-2161-AIR-E on June 28, 2012 assessing $36,720 in administrative penalties with $7,344 deferred.

Information concerning any aspect of this order may be obtained by contacting Trina Grieco, Enforcement Coordinator at (210) 403-4006, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

A default order was entered regarding Frank Roberts and Linda Roberts, Docket No. 2011-2198-MSW-E on June 28, 2012 assessing $22,750 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Steven M. Fishburn, Staff Attorney at (512) 239-3400, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Eastman Chemical Company, Docket No. 2011-2228-AIR-E on June 28, 2012 assessing $7,975 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Exxon Mobil Corporation, Docket No. 2011-2280-AIR-E on June 28, 2012 assessing $10,154 in administrative penalties.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Chevron Phillips Chemical Company LP, Docket No. 2011-2293-AIR-E on June 28, 2012 assessing $23,000 in administrative penalties with $4,600 deferred.

Information concerning any aspect of this order may be obtained by contacting John Muennink, Enforcement Coordinator at (713) 422-8970, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding S ALWADI, INC. dba S & D Mart, Docket No. 2011-2307-PST-E on June 28, 2012 assessing $8,772 in administrative penalties with $1,754 deferred.

Information concerning any aspect of this order may be obtained by contacting Judy Kluge, Enforcement Coordinator at (817) 588-5825, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding RACETRAC PETROLEUM, INC. dba Racetrac 423, Docket No. 2012-0074-PST-E on June 28, 2012 assessing $7,658 in administrative penalties with $1,531 deferred.

Information concerning any aspect of this order may be obtained by contacting Andrea Park, Enforcement Coordinator at (512) 239-4575, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

An agreed order was entered regarding Brazos Electric Power Cooperative, Inc., Docket No. 2012-0099-AIR-E on June 28, 2012 assessing $9,200 in administrative penalties with $1,840 deferred.

Information concerning any aspect of this order may be obtained by contacting Heather Podlipny, Enforcement Coordinator at (512) 239-2603, Texas Commission on Environmental Quality, P.O. Box 13087, Austin, Texas 78711-3087.

TRD-201203580
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: July 11, 2012

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Notice of Opportunity to Comment on Agreed Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Agreed Orders (AOs) in accordance with Texas Water Code (TWC), §7.075. TWC, §7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. TWC, §7.075 requires that notice of the opportunity to comment must be published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **August 20, 2012.** TWC, §7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about an AO should be sent to the attorney designated for the AO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 20, 2012.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; how-

ever, TWC, §7.075 provides that comments on an AO shall be submitted to the commission in **writing.**

(1) COMPANY: Ahmed Fayyaz d/b/a Super Stop 10; DOCKET NUMBER: 2011-0595-PST-E; TCEQ ID NUMBER: RN102399342; LOCATION: 6701 West Port Arthur Road, Port Arthur, Jefferson County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.49(a) and TWC, §26.3475(d), by failing to provide corrosion protection to all underground components of a UST system which is designed or used to convey, contain, or store regulated substances; 30 TAC §334.48(c), by failing to conduct effective manual or automatic inventory control procedures for all USTs involved in the retail sale of petroleum substances used as motor fuel; 30 TAC §334.72(3), by failing to report a suspected release to the TCEQ within 24 hours; 30 TAC §334.74, by failing to investigate a suspected release within 30 days of discovery; 30 TAC §334.50(b)(2)(A)(i)(III) and TWC, §26.3475(a), by failing to test the line leak detectors at least once per year for performance and operational reliability; 30 TAC §334.50(d)(1)(B)(ii) and TWC, §26.3475(c)(1), by failing to conduct reconciliation of detailed inventory control records at least once each month, sufficiently accurate to detect a release which equals or exceeds the sum of 1.0 percent of the total substance flow-through for the month plus 130 gallons; 30 TAC §334.50(d)(1)(B)(iii)(I) and TWC, §26.3475(c)(1), by failing to record inventory volume measurement for regulated substance inputs, withdrawals, and the amount still remaining in the tank each operating day; 30 TAC §115.245(2) and Texas Health and Safety Code (THSC), § 382.085(b), by failing to verify proper operation of the Stage II equipment at least once every 12 months and the Stage II vapor space manifolding and dynamic back pressure at least once every 36 months or upon major system replacement or modification; 30 TAC §115.242(3) and THSC, §382.085(b), by failing to maintain the Stage II vapor recovery system in proper operating condition, as specified by the manufacturer and/or any applicable California Air Resources Board Executive Order, and free of defects that would impair the effectiveness of the system; and 30 TAC §115.242(9) and THSC, §382.085(b), by failing to post operating instructions conspicuously on the front of each gasoline dispensing pump equipped with a Stage II vapor recovery system; PENALTY: $27,208; STAFF ATTORNEY: Rudy Calderon, Litigation Division, MC 175, (512) 239-0205; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(2) COMPANY: Amana Rose, LLC d/b/a Tejas Village; DOCKET NUMBER: 2011-0924-PWS-E; TCEQ ID NUMBER: RN102684339; LOCATION: 509 Tejas Road, Jefferson, Marion County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.109(c)(2)(A)(i) and §290.122(B) and Texas Health and Safety Code, §341.033(d), by failing to collect routine distribution water samples for coliform analysis; 30 TAC §§290.106(e), 290.108(e), and 290.116(e), by failing to provide the monitoring results of triennial sampling for metals, minerals, and Stage 1 disinfectant by-product levels to the executive director; and 30 TAC §290.106(e), by failing to provide the monitoring results of annual sampling for nitrate to the executive director; PENALTY: $18,357; STAFF ATTORNEY: Rudy Calderon, Litigation Division, MC 175, (512) 239-0205; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(3) COMPANY: BUCCANEER FOOD STORES INC.; DOCKET NUMBER: 2011-1557-PST-E; TCEQ ID NUMBER: RN101665172; LOCATION: 1309 Prairie Lea Street, Brenham, Washington County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(a) and (c)(1) and 30 TAC §334.50(b)(1)(A) and (2), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring), and by failing to provide release detection for the piping associated with the UST system; and 30 TAC §334.10(b), by failing to maintain UST records and make them immediately available for inspection upon request by agency personnel; PENALTY: $3,629; STAFF ATTORNEY: Elizabeth Lieberknecht, Litigation Division, MC 175, (512) 239-0620; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(4) COMPANY: Donald E. Crane d/b/a Sherwood Estates Manufactured Townhome Community, d/b/a Country Village Mobile Home Estates, and d/b/a Westgate Manufactured Townhome Community; DOCKET NUMBER: 2011-1125-PWS-E; TCEQ ID NUMBERS: RN101225506, RN101267466, and RN102675121; LOCATION: 3801 East Highway 80, Midland County (RN101225506), 3401 South County Road 1223 1/2, Midland County (RN101267466) and 4813 West Interstate 20, Midland County (RN102675121); TYPE OF FACILITY: public water systems; RULES VIOLATED: 30 TAC §290.110(e)(4)(A) and (f)(3), by failing to submit a Disinfectant Level Quarterly Operating Report to the executive director each quarter by the tenth day of the month following the end of each quarter; 30 TAC §290.271(b) and §290.274(a) and (c), by failing to mail or directly deliver one copy of the Consumer Confidence Report (CCR) to each bill paying customer by July 1 of each year and by failing to submit to the TCEQ by July of each year a copy of the annual CCR and certification that the CCR has been distributed to the customers of Sherwood Estates (RN101225506) and Country Village (RN101267466) and that the information in the CCR is correct and consistent with compliance monitoring data; TWC, §5.702 and 30 TAC §290.51(a)(3) and (6), by failing to pay all annual and late Public Health Service fees for TCEQ Financial Administration Account Number 91650022 for Fiscal Years 2007 - 2011; TWC, §5.702 and 30 TAC §290.51(a)(3) and (6), by failing to pay all annual and late Public Health Service fees for TCEQ Financial Administration Account Number 91650111 for Fiscal Years 2005 - 2011; and TWC, §5.702 and 30 TAC §290.51(a)(3) and (6), by failing to pay all annual and late Public Health Service fees for TCEQ Financial Administration Account Number 91650047 for Fiscal Years 1998 - 2011; PENALTY: $8,551; STAFF ATTORNEY: Peipey Tang, Litigation Division, MC 175, (512) 239-0654; REGIONAL OFFICE: Midland Regional Office, 3300 North A Street, Building 4, Suite 107, Midland, Texas 79705-5406, (432) 570-1359.

(5) COMPANY: Homayon Rashid d/b/a J & P One Stop FFP 601; DOCKET NUMBER: 2011-2085-PST-E; TCEQ ID NUMBER: RN102350675; LOCATION: 700 West Main Street, Madisonville, Madison County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,703; STAFF ATTORNEY: Joel Cordero, Litigation Division, MC 175, (512) 239-0672; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

(6) COMPANY: LEAGUE CITY INTERESTS, INC. d/b/a Super Food 1; DOCKET NUMBER: 2012-0190-PST-E; TCEQ ID NUMBER: RN101725331; LOCATION: 351 Farm-to-Market Road 646 East, Dickinson, Galveston County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: Texas Health and Safety Code (THSC), §382.085(b) and 30 TAC §115.245(2), by failing to verify proper operation of the Stage II equipment at least once every 12 months; and THSC, §382.085(b) and 30 TAC §115.248(1), by failing to ensure that at least one station representative received training in the operation and maintenance of the Stage II vapor recovery system,

and each current employee receives Stage II vapor recovery training regarding the purpose and correct operation of the Stage II equipment; PENALTY: $3,299; STAFF ATTORNEY: Kari L. Gilbreth, Litigation Division, MC 175, (512) 239-1320; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(7) COMPANY: NORTH TEXAS FIXTURE COMPANY, INC. d/b/a Alvord Express; DOCKET NUMBER: 2012-0076-PST-E; TCEQ ID NUMBER: RN104399043; LOCATION: 812 West State Street, Alvord, Wise County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide proper release detection for the pressurized piping associated with the USTs; PENALTY: $2,004; STAFF ATTORNEY: Ryan Rutledge, Litigation Division, MC 175, (512) 239-0630; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(8) COMPANY: Plano Shell, Inc. DBA Cooks Shell Mart; DOCKET NUMBER: 2011-1235-PST-E; TCEQ ID NUMBER: RN101552495; LOCATION: 1401 Cooks Lane, Fort Worth, Tarrant County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(a), by failing to monitor the UST for releases at a frequency of at least once every month (not to exceed 35 days between each monitoring); 30 TAC §334.72(3)(b), by failing to report a suspected release to the TCEQ within 24 hours of the discovery; 30 TAC §334.74, by failing to investigate a suspected release within 30 days of discovery; and TWC, §26.121 and 30 TAC §334.48(a), by failing to prevent an unauthorized discharge of petroleum fuel into or adjacent to any water in the state; PENALTY: $24,525; STAFF ATTORNEY: Jim Sallans, Litigation Division, MC 175, (512) 239-2053; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(9) COMPANY: Prestonwood Golf Club LLC; DOCKET NUMBER: 2011-1881-WR-E; TCEQ ID NUMBER: RN101444826; LOCATION: 6600 Columbine Way, Plano, Denton County; TYPE OF FACILITY: golf course; RULES VIOLATED: TWC, §11.121 and 30 TAC §297.11, by failing to obtain authorization prior to diverting state water; PENALTY: $1,600; STAFF ATTORNEY: Jim Sallans, Litigation Division, MC 175, (512) 239-2053; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(10) COMPANY: Randy Scobee; DOCKET NUMBER: 2011-1958-PST-E; TCEQ ID NUMBER: RN102274057; LOCATION: 322 West Highway Street, Iowa Park, Wichita County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.72(3)(B), by failing to report a suspected release to the TCEQ within 24 hours of discovery; and 30 TAC §334.74, by failing to investigate a suspected release within 30 days of discovery; PENALTY: $13,600; STAFF ATTORNEY: Phillip Goodwin, Litigation Division, MC 175, (512) 239-0675; REGIONAL OFFICE: Abilene Regional Office, 1977 Industrial Boulevard, Abilene, Texas 79602-7833, (325) 698-9674.

(11) COMPANY: SABIR, INC. d/b/a Stop N Drive 7; DOCKET NUMBER: 2012-0179-PST-E; TCEQ ID NUMBER: RN101867992; LOCATION: 2500 Gulfway Drive, Port Arthur, Jefferson County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: Texas Health and Safety Code (THSC), §382.085(b) and 30 TAC §115.245(2), by failing to verify proper operation of the Stage II equipment at least once every 12 months; and THSC, §382.085(b) and 30 TAC §115.246(4), by failing to maintain Stage II records at the station and make them immediately available for review upon request by agency personnel; PENALTY: $6,548; STAFF ATTORNEY: Joel Cordero, Litigation Division, MC 175, (512) 239-0672; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(12) COMPANY: Sam Rayburn Water, Inc.; DOCKET NUMBER: 2011-1572-PWS-E; TCEQ ID NUMBER: RN101256949; LOCATION: the end of Farm-to-Market Road 1751, Pineland, San Augustine County; TYPE OF FACILITY: public water system; RULES VIOLATED: 30 TAC §290.46(s)(1), by failing to calibrate the well meter Number 2 at least once every three years; 30 TAC §290.41(c)(3)(N), by failing to provide an operational flow measuring device on Well Number 3 to measure production yields and provide for the accumulation of water production data; 30 TAC §290.42(e)(3)(D), by failing to provide facilities for determining the amount of disinfectant used daily and the amount of disinfectant remaining for use; 30 TAC §290.43(c)(1) and (4), by failing to maintain the ground storage tank in strict accordance with American Water Works Association standards; 30 TAC §290.43(d)(7), by failing to maintain the pressure tank thoroughly tight against leakage; 30 TAC §290.46(v), by failing to securely install all wiring in compliance with a local or national electrical code; 30 TAC §290.46(m)(1)(B), by failing to conduct an internal inspection of the pressure tank at least once every five years; 30 TAC §290.41(c)(3)(O), by failing to maintain an intruder-resistant fence around Well Number 3 which includes a six-foot high fence with three strands of barbed wire extending outward from the top of the fence at a 45 degree angle; Texas Health and Safety Code, §341.033(a) and 30 TAC §290.46(e)(4)(A), by failing to have all production, treatment and distribution facilities operated at all times under the direct supervision of a water works operator who hold a Class "D" or higher license issued by the executive director; 30 TAC §290.46(s)(2)(C)(i), by failing to verify the accuracy of the manual disinfectant residual analyzers at least once every 30 days using chlorine solutions of known concentrations; and 30 TAC §290.46(f)(2) and (3)(A)(iii), by failing to make all facility records accessible for review by commission personal at the time of the inspection; PENALTY: $1,637; STAFF ATTORNEY: Peipey Tang, Litigation Division, MC 175, (512) 239-0654; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(13) COMPANY: SCCW Industrial Services, LLC; DOCKET NUMBER: 2012-0249-AIR-E; TCEQ ID NUMBER: RN106255300; LOCATION: 17182 Farm-to-Market Road 105, Vidor, Orange County; TYPE OF FACILITY: outdoor dry abrasive cleaning site; RULES VIOLATED: Texas Health and Safety Code, §382.0518(a) and §382.085(b) and 30 TAC §116.110(a), by failing to obtain authorization prior to conducting outdoor dry abrasive blast cleaning operations; PENALTY: $1,250; STAFF ATTORNEY: Anna Treadwell, Litigation Division, MC 175, (512) 239-0974; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

(14) COMPANY: Sunset Enterprises Inc. d/b/a Fast Fuels 1; DOCKET NUMBER: 2012-0591-PST-E; TCEQ ID NUMBER: RN102264140; LOCATION: 1108 South Jackson Street, Jacksonville, Cherokee County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(C) and (5)(B)(ii), by failing to renew a delivery certificate by submitting a properly completed UST registration and self-certification form within 30 days of ownership change; and TWC, §26.3467(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance

into the UST; PENALTY: $1,350; STAFF ATTORNEY: Ryan Rutledge, Litigation Division, MC 175, (512) 239-0630; REGIONAL OFFICE: Tyler Regional Office, 2916 Teague Drive, Tyler, Texas 75701-3734, (903) 535-5100.

(15) COMPANY: TC JESTER MOBIL, INC.; DOCKET NUMBER: 2011-0944-PST-E; TCEQ ID NUMBER: RN101907418; LOCATION: 2218 North Loop West, Houston, Harris County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(c)(1) and 30 TAC §334.50(b)(1)(A), by failing to monitor the USTs for releases at least once every month (not to exceed 35 days between each monitoring); PENALTY: $2,250; STAFF ATTORNEY: Phillip Goodwin, Litigation Division, MC 175, (512) 239-0675; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(16) COMPANY: TERRY'S SUPERMARKET #8, INC; DOCKET NUMBER: 2011-0487-PST-E; TCEQ ID NUMBER: RN102713658; LOCATION: 1710 West Irving Boulevard, Irving, Dallas County; TYPE OF FACILITY: underground storage tank system and a convenience store with retail sales of gasoline; RULES VIOLATED: Texas Health and Safety Code (THSC), §382.085(b) and 30 TAC §115.244(3), by failing to conduct monthly inspections of the Stage II vapor recovery system; THSC, §382.085(b) and 30 TAC §115.248(1), by failing to ensure that at least one station representative received training in the operation and maintenance of the Stage II vapor recovery system and that each current employee received in-house Stage II vapor recovery training regarding the purpose and correct operation of the Stage II vapor recovery equipment; THSC, §382.085(b) and 30 TAC §115.246(1) and (5), by failing to maintain all required Stage II records at the station and make them immediately available for review upon request by agency personnel; and THSC, §382.085(b) and 30 TAC §115.245(2), by failing to verify proper operation of the Stage II equipment at least once every 12 months or upon major system replacement or modification, whichever occurs first; PENALTY: $6,134; STAFF ATTORNEY: Mike Fishburn, Litigation Division, MC 175, (512) 239-0635; REGIONAL OFFICE: Dallas-Fort Worth Regional Office, 2309 Gravel Drive, Fort Worth, Texas 76118-6951, (817) 588-5800.

(17) COMPANY: TOWN & COUNTRY FOOD STORES, INC. DBA Stripes 203; DOCKET NUMBER: 2011-0751-PST-E; TCEQ ID NUMBER: RN101890747; LOCATION: 2500 Hall Avenue, Littlefield, Lamb County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: TWC, §26.3475(a) and 30 TAC §334.50(b)(2), by failing to provide proper release detection for the pressurized piping associated with the UST system; and TWC, §26.121(a)(3) and 30 TAC §334.48(a), by failing to prevent an unauthorized discharge of gasoline into or adjacent to any water in the state; PENALTY: $8,750; STAFF ATTORNEY: Tammy Mitchell, Litigation Division, MC 175, (512) 239-0736; REGIONAL OFFICE: Lubbock Regional Office, 5012 50th Street, Suite 100, Lubbock, Texas 79414-3421, (806) 796-7613.

(18) COMPANY: UNIVERSAL ENTERPRISES, INC. DBA Handi Stop 4; DOCKET NUMBER: 2011-1899-PST-E; TCEQ ID NUMBER: RN100869742; LOCATION: 5115 Airline Drive, Houston, Harris County; TYPE OF FACILITY: underground storage tank (UST) system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.49(a)(1) and TWC, §26.3475(d), by failing to provide proper corrosion protection for the UST system; PENALTY: $2,650; STAFF ATTORNEY: Tammy Mitchell, Litigation Division, MC 175, (512) 239-0736; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

TRD-201203565
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: July 10, 2012

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Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **August 20, 2012.** The commission will consider any written comments received and the commission may withdraw or withhold approval of a DO if a comment discloses facts or considerations that indicate that consent to the proposed DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed DO is not required to be published if those changes are made in response to written comments.

A copy of each proposed DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the DO should be sent to the attorney designated for the DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 20, 2012.** Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission's attorneys are available to discuss the DOs and/or the comment procedure at the listed phone numbers; however, §7.075 provides that comments on the DOs shall be submitted to the commission in **writing.**

(1) COMPANY: Michael Smith and Theresa Smith; DOCKET NUMBER: 2011-0311-MSW-E; TCEQ ID NUMBER: RN101479178; LOCATION: 1.3 miles west of State Highway 152, Farm-to-Market Road 2171, 1,000 feet South of State Highway 152, Borger, Hutchison County; TYPE OF FACILITY: landfill; RULES VIOLATED: 30 TAC §§330.165(f), 330.453, and 330.461, by failing to provide adequate final cover for a municipal solid waste (MSW) landfill and by failing to comply with closure requirements and to certify final closure of the landfill; and TWC, §26.121(a) and 30 TAC §330.15(a)(1), by failing to prevent the unauthorized discharge of MSW from the facility; PENALTY: $8,500; STAFF ATTORNEY: Jeff Huhn, Litigation Division, MC R-13, (210) 403-4023; REGIONAL OFFICE: Amarillo Regional Office, 3918 Canyon Drive, Amarillo, Texas 79109-4933, (806) 353-9251.

(2) COMPANY: Robert Maxey d/b/a J & H Auto Repair; DOCKET NUMBER: 2011-1737-PST-E; TCEQ ID NUMBER: RN105062467;

LOCATION: 4308 Farm-to-Market Road 1765, Texas City, Galveston County; TYPE OF FACILITY: property with an inactive underground storage tank (UST) system; RULES VIOLATED: 30 TAC §334.7(a)(1), by failing to register USTs in existence on or after September 1, 1987; and 30 TAC §334.47(a)(2), by failing to permanently remove from service, no later than 60 days after the prescribed upgrade implementation date, a UST system for which any applicable component of the system is not brought into timely compliance with the upgrade requirements; PENALTY: $6,900; STAFF ATTORNEY: Elizabeth Lieberknecht, Litigation Division, MC 175, (512) 239-0620; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023-1452, (713) 767-3500.

(3) COMPANY: Vicente Munoz; DOCKET NUMBER: 2011-0412-PST-E; TCEQ ID NUMBER: RN101871549; LOCATION: Highway 57, approximately one mile west of the intersection of Highway 57 and Farm-to-Market Road 117 (across Highway 57 from Winter Garden Cooperative Gin), Batesville, Zavala County; TYPE OF FACILITY: underground storage tank (UST) system and property; RULES VIOLATED: 30 TAC §334.47(a)(2) and §334.54(b), by failing to permanently remove from service, no later than 60 days after the prescribed implementation date, a UST system for which any applicable component of the system is not brought into timely compliance with the upgrade requirements, and by failing to maintain all piping, pumps, manways, tank access points and ancillary equipment in a capped, plugged, locked, and/or otherwise secured manner to prevent access, tampering, or vandalism by unauthorized persons; PENALTY: $2,625; STAFF ATTORNEY: Elizabeth Lieberknecht, Litigation Division, MC 175, (512) 239-0620; REGIONAL OFFICE: Laredo Regional Office, 707 East Calton Road, Suite 304, Laredo, Texas 78041-3887, (956) 791-6611.

TRD-201203566
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: July 10, 2012

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Notice of Opportunity to Comment on Shutdown/Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Shutdown/Default Orders (S/DOs). Texas Water Code (TWC), §26.3475 authorizes the commission to order the shutdown of any underground storage tank (UST) system found to be noncompliant with release detection, spill and overfill prevention, and/or, after December 22, 1998, cathodic protection regulations of the commission, until such time as the owner/operator brings the UST system into compliance with those regulations. The commission proposes a Shutdown Order after the owner or operator of a UST facility fails to perform required corrective actions within 30 days after receiving notice of the release detection, spill and overfill prevention, and/or, after December 22, 1998, cathodic protection violations documented at the facility. The commission proposes a Default Order when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. In accordance with TWC, §7.075, this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **August 20, 2012.** The commission will consider any written comments received and the commission may withdraw or withhold approval of a S/DO if a comment discloses facts or considerations that indicate that consent to the proposed S/DO is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction, or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed S/DO is not required to be published if those changes are made in response to written comments.

Copies of each of the proposed S/DO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building A, 3rd Floor, Austin, Texas 78753, (512) 239-3400 and at the applicable regional office listed as follows. Written comments about the S/DO shall be sent to the attorney designated for the S/DO at the commission's central office at P.O. Box 13087, MC 175, Austin, Texas 78711-3087 and must be **received by 5:00 p.m. on August 20, 2012.** Written comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The commission attorneys are available to discuss the S/DOs and/or the comment procedure at the listed phone numbers; however, comments on the S/DOs shall be submitted to the commission in **writing.**

(1) COMPANY: Ahmed Abu-Alghanam d/b/a Energy Exxon; DOCKET NUMBER: 2011-2004-PST-E; TCEQ ID NUMBER: RN102985520; LOCATION: 3838 Andrews Highway, Odessa, Ector County; TYPE OF FACILITY: UST system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii), (4)(C), and (5)(B)(ii), by failing to timely renew a previously issued TCEQ delivery certificate by submitting a properly completed UST registration and self-certification form within 30 days of the ownership change; TWC, §26.3467(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; and 30 TAC §334.10(b), by failing to maintain UST records and make them immediately available for inspection upon request by agency personnel; PENALTY: $5,000; STAFF ATTORNEY: Kari L. Gilbreth, Litigation Division, MC 175, (512) 239-1320; REGIONAL OFFICE: Midland Regional Office, 3300 North A Street, Building 4, Suite 107, Midland, Texas 79705-5406, (432) 570-1359.

(2) COMPANY: Alexis To Kik d/b/a Tobys 2; DOCKET NUMBER: 2011-1783-PST-E; TCEQ ID NUMBER: RN102438835; LOCATION: 2915 Northwest Stallings Drive, Nacogdoches, Nacogdoches County; TYPE OF FACILITY: UST system and a convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §334.8(c)(4)(A)(vii) and (5)(B)(ii), by failing to timely renew a previously issued UST delivery certificate by submitting a properly completed UST registration and self-certification form at least 30 days before the expiration date; TWC, §26.3467(a) and 30 TAC §334.8(c)(5)(A)(i), by failing to make available to a common carrier a valid, current TCEQ delivery certificate before accepting delivery of a regulated substance into the USTs; TWC, §26.3475(d) and 30 TAC §334.49(a)(1), by failing to provide proper corrosion protection for the UST system; TWC, §26.3475(a) and (c)(1) and 30 TAC §334.50(b)(1)(A) and (2), by failing to monitor the USTs for releases at a frequency of at least once per month (not to exceed 35 days between each monitoring), and by failing to provide release detection for the piping associated with the UST system; and 30 TAC §37.815(a) and (b), by failing to demonstrate acceptable financial assurance for taking corrective action and for compensating third parties for bodily injury and property damage caused by accidental releases arising from the operation of petroleum USTs; PENALTY: $13,926; STAFF ATTORNEY: Peipey Tang, Litigation Division, MC 175,

(512) 239-0654; REGIONAL OFFICE: Beaumont Regional Office, 3870 Eastex Freeway, Beaumont, Texas 77703-1830, (409) 898-3838.

TRD-201203567
Kathleen C. Decker
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: July 10, 2012

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Notice of Water Quality Applications

The following notices were issued on June 29, 2012 through July 6, 2012.

The following require the applicants to publish notice in a newspaper. Public comments, requests for public meetings, or requests for a contested case hearing may be submitted to the Office of the Chief Clerk, Mail Code 105, P.O. Box 13087, Austin, Texas 78711-3087, WITHIN 30 DAYS OF THE DATE OF NEWSPAPER PUBLICATION OF THE NOTICE.

INFORMATION SECTION

CHAMPION TECHNOLOGIES INC which operates the Fresno Plant, an organic chemical manufacturing plant, has applied for a major amendment to Texas Pollutant Discharge Elimination System (TPDES) Permit No. WQ0004306000 to authorize the removal of stormwater from the permit; relocation of Outfall 001; an increase in the daily average flow limit from 4,400 to 15,000 gallons per day and daily maximum flow limit from 15,000 to 25,000 gallons per day for Outfall 001; creation of an internal sampling point, Outfall 101, for Outfall 001 at the cooling tower merge point; creation of a new Outfall 002 for boiler blowdown with a daily average flow limit of 20,000 gallons per day and a daily maximum flow limit of 25,000 gallons per day; creation of a new internal sampling point, Outfall 102, near the boiler; and removal of or higher limitations on E. coli. The current permit authorizes the discharge of cooling tower blowdown, stormwater runoff, and previously monitored effluent (boiler blowdown) at a daily average flow of 4,400 gallons per day. The facility is located at 3130 Farm-to-Market Road 521, approximately 2.25 miles north of the intersection of Farm-to-Market Road 521 and State Highway 6, in the City of Fresno, Fort Bend County, Texas 77545.

REAGENT CHEMICAL AND RESEARCH INC which operates Reagent Chemical - Jacintoport, a hydrochloric acid bulk terminal, has applied for a renewal of TPDES Permit No. WQ0004552000, which authorizes the intermittent and flow variable discharge of trailer rinse water via Outfall 002 and the intermittent and flow variable discharge of steam condensate and stormwater via Outfall 003. The draft permit authorizes the intermittent and flow variable discharge of trailer rinse water and stormwater via Outfall 002 and the intermittent and flow variable discharge of steam condensate and stormwater via Outfall 003. The facility is located at 2250 Appelt Drive, approximately 0.6 miles north of the intersection of Appelt Drive and Jacintoport Boulevard, Harris County, Texas 77015. The Executive Director has reviewed this action for consistency with the goals and policies of the Texas Coastal Management Program (CMP) in accordance with the regulations of the Coastal Coordination Council (CCC) and has determined that the action is consistent with the applicable CMP goals and policies.

SOUTH ATLANTIC SERVICES INC which operates a facility that stores, blends, and packages liquid automotive products, has applied for a major amendment to TPDES Permit No. WQ0004953000 to authorize replacing the daily average and daily maximum flow limits with "Report" requirements and to specify that effluent sampling frequencies apply only during discharge. The current permit authorizes the discharge of reverse osmosis concentrate water at a daily average flow of 10,500 gallons per day. The facility is located at 16530 Peninsula Street, City of Houston, Harris County, Texas 77015. The TCEQ Executive Director has reviewed this action for consistency with the Texas Coastal Management Program goals and policies in accordance with the regulations of the Coastal Coordination Council, and has determined that the action is consistent with the applicable CMP goals and policies.

UA HOLDINGS 1994-5 LP has applied for a renewal of TPDES Permit No. WQ0012000001, which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 5,000 gallons per day. The facility is located at 9110 Meadow Vista Boulevard, immediately northeast of the intersection of Palmerton Drive and Meadow Vista Boulevard, approximately 2,700 feet northeast of the intersection of Perry Road and Farm-to-Market Road 1960 and approximately 5,000 feet southwest of the intersection of Farm-to-Market Road 249 with Farm-to-Market Road 1960 in Harris County, Texas 77064.

ALLIANCE HC III LIMITED PARTNERSHIP has applied for a renewal of TPDES Permit No. WQ0013764001 which authorizes the discharge of treated domestic wastewater at a daily average flow not to exceed 150,000 gallons per day. The facility is located at 1660 W T C Jester Boulevard in Houston approximately 1000 feet south of the intersection of West 18th Street and E T C Jester Boulevard on the west bank of Whiteoak Bayou in Harris County, Texas 77008.

LAUGHLIN THYSSEN INC has applied for a renewal of TPDES Permit No. WQ0014947001, which authorizes the discharge of treated filter backwash effluent from a water treatment plant at a daily average flow not to exceed 990,000 gallons per day. The facility is located at 928 19th Street, Galena, Texas adjacent to Hunting Bayou, west of the intersection of the confluence of Hunting Bayou and the Houston Ship Channel, 1.1 miles upstream of the Federal Road crossing of Hunting Bayou in Harris County, Texas 77547.

If you need more information about these permit applications or the permitting process, please call the TCEQ Public Education Program, toll free, at 1-800-687-4040. General information about the TCEQ can be found at our web site at www.tceq.texas.gov. Si desea información en español, puede llamar al 1-800-687-4040.

TRD-201203578
Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: July 11, 2012

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Notice of Water Rights Applications

Notices issued June 28, 2012 through July 6, 2012.

APPLICATION NO. 12657, TransCanada Keystone Pipeline LP, 2700 Post Oak Boulevard, Suite 400, Houston, Texas 77056, seeks a temporary water use permit to divert and use not to exceed 27.21 acre-feet of water within a period of one year from the Red River, Red River Basin for industrial purposes in Fannin County, Texas. The application was received on November 22, 2010. Additional information and fees were received on March 3, 2011. The application was declared administratively complete and filed with the Office of the Chief Clerk on March 31, 2011. The TCEQ Executive Director has completed the technical review of the application and prepared a draft temporary permit. The draft temporary permit, if granted, would contain special conditions, including but not limited to, streamflow restrictions and the installation of screens on diversion structures. The application, technical memo-

randa, and Executive Director's draft permit are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78753. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, by July 27, 2012.

APPLICATION NO. 12679, BP America Production Company, P.O. Box 959, Hallsville, Texas 75650, seeks a temporary water use permit to divert and use not to exceed 300 acre-feet of water from an existing dam and reservoir (Shadowood Lake) on an unnamed tributary of Deboldin Creek, Cypress Creek Basin within a period of three years for mining purposes in Harrison County. The application and fees were received on February 28, 2011. Additional information was received on June 20, July 29, and August 8, 2011. The application was declared administratively complete and accepted for filing with the Office of the Chief Clerk on August 16, 2011. The Executive Director completed the technical review of the application and prepared a draft permit. The draft permit, if granted, would include special conditions including, but not limited to streamflow restrictions. The application, technical memoranda, and Executive Director's draft permit are available for viewing and copying at the Office of the Chief Clerk, 12100 Park 35 Circle, Building F, Austin, Texas 78753. Written public comments and requests for a public meeting should be submitted to the Office of Chief Clerk, at the address provided in the information section below, by July 19, 2012.

INFORMATION SECTION

To view the complete issued notice, view the notice on our web site at www.tceq.texas.gov/comm_exec/cc/pub_notice.html or call the Office of the Chief Clerk at (512) 239-3300 to obtain a copy of the complete notice. When searching the web site, type in the issued date range shown at the top of this document to obtain search results.

A public meeting is intended for the taking of public comment, and is not a contested case hearing.

The Executive Director can consider approval of an application unless a written request for a contested case hearing is filed. To request a contested case hearing, you must submit the following: (1) your name (or for a group or association, an official representative), mailing address, daytime phone number, and fax number, if any; (2) applicant's name and permit number; (3) the statement [I/we] request a contested case hearing; and (4) a brief and specific description of how you would be affected by the application in a way not common to the general public. You may also submit any proposed conditions to the requested application which would satisfy your concerns. Requests for a contested case hearing must be submitted in writing to the TCEQ Office of the Chief Clerk at the address provided below.

If a hearing request is filed, the Executive Director will not issue the requested permit and may forward the application and hearing request to the TCEQ Commissioners for their consideration at a scheduled Commission meeting.

Written hearing requests, public comments or requests for a public meeting should be submitted to the Office of the Chief Clerk, MC 105, TCEQ, P.O. Box 13087, Austin, Texas 78711-3087. For information concerning the hearing process, please contact the Public Interest Counsel, MC 103, at the same address. For additional information, individual members of the general public may contact the Office of Public Assistance at 1-800-687-4040. General information regarding the TCEQ can be found at our web site at www.tceq.texas.gov. Si desea información en español, puede llamar al 1-800-687-4040.

TRD-201203579

Bridget C. Bohac
Chief Clerk
Texas Commission on Environmental Quality
Filed: July 11, 2012

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Texas Facilities Commission

Request for Proposal #303-4-20343

The Texas Facilities Commission (TFC), on behalf of the Comptroller of Public Accounts (CPA), announces the issuance of Request for Proposal (RFP) #303-4-20343. TFC seeks a five (5) or ten (10) year lease of approximately 4,004 square feet of office space in Fort Worth, Tarrant County, Texas.

The deadline for questions is July 25, 2012, and the deadline for proposals is August 1, 2012, at 3:00 p.m. The award date is September 1, 2012. TFC reserves the right to accept or reject any or all proposals submitted. TFC is under no legal or other obligation to execute a lease on the basis of this notice or the distribution of a RFP. Neither this notice nor the RFP commits TFC to pay for any costs incurred prior to the award of a grant.

Parties interested in submitting a proposal may obtain information by contacting the Regional Leasing Assistant, Evelyn Esquivel, at (512) 463-6494. A copy of the RFP may be downloaded from the Electronic State Business Daily at *http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=101263.*

TRD-201203511
Kay Molina
General Counsel
Texas Facilities Commission
Filed: July 6, 2012

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Texas Health and Human Services Commission

Notice of Adopted Nursing Facility Payment Rates for State Veterans Homes

Adopted Rates. As the single state agency for the state Medicaid program, the Texas Health and Human Services Commission (HHSC) adopts the following per day payment rates for the state-owned veterans nursing facilities effective March 1, 2012: Big Spring, $146.00; Bonham, $146.00; Floresville, $146.00; Temple, $146.00; McAllen, $146.00; El Paso, $146.00; and Amarillo, $146.00.

HHSC conducted a public hearing to receive public comment on the proposed payment rates for state-owned veterans homes in the nursing facility program operated by the Texas Department of Aging and Disability Services. There were no comments received during this hearing. The hearing was held in compliance with 1 Texas Administrative Code (TAC) §355.105(g), which requires public hearings on proposed payment rates. The public hearing was held on June 21, 2012, at 1:00 p.m. in the Permian Basin Conference Room of Building H, Braker Center, at 11209 Metric Boulevard, Austin, Texas 78758-4021.

Methodology and Justification. The adopted rates were determined in accordance with the rate reimbursement setting methodology at 1 TAC §355.311.

TRD-201203501
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: July 5, 2012

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Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on Wednesday, August 8, 2012, at 10:30 a.m. to receive public comment on proposed interim per diem Medicaid reimbursement rates for small and large, state-operated Intermediate Care Facilities for Individuals who are Intellectually Disabled (ICFs/IID) operated by the Texas Department of Aging and Disability Services (DADS).

The hearing will be held in compliance with Human Resources Code §32.0282 and 1 Texas Administrative Code (TAC) §355.105(g), which require public notice and hearings on proposed Medicaid reimbursements before such rates are approved by HHSC. The public hearing will be held in the Lone Star Conference Room of the Texas Health and Human Services Commission, Braker Center, Building H, located at 11209 Metric Boulevard, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Metric Boulevard. Persons requiring Americans with Disability Act (ADA) accommodation or auxiliary aids or services should contact Esther Brown by calling (512) 491-1445, at least 72 hours prior to the hearing so appropriate arrangements can be made.

Proposal. As the single state agency for the state Medicaid program, HHSC proposes the following interim reimbursement rates for small and large state-operated ICFs/IID operated by DADS. The proposed rates will be effective September 1, 2012, and were determined in accordance with the rate setting methodology listed below under "Methodology and Justification."

Small State-Operated ICFs/IID Proposed interim daily rate: $625.18

Large State-Operated ICFs/IID - Medicaid Only clients Proposed interim daily rate: $656.00

Large State-Operated ICFs/IID - Dual-eligible Medicaid/Medicare clients Proposed interim daily rate: $634.26

HHSC is proposing these interim rates so that adequate funds will be available to serve clients in these facilities. The proposed interim rates account for actual and projected increases in costs to operate these facilities.

Methodology and Justification. The proposed rates were determined in accordance with the rate setting methodologies codified at 1 TAC Chapter 355, Subchapter D, §355.456(e), relating to Reimbursement Methodology.

Briefing Package. A briefing package describing the proposed payment rates will be available at http://www.hhsc.state.tx.us/rad/rate-packets.shtml on July 25, 2012. Interested parties also may obtain a copy of the briefing package prior to the hearing by contacting Esther Brown by telephone at (512) 491-1445; by fax at (512) 491-1998; or by e-mail at Esther.Brown@hhsc.state.tx.us. The briefing package also will be available at the public hearing.

Written Comments. Written comments regarding the proposed payment rates may be submitted in lieu of, or in addition to, oral testimony until 5:00 p.m. the day of the hearing. Written comments may be sent by U.S. mail to the attention of Esther Brown, Texas Health and Human Services Commission, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Esther Brown at (512) 491-1998; or by e-mail to Esther.Brown@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to Esther Brown, HHSC, Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

TRD-201203583
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: July 11, 2012

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Public Notice

The Texas Health and Human Services Commission (HHSC) announces its intent to submit an amendment to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The proposed amendment is effective October 1, 2012.

The amendment will modify the reimbursement methodology in the State Plan for Nursing Facilities (NFs) to add a methodology for supplemental payments for non-state government-owned NFs. This change is being made to allow non-state government-owned NFs the option of accessing additional funding through supplemental payments.

The proposed amendment is estimated to result in annual aggregate expenses of $16,640,978 for federal fiscal year (FFY) 2013, with approximately $9,853,123 in federal funds and $6,787,855 in intergovernmental transfers from non-state governmental entities. Estimated aggregate expenses for FFY 2014 and FFY 2015 are equal to those for FFY 2013.

Interested parties may obtain copies of the proposed amendment by contacting Pam McDonald, Director of Rate Analysis, by mail at the Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, H-400, Austin, Texas 78708-5200; by telephone at (512) 491-1373; by facsimile at (512) 491-1998; or by e-mail at pam.mcdonald@hhsc.state.tx.us. Copies of the proposal will also be made available for public review at the local offices of the Texas Department of Aging and Disability Services.

TRD-201203500
Steve Aragon
Chief Counsel
Texas Health and Human Services Commission
Filed: July 5, 2012

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Department of State Health Services

Licensing Actions for Radioactive Materials

The Department of State Health Services has taken actions regarding Licenses for the possession and use of radioactive materials as listed in the tables. The subheading "Location" indicates the city in which the radioactive material may be possessed and/or used. The location listing "Throughout TX" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Fort Worth	Texas Health Harris Methodist Hospital Alliance	L06484	Fort Worth	00	06/22/12
Harker Heights	HH/Killeen Health System, L.L.C. dba Seton Medical Center Harker Heights	L06481	Harker Heights	00	06/18/12
Plano	Texas Health Resources dba Heart First	L06480	Plano	00	06/18/12
San Antonio	BHS Specialty Network, Inc. dba Heart and Vascular Institute of Texas	L06482	San Antonio	00	06/19/12
San Antonio	Heart and Vascular Clinic of San Antonio, P.L.L.C.	L06485	San Antonio	00	06/22/12

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Andrews	Waste Control Specialists, L.L.C.	L06153	Andrews	04	06/14/12
Angleton	Isotherapeutics Group, L.L.C.	L05969	Angleton	21	06/15/12
Arlington	Columbia Medical Center of Arlington Subsidiary, L.P. dba Medical Center of Arlington	L02228	Arlington	75	06/26/12
Arlington	Cardiology Partners, L.L.P.	L05999	Arlington	03	06/15/12
Austin	Seton Family of Hospitals dba University Medical Center at Brackenridge	L00268	Austin	120	06/26/12
Austin	Seton Family of Hospitals dba Seton Medical Center Austin	L02896	Austin	129	06/27/12
Austin	Seton Family of Hospitals dba Dell Children's Medical Center of Central Texas	L06065	Austin	26	06/26/12
Austin	Seton Family of Hospitals dba Seton Medical Center Williamson	L06128	Austin	20	06/27/12
Austin	Seton Family of Hospitals dba Seton Medical Center Hays	L06254	Austin	12	06/27/12
Baytown	Chevron Phillips Chemical Company, L.P.	L00962	Baytown	42	06/27/12
Beaumont	Christus Health Southeast Texas dba Christus Hospital - St. Elizabeth	L00269	Beaumont	113	06/26/12
Beaumont	Baptist Hospital of Southeast Texas	L00358	Beaumont	134	06/15/12
Brownsville	Heart Institute of Brownsville	L05261	Brownsville	10	06/27/12
Burnet	Seton Family of Hospitals dba Seton Highland Lakes Hospital	L03515	Burnet	48	06/26/12
Cameron	DMS Health Technologies, Inc.	L05594	Cameron	16	06/22/12
Conroe	CHCA Conroe, L.P. dba Conroe Regional Medical Center	L01769	Conroe	88	06/18/12
Corpus Christi	Cardinal Health	L04043	Corpus Christi	44	06/27/12
Cypress	North Cypress Medical Center Operating Company, L.L.C. dba North Cypress Medical Center	L06020	Cypress	22	06/29/12
Dallas	Texas Health Presbyterian Hospital Dallas	L01586	Dallas	100	06/22/12
Dallas	Medical City Dallas Hospital dba Medical City	L01976	Dallas	190	06/27/12
Dallas	Animal Radiology Clinic, P.L.L.C.	L03535	Dallas	24	06/19/12

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED):

Location	Name	License #	City	Amend-ment #	Date of Action
Denton	Columbia Medical Center of Denton Subsidiary, L.P. dba Denton Regional Medical Center	L02764	Denton	68	06/29/12
Denton	Texas Health Presbyterian Hospital Denton	L04003	Denton	47	06/29/12
Dumas	Moore County Hospital District dba Memorial Hospital	L03540	Dumas	29	06/18/12
El Paso	Cardiology Care Consultants	L05045	El Paso	12	06/28/12
Fort Worth	Baylor All Saints Medical Center Radiology Department	L02212	Fort Worth	88	06/25/12
Fort Worth	Physician Reliance, L.P. dba Texas Oncology at Klabzuba	L05545	Fort Worth	44	06/22/12
Fort Worth	University of North Texas Health Science Center dba UNT Health	L06123	Fort Worth	04	06/25/12
Fort Worth	Gorrondona & Associates, Inc.	L06359	Fort Worth	04	06/19/12
Greenville	Hunt Memorial Hospital District dba Hunt Regional Medical Center	L01695	Greenville	46	06/21/12
Houston	Baylor College of Medicine	L00680	Houston	107	06/26/12
Houston	Cardinal Health	L01911	Houston	149	06/26/12
Houston	The University of Texas Health Science Center at Houston	L02774	Houston	62	06/26/12
Houston	Institute of Biosciences and Technology	L04681	Houston	35	06/27/12
Houston	NIS Holdings, Inc. dba Nuclear Imaging Services	L05775	Houston	81	06/22/12
Houston	University General Hospital, L.P.	L06018	Houston	07	06/20/12
Houston	CHCA West Houston, L.P. dba West Houston Medical Center	L06055	Houston	13	06/26/12
Houston	Sightline West Houston IMRT, L.L.C. dba Sightline West Houston	L06299	Houston	07	06/18/12
Houston	Amerapex Corporation	L06417	Houston	04	06/26/12
Houston	Memorial Hermann Medical Group	L06430	Houston	05	06/22/12
Houston	Baker Hughes Oilfield Operations, Inc.	L06453	Houston	02	06/27/12
Irving	Baylor Medical Center at Irving dba Irving Healthcare System	L02444	Irving	94	06/15/12
Jacksonville	East Texas Medical Center Jacksonville	L00169	Jacksonville	42	06/26/12
La Grange	St. Mark's Medical Center	L03572	La Grange	26	06/18/12
Laredo	Laredo Texas Hospital Company, L.P. dba Laredo Medical Center	L01306	Laredo	73	06/18/12
Laredo	Laredo Texas Hospital Company, L.P. dba Laredo Medical Center	L01306	Laredo	74	06/20/12
Lewisville	Columbia Medical Center of Lewisville Subsidiary, L.P. dba Medical Center of Lewisville	L02739	Lewisville	60	06/28/12
Lewisville	Cardiovascular Specialists, P.A.	L05507	Lewisville	19	06/26/12
Midlothian	Holcim (Texas), L.P.	L05888	Midlothian	10	06/20/12
Palestine	Techcorr USA, L.L.C. dba AUT Specialists, L.L.C.	L05972	Palestine	91	06/27/12
Plainview	Methodist Hospital Plainview dba Covenant Hospital Plainview	L02493	Plainview	32	06/27/12
San Antonio	Methodist Healthcare System of San Antonio Ltd., L.L.P.	L00594	San Antonio	305	06/20/12
San Antonio	The University of Texas Health Science Center at San Antonio	L01279	San Antonio	139	06/22/12
San Antonio	South Texas Cardiovascular Consultants, P.L.L.C.	L03833	San Antonio	36	06/20/12
San Antonio	Petnet Solutions, Inc.	L05569	San Antonio	24	06/27/12

AMENDMENTS TO EXISTING LICENSES ISSUED (CONTINUED):

Location	Name	License #	City	Amend-ment #	Date of Action
San Antonio	Jeremy Nyle Wiersig, M.D., P.A. dba Concord Imaging	L05915	San Antonio	08	06/22/12
San Marcos	Adventist Health System/Sunbelt, Inc. dba Central Texas Medical Center	L03133	San Marcos	26	06/29/12
Sherman	Texas Oncology, P.A. dba North Texas PET Imaging	L05502	Sherman	15	06/22/12
Temple	Texas A&M University System Health Science Center	L05494	Temple	17	06/27/12
The Woodlands	Memorial Hermann Hospital System dba Memorial Hermann Hospital The Woodlands	L03772	The Woodlands	96	06/22/12
Throughout TX	Statewide Maintenance Company dba Diamond G Inspection, Inc.	L06229	Houston	06	06/27/12
Throughout TX	Enviroklean Product Development, Inc.	L06350	Houston	04	06/21/12
Throughout TX	Advanced Inspection Technologies, L.L.C.	L06423	Spring	05	06/26/12
Tyler	Mother Frances Hospital Regional Health Care Center	L01670	Tyler	176	06/28/12

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Houston	Mohammed Attar, M.D., P.A.	L05615	Houston	06	06/28/12
Kingsville	Texas A&M University Kingsville	L01821	Kingsville	47	06/29/12
Lubbock	Ayman Karkoutly, M.D., P.A.	L05506	Lubbock	04	06/22/12
Throughout TX	City of Lubbock	L01735	Lubbock	38	06/18/12
Throughout TX	Port Arthur	L04677	Port Arthur	09	06/20/12

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
San Antonio	Heart and Vascular Institute of Texas	L04799	San Antonio	24	06/19/12

In issuing new licenses, amending and renewing existing licenses, or approving license exemptions, the Department of State Health Services (department), Radiation Safety Licensing Branch, has determined that the applicant has complied with the applicable provisions of 25 Texas Administrative Code (TAC) Chapter 289 regarding radiation control. In granting termination of licenses, the department has determined that the licensee has complied with the applicable decommissioning requirements of 25 TAC Chapter 289. In denying the application for a license, license renewal or license amendment, the department has determined that the applicant has not met the applicable requirements of 25 TAC Chapter 289.

This notice affords the opportunity for a hearing on written request of a person affected within 30 days of the date of publication of this notice. A person affected is defined as a person who demonstrates that the person has suffered or will suffer actual injury or economic damage and, if the person is not a local government, is (a) a resident of a county, or a county adjacent to the county, in which radioactive material is or will be located, or (b) doing business or has a legal interest in land in the county or adjacent county. A person affected may request a hearing by writing Richard A. Ratliff, Radiation Program Officer, Department of State Health Services, Radiation Material Licensing - Mail Code 2835, P.O. Box 149347, Austin, Texas 78714-9347. For information call (512) 834-6688.

TRD-201203533
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: July 9, 2012

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Texas Department of Insurance

Company Licensing

Application for admission to the State of Texas by GUARANTEE SECURITY LIFE INSURANCE COMPANY OF ARIZONA, a foreign

life, accident and/or health company. The home office is in Scottsdale, Arizona.

Application to change the name of GUARANTEE SECURITY LIFE INSURANCE COMPANY OF ARIZONA to EVERGREEN LIFE INSURANCE COMPANY, a foreign life, accident and/or health company pending admission to Texas.

Any objections must be filed with the Texas Department of Insurance, within twenty (20) calendar days from the date of the *Texas Register* publication, addressed to the attention of Godwin Ohaechesi, 333 Guadalupe Street, MC 305-2C, Austin, Texas 78701.

TRD-201203584
Sara Waitt
General Counsel
Texas Department of Insurance
Filed: July 11, 2012

♦ ♦ ♦

Correction of Error

The Texas Department of Insurance proposed amendments to 28 TAC §§3.3701 - 3.3710 and new 28 TAC §§3.3720 - 3.3725 in the June 29, 2012, issue of the *Texas Register* (37 TexReg 4783).

On page 4788, the preamble contained an error in the fourth sentence of the paragraph describing new §3.3725(c). The word "not" was omitted before the word "applicable." The corrected sentence should read as follows:

"If the insured selects a nonpreferred provider that is not included in the list provided by the insurer, then §3.3725(d) -(f) are not applicable and, notwithstanding §3.3708(e), the insurer must pay the claim in accordance with §3.3708."

TRD-201203572

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Texas Department of Licensing and Regulation

Public Notice - Deadline Extended for Public Comments

In the June 8, 2012, issue of the *Texas Register* (37 TexReg 4145), the Texas Department of Licensing and Regulation filed a proposed amendment to an existing rule at 16 Texas Administrative Code Chapter 83, §83.25, regarding the cosmetology program.

The deadline for receipt of public comments in response to the rule proposal was originally set for July 9, 2012. This notice is to extend the public comment period to 5:00 p.m. on August 10, 2012.

Any questions or written comments pertaining to the proposed rule amendment may be submitted by mail to Shanna Ducros, Legal Assistant, General Counsel's Office, Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711, or by facsimile to (512) 475-3032, or electronically to erule.comments@license.state.tx.us.

TRD-201203574
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Filed: July 11, 2012

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Public Notice - Revised Enforcement Plan

The Texas Commission of Licensing and Regulation (Commission) provides this public notice that at their regularly scheduled meeting held May 29 and 30, 2012, the Commission adopted the Texas Department of Licensing and Regulation's (Department) revised enforcement plan which was established in compliance with Texas Occupations Code, §51.302(c).

The enforcement plan gives all license holders notice of the specific ranges of penalties and license sanctions that apply to specific alleged violations of the statutes and rules enforced by the Department. The enforcement plan also presents the criteria that are considered by the Department's Enforcement staff in determining the amount of a proposed administrative penalty or the magnitude of a proposed sanction.

The enforcement plan is revised to update penalty matrices for the Air Conditioning and Refrigeration and Barber programs, and to adopt an original penalty matrix for the Property Tax Professionals program. Acts of the 81st Legislature, House Bill 2310 amended Texas Occupations Code, Chapter 51, the Department's enabling statute, which required changes to Texas Administrative Code, Title 16, Procedural Rules of the Commission and the Department. One of the changes in the rules was to renumber the sections regarding cheating on exams and fraud in seeking to obtain a license in both the Air Conditioning and Refrigeration and Barber programs, which are Class C and Class H violations, respectively, referenced in the Enforcement Plan. The penalty matrix for the Air Conditioning and Refrigeration program was updated to reflect updates from the 80th Legislature, House Bill 463, which added technician registration requirements, and from the 82nd Legislature, House Bill 2643, which clarified responsibilities of contractors and technicians. The penalty matrix for the Barber program was also updated to reflect changes from the 80th Legislature, House Bill 2106, which created dual shop and mobile shop licenses, hair weaving and hair braiding specialties, and clarified each of the eligibility statutes. Additionally, the Commission adopted an original penalty matrix for the Property Tax Professionals program, which was transferred to the Department by the 81st Legislature, House Bill 2447, in 2009.

A copy of the revised enforcement plan is posted on the Department's website and may be downloaded at www.license.state.tx.us. You may also contact the Enforcement Division at (512) 539-5600 or by e-mail at enforcement@license.state.tx.us to obtain a copy of the revised plan.

TRD-201203573
William H. Kuntz, Jr.
Executive Director
Texas Department of Licensing and Regulation
Filed: July 11, 2012

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Public Utility Commission of Texas

Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 3, 2012, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Allegiance Communications, LLC to Amend its State-Issued Certificate of Franchise Authority, Project Number 40532.

The requested amendment is to expand its service area footprint to include the municipalities of New Boston and Winters, Texas, as defined on the map attached to the application.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888)

782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 40532.

TRD-201203506
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 3, 2012, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Friendship Cable of Texas, Inc. d/b/a Suddenlink Communications to Amend its State-Issued Certificate of Franchise Authority; Add Unincorporated Areas of Houston, McCulloch, San Saba, Sutton, and Upshur Counties, Project Number 40533.

The requested amendment is to expand its service area footprint to include the unincorporated areas of Houston, McCulloch, San Saba, Sutton, and Upshur counties, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 40533.

TRD-201203507
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 3, 2012, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Cebridge Acquisition, L.P. d/b/a Suddenlink Communications to Amend its State-Issued Certificate of Franchise Authority, Project Number 40534.

The requested amendment is to include the unincorporated areas of Abilene, Coryell, Red River, and Van Zandt Counties.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 40534.

TRD-201203508
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 3, 2012, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Universal Cable Holdings, Inc. d/b/a Suddenlink Communications to Amend its State-Issued Certificate of Franchise Authority; unincorporated areas of Reagan County, Texas, Project Number 40535.

The requested amendment is to expand the service area footprint to include the unincorporated areas of Reagan County, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 40535.

TRD-201203509
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Announcement of Application for Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on July 3, 2012, to amend a state-issued certificate of franchise authority (CFA), pursuant to §§66.001 - 66.016 of the Public Utility Regulatory Act (PURA).

Project Title and Number: Application of Cequel III Communications I, LLC d/b/a Suddenlink Communications to Amend its State-Issued Certificate of Franchise Authority; unincorporated areas of Grimes County, Project Number 40536.

The requested amendment is to expand the service area footprint to include the unincorporated area of Grimes County, Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Project Number 40536.

TRD-201203510
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Notice of Application for Retail Electric Provider Certification

Notice is given to the public of the filing with the Public Utility Commission of Texas of an application on July 2, 2012, for retail electric provider (REP) certification, pursuant to §39.352 of the Public Utility Regulatory Act (PURA).

Docket Title and Number: Application of V247 Power Corporation for Retail Electric Provider Certification, Docket Number 40529.

Applicant's requested service area is for the geographic area of the entire state of Texas.

Information on the application may be obtained by contacting the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll free) (800) 735-2989. All inquiries should reference Docket Number 40529.

TRD-201203505
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Notice of ERCOT Filing Accounting of the Costs and Revenues of Implementing the Nodal Market

Notice is hereby given to the public of the July 2, 2012, filing with the Public Utility Commission of Texas (commission) of the Electric Reliability Council of Texas, Inc. (ERCOT) an accounting of the costs and revenues of implementing the nodal market.

Docket Style and Number: Electric Reliability Council of Texas, Inc. Accounting of the Costs and Revenues of Implementing the Nodal Market, Docket Number 40524.

The Application: ERCOT filed an accounting of the costs and revenues of implementing the nodal market pursuant to commission orders in Docket Numbers 32686, 36851, 38840, and 39865. In addition, ERCOT also included information required by settlement agreements and commission orders in the above-referenced nodal program funding proceedings.

This is the first of two nodal accounting compliance filings. ERCOT will file the second part of its nodal accounting within 12 months after ERCOT stops collecting the nodal surcharge. In this application, ERCOT seeks commission approval that ERCOT has complied with prior commission orders requiring the submission of this accounting of nodal costs and revenues. ERCOT does not propose any change in the amount of the nodal surcharge or in the manner or timing of its collection.

Persons wishing to intervene or comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll-free at (888) 782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) (800) 735-2989. All comments should reference Docket Number 40524.

TRD-201203504
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 6, 2012

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Notice of Petition for Adjustments to Universal Service Plan

Notice is given to the public of a petition filed with the Public Utility Commission of Texas on June 28, 2012.

Docket Style and Number: Adjustments to Support from the Small and Rural Incumbent Local Exchange Company Universal Service Plan Pursuant to Public Utility Regulatory Act §56.032. Docket Number 40447.

The Application: The staff of the Public Utility Commission of Texas (commission) filed a petition for adjustments to support from the Small and Rural Incumbent Local Exchange Company Universal Service Plan (the plan) to small and rural incumbent local exchange companies pursuant to Public Utility Regulatory Act §56.032 and House Bill 2603 of the 82nd Regular Session of the Texas Legislature.

In Docket Number 39643, *Adjustments to Support from the Small and Rural Incumbent Local Exchange Company Universal Service Plan Pursuant to PURA §56.032* (October 3, 2011), the commission established a procedure for calculation of the initial monthly support amounts from the plan. This instant docket is an annual update to the amounts established in Docket Number 39643 pursuant to Public Utility Regulatory Act §56.032(d)(2). The purpose of this petition is to update the amount of support for eligible small and rural incumbent local exchange companies (ILECs) for the 12-month period following the initial 12-month period established in Docket Number 39643.

Persons who wish to intervene in the proceeding or comment upon the action sought should contact the Public Utility Commission of Texas, P.O. Box 13326, Austin, Texas 78711-3326. Hearing-and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or use Relay Texas (toll-free) (800) 735-2989. The deadline to file comments and the deadline to request to intervene is August 10, 2012. All correspondence should refer to Docket Number 40447.

TRD-201203539
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: July 10, 2012

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Texas Department of Transportation

Aviation Division - Second Request for Proposal for Professional Engineering Services

The City of Castroville, through its agent the Texas Department of Transportation (TxDOT), intends to engage an aviation professional engineering firm for services pursuant to Government Code, Chapter 2254, Subchapter A. TxDOT Aviation Division will solicit and receive proposals for professional aviation engineering design services described below.

The following is a listing of proposed projects at the Castroville Municipal Airport during the course of the next five years through multiple grants.

Current Project: City of Castroville.

TxDOT CSJ No.: 1215CASTR.

Scope: Provide engineering/design services to construct a multi-unit Hangar Complex with common walls, including pavement.

The DBE goal for the current project is **11 percent.** The TxDOT Project Manager is Ed Mayle.

Future scope of work items for engineering/design services within the next five years may include the following:

1. Rehabilitate and mark Runway 15-33
2. Rehabilitate and mark parallel Taxiway Runway 15-33
3. Rehabilitate and mark hangar access Taxiways
4. Reconstruct hangar access Taxiways
5. Rehabilitate and mark stub Taxiway
6. Rehabilitate Apron
7. MIRL, Signage, Vault upgrades/improvements
8. Install fence

The City of Castroville reserves the right to determine which of the above scope of services may or may not be awarded to the successful firm and to initiate additional procurement action for any of the services above.

To assist in your proposal preparation, the criteria, 5010 drawing, project diagram, and most recent Airport Layout Plan are available online at www.txdot.gov/avn/avninfo/notice/consult/index.htm by selecting "Castroville Municipal Airport." The proposal should address a technical approach for the current scope only. Firms shall use page 4, Recent Airport Experience, to list relevant past projects for both current and future scope.

Interested firms shall utilize the latest version of Form AVN-550, titled "Aviation Engineering Services Proposal." The form may be requested from TxDOT Aviation Division, 125 East 11th Street, Austin, Texas 78701-2483, telephone number, 1-800-68-PILOT (74568). The form may be emailed by request or downloaded from the TxDOT website at http://www.txdot.gov/business/projects/aviation.htm. The form may not be altered in any way. All printing must be in black on white paper, except for the optional illustration page. Firms must carefully follow the instructions provided on each page of the form. Proposals may not exceed the number of pages in the proposal format. The proposal format consists of seven pages of data plus two optional pages consisting of an illustration page and a proposal summary page. A prime provider may only submit one proposal. If a prime provider submits more than one proposal, that provider will be disqualified. Proposals shall be stapled but not bound in any other fashion. PROPOSALS WILL NOT BE ACCEPTED IN ANY OTHER FORMAT.

ATTENTION: To ensure utilization of the latest version of Form AVN-550, firms are encouraged to download Form AVN-550 from the TxDOT website as addressed above. Utilization of Form AVN-550 from a previous download may not be the exact same format. Form AVN-550 is a PDF Template.

Please note:

FIVE completed copies of Form AVN-550 **must be received** by TxDOT Aviation Division at 150 East Riverside Drive, 5th Floor, South Tower, Austin, Texas 78704 no later than **August 14, 2012, 4:00 p.m.** Electronic facsimiles or forms sent by email will not be accepted. Please mark the envelope of the forms to the attention of Beverly Longfellow.

The consultant selection committee will be composed of Aviation Division staff members and one local Sponsor member. The final selection by the committee will generally be made following the completion of review of proposals. The committee will review all proposals and rate and rank each. The Evaluation Criteria for Engineering Proposals can be found at http://www.txdot.gov/business/projects/aviation.htm under the Notice to Consultants link. All firms will be notified and the top rated firm will be contacted to begin fee negotiations. The selection committee does, however, reserve the right to conduct interviews for the top rated firms if the committee deems it necessary. If interviews are conducted, selection will be made following interviews.

Please contact TxDOT Aviation for any technical or procedural questions at 1-800-68-PILOT (74568). For procedural questions, please contact Beverly Longfellow, Grant Manager. For technical questions, please contact Ed Mayle, TxDOT Project Manager.

TRD-201203534
Bob Jackson
General Counsel
Texas Department of Transportation
Filed: July 9, 2012

Public Hearing Notice - Unified Transportation Program and Statewide Transportation Improvement Program

The Texas Department of Transportation (department) will hold a joint public hearing on Wednesday, August 15, 2012, at 10:00 a.m. at 200 East Riverside Drive, Room 1A-2, in Austin, Texas, to receive public comments on the proposed updates to the 2012 Unified Transportation Program (UTP) and 2013 UTP and the proposed 2013-2016 Statewide Transportation Improvement Program (STIP).

The UTP is a 10-year program that guides the development and authorizes construction of transportation projects and projects involving aviation, public transportation, and the state's waterways and coastal waters. The Texas Transportation Commission has adopted rules located in the 43 Texas Administrative Code Chapter 16, governing the planning and development of transportation projects, which include guidance regarding public involvement related to adoption of the UTP and approval of any updates to the program.

The STIP reflects the federally funded transportation projects in the FY 2013-2016 Transportation Improvement Programs (TIPs) for each Metropolitan Planning Organization (MPO) in the state. The STIP includes both state and federally funded projects for the nonattainment areas of Beaumont, Dallas-Fort Worth, El Paso, and Houston. The STIP also contains information on federally funded projects in rural areas that are not included in any MPO area, and other statewide programs as listed.

United States Code, Title 23, §134 and §135 require each designated MPO and the state, respectively, to develop a TIP and STIP as a condition to securing federal funds for transportation projects under Title 23 or the Federal Transit Act (49 U.S.C. §5301, et seq.). Section 134(j) requires an MPO to develop its TIP in cooperation with the state and affected public transit operators and to provide an opportunity for interested parties to participate in the development of the program. Section 135(g) requires the state to develop a STIP for all areas of the state in cooperation with the designated MPOs and, with respect to non-metropolitan areas, in consultation with affected local officials, and further requires an opportunity for participation by interested parties as well as approval by the Governor or the Governor's designee.

Information regarding the proposed updates to the 2012 UTP and the 2013 UTP will be available at each of the department's district offices, at the department's Transportation Planning and Programming Division offices located in Building 118, Second Floor, 118 East Riverside Drive, Austin, Texas, or (512) 486-5043, and on the department's website at: http://www.txdot.gov/public_involvement/utp.htm.

A copy of the proposed FY 2013-2016 STIP will be available for review, at the time the notice of hearing is published, at each of the department's district offices, at the department's Transportation Planning and Programming Division offices located in Building 118, Second Floor,

118 East Riverside Drive, Austin, Texas, or (512) 486-5033, and on the department's website at: www.txdot.gov.

Persons wishing to speak at the hearing may register in advance by notifying David Plutowski, Transportation Planning and Programming Division, at (512) 486-5043 not later than Tuesday, August 14, 2012, or they may register at the hearing location beginning at 9:00 a.m. on the day of the hearing. Speakers will be taken in the order registered. Any interested person may appear and offer comments or testimony, either orally or in writing; however, questioning of witnesses will be reserved exclusively to the presiding authority as may be necessary to ensure a complete record. While any persons with pertinent comments or testimony will be granted an opportunity to present them during the course of the hearing, the presiding authority reserves the right to restrict testimony in terms of time or repetitive content. Groups, organizations, or associations should be represented by only one speaker. Speakers are requested to refrain from repeating previously presented testimony. Persons with disabilities who have special communication or accommodation needs or who plan to attend the hearing may contact the Transportation Planning and Programming Division, at 118 East Riverside Drive Austin, Texas 78704-1205, (512) 486-5038. Requests should be made no later than three days prior to the hearing. Every reasonable effort will be made to accommodate the needs.

Interested parties who are unable to attend the hearing may submit comments regarding the proposed updates to the 2012 UTP and the 2013 UTP and the proposed FY 2013-2016 STIP to Marc D. Williams, Director of Planning, P.O. Box 149217, Austin, Texas 78714-9217. Interested parties may also submit comments regarding the updates to the 2012 UTP and 2013 UTP by telephone at (800) 687-8108. In order to be considered, all comments must be received at the Transportation Planning and Programming office by 4:00 p.m. on Monday, August 20, 2012.

TRD-201203520
Bob Jackson
General Counsel
Texas Department of Transportation
Filed: July 9, 2012

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Rescission of Notice of Intent to Prepare a Supplemental Environmental Impact Statement - State Highway 71/United States Highway 290 West, Travis County, Texas

The Texas Department of Transportation (department), in cooperation with the Federal Highway Administration (FHWA), is issuing this notice that the notice of intent (NOI) to prepare a supplemental environmental impact statement (SEIS) for a proposed transportation project is being rescinded. On August 15, 2008, the department and FHWA announced their intent to prepare a limited-scope SEIS for proposed improvements to U.S. Highway 290 (US 290)/State Highway (SH) 71 West through Oak Hill, in Travis County, Texas. The improvements proposed between Ranch-to-Market Road (RM) 1826 and Joe Tanner Lane were originally considered in a final environmental impact statement (FEIS) covering improvements to SH 71/US 290 from RM 1826 to Farm-to-Market Road (FM) 973. A Record of Decision (ROD) was issued by FHWA on August 22, 1988. The mid-section of the original project limits, between Joe Tanner Lane and Riverside Drive, has been constructed. The limited-scope SEIS for the western section of the original project would have evaluated potential impacts resulting from changes in funding mechanisms, changes in adjacent land use, State and Federal listing of the Barton Springs salamander as endangered, public input, and proposed design modifications since the issuance of the ROD.

The department and FHWA have decided to rescind the NOI to prepare an SEIS for US 290/SH 71 West through Oak Hill from RM 1826 to Joe Tanner Lane. The project was placed on hold in 2008 due to the limited availability of funds and local planning priorities. The SEIS was in the preliminary stages of development. The FHWA has determined that a new environmental impact statement would be required to evaluate potential impacts.

Agency Contact: Comments or questions concerning this proposed action should be sent to Carlos Swonke, Director, Environmental Affairs Division, Texas Department of Transportation, 125 East 11th Street, Austin, Texas 78701-2483; telephone (512) 416-3001.

TRD-201203535
Bob Jackson
General Counsel
Texas Department of Transportation
Filed: July 9, 2012

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Texas Water Development Board

Applications for July 2012

Pursuant to Texas Water Code §6.195, the Texas Water Development Board provides notice of the following applications:

Project ID #73638, a request from the City of Brady, P.O. Box 351, Brady, Texas 76825, received January 17, 2012, for financial assistance in the amount of $2,651,990 consisting of a loan in the amount of $1,210,000 and $1,441,990 in loan forgiveness from the Clean Water State Revolving Fund to finance planning, acquisition and design costs related to water system improvements.

Project ID #62519, a request from the City of Breckenridge, 105 N. Rose Avenue, Breckenridge, Texas 76424, received April 13, 2012, for financial assistance in the amount of $2,384,878 consisting of a loan in the amount of $1,680,000 and $704,878 in loan forgiveness from the Drinking Water State Revolving Fund to finance water system improvements, utilizing the pre-design commitment option.

Project ID #21717, a request from the City of Cumby, P.O. Box 349, Cumby, Texas 75433, received January 9, 2012, for financial assistance in the amount of $695,000 from the Texas Water Development Fund to finance water and wastewater system improvements, utilizing the pre-design funding option.

Project ID #73641, a request from the City of Grand Prairie, P.O. Box 534045, Grand Prairie, Texas 75053, received March 9, 2012, for financial assistance in the amount of $582,000 consisting of a loan in the amount of $495,000 and $87,000 in loan forgiveness from the Clean Water State Revolving Fund to finance costs related to wastewater system improvements, utilizing the pre-design funding option.

TRD-201203568
Kenneth Petersen
General Counsel
Texas Water Development Board
Filed: July 10, 2012

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Workforce Solutions Deep East Texas

Request for Quotes for Monitoring Services

Request for Quotes (RFQ) #12-303

The Deep East Texas Local Workforce Development Board dba Workforce Solutions Deep East Texas is seeking quotes from qualified enti-

ties for monitoring of subcontractors, which include child care services and the management and operation of the workforce centers in the Deep East Texas Workforce Development Area.

Qualified persons or entities will be knowledgeable of the Texas Workforce Network and Federal and Texas workforce legislation; and have experience in and qualifications for monitoring workforce boards fiscal and program operations.

The period of service will be October 1, 2012 through September 30, 2013. The contract may be renewed for twelve (12) months at a time for up to forty-eight (48) months, contingent upon satisfactory performance and Board approval. Additional information on the Board and the RFQ can be accessed at the Board's website www.detwork.org.

Requests for copies of the RFQ can be made to:

Darla Johnson, Procurement/Contract Manager

Workforce Solutions Deep East Texas

539 S. Chestnut, Suite 300

Lufkin, Texas 75901

Phone: (936) 639-8898

Fax: (936) 633-7491

E-mail: djohnson@detwork.org

OR

The RFQ can be accessed at www.detwork.org.

Deadline for submission of quotes: 3:00 p.m., August 1, 2012.

TRD-201203582
Charlene Meadows
Executive Director
Workforce Solutions Deep East Texas
Filed: July 11, 2012

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Open Meetings

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

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

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

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

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

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

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

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

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

How to Use the Texas Register

Information Available: The 14 sections of the ***Texas Register*** represent various facets of state government. Documents contained within them include:

Governor - Appointments, executive orders, and proclamations.

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

Secretary of State - opinions based on the election laws.

Texas Ethics Commission - summaries of requests for opinions and opinions.

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

Proposed Rules - sections proposed for adoption.

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

Adopted Rules - sections adopted following public comment period.

Texas Department of Insurance Exempt Filings - notices of actions taken by the Texas Department of Insurance pursuant to Chapter 5, Subchapter L of the Insurance Code.

Texas Department of Banking - opinions and exempt rules filed by the Texas Department of Banking.

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

Transferred Rules- notice that the Legislature has transferred rules within the *Texas Administrative Code* from one state agency to another, or directed the Secretary of State to remove the rules of an abolished agency.

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

Review of Agency Rules - notices of state agency rules review.

Specific explanation on the contents of each section can be found on the beginning page of the section. The division also publishes cumulative quarterly and annual indexes to aid in researching material published.

How to Cite: Material published in the ***Texas Register*** is referenced by citing the volume in which the document appears, the words "TexReg" and the beginning page number on which that document was published. For example, a document published on page 2402 of Volume 36 (2011) is cited as follows: 36 TexReg 2402.

In order that readers may cite material more easily, page numbers are now written as citations. Example: on page 2 in the lower-left hand corner of the page, would be written "36 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 36 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online at: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the internet. For website information, call the Texas Register at (512) 463-5561.

Texas Administrative Code

The ***Texas Administrative Code (TAC***) is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles and Parts (using Arabic numerals). The Titles are broad subject categories into which the agencies are grouped as a matter of convenience. Each Part represents an individual state agency.

The complete TAC is available through the Secretary of State's website at http://www.sos.state.tx.us/tac.

The following companies also provide complete copies of the TAC: Lexis-Nexis (800-356-6548), and West Publishing Company (800-328-9352).

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

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

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Index of Rules***. The *Index of Rules* is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register***. If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with the ***Texas Register*** page number and a notation indicating the type of filing (emergency, proposed, withdrawn, or adopted) as shown in the following example.

TITLE 1. ADMINISTRATION
Part 4. Office of the Secretary of State
Chapter 91. Texas Register
40 TAC §3.704.....950 *(P)*