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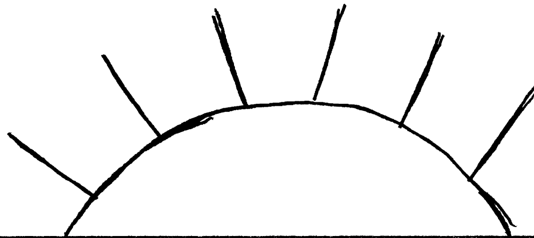
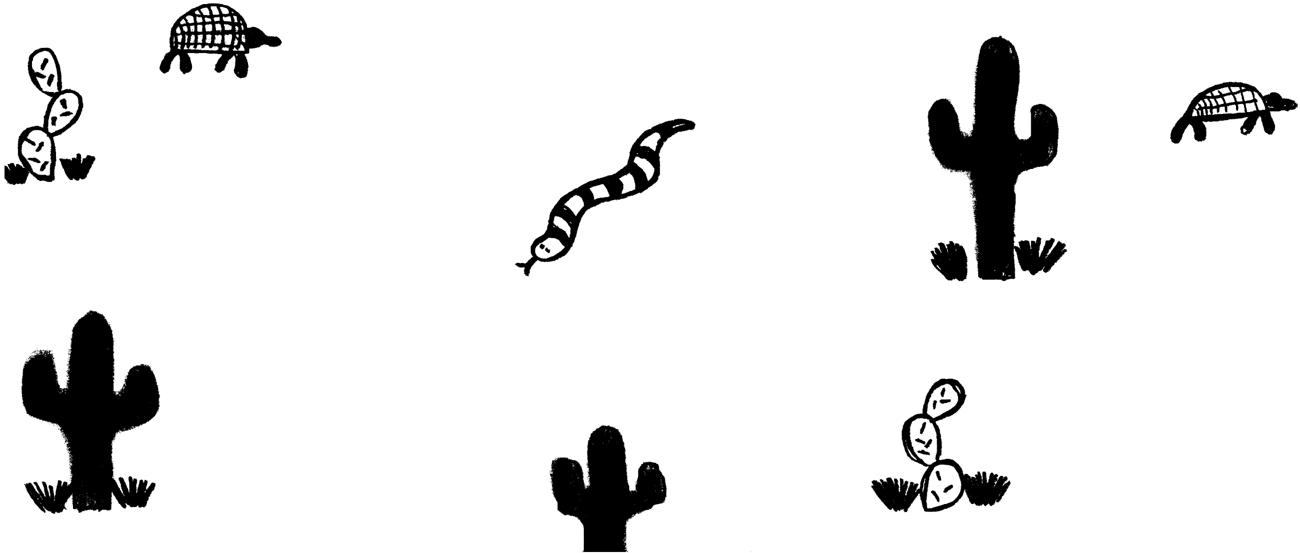
Steven Koehne
4th Grade





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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 463-5561 in Austin. For out-of-town callers our toll-free number is 800-226-7199. 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

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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.

ADOPTED RULES

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

TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 355. REIMBURSEMENT RATES

SUBCHAPTER C. REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

1 TAC §355.313

The Texas Health and Human Services Commission (HHSC) adopts new §355.313, concerning the Reimbursement Methodology for Rehabilitative and Specialized Services, in its Reimbursement Rates Chapter, without changes to the proposed text as published in the November 9, 2007, issue of the *Texas Register* and will not be republished (32 TexReg 8072).

Background and Justification

In order for the Health and Human Services Commission (HHSC) to update nursing facility rehabilitative and specialized services rates, revisions need to be made to the applicable reimbursement methodology rules. Currently, both program and reimbursement rules are included in the same rule at the Department of Aging and Disability Services (DADS) at 40 Texas Administrative Code (TAC) §19.1306, Payment for Specialized and Rehabilitative Services. Therefore, reimbursement rule language is being removed from 40 TAC §19.1306, Payment for Specialized and Rehabilitative Services and a new reimbursement rule is being proposed in the HHSC rules at 1 TAC §355.313, Reimbursement Methodology for Rehabilitative and Specialized Services. HHSC is the agency responsible for the development of reimbursement rates and rules for these services. DADS is responsible for updating program-related rules. DADS program staff will amend the current program rules to repeal the reimbursement-related language in 40 TAC §19.1306.

Comments

The 30-day comment period ended December 9, 2007, and HHSC did not receive any comments to the proposed rule.

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

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

Filed with the Office of the Secretary of State on December 31, 2007.

TRD-200706646
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Effective date: January 20, 2008
Proposal publication date: November 9, 2007
For further information, please call: (512) 424-6900

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TITLE 22. EXAMINING BOARDS

PART 7. STATE COMMITTEE OF EXAMINERS IN THE FITTING AND DISPENSING OF HEARING INSTRUMENTS

CHAPTER 141. FITTING AND DISPENSING OF HEARING INSTRUMENTS

22 TAC §141.16

The State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments (committee), with the approval of the Executive Commissioner of the Health and Human Services Commission (commission) adopts an amendment to §141.16, concerning the licensing and regulation of fitters and dispensers of hearing instruments without changes to the proposed text as published in the June 29, 2007, issue of the *Texas Register* (32 TexReg 3954) and, therefore, the section will not be republished.

BACKGROUND AND PURPOSE

Amendments to §141.16(g) and (h) relate to audiometric testing standards for hearing instrument fitters and dispensers. The amendments are adopted to ensure that the rule correctly reflects the provisions of Texas Occupations Code, §402.353, related to the requirement that audiometric testing not conducted in a stationary acoustical enclosure be in compliance with standards as established by the American National Standards Institute (ANSI) "ears covered" octave band criteria for Permissible Ambient Noise Levels During Audiometric Testing.

SECTION-BY-SECTION SUMMARY

Amendments to §141.16(g) update the rule, reorganize existing language for clarity, and ensure that the rule references the most current national standards for audiometric testing as required by the statute.

The amendment to §141.16(h) removes an obsolete chart containing maximum permissible ambient noise levels as previously established by the American National Standards Institute.

COMMENTS

The committee, on behalf of the commission, received comments from three individuals during the public hearing that was held on September 11, 2007. The commenters were not in favor of the amendments, but the commenters suggested recommendations for change as discussed in the summary of comments.

Comment: Regarding §141.16(h)(2)(C), a commenter stated that by removing the chart that the committee brings an end to requirements for testing inside a stationary acoustical enclosure, which would be harmful to the public.

Response: The committee disagrees because establishing requirements for testing inside a stationary acoustical enclosure is not within the committee's statutory directive of Occupations Code, §402.353(a). No change was made as a result of the comment.

Comment: Regarding §141.16, a commenter stated that the proposed rule would conflict with §141.16(a)(4)(F), as well as federal regulations relating to performing hearing evaluations through calibrated systems.

Response: The committee disagrees that the proposed rule is in conflict with other rules in the chapter or with federal regulations. The statutory directive of Occupations Code, §402.353(a), is to establish requirements for testing conducted outside of a stationary acoustical enclosure. No change was made as a result of the comment.

Comment: Regarding §141.16, a commenter stated that the proposed rule would conflict with §141.16(f)(1) and (2), relating to audiometric testing devices required to meet current ANSI standards.

Response: The committee disagrees that the proposed rule is in conflict with §141.16(f)(1) and (2). The proposal does not affect or make a change in the section to which the commenter is referring and audiometric test rooms do not qualify as portable or stationary testing equipment. No change was made as a result of the comment.

Comment: A commenter stated that the proposed rule does not include provisions intended to enforce Occupations Code, §402.353(a), which relates to audiometric testing not conducted in a stationary acoustical enclosure, as required by Occupations Code, §402.353(c).

Response: The committee disagrees. The current proposal fulfills the statutory directive of Occupations Code, §402.353(a), to establish requirements for testing conducted outside of a stationary acoustical enclosure. The rule at §141.17(a)(1)(A) and (B) enforces the chapter and the Act (Occupations Code, Chapter 402). No change was made as a result of the comment.

Comment: A commenter stated that the proposed rule would create professional incompetence during the hearing evaluation for current and future license holders, resulting in consumer harm.

Response: The committee disagrees. The statutory directive of Occupations Code, §402.353(c), is limited to establishing requirements for testing conducted outside of a stationary acoustical enclosure. The statute and this Chapter 141 do not create professional incompetence. No change was made as a result of the comment.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Lisa Hernandez, certifies that the rule, as adopted, has been reviewed by legal counsel and found to be a valid exercise of the agencies' legal authority.

STATUTORY AUTHORITY

The adopted amendment is authorized by the Texas Occupations Code, §402.102, which authorizes the committee to adopt rules necessary for the performance of the committee's duties.

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

Filed with the Office of the Secretary of State on December 27, 2007.

TRD-200706638
Ronald Ensweiler
Chair
State Committee of Examiners in the Fitting and Dispensing of Hearing Instruments
Effective date: January 16, 2008
Proposal publication date: June 29, 2007
For further information, please call: (512) 458-7111 x6972

TITLE 28. INSURANCE

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

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division), adopts amended §134.1 and new §§134.2, 134.203, and 134.204 concerning the Medical Fee Guideline (MFG) with changes to the proposed text published in the October 5, 2007, issue of the *Texas Register* (32 TexReg 6966) and error corrections published in the October 12, 2007, issue of the *Texas Register* (32 TexReg 7329).

In accordance with Government Code §2001.033, the preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, and the reasons why the Division made changes based on the comments or disagreed with the comments and proposals.

The Texas workers' compensation law was enacted in 1913, and revised in 1917 to include state regulation of medical fees. In July 1987, the Legislature created the Joint Select Committee on Workers' Compensation Insurance. The Committee Report issued in December 1988, concluded that workers' compensation medical costs were high in relation to those in other states and that they had increased faster than medical costs outside the system and faster than indemnity costs. In other words, the Committee Report concluded that workers' compensation had been subsidizing the provision of non-workers' compensation medical care.

The overhaul of the workers' compensation law with the enactment of the "new law" in 1989 resulted in the addition of a statutory mandate that the medical fee guidelines enacted by the Industrial Accident Board (IAB) (the precursor of the Texas Workers' Compensation Commission (Commission)) be designed to also achieve effective medical cost control. This was the first time that Texas workers' compensation law specifically mandated that a state agency work to control medical costs within the workers' compensation system, and sent a strong message that the steps taken by the Commission in this area must differ markedly from those of the IAB in the past.

As noted by the Texas Supreme Court in Texas Workers' Compensation Comm'n v. Garcia, 893 S.W.2d 504, 512 (Tex. 1994), "In 1989, the Legislature enacted a new Workers' Compensation Act (hereinafter the "Act") restructuring the workers' compensation law in Texas. The new Act replaced the old system that had become increasingly expensive and was suffering from a loss of public confidence. Medical costs for injured workers within the workers' compensation system began increasing at a much higher rate than similar costs outside the system. These increases, in part, caused workers' compensation insurance premiums to more than double between 1984 and 1988."

In response to these mounting costs, the Legislature gave the newly created Commission sweeping new powers. One of these powers was in the area of medical costs and reimbursement. See Labor Code §413.011. Pursuant to that section, the Legislature directed the Commission to set new guidelines for reimbursements to healthcare providers treating injured workers. Labor Code §413.011(a)(1). In so doing, the Legislature assigned the Commission the daunting task of designing a guideline that provides fair and reasonable reimbursements, ensures the quality of medical care, and simultaneously achieves effective medical cost control. Labor Code §413.011(b).

An extensive research program and review of the relevant literature and §134.200 (concerning Medical Fee Guideline) (1991 MFG) was undertaken by the Commission to assist in evaluating the strengths and deficiencies of the 1991 MFG, prior to the development of §134.201 (concerning Medical Fee Guideline for Medical Treatment and Services Provided Under the Texas Workers' Compensation Act) (1996 MFG).

The objectives for the 1996 MFG were to move Texas MFG reimbursements toward a median position in comparison with other states, away from a charge-based reimbursement structure, and more toward a market-based system. Consequently, to accomplish these objectives, and because no reference point or benchmarking against market based charges was done during the development of the 1991 MFG, in developing the 1996 MFG, the Commission determined that it was appropriate to obtain data from outside sources to use in evaluating what changes in reimbursements were necessary. The Commission also elected to switch from the California Relative Value System, to the more widely used and recognized McGraw-Hill Relative Values for Physicians. Commercial market data was supplied from an outside source and included conversion factors based on charges for every 10th percentile starting at the 20th percentile and ending at the 90th percentile. This revealed that the lack of benchmarking in 1991 resulted in some medical services groups being reimbursed around the 10th percentile when compared to the commercial market data, while other groups were reimbursed above the 90th percentile. In addition, some of the individual codes within each group were reimbursed far above or far below the median of the data. As noted in Congressional Budget Office testimony: a charge-based reimbursement system gives physicians the incentive to increase their charges from year to year to boost their revenues; this leads to spiraling expenditures. (Statement of Dan L. Crippen, Director, Congressional Budget Office, Testimony Before the Subcommittee on Health of the House Committee on Ways and Means, Hearing on Physician Payments, February 28, 2002.)

The conversion factors for the 1996 MFG were derived by dividing the sum of all charges for each American Medical Association (AMA) Current Procedural Terminology (CPT) category group by the sum of the relative value units for each charge in the same group. At this point in developing the 1996 MFG the Commission was concerned that a full shift away from the 1991 MFG could destabilize the system. Therefore, the goal of establishing a 1996 MFG that produced the same level of total expenditures as the 1991 MFG was identified as an alternative to a fully market based system. Thus, the move to a fully market based system was restricted by Commission goals to maintain the same level of expenditure overall, and as much as possible in each individual service category. Adjustment restrictions per procedure were also established to avoid extreme changes. Conversion factors for service categories ranged from the 20th to the 60th percentiles. In essence, this methodology retained the reimbursement relationships established in the 1991 MFG so that the 1996 MFG still did not reflect median or average commercial reimbursements.

In developing the 1996 MFG, the Commission's expenditure goals included keeping reimbursements for medical services in Texas relatively stable so that over time the effects of inflation and changes in other states' medical fee guidelines would help move Texas towards a median position. The 1996 MFG was thus a transitional step to the Commission's stated intent to review and revise the MFG on a regular basis in developing a market-based system. These assumptions were not fully realized because medical inflation during the late 1990's was much less intense than in the previous decade, there was significant realignment in reimbursement structures in both the commercial and Medicare systems, and other states' compensation systems began to adjust their fee schedules accordingly.

These factors, in addition to the transitional implementation of the McGraw-Hill relative value system and the overall restriction in total system reimbursement, would result in a significant realignment and significant reduction of reimbursements for some services in the 2002 MFG.

After the adoption of the 1996 MFG, several research reports showed that Texas workers' compensation medical costs continued to exceed those in other states and other health care delivery systems.

* Policy year 1995 data show that the average medical cost per claim in Texas exceeded the national average by almost 80 percent. (Texas Research and Oversight Council (ROC) on Work-

ers' Compensation and Med-FX, LLC., Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System, A Report to the 77th Texas Legislature, January 2001, citing National Council on Compensation Insurance (NCCI), Annual Statistical Bulletin, 1999.)

* The average medical payment (paid and incurred) per claim with more than seven days' lost-time in Texas was the highest of the eight states analyzed (California, Connecticut, Florida, Georgia, Massachusetts, Minnesota, Pennsylvania, and Texas). Together these states account for at least 40 percent of the nation's workers' compensation benefits. (Workers' Compensation Research Institute (WCRI), Benchmarking the Performance of Workers' Compensation Systems: CompScope Multistate Comparisons, July 2000.)

* When similar types of injuries were compared in the group health and workers' compensation systems, Texas had higher than average medical costs for the top five types of injuries. (ROC, January 2001.)

* When compared with group health (a State of Texas employee Preferred Provider Organization (PPO) group health plan), average workers' compensation medical costs for State of Texas injured employees were approximately six times higher per worker ($578 per worker in this group health system compared to $3,463 per worker in the Texas workers' compensation system, 18 months post-injury). (ROC, January 2001.)

* In general, the amount of medical treatment (often called treatment utilization) and the length of medical treatment (often called treatment duration) provided to Texas injured workers accounted for the majority of these cost differences between other state workers' compensation systems and other health care delivery systems. Additional differences between Texas workers' compensation and Texas group health systems also widened the cost gap. These differences included the lower cost of many individual medical treatments in group health (due to the PPO or other negotiated discounts), the existence of pharmaceutical formularies in the group health system, and in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning). (ROC, January 2001).

The January 2001 ROC report concluded that Texas policymakers and system regulators should consider developing a comprehensive plan to address:

* the amount of medical care provided to injured employees;

* the price of individual treatments and services in workers' compensation;

* the method by which the system resolves disputes; and

* the method by which the system regulates doctors and insurance carrier utilization review agents.

With this background of information and reports, the 77th Texas Legislature enacted House Bill 2600 which amended §413.011 of the Labor Code to address reimbursement policies.

Prior to the revisions of House Bill 2600, §413.011 required that guidelines for medical services fees be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

Section 413.011 also stated that the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission was to consider the increased security of payment afforded by the Texas Workers' Compensation Act (the Act) in establishing the fee guidelines.

In addition to the previous requirements, the revised statute also required that the commission:

* use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements;

* adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration (HCFA) to achieve standardization, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of §413.053 of the Act (relating to Standards of Reporting and Billing);

* develop conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care; and

* provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commission rules.

Section 413.011(b) stated that this section of the law does not adopt the Medicare fee schedule, and the commission shall not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the HCFA.

On April 25, 2002, the Texas Workers' Compensation Commission adopted §134.202, (concerning Medical Fee Guideline) (2002 MFG), to be effective for professional medical services provided on or after September 1, 2002.

On July 10, 2002, the Texas Medical Association and Texas AFL-CIO filed a lawsuit against the Commission. Texas Medical Assoc., et al. v. Texas Workers' Compensation Commission, Cause No. GN 202203 (126th Judicial Dist., Travis County, Texas) (TMA v. TWCC I), which challenged the 2002 MFG on various statutory authority grounds and also alleged that it was adopted without substantial compliance with the reasoned justification requirements of notice-and-comment rulemaking under Government Code §2001, subchapter B. After a temporary injunction hearing, the district court judge issued a Temporary Injunction and Remand Order, pending trial on the merits.

The temporary injunction order included a remand to the Commission, under amendments added to the Government Code's provisions for challenges to agency rules in 1999. These amendments make a court's decision after trial on the merits that a rule's adoption was not in substantial compliance with reasoned justification requirements voidable, rather than void, and confirm that a trial court may allow a rule to go into effect pending efforts to revise the preamble to satisfy reasoned justification standards. The Court in this case made a number of statements from the bench identifying the Commission's decision to adopt a multiplier as the focus of its concerns and shedding further light on the nature and extent of the Court's concerns with the reasoned justification for the 125 percent multiplier as stated in the preamble for the 2002 MFG, published in the May 10, 2002, issue of the *Texas Register* (27 TexReg 4048).

The Commission clarified the reasons for the 125 percent multiplier issue with particular focus on TMA's challenges and the Court's concerns. In addition to the parties' briefs, testimony

and exhibits in the temporary injunction hearing, the Commission's Executive Director invited stakeholders to a September 16, 2002 meeting and requested further input, in particular on the extra administrative burdens of the workers' compensation system, the appropriate conversion factor, and the access to care issue. On September 19, 2002, the Commissioners directed the Executive Director and staff to review any additional stakeholder input and all other relevant information and to make reports and recommendations to the Commission at the October or another future meeting. The Commission's staff reviewed the input received in that process, and relevant new publications. Staff also reviewed the Commission's previous statement of factual and legal analyses as reflected in the existing preamble in light of additional staff analysis. Based on its review, the staff prepared and the Executive Director submitted for the Commission's consideration a supplemental order/preamble.

The Commission adopted the "Supplemental Preamble" on December 12, 2002 and readopted the 2002 MFG with no textual changes to the rule. The 2002 MFG was republished in the December 27, 2002, issue of the *Texas Register* (27 TexReg 12304).

In April 2003, the district court held another hearing, this time on the appellants' request for a permanent injunction and on the merits of the rule's validity. After hearing evidence and argument, the court determined that the Commission's Supplemental Preamble substantially complied with the reasoned-justification requirement and issued an order declaring the 2002 MFG valid in all respects, effective August 1, 2003. The appellants filed a motion for rehearing, which the district court denied. The appellants then brought an appeal, reasserting their arguments urged to the district court and the Third Court of Appeals upheld the district court's findings in Texas Medical Assoc. v. Texas Workers' Compensation Commission, 137 S.W.3d 342 (Tex. App. - Austin 2004, no pet.). (TMA v. TWCC II).

The new sections and the amendments to the 2002 MFG build on the prior history and prior court decisions, and address statutory changes that have come into effect subsequent to the 2002 MFG.

The Commissioner adopts amended §134.1 and new §§134.2, 134.203, and 134.204 to comply with Labor Code §413.012, which directs fee guidelines to be reviewed and revised to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision are conducted. In response to written comments received from interested parties and testimony at a public hearing held on November 5, 2007, the Division has changed some of the language in the text of the proposed rules as adopted. These changes, however, do not introduce new subject matter or affect persons in addition to those subject to the proposal as published. Other changes are made for consistency.

The amendments to §134.1 are necessary to address rule name changes and the addition of the new §§134.2, 134.203 and 134.204, to clarify when fair and reasonable reimbursement applies, to correct grammatical inconsistencies in the section, to add a definition of maximum allowable reimbursement (MAR) as requested by one commenter, and to renumber the subsections to accommodate the added definition.

Adopted §134.2 is added pursuant to Labor Code §408.0252, which allows the Commissioner to identify areas of the state in which access to health care providers is less available and to adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. The text in the adopted section provides an incentive reimbursement of 10 percent over the regular reimbursement amount to encourage health care providers to provide services to injured employees in areas identified by the Division as being underserved. In specifying workers' compensation underserved areas, the Division utilized three criteria simultaneously: a ZIP Code that was not in a designated Medicare Health Professional Shortage Area (HPSA), a ZIP Code that had at least one Division approved request for a case-by-case exception to the appointment of a provider who was not on the Division's Approved Doctor List (ADL), and a ZIP Code that had no ADL provider listed. Using those three criteria, the Division has designated 122 of the 4,254 Texas ZIP Codes as eligible for the 10 percent incentive payment. The Division determined that 10 percent is a fair and reasonable incentive because it is consistent with the percentage factor currently used as the physician bonus payment provided by the Centers for Medicare and Medicaid Services (CMS) for its 2007 Primary Care HPSA. The 10 percent incentive payment is anticipated to improve participation because it is a reasonable financial bonus in a physician scarcity geographic area and it is a measure that has been used historically by the federal Medicare system. Because the ADL was abolished effective September 1, 2007, the Division anticipates revision of the selection criteria when §134.2 is next revised. A more detailed explanation of the methodology used for selecting the 122 ZIP Codes is set forth in the Division's responses to comments received as part of the rule proposal.

New §134.203 and §134.204 are based on and address the same subject matter as the current §134.202 medical fee guidelines; however, the new sections apply to medical services provided on or after March 1, 2008, and contain changes that provide for fair and reasonable reimbursement in the current health care market. Section 134.202 will remain in effect for reimbursements related to professional medical services provided between August 1, 2003 and March 1, 2008. Rather than modifying §134.202, two new sections (§134.203 and §134.204) are adopted to create a separation of the conversion factors for Medicare-based fee schedules from workers' compensation specific services and reimbursements that are currently combined in §134.202. With two separate sections, any future amendments will be easier for the Division to manage and for system participants to implement. New §134.203 relates to medical fees for reimbursements predominantly based on conversion factors and Medicare. New §134.204 relates to medical fees for reimbursement of workers' compensation specific codes, services, and programs that, for the most part, are needed in the Texas workers' compensation system but are not as dependant on the RBRVS system and the Medicare methodologies.

HB 7, enacted by the 79th Texas Legislature, Regular Session, effective September 1, 2005, added new duties for designated doctors to Labor Code §408.0041. The adopted rules, specifically §134.204(i) and (k), are required in order to reflect the new duties, provide appropriate modifiers to be used in billing for the new duties, and to structure reimbursement to take into account the new duties.

At the time the 2002 MFG rules were adopted, there was no statutory provision for more than one conversion factor. With the passage of HB 7, the Labor Code was amended at §413.011(b) to direct the Commissioner to develop one or more conversion factors taking into account economic indicators in health care

and the requirements of subsection (d), which requires that reimbursement be fair and reasonable and designed to ensure the quality of medical care. In place of the single conversion factor provided by §134.202, new §134.203 adopts two conversion factors. The two conversion factors are established in consultation with the Medical Advisor pursuant to Labor Code §413.0511(b)(1) and in consideration of the amendments made by HB 7.

The conversion factor of $52.83 for calendar year 2008 is to be used for all professional service categories, with the exception of surgical procedures when performed in a facility setting, such as a hospital or an ambulatory surgical center (ASC). This "non-facility" conversion factor is based on the Medicare Economic Index (MEI) used by CMS to develop its adopted 2008 conversion factor. Labor Code §413.011 requires that reimbursement be fair and reasonable. In 2003, the Texas court of appeals validated the conversion factor of 125 percent of Medicare in the 2002 MFG. In reaching that decision, the court said, "the Commission was not required to demonstrate that 125% is the only reasonable or factually defensible policy alternative. Rather, it needed only to demonstrate that there is a rational connection between its conversion factor and the factual material it has received or otherwise considered, and that 125% is a legitimate and factually defensible choice that complies with the multiple statutory requirements of the labor code." TMA v. TWCC II at 355. That conversion factor was adopted and has been used for setting reimbursement since the 2002 MFG became effective on August 1, 2003. A review by the Division shows that erosion of the value of reimbursement over the past four years due to yearly practice expense increases has caused the 125 percent conversion factor to not fully recognize changes in the economic indicators of health. This reimbursement is no longer fully consistent with the requirements of Labor Code §413.011. Rather than continue using 125 percent of the most current Medicare conversion factor, the adopted §134.203 establishes a conversion factor that reflects the aggregate changes in the MEI since the baseline year of 2002. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. The MEI is a portion of Medicare's Sustainable Growth Rate (SGR). The other components of the SGR serve as major price restraints necessary to comply with Medicare's budget neutrality requirements, and do not directly relate to workers' compensation reimbursements. This change updates the 125 percent conversion factor to essentially reflect the changes in the cost of providing the covered goods, services, and practice expenses that have occurred over the prior four years. The adopted conversion factor of $52.83 for calendar year 2008 begins with the 125 percent multiplier developed for §134.202, and applying the annual MEI adjustment year-to-year beginning with the baseline year of 2002. In 2002, the reimbursement amount was $45.25. The MEI increased 3.0 percent for 2003, 2.9 percent for 2004, 3.1 percent for 2005, 2.8 percent for 2006, 2.1 percent for 2007, and 1.8 percent for 2008. In order to minimize the need for rulemaking activity and to provide predictability to system participants, the Division adopts, as part of §134.203, a provision that will automatically update the conversion factor each year based on the MEI. The Division will monitor the resulting change to ensure that the conversion factor is reflective of the mandatory statutory factors. This approach is analogous to the approach that was upheld in the 2002 MFG suit where the plaintiffs complained that use of the Medicare conversion factor to develop a conversion factor was an improper delegation of agency duty; however, the court found that there was no delegation. TMA v. TWCC II, 137 S.W.3d at 348. The section that was challenged stated, "The 2002 fee guidelines provide that fees for certain services are to be calculated by using the 'effective conversion factor adopted by CMS multiplied by 125%.'" TMA v. TWCC II, 137 S.W.3d at 348. In finding that there was no delegation, the court stated, "Changes to the Medicare conversion factor are historically announced several months before they become effective. See, e.g., 42 C.F.R. §414.4 (2003) (CMS announces proposed changes in Federal Register and provides opportunity for public comments prior to publication of final changes); 67 Fed. Reg. 79,966 (Dec. 31, 2002) (2003 conversion factor published on December 31, 2002, to be effective on March 1, 2003). Thus, the Commission will have an opportunity to make any necessary changes to the Texas multiplier prior to the date the Medicare conversion factor becomes effective. Indeed, the Commission has already adjusted the Texas conversion factor to 125%, up from 120%, after the Medicare conversion factor for 2002 was reduced. Supp. Preamble 12,335; see also 66 Fed. Reg. 55,320 (Nov. 1, 2001). Even without the Commission's statement in the Supplemental Preamble, the Commission has the ongoing statutory duty to review and revise the fee guidelines to ensure they are in compliance with the statutory factors. See Tex. Lab. Code Ann. §413.012 (Commission is to review and revise guidelines at least every two years). Appellants' contention that the adjustment to the Texas conversion factor is "automatic" is thus overstated. The Commission will have the ultimate authority, and the ongoing duty, to make adjustments to the Texas conversion factor to keep it reflective of the mandatory statutory factors." TMA v. TWCC II, 137 S.W.3d at 349.

As with the Medicare conversion factor, the annual MEI is published in the Federal Register each November for the following year. Estimates of the MEI are available throughout the year prior to November. The Commissioner, exercising his ultimate authority and his statutory duty to review and revise, has the opportunity to implement any necessary changes to the reimbursement rate prior to its effective date.

Using the estimates and the final annual MEI also provides an element of stability and predictability to the system. Insurance carriers can anticipate changes in the conversion factor well in advance of their implementation. Also, in the past, there have been situations where Medicare has lowered the Medicare conversion factor below the then current year and Congress has stepped in to maintain the conversion factor at the prior rate. On at least one occasion, the congressional action occurred well after January 1 effective date of the change, which meant that the congressional action was retroactive and caused reimbursement and billing problems for both carriers and health care providers (HCPs). With the adoption of the rule, this will no longer be a problem since the change is tied to the MEI rather than to the Medicare conversion factor.

The adopted section establishes a second conversion factor of $66.32 for calendar year 2008 to be used for surgical procedures when performed in a facility setting, such as a hospital or ASC. This conversion factor is based on the average reimbursement differential between reimbursement rates for surgical services and overall services of those state workers' compensation systems using the Resource Based Relative Value Scale (RBRVS) as listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (Workers' Compensation Research Institute, 2006). This WCRI Report also states that for surgical services, 23 of the states that use RBRVS, set their workers' compensation fee schedule more than double the

state's Medicare fee schedule; about half of the states have fee schedules that range from 30-65 percent above the state's Medicare rates; and the interstate differences are greatest for surgical and specialty care, and smallest for primary care and physical medicine services. This Division conversion factor also takes into consideration the limited availability of HCPs with the specialized expertise necessary to provide those services. As reported by the Texas Medical Association in their 2006 Survey of Texas Physicians Research Findings, there has been a dramatic loss of access to surgical specialties by injured employees since the adoption of §134.202. As a result of stakeholder input received in response to the posting of the informal working draft sections and in consultation with the Medical Advisor, the $66.32 conversion factor applies only to surgical services when performed in a facility setting, rather than the earlier suggestion of specialty surgical procedures distinguished by CPT codes. Use of specific CPT codes would result in an increased administrative burden due to the changing nature of the CPT codes. Current billing practices allow the designation of the setting where the surgical procedure was performed (i.e., office versus facility). Medicare now allows site of service preference deemed by the physician as long as the procedure may be performed safely in that setting. Under the adopted conversion factors, the HCP will generally be paid at a higher rate for services when performed in a facility than a comparable service when performed in the HCP's office. The relative value units (RVUs) for professional services provided in the facility are generally less than RVUs for comparable services provided in an office, because the doctor does not encumber the overhead costs of the facility.

In order to clarify and improve billing procedures, new billing modifiers are added. The new modifiers are for coding the examinations performed by designated doctors and for the identification of treating doctors performing their case management functions. Those new modifiers are set out in §§134.204(e), 134.204(i), and 134.204(n). Proper use of the modifiers in conjunction with eBilling will decrease the administrative burden on both the HCP and the carrier in submitting, processing, and paying bills.

Case management fees have previously been a part of §134.202, but the reimbursement was left to the carriers to determine a fair and reasonable amount since Medicare does not place a value on the relevant CPT codes. In §134.204, the Division has set the case management fees to eliminate the multiple fair and reasonable determinations and to provide for uniform reimbursement for HCPs performing case management activities. The established fees are derived from the 2007 Ingenix publication of The Essential RBRVS for determining the gap-filled, non-facility value, and then multiplied by the Division's 2007 conversion factor used during the early 2007 calendar year rule adoption stage. In developing these fees, the Division considered Labor Code §413.011(b) that indicates that the Commissioner may also provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and Division rules. Adopted §134.204(e) also establishes set fees, which are 25 percent of the total provided to treating doctors, when a referral health care provider contributes to the case management activity.

In developing these rules concerning the MFG, the Division has carefully and fully analyzed all of the statutory and policy mandates and objectives and all the facts and evidence gathered and submitted, as well as all informal and formal system participants' input and comments received throughout the development process. The Division has utilized the information gathered and submitted, along with its expertise and experience, to develop these guidelines in a way that best balances the statutory mandates, including the mandate to ensure that injured employees receive the quality health care reasonably required by the nature of their injury, the mandate to ensure that fee guidelines are fair and reasonable, and the mandate to achieve effective medical cost control.

The Division considered all the factors put forth by the Legislature over the past decade. These rules take into consideration not only the specific provisions of §413.011 but the overall intent of the Legislature to bring about reform to the workers' compensation system in Texas.

The following summary provides a few examples of how these adopted new and amended MFG rules, as well as other Division rules and policy, address and implement some of these key factors as well as the statutory requirements of §413.011:

* For effective medical treatment utilization: The Disability Management Concepts of Chapter 137 are anticipated to reduce costs in the Texas workers' compensation systems, as they have resulted in reduced system cost when implemented in other settings, such as group health and other states' workers' compensation systems. Reduced costs benefit all system participants through the potential for reduced premiums and an option for reallocation of savings to other system needs.

* For fair and reasonable reimbursements: Reimbursement modifications in these adopted MFG rules, including conversion factor increases, which are reflective of the increased costs as identified through the MEI for the provision of medical services, more accurately reflect the increases in costs of providing health care than the previous index to Medicare. Licensed home health agencies, as providers, will benefit from clarification as to reimbursement for home health services provided to injured employees; and designated doctors will benefit from a more streamlined and tiered reimbursement structure for non-Maximum Medical Improvement (MMI) and Impairment Rating (IR) designated doctor examinations.

* For standardized reimbursement structures, as found in other health care delivery systems with minimal modifications to meet occupational injury requirements: The continued use of standardized and current Medicare methodologies, models, and value units, and use of standardized reporting, billing, and coding requirements, in addition to considering economic indicators in health care, will benefit all system participants. Additional benefits to all system participants include the specification of the tired reimbursement structure for the non-MMI and IR designated doctor examinations, as well as guidance on the coding and billing for licensed home health services, and the new modifiers, all of which lend certainty and stability to the system.

* For reasonable and timely access to medical care: Injured employees in underserved areas will benefit from the inducement to providers created by the provisions for an additional 10 percent reimbursement to health care providers who provide services in designated shortage areas represented by specific ZIP Codes. Increased reimbursement rates may encourage additional providers to participate in the Texas workers' compensation system.

* For reasonable fees for the evaluation and management of care: Treating doctors that perform the majority of evaluation and management codes and functions, will benefit from the set reimbursement amounts for case management as these activi-

ties become increasingly important in the Texas workers' compensation disability management model. The Division acknowledged during the adoption process of the Chapter 137 Disability Management Rules that the treating doctor will assume an essential role in the coordination of care on behalf of the injured employee. In accordance with Labor Code §408.023(l) and §408.025(c), the responsibility of a treating doctor to effectively medically case manage and maintain efficient utilization of health care is fulfilled through the process of treatment planning. Medical case management fosters a framework for the treating doctor to facilitate and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division. The Division expects case management, including the treatment planning process, to lead to consensus between the treating doctor and insurance carrier regarding health care to be provided. Additionally, clarifications and specificities associated with this change in reimbursement methodology will allow providers to be more consistently reimbursed for case management responsibilities, and this change further supports the responsibilities of the treating doctor and contributing health care providers to fulfill the disability management objectives of the Division.

The amendments to §134.1 address rule name changes and the addition of the new §§134.2, 134.203 and 134.204, clarify when fair and reasonable reimbursement applies, correct grammatical inconsistencies in the section, and define MAR.

The new §134.2 provides a listing of the ZIP Codes that are designated as workers' compensation underserved areas, which are determined by the ZIP Code where the service is provided. The section provides that when required by Division rule, an incentive payment shall be added to the MAR for services performed in a designated workers' compensation underserved area.

New §134.203 and §134.204 are based on and address the same subject matter as the current §134.202 medical fee guidelines; however, the new sections apply to medical services provided on or after March 1, 2008, and contain changes that provide for fair and reasonable reimbursement in the current health care market.

New §134.203 is applicable to professional services provided on or after March 1, 2008. It does not apply to facility, pharmaceutical, dental, and other services and it is not applicable to services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

In place of the single conversion factor currently provided by §134.202, new §134.203 adopts two conversion factors. The conversion factor of $52.83 for calendar year 2008 is to be used for all professional service categories, with the exception of surgical procedures performed in a facility setting, such as a hospital or ambulatory surgical center (ASC). The conversion factor of $66.32 for calendar year 2008 is to be used for surgical procedures performed in a facility setting. Both adopted conversion factors are to be updated each subsequent calendar year to reflect the annualized MEI percentage adjustment published in the Federal Register each November.

Adopted §134.203 maintains reimbursement of Healthcare Common Procedure Coding System (HCPCS) Level II codes at the level specified in §134.202, 125 percent of fees listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, or 125 percent of the published Texas Medicaid fee schedule for durable medical equipment if the code has no published Medicare DMEPOS rate. The reimbursement for these services was not developed as part of the Medicare Physicians Fee Schedule and has not been subject to the SGR provisions that are required by the Medicare budget neutrality provisions. In addition, Medicare updates the DMEPOS fee schedule on a quarterly basis and the Division adopts those updates as they occur. For those reasons, the reimbursement for these items will not be subject to the MEI adjustment.

Adopted §134.203(a) describes the applicability of the section. Section 134.203(a)(1) states that the section does not apply to workers' compensation specific codes, services, and programs described in §134.204; prescription drugs or medicine; dental services; facility services of a hospital or other health care facility; or medical services provided through a workers compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305. Section 134.203(a)(2) notes that the section only applies to professional medical services provided on or after March 1, 2008, the applicability date of adopted new §134.203. Section 134.203(a)(3) provides that §134.202 is to be applied to professional medical services provided between August 1, 2003 and March 1, 2008.

Adopted §134.203(a)(4) states that for professional medical services provided before August 1, 2003, §134.201 (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 (relating to Dental Fee Guideline) apply. Adopted §134.203(a)(5) defines the term "Medicare payment policies" to mean reimbursement methodologies, models, and values or weights, including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare, when used in this section. As with current §134.202, this section allows for the basic Medicare program provisions to be applied with any additions or exceptions necessary for adaptation to the Texas workers' compensation system. The Medicare program is not a static system. Medicare policies change frequently. To achieve standardization it is necessary to use the Medicare billing and reimbursement policies as they are modified by CMS.

As in §134.202(a)(3), adopted §134.203(a)(6) clarifies that, notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act, since, in accordance with the Labor Code §401.011(17), they are included in the definition of "doctor" in the Texas workers' compensation system.

Adopted §134.203(a)(7) states that specific provisions contained in the Labor Code or the Division rules, including Chapter 134, take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program and that Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies. Adopted §134.203(a)(8) establishes that whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

Adopted §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for HPSAs, and physician scarcity areas (PSAs); and other applicable payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Adopted §134.203(b)(2) provides that a 10 percent incentive payment shall be added to the MAR for services outlined in subsections (c) - (f) and (h) of the section that are performed in designated workers' compensation underserved areas in accordance with §134.2.

Adopted §134.203(c) requires system participants to apply the Medicare payment policies with minimal modifications to determine the MAR. Adopted §134.203(c)(1) provides the annual conversion factors for use in various service categories beginning in calendar year 2008. Adopted §134.203(c)(2) indicates that the conversion factors in paragraph (1) of that subsection are for calendar year 2008 and that the subsequent year's conversion factors will be determined by applying the annual percentage adjustment of the MEI to the previous year's conversion factors and the new conversion factors shall be effective January 1 of the new calendar year. Paragraph (2) also provides an example of the calculation methodology used early in rule development in calendar year 2007 to describe the 2007 workers' compensation conversion factor based on the Medicare 2006 conversion factor with the annual increase of 2.1 percent of the MEI. This calculation methodology is to be applied each subsequent calendar year based on the annualized MEI percentage adjustment published each November in the Federal Register for the following calendar year.

As in §134.202(c)(2), adopted §134.203(d) provides that the MAR for HCPCS Level II codes A, E, J, K, and L shall be 125 percent of the Medicare DMEPOS fee schedule, or 125 percent of the published Medicaid fee schedule, or, if neither applies, according to subsection (f) of this section.

As in §134.202(c)(3), adopted §134.203(e) provides that the MAR for pathology and laboratory services not addressed in (c)(1) of this section or in other Division rules shall be 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component, and 45 percent of the Division established MAR for the technical component shall be the professional component.

Adopted §134.203(f) contains a clarification change from proposal and establishes that where no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f), or the Division, reimbursement shall be provided in accordance with §134.1.

Adopted §134.203(g) establishes that where there is a negotiated or contracted amount that complies with Labor Code §413.011, that amount shall be the reimbursement amount that applies to the billed services.

Adopted §134.203(h) establishes that where there is no negotiated or contracted amount that complies with Labor Code §413.011, the reimbursement shall be the lesser of the MAR amount; the HCP's usual and customary charge, unless a Division rule specifies a specific bill amount; or the fair and reasonable amount consistent with the standards of §134.1.

Adopted §134.203(i) requires HCPs to bill their usual and customary charges using the most current HCPCS Level I and Level II codes and to submit medical bills in accordance with the Labor Code and Division rules.

Adopted §134.203(j) describes that appropriate modifiers, including more than one modifier if necessary, shall follow the appropriate Level I and Level II HCPCS codes on the bill to identify modifying circumstances. Division-specific modifiers are identified in proposed new §134.204(n) along with instructions for application.

Adopted new §134.204 provides for reimbursement of workers' compensation specific services, and provision of a separate section from new proposed §134.203 is required for ease in future amendments by the Division and for ease of implementation by system participants. Section 134.204 applies to workers' compensation specific codes, services, and programs provided on or after March 1, 2008. The adopted section is not applicable to professional medical services described in adopted new §134.203; prescription drugs or medicines; dental services; facility services of a hospital or other health care facility; or medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

Adopted §134.204(a)(3) provides that §134.202 (relating to Medical Fee Guideline) applies to workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, the applicability date of adopted §134.204. Adopted §134.204(a)(4) provides that for workers' compensation specific codes, services, and programs provided before August 1, 2003, §134.201 (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 (relating to Dental Fee Guideline) apply. Adopted §134.204(a)(5) sets forth that specific provisions contained in the Labor Code or the Division rules, including this chapter, take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program and that IRO decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

Adopted §134.204(b)(1) requires HCPs to bill their usual and customary charges using the most current HCPCS Level I and Level II codes and to submit medical bills in accordance with the Labor Code and Division rules.

Adopted §134.204(b)(2) states that appropriate modifiers, including more than one modifier if necessary, shall follow the appropriate Level I and Level II HCPCS codes on the bill to identify modifying circumstances. Division-specific modifiers are identified in subsection (n) of this section along with instructions for their application.

Adopted §134.204(b)(3) provides that a 10 percent incentive payment shall be added to the MAR for services outlined in subsections (d), (e), (g), (i), (j), and (k) of the section that are performed in designated workers' compensation underserved areas in accordance with §134.2.

Adopted §134.204(c) establishes that when there is a negotiated or contracted amount that complies with Labor Code §413.011, that amount shall be the reimbursement amount for the billed services.

Adopted §134.204(d) establishes that when there is no negotiated or contracted amount that complies with Labor Code §413.011, the reimbursement shall be the least of the MAR amount; the HCP's usual and customary charge, unless Division rule specifies a specific bill amount; or the fair and reasonable amount consistent with the standards of §134.1.

Adopted §134.204(e) sets forth the case management responsibilities for the treating doctor, establishes set fees for treating doctor case management services, directs the treating doctor to use a specific modifier when billing for these services that will distinguish treating doctors from other health care providers, and allows treating doctors a payment commensurate with case management responsibilities and workers' compensation administrative tasks. Adopted §134.204(e) also establishes set fees, which are 25 percent of the total provided to treating doctors, when a referral health care provider contributes to the case management activity. These established fees are derived from the 2007 Ingenix publication of The Essential RBRVS for determining the gap-filled, non-facility value, and then multiplied by the Division's 2007 conversion factor used during the early 2007 calendar year rule development stage. In developing these rules, the Division considered Labor Code §413.011(b) that indicates the Commissioner may also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and Division rules.

Adopted §134.204(f) is changed from the proposed rule text as a result of a comment. It establishes that to determine the MAR for home health services provided by a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

As in §134.202(e)(4), adopted §134.204(g) sets forth the requirements and limitations on functional capacity evaluations (FCEs), including limits on the number of FCEs allowed, the maximum number of hours to be reimbursed, the required billing code and modifier, and the required elements of a physical examination and neurological evaluation.

As in §134.202(e)(5), adopted §134.204(h) sets forth the billing and reimbursement requirements for Return to Work Rehabilitation Programs including appropriate coding, modifiers, and reimbursement rates. The section includes details of comparable Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs.

Adopted §134.204(i) addresses the examinations and reimbursements with new modifiers that are associated with the expanded duties of designated doctors. This subsection is established for whichever examination is appropriate, and sets forth an established cap with a prorated payment method for the four examinations not associated with MMI and IR.

As in §134.202(e)(6), adopted §134.204(j) sets forth the billing, coding, and reimbursement requirements, including modifiers, for MMI and IR examinations. The subsection specifies what shall be included in the examinations; any limitations on the number of examinations allowed; billing and reimbursement for testing not outlined in the AMA Guides; and that the doctor performing the examinations be an authorized doctor under the Act, Division rules, and Chapter 130 relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment. The subsection further sets out different billing, coding, including modifiers and reimbursement rates, depending on whether the examining HCP is the treating doctor, a referral doctor, or a referral specialist. A new clarifying provision has been added for the billing and reimbursement of an IR evaluation in circumstances when there is no test to determine an IR for a non-musculoskeletal condition.

Adopted §134.204(k) sets forth the billing, coding, including modifiers, and reimbursements rates for Return to Work and Evaluation of Medicare Care examinations (RTW/EMC), that are not done for the purpose of certifying MMI or assigning IR. As proposed, the adopted subsection addresses the newer designated doctor responsibilities and raises the overall reimbursement rate from $350 to $500 for whichever examination is appropriate as outlined in subsection (i) of this section. Additionally, any required testing is to be billed using appropriate codes and modifiers in addition to the examination fee.

Adopted §134.204(l) refers a HCP to §129.5 (relating to Work Status Reports) when billing for a Work Status Report that is not conducted as part of the examination outlined in subsections (i) and (j) of this section.

Adopted §134.204(m) refers a treating doctor to §126.14 (relating to Treating Doctor Examination to Define Compensable Injury) when billing for an examination to define the compensable injury.

Adopted §134.204(n) sets forth Division modifiers to be used by HCPs in conjunction with procedure codes to ensure correct coding, reporting, billing, and reimbursement. The adopted subsection includes six new modifiers associated with treating doctor case management functions and requested designated doctor examinations.

Comment: Commenters support and endorse the proposed fee schedule rules with expressions that it is long over-due, it is an improvement from the current fee schedule, and that it hopefully will attract more doctors to the system, thus improving treatment and access to quality medical care of employees sustaining on the job injuries.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenter opposes adoption of these rules as it will result in drastic increase in cost of medical care in the Government Employees Workers' Compensation Program. While it appears the goal is to improve access, there is no substantive fiscal analysis on the actual impact of the rules on the system.

Agency Response: The Division disagrees that analysis of impact of the proposed rules on the system has not been conducted or shared. Fiscal impacts were developed and provided in the "Public Benefit/Cost Note" portion of the proposal preamble that states for proposed reimbursements for professional services other than surgical procedures performed in a facility setting, the estimated approximate increase is $51 million, or 9.8 percent. Additionally, the proposal preamble reflects reimbursement for surgical services performed in a facility setting to increase approximately $20.6 million, or 39.5 percent. Overall, this is an approximate increase of $71.6 million in system costs with a net change of approximately 7.2 percent of total system medical payments. These estimates for overall impact are consistent with the estimated impact developed by the NCCI, which calculates an increase in medical costs in Texas of 7.1 percent, and also includes the 10 percent incentive payment for workers' compensation underserved areas, and the increase in payments to designated doctors.

Comment: Commenter requests further definition of what encompasses professional services (e.g., §134.203) and workers'

compensation specific codes, services, and programs (e.g., §134.204) as it is not clear which is to be referenced in a particular circumstance.

Agency Response: The Division clarifies that adopted §134.203 is the appropriate rule reference that provides guidance for reimbursement of CPT code service categories; HCPCS level II codes A, E, J, K, and L; and the Medicare Clinical Fee Schedule for laboratory and pathology services, with appropriate instruction of workers' compensation conversion factors to be applied. Adopted §134.204 is the appropriate rule reference that provides guidance for reimbursement of provider case management services; home health services; functional capacity evaluations (FCEs); return to work rehabilitation programs; designated doctor examinations; MMI and IR examinations; return to work and/or evaluation of medical care examinations; references to work status reports and treating doctor examinations to define the compensable injury; and Division modifiers. Depending on the circumstance of the medical care being provided to the injured employee, both adopted rules, and other Division rules, may be applicable.

Comment: Commenter requests a definition for the term "maximum allowable reimbursement," and states it should clarify whether or not the medical fee guidelines (MFG) are a ceiling or not, thus making it clear if physicians can negotiate through a contract for reimbursement above the MFG.

Agency Response: The Division agrees that the term "maximum allowable reimbursement" requires a definition, as the statute does not reference the term, yet it is frequently used in Division rules. The Division has defined the term in adopted §134.1(a) as "the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 and Division rules." The Division clarifies that the medical fee guideline is not to be considered either a floor or a ceiling on reimbursement. HCPs are free to contract for different reimbursement when done pursuant to the requirements of statute and Division rules.

Comment: Commenters assert that increase in fees to health care providers will not hurt and might help in bringing doctors back into the workers' compensation system; however, they note, it is the system's "hassle factors" that need to be addressed as the most significant system problem. A commenter reminds the Division that physicians have continually adjusted their practices to the shifting and increasing administrative requirements and have absorbed most of the costs while doing so.

Agency Response: The Division agrees that the reimbursement rates are an important factor, and also agrees that there are administrative burdens that are unique to a workers' compensation system. The Division notes, however, that numerous steps have been implemented to minimize these burdens within the parameters of the Labor Code. For example, the Division has taken steps to implement new eBilling rule requirements to offset the more burdensome paper billing process. Additionally, adopted fee guidelines by the Division lend certainty to the system with consistency in payments, thereby reducing the number of medical fee dispute resolution requests. Two additional examples include the agency's goal and commitment to limit the creation of new forms, and the abolishment of the Approved Doctors List (ADL), the ADL application, training, and certification processes.

Comment: Commenters recommend a $500 "no show" reimbursement amount to compensate for a patient who does not keep an RME appointment that is blocked by the busy doctor's practice.

Agency Response: The Division declines to make the change. The reimbursement for broken appointments was removed from the MFG by adopted §134.202 in 2002, in part, because the reimbursement structure for MMI examinations changed, which resulted in an overall increase in reimbursement for MMI examinations from the previous §134.201 of 1996. The overall increase in MMI and IR reimbursement in the 2002 update factored in the no-show rate and was intended to compensate for possible costs a health care provider may incur due to broken appointments. More recently, a Division survey conducted from August to October, 2006 demonstrated that of 14,283 designated doctor appointments, injured employees missed approximately 656 (4.7 percent) of these visits, while designated doctors missed approximately (510) 3.7 percent of these appointments. Based on those factors, the Division has determined that the current policy adequately addresses the issue.

§134.1 and §134.203(g)

Comment: Commenter supports the decision to reimburse products without a Medicare or Medicaid code under "usual and customary" approach of the proposed rules. The commenter suggests that such a policy is consistent with workers' compensation legislation in other states, as well as the commercial market. The commenter asserts that such a system of using usual and customary charges will work more effectively, be applied more fairly and implemented easier.

Agency Response: The Division appreciates the commenter's support. However, the Division would clarify that when §134.203(g) is applied, reimbursement should be the lesser of the MAR, the usual and customary charge, or the fair and reasonable amount consistent with the standards of §134.1. Additionally, §134.1 requires that reimbursement be made in accordance with the Divisions' fee guidelines, a negotiated contract, or be a fair and reasonable amount.

§134.1(a), (b), and (d)

Comment: Commenter recommends added language to ensure that the intent of the MFG stays intact and that rental networks do not erode the protections and safeguards that the MFG provides patients. The commenter asserts that all reimbursements for Chapter 408 Labor Code (non-network) services provided to patients according to a negotiated contract must be based on a contract apart and separate from Insurance Code Chapter 1305 Network (certified network) patients. In the new managed care networks (informal or voluntary networks), many of the contracts contain provisions that allow discounts to be sold and repriced. These "silent brokering" transactions could circumvent the protections provided by the MFG.

Agency Response: The Division disagrees that §134.1 is an appropriate place to address what provisions may or may not be included in a private contract between a provider and a network certified pursuant to Insurance Code Chapter 1305 (certified network) or an informal or voluntary network arranged pursuant to Labor Code §§413.011(d-1) - (d-5) and 413.0115. Certified networks are regulated pursuant to Insurance Code Chapter 1305 and 28 TAC Chapter 10. The informal working draft rules implementing Labor Code §§413.011(d-1) - (d-5) and 413.0115, to be located at 28 TAC §§133.2, 133.4, and 132.5, were posted on the Division's website in November, and will be formally proposed and open for public comment on a future date.

§134.1(d) and §134.203(g)

Comment: Commenter recommends language be re-written in proposed §134.1(d) as follows: "(3) In conforming with §134.203(f) of this chapter, in the absence of an applicable fee guideline or a negotiated contract, separate from a Chapter 1305 network contract, a fair and reasonable reimbursement amount as specified in subsection (e) of this section."

Agency Response: The Division disagrees with commenter's recommendation. It would be unsuitable to limit §134.1(d) applicability to §134.203, because §134.1 is applicable to all medical reimbursement made pursuant to Title 5 of the Labor Code, not just that which falls under §134.203. Additionally, it would not be correct to make a distinction concerning a contract between a certified network and a provider. In most instances such reimbursement is regulated by Insurance Code Chapter 1305 and 28 TAC Chapter 10. However, some provisions in Insurance Code chapter 1305 do contemplate carrier liability for out-of-network services. In such instances, §134.1 might be applicable.

§134.1(d)(1) and §134.2(a)

Comment: Commenter states that fee "guidelines" is an ambiguous term as it implies "guidance," and not the set fees actually established by a MAR or a fee "schedule." The commenter asks whether, due to the ambiguity of the terminology, there is a difference between fee guidelines, fee schedules, and MARs.

Agency Response: The Division clarifies that there is a difference between "fee guidelines," "fee schedules," and "MAR." "Fee guidelines" is a term used by the Legislature in Labor Code §413.011, where the Division is directed to develop a system for reimbursement, using the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicaid and Medicare Services (CMS). "Fee schedule" is also a term used by the Legislature in Labor Code §413.011, as well as a term frequently used by CMS in describing its reimbursement methodologies--the adopted sections use the term "fee schedule" when necessary for clear references to CMS. "MAR" is a term used by the Division that means "The maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with Labor Code §413.011 and Division rules." To clarify the meaning of "MAR," this definition has been added to §134.1.

§§134.1(d)(2), 134.2(a), and 134.2(b)

Comment: Commenter recommends that HCPs in markets where their services are in limited supply be allowed to negotiate above the "guidelines," which in turn, would negate the need for a MAR. Commenter questions if, on the other hand, the MAR is intended to apply to those instances where there has been no negotiated contract. Commenter recommends deletion of the term "MAR" in subsection (a) of §134.2, and to make rule language clear in §134.2(b) that providers may enter into a negotiated contract that is either above or below the fee set by the "guidelines."

Agency Response: The Division declines to make the change that deletes the provisions concerning MAR. The Division notes that Labor Code §413.011(d) allows providers and carriers to contract for fees that differ from the Division's fee guidelines, and the sections as proposed contemplate this provision and the existence of contractual arrangements. Specifically, §134.203(g) and §134.204(c) only require payment at MAR if there is not a negotiated or contracted amount that complies with the requirements of Labor Code §413.011. It would be inappropriate to delete the provisions addressing MAR, because Labor Code §413.011 requires the Commissioner to adopt health care reimbursement policies, and merely providing for contractual arrangements would not satisfy this legislative mandate. Language changes to make it clear a provider may enter into a negotiated contract that is either above or below the fee set by the fee guidelines are unnecessary, because the rules as adopted sufficiently state this.

§134.1(e)(3)

Comment: Commenters recommend deleting §134.1(e)(3). One commenter states that the paragraph would negate "fair and reasonable" used in disputes, asserting that "fair and reasonable" should not be defined by inconsistent medical dispute decisions, which could ultimately be overturned. Another commenter states that it is unclear which nationally recognized studies are meant by the reference or the manner in which a study would qualify as a "nationally recognized published study."

Agency Response: The Division disagrees with commenters' suggestion and declines to make the suggested change. The provisions in §134.1(e)(3) are not new language, and are thus currently applicable in the determination of "fair and reasonable" as it occurs in disputes. The language in §134.1(e)(3) has not resulted in difficulty in application in the past, and the Division anticipates that parties will continue to apply §134.1(e)(3) without difficulty. The Division clarifies that the rule is not referencing any specific nationally recognized published studies. Rather, this provision is included due to the Division's awareness that workers' compensation is an area with ongoing research. As new studies are published, parties may take them into consideration.

§134.1(f)

Comment: Commenter recommends rule language addition to last sentence of this paragraph to read, "Upon request of the Division or a HCP, an insurance carrier. . . ." Commenter states that health care providers will have data on reimbursement amounts from various insurance carriers and will be able to readily determine if the fee by one specific carrier is outside the norm.

Agency Response: The Division disagrees with the suggestion and declines to make the requested provision, because the requested change is unnecessary. The section referenced by the commenter anticipates that monitoring of carrier fees and reimbursements will be carried out as part of the Division's medical bill review and audit procedures. The Division also clarifies that the section referenced by the commenter as §134.1(f) has been renumbered as §134.1(g) due to the addition of the definition of MAR in §134.1(a).

§134.2

Comment: Commenters express support for incentive payments for the critical access shortage areas.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenter supports the 10 percent incentive payment by ZIP Code, but recommends the language be tightened to clarify that a provider's facility must be established in that ZIP Code and it cannot have a mailing address for the purpose of qualifying for the 10 percent pay incentive. Commenter also recommends the Division address providers with multiple offices in multiple ZIP Codes. If a provider has one office in an under-

served area and another office in an area that does not qualify, the Division should ensure that providers not be eligible to receive the incentive pay when a patient is seen in an office in a qualifying area because of the provider's schedule rather than geographical location.

Agency Response: The Division appreciates the supportive comment. The Division believes that all references to the proposed 10 percent incentive payment by ZIP Code under §§134.2, 134.203(b)(2), and 134.204(b)(3) clearly state that the services must be performed in one of the 122 designated ZIP Codes qualifying as a workers' compensation underserved areas, therefore, further clarification is unnecessary. Using a mailing address to qualify for the incentive payment would be fraud, and is outside the scope of this rule. The Division declines to address multiple offices and multiple ZIP Codes, because choices of office locations and practice schedules are business decisions providers make and are beyond the Division's control.

Comment: Commenter supports the concept of providing an incentive payment to increase participation in the underserved areas, and suggests the additional criteria of access within a reasonable distance of the ZIP Code. The methodology should consider the availability of care in nearby areas, rather than just within the ZIP Code itself.

Agency Response: The Division appreciates the support. At this time, the Division declines to add the additional criterion of access to care within a reasonable distance of the ZIP Code to its methodology. The Division considers its current methodology appropriate and allowable under Labor Code §408.0252. The Division will consider whether additional criteria and changes in methodology are necessary during future reviews.

Comment: Commenter asks if these rule provisions are applicable to pharmacies, since the observation is made that the rule provisions appear to be applicable to durable medical equipment (DME).

Agency Response: The Division clarifies that the adopted rules do not apply to prescription drugs or medicine as provided by pharmacies, as stated in §134.203(a)(1)(B) and §134.204(a)(1)(B). The commenter may refer to Division rules at 28 TAC, Subchapter F, §§134.500 - 134.504 and §134.506 to view the rules concerning pharmaceutical benefits and reimbursements.

Comment: Commenter asserts that one DWC Form-75 request is not proof of a reasonable amount of demand to justify the 10 percent incentive.

Agency Response: The Division clarifies that one approved DWC Form-75 request is not the sole criterion used in the Division methodology. Providers must also meet two other Division criteria simultaneously to qualify for the incentive payments: a ZIP Code that is non-HPSA designated and a ZIP Code where there was no provider on the ADL.

Comment: Commenter asserts that the determination to pay an incentive to physical therapists based on the three part test for determining the 122 underserved ZIP Codes is flawed. A physical therapist is not a doctor or eligible to fill out a DWC Form-75; however, a physical therapist shall receive a 10 percent incentive payment for performing an FCE under §134.204(g).

Agency Response: The Division clarifies that a physical therapist is a recognized ancillary provider under Labor Code §401.011(21)(A) and a treating doctor's approval is needed before a physical therapist can initiate care.

Comment: Commenter asserts that the 122 underserved ZIP Code areas that are based, in part, on PSAs are flawed, since Medicare PSA ZIP Code maps do not consider chiropractors, optometrists or podiatrists and they do not qualify for the PSA payment, nor do they qualify for any HPSA payment as a primary care, dental or mental health physician.

Agency Response: The Division clarifies that chiropractors, optometrists and podiatrists are included in the definition of "Doctor" under Labor Code §401.011(17). Therefore they would be eligible to receive the 10 percent incentive payment under proposed §§134.2, 134.203(b)(2) and 134.204(b)(3).

§134.2(a)

Comment: Commenter recommends a designated modifier for the 10 percent incentive payments for workers' compensation underserved areas.

Agency Response: The Division declines to use a designated modifier for the 10 percent incentive payments for workers' compensation underserved areas. The ZIP Codes that comprise the designated workers' compensation underserved areas designate where the workers' compensation services were performed. Further, the Division points out that under Medicare's current automated Primary Care HPSA bonus payment, health care providers automatically receive the 10 percent incentive if the health care provider's ZIP Code is on the HPSA list of ZIP Codes where the services were rendered, without the use of a modifier.

§134.2(b)

Comment: Commenter asks if the ZIP Codes listed are the only ones that qualify for the 10 percent HPSA incentive.

Agency Response: The Division clarifies that if a provider qualifies for a HPSA payment as established by Medicare, then the provider does not meet the criteria for the incentive payment of providing services in a designated workers' compensation underserved area. In specifying workers' compensation underserved areas, the Division utilized three criteria simultaneously: a ZIP Code that was not in a designated Medicare HPSA, a ZIP Code that had at least one approved case-by-case exception of Division-approved request to the appointment of a provider who was not on the Division's ADL, and a ZIP Code where there was no provider on the ADL. Using those three criteria, the Division designates 122 of the 4,254 Texas ZIP Codes as eligible for the 10 percent incentive payment. The Texas ZIP Codes that qualify for the 10 percent HPSA incentive payment as established by Medicare will continue to receive the incentive payment from Medicare.

Comment: Commenter recommends a different mechanism, other than by rule, for identifying those applicable ZIP Codes as it seems a continuous list update adjustment, and the ADL is already obsolete. The commenter asserts that not doing this will eventually lead to distortions in the market for what constitutes underserved areas.

Agency Response: The Division declines to use a different mechanism, other than by rule, in identifying and updating workers' compensation underserved areas at this time. The Division notes that Labor Code §408.0252 requires the Commissioner to use a rule to identify areas of the state in which access to HCPs is less available. The Department will utilize alternatives to the ADL to determine applicable ZIP Codes in the future, after it has performed sufficient research in identifying viable alternatives.

Comment: Commenter recommends the Division's Medical Advisor office administer a survey similar to the case-by-case exception from the ADL, in order to encourage an improved and re-defined methodology for determining underserved areas.

Agency Response: The Division declines to administer such a survey at this time. Development and use of a survey of the type the commenter requests would impose a significant administrative burden on both the Division and the stakeholders required to respond with no guarantee of benefits greater than those received through analysis of data currently collected by the Division. The Division will, however, be open to revisiting that issue during future rule reviews.

§§134.2, 134.203(b)(2) and 134.204(b)(3)

Comment: Commenter supports a 10 percent incentive payment to be added to the MAR for areas underserved by health care providers. However, the commenter also recommends that HPSA designated areas should be included, as most physicians in HPSA areas are not servicing or are not the type of physicians that would service workers' compensation patients. The entire purpose of offering the incentive is to encourage physicians in these areas to start participating and treating workers' compensation patients; if most physicians in the HPSA ZIP Codes will not participate in the workers' compensation system, then the cost of offering the incentive in a larger geographical area would be minimal. The commenter recommends using more current and reliable data to establish underserved areas, and suggests that workers' compensation underserved areas be based on whether an injured employee has access to a health care provider and not on the number of available health care providers in that specific geographical region.

Agency Response: The Division appreciates the supportive comment, but at this time declines to include the 452 ZIP Codes designated as 2007 Primary Care HPSAs as workers' compensation underserved areas. Increasing the workers' compensation underserved areas by 330 ZIP Codes without independently researched and verified Division support is premature. Further, Medicare already provides a 10 percent incentive payment to those shortage areas. The Division does not believe that an additional 10 percent over Medicare for a total incentive of 20 percent is a fair and reasonable amount at this time. Additionally, those shortage areas are already federally identified areas for the delivery of primary medical care which overlap with services that injured employees in Texas will need. The Division clarifies that it used the most reasonably current and reliable data it had available when it undertook the methodology of establishing the workers' compensation underserved areas given the constraints of limited resources and timelines.

Comment: Commenter states that it is unclear on what basis the 10 percent incentive payment is justified, because the ZIP Codes do not consistently reflect a shortage of providers within a given mileage radius or geographic area. The commenter asserts that ignoring travel reimbursement provisions and using ZIP Codes as criteria for determining provider shortages is flawed, noting that in large cities ZIP Codes tend to be geographically small but densely populated areas. In addition, the commenter notes that medical facilities often concentrate themselves geographically to serve population clusters, so absence of a provider or specialty in a ZIP Code does not equate to underserved.

Agency Response: The Division clarifies that 10 percent is a measure used by Medicare which the Division considers fair and reasonable. The Division's criteria for establishing underserved areas are: a non-HPSA designated ZIP Code, a ZIP Code with at least one approved case-by-case exception and a ZIP Code where there was no ADL provider. The points regarding mileage radius and travel reimbursements are well taken, and the Division thanks the commenter for this insight. The Division will consider this suggestion in future rulemaking.

Comment: Commenter recommends deletion of the provisions regarding workers' compensation underserved areas, because the methodology set forth in the proposed rule captures areas that are not truly underserved. Since the rationale is based on the ADL, now deleted, the commenter says that it is not clear how the Division will update the list in the future.

Agency Response: The Division declines the recommendation to delete the subsections and disagrees that the methodology does not capture areas that are underserved. Each of the 122 ZIP Codes has at least one injured employee requesting and getting approval for an exception to get treated by a non-ADL provider. Simultaneously, each ZIP Code also has no approved doctor on the ADL. To avoid double reimbursement, none of the ZIP Codes is on the HPSA list. The Division clarifies that a "point in time" methodology, partially based on the ADL when it was formulated, may be reviewed and revised under Labor Code §413.012. Comments regarding underserved areas will be considered in the Division's review process.

§§134.2(a), 134.2 (b), 134.203(b)(2), and 134.204(b)(3)

Comment: Commenters recommend that §134.2 and any associated references to a workers' compensation underserved area incentive payment be deleted from the rules until there is solid research and information on which to base this payment adjustment. The commenters criticize the methodology used for establishing the ZIP Code inclusion, stating that it does not adequately demonstrate health care provider shortage in all ZIP Codes, no apparent indication is given to access for reasonable travel distances, and is not an accurate representation of an underserved area. Carriers have provided mileage reimbursement and travel expenses for injured employees for decades to help alleviate the problem of underserved areas. Commenter notes ZIP Code 79411 is adjacent to 79410 in the city limits of Lubbock, and further objects to the listing of 79411 when there is ample availability of 127 ADL doctor in ZIP Code 79410. One commenter recommends further analysis be done to address these concerns, as there is no need to add unnecessary medical costs to areas of the state when there is adequate access to health care services.

Agency Response: The Division declines to make the deletions. Carriers have historically provided mileage reimbursement and travel expenses for injured employees, yet the 79th Legislature considered the issue of underserved areas and deemed it of enough importance to pass Labor Code §408.0252 as part of HB 7. This section, effective September 1, 2005, allows the Commissioner to identify the areas of the state in which access to health care providers is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. In early 2007, Division staff began conducting an extensive analysis of Division data and ZIP Code records to identify underserved areas of the state. Data reviewed were: HPSA ZIP Code designation, provider specialty groups, and injuries per ZIP Code. First, Division staff reviewed the 4,254 Texas ZIP Codes and set aside those ZIP Codes that contained one or more of the following information: a HPSA designation, an approved DWC Form-75, a provider on the ADL by specialty

group, a Texas Medical Board provider by specialty group and at least one record of injury. There were 3,527 records in the data analysis. After deleting ZIP Codes that were included more than once, the result was a count of 2,198 ZIP Codes. The next step was the separation of the 2,198 ZIP Codes into non-HPSA and HPSA designated ZIP Codes. The Division determined the HPSA designation from the 2007 list of Texas HPSA primary care ZIP Codes available from the CMS. There are currently 452 HPSA primary care ZIP Codes. Starting from the 2,198 ZIP Codes, the Division subtracted the 452 HPSA ZIP Codes resulting in 1,746 non-HPSA ZIP Codes. Next, the analysis identified non-HPSA ZIP Codes from the 1,746 that had at least one approved request for a case-by-case exception for a non-ADL doctor, using DWC Form-75. The Division selected approved requests for case-by-case exception that included only one claim number, and excluded any invalid or missing claim identification. The Division used the time period between September 2006 and February 15, 2007. Out of the 1,726 non-HPSA ZIP Codes, 536 ZIP Codes also had at least one approved DWC Form -75. The next step was to drill down the 536 ZIP Codes into ZIP Codes that had no ADL providers practicing in those 536 ZIP Codes where there was an approved exception. The Division looked at current "Active" license status providers approved to provide treatment that had a Texas practice address or indicated a primary address in Texas in the particular ZIP Code that was not a mailing or correspondence address. ZIP Codes from the ADL practice addresses were used first, limiting the count of ADL providers to one per ZIP Code where there were multiple office locations within the same ZIP Code. 122 ZIP Codes qualified.

The Division points out that Labor Code §408.0252 is stated in terms of "appropriate" standards. Even in the strictest of statutory construction, it is improbable that "appropriate" would be interpreted that the Commissioner must have an optimal methodology in setting the criteria when designating the workers' compensation underserved areas. Further, the 122 ZIP Codes constitute only 2.8 percent of the total ZIP Codes in Texas and a spike in unnecessary medical costs is unlikely compared with the possible benefit of health care provider access for injured employees.

§134.203(a)(5)

Comment: Commenter recommends the deletion of Medicare Local Carrier Determination (LCD) policies due to payers distortion of proper application, such as using the LCDs to deny reimbursement for services that are properly covered under workers' compensation. Local Carrier Determinations are designed for traditional Medicare-aged population and not the working-age patients with return to work concerns. The commenter asserts this will still retain the policy goal of achieving standardization by using the Medicare billing and reimbursement policies as modified by the CMS.

Agency Response: The Division declines to make the change. The rule language is consistent with the requirements of the Labor Code and §137.1 (relating to Disability Management Concept). The Labor Code requires the use of evidence-based medicine and CMS and its fiscal intermediaries follow these concepts in establishing payment policies. However, any rules specifically adopted by the Division take precedence over the Medicare policies. The Division believes a potential misapplication of a policy is a poor reason to delete the policy, and sets a poor precedent in evaluating system requirements.

§§134.203(a)(2), 134.204(a)(2), and 134.204(a)(3)

Comment: Commenters recommend the implementation date of these rules be changed to six months after the rules are adopted, in order to give insurance carriers an appropriate amount of time to make programming changes to their claims management/payment computer systems. The commenters express concerns with similar implementation deadlines for eBilling processes and preparation for hospital inpatient and outpatient fee guidelines.

Agency Response: The Division declines to extend the implementation date. The activities necessary to implement these rule changes are consistent with the changes insurance carriers have made on an annual basis since the adoption and implementation of the 2002 MFG, and the applicable date of these sections has been the Division's recommendation to system participants since the May 2007 posting of the informal working draft rules on the Division's website.

§134.203(a)(5) and §134.203(a)(7)

Comment: Commenter supports the provisions added to the rule by §134.203(a)(5) and (7).

Agency Response: The Division appreciates the supportive comment.

§134.203(a)(6)

Comment: Commenter recommends this paragraph be deleted as it is bad public policy and inconsistent with the provisions of the Labor Code. The commenter notes that Medicare reimbursement methodology appropriately does not permit chiropractors to be reimbursed for evaluating and directing care that is outside their scope of practice, and it is essential that the Division not open the door to allow chiropractors to be reimbursed for evaluating and directing care of all medical conditions.

Agency Response: The Division declines to delete §134.203(a)(6). In accordance with Labor Code §413.011(c), reimbursement policies may not restrict the ability of chiropractors to serve as treating doctors, and they have the same rights and responsibilities as any other treating doctor in the workers' compensation system working within the scope of their practice act. This paragraph is necessary to modify the Medicare system to adapt to features unique to the Texas workers' compensation system, such as the ability of chiropractors to serve as treating doctors. Thus, chiropractors are an exception to the CMS payment policies, and may be reimbursed for services provided within the scope of their practice act. Specific provisions contained in the workers' compensation Act, or commission rules, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Finally, the statute states that it is not to be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 1451.104, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. Chiropractors have been reimbursed as treating doctors since the effective date of §134.202, and will continue to be reimbursed as treating doctors according to statute.

§134.203(a)(7) and §134.204(a)(5)

Comment: Commenter recommends the provisions in §134.203(a)(7) and §134.204(a)(5) be deleted, as they are confusing and unnecessary. The commenter further references the rule language "including timed procedures and other limitations."

Agency Response: The Division declines to make the change and clarifies that these comments were written based on input to the informal draft rules. The referenced language was deleted in the proposed rules.

§134.203(b)

Comment: Commenter recommends that, any Federal policies related to budget adjustments be specifically excluded, as Georgia and Maryland workers' compensation systems have done in their fee schedules, because this additional adjustment in the calculation of the Medicare physician fee schedule was intended solely as a Federal adjustment and should not impact the state of Texas workers' compensation system. Commenter states such ongoing action at the federal level, if applied in workers' compensation, will drag down the overall work RVUs by 11.94 percent in the coming year.

Agency Response: The Division declines to make the change. In order to achieve standardization with the most current reimbursement methodologies, models, and values or weights used by the CMS, as statutorily required in §413.011 of the Labor Code, the Division retains the budget neutrality factors included in the Medicare reimbursement calculations. Modifying the formula would negate standardization and create a more complex calculation in the workers' compensation system. This complexity might increase the volume of fee disputes, making it more time consuming for the Division's Medical Fee Dispute Resolution to resolve such disputes. In addition, excluding a factor of the Medicare reimbursement formula might set a precedent for further expectations to alter Medicare's formulas.

§134.203(b)(2)

Comment: Commenter states it is unclear whether a payment that is to be added for a workers' compensation underserved area is to be made in addition to any "bonus" payment that is to be made for HPSA and PSAs.

Agency Response: The Division clarifies that the incentive payment applied to the reimbursement for workers' compensation services provided by doctors in underserved areas is not intended to apply to services that are provided in Medicare designated HPSAs and/or PSAs. In accordance with Medicare policies, incentive payments are already automatically applied to reimbursements for workers' compensation services provided in areas of Texas that are designated as either a HPSA and/or a PSA by Medicare. These areas were intended to be eliminated from the criteria of the designated workers' compensation underserved areas to prevent a double incentive bonus payment for providing the services in these areas. While the Division strives to address the issue of underserved areas as authorized in §408.0252 of the Labor Code, the Division, at the same time must balance the requirement in §413.011 to achieve effective cost containment measures. Allowing for a double incentive bonus does not achieve the goal of effective cost containment.

§134.203(c)(1)

Comment: Commenters support the proposed conversion factors, noting that the fee increase will attract orthopedists and orthopedic surgeons into the system. The commenters also state that the proposed conversion factor will cover the administrative costs associated with workers' compensation. A commenter noted that Medicare reduced reimbursement for mental and behavioral services by nine percent in 2007. The increased reimbursement, as well as the annual increases, will offset overhead costs and attract and keep quality providers in the workers' compensation system. The commenters stated improving access to medical care will result in better, earlier and more cost-effective medical care.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenters support an increase in reimbursement amount, but do not believe the adopted conversion factors are adequate. The commenters expressed various opinions for the inadequacy of the rates. The commenters state that the proposed conversion factors will not attract physicians back into the system and will not attract a robust physician network to workers' compensation in the daily treatment injured workers. The commenters state the result is that patients cannot find needed health care, which is supposed to be guaranteed.

The commenters state the proposed conversion factors will not cover the administrative costs in dealing with the system as a whole, including preauthorization requirements, treatment planning, treatment guidelines, and return to work guidelines, along with new electronic billing requirements.

The commenters recommend an increase in fees to 155 percent for evaluation and management codes and 190 percent for surgical codes to cover the administrative requirements and costs associated with workers' compensation claims. To attract doctors back into the system, a commenter recommends the conversion factor for evaluation and management should be set at 200 percent of Medicare's 2007 conversion factor and the conversion factor for surgery should be set at 300 percent of Medicare.

Agency Response: The Division disagrees that the adopted conversion factors are inadequate. In determining "fair and reasonable" reimbursement levels, the Division must look at several factors. The Division is tasked with several rigorous statutory requirements that must be balanced. Labor Code §413.011(d) requires that a fair and reasonable standard must be met and fees must be "designed to ensure the quality of medical care and to achieve effective medical cost control." In addition, the statute provides that, "The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

In addition to the medical practice expenses, the Division examines the administrative requirements of the Texas workers' compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL, but must continue with requirements related to types of injured employee examinations (e.g., maximum medical improvement, impairment ratings, and functional restoration). Doctors now must comply with the Division's adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is presumed medically necessary. Treatment outside or in excess of the guidelines must be preauthorized. Beginning January 1, 2008 providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Comment: Commenter generally supports the proposed reimbursement rates, but states orthopedic surgeons will not sign up with networks unless the adopted reimbursement conversion factor is at least 155 percent of Medicare and 165 percent of Medicare for surgeries.

Agency Response: The Division clarifies that these adopted rules relate to workers' compensation fee guidelines and do not apply to the rates established by certified networks or political subdivisions contracting directly with health care providers. Subsections (a) in both sections 134.203 and 134.204 state that medical services provided through workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapters 1305, are not applicable.

Comment: Commenter states the proposed rates will strengthen the certified workers' compensation networks by giving them a margin to create a cost efficient system that will allow creation of high quality panels, which will lower total workers' compensation costs.

Agency Response: The Division agrees and appreciates the supportive comment.

Comment: Commenters are supportive of increased fees but are concerned that they will only apply to non-network patients. A commenter states that no "discounts" should be allowed by the insurers who "buy" their way into other networks silently, and then take 20-30 percent discounts off the top. Another commenter questioned what will happen to existing network contracts.

Agency Response: The Division clarifies that rule §134.203 will not apply to certified networks or political subdivisions contracting directly with health care providers. The Division suggests, however, that carriers and providers review existing contracts to determine the relationship between contract fees and the Division's MFG.

HB 473, adopted during the 80th legislative session, amends Labor Code §413.011(d-2) to require informal and voluntary networks or the carrier or the carrier's authorized agent, to notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by Division rule. Rules implementing this bill are to be located at 28 TAC §§133.2, 133.4, and 132.5.

Comment: Commenter states the introduction of managed care networks in workers' compensation has a significant effect on prices for physician services in-network, but should not affect non-network medical fee guidelines. The commenter states workers' compensation insurers have adequate means for negotiating lower fees with physicians. Networks allow market forces to be applied to workers' compensation fees so that the standard fee schedule is not needed to micromanage the marketplace, but can be used to provide a cap that prevents price-gouging. The fee schedule should be set as a higher cap on prices, thereby allowing a wider range of acceptable fee amount to be governed by market forces and giving freedom of negotiation to managed care networks.

Commenters assert that the proposed rates will result in unnecessary increases in system medical costs that will undermine the viability of networks and their ability to negotiate reimbursement rates that are not impacted or tied to the fee guideline. A commenter recommends that the Division understand the direct viable impact the proposed reimbursement rates will have on political subdivisions that choose to directly contract with health care providers.

Commenters state this will cause employers to leave the system, which could harm the economy of Texas. Another commenter states the proposed reimbursement rates will undermine certified network expansion by reducing the costs savings that the certified networks were created to promote. The commenters assert that the proposed increases will result in a floor for renegotiating fees with network providers. One commenter says many providers have already begun renegotiating their contracts to the proposed rates.

Commenter references TDI's Research and Evaluation Group network rate study and recommends that the market should continue to play a significant role in price determination. The commenter states that more than 85 percent of orthopedic surgeons are being reimbursed at or below 150 percent of Medicare, and in general, 60 percent of physicians, including specialists, are being paid at 150 percent of Medicare or less. The commenter states neurosurgeons are the only providers being paid above 175 percent of Medicare, although the surgical reimbursement range for neurosurgeons is anywhere from 96 to 205 percent of Medicare.

Agency Response: The Division clarifies that these rules do not apply to certified networks or political subdivisions contracting directly with health care providers. The Division disagrees with the implication that fee guidelines should be construed as either a floor or ceiling for certified network contract reimbursement levels or that they would undermine the ability of certified networks to negotiate reimbursement rates. Experience has shown that even with the current conversion factor of 125 percent, networks have negotiated reimbursement rates both above and below the conversion factor. Labor Code §413.011 (relating to Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols) establishes the requirements for fee guidelines that are fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

Labor Code §413.011 also requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels the Division must consider several factors because "fair and reasonable" is a balance of all the required components of the Labor Code. However, the Division is not required to establish reimbursement levels that reflect the average current payment within the current certified network system or to set reimbursement levels that establish a floor for certified network contractual arrangements. Certified network issues and regulations are a separate set of laws and rules under the Workers' Compensation Health Care Network Act, which is codified at Texas Insurance Code Chapter 1305, and is not administered by the Division of Workers' Compensation.

Health care providers affiliated with certified workers' compensation health care networks may favor the benefits of participating in a network as they tend to experience fewer administrative requirements, less confusion with rule interpretation, and experience increased clarity of payment than those providers who are regulated by the requirements of the Labor Code for non-network care of injured employees. Further, Insurance Code §1305.153 provides that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider or group of providers. Network rules at §10.42(b)(11) require network contracts with providers to contain the schedule of fees that will be paid to the contracting provider. The parties are free to negotiate the schedule of fees and are free to tailor contracts to meet the specific needs of both the network

and the health care providers. The parties are not constrained by the Division's fee guideline reimbursement amounts.

The Division is aware that as certified networks expand, they are likely to comprise a significant portion of the workers' compensation market. However, the Division has significant responsibilities to assure, through the fee guidelines, access to care for injured employees not subject to certified network requirements. The Division has considered this in establishing these fee guidelines, which apply to the population of injured employees who are not in a network. Consequently, while reimbursement rate comparisons of network payment levels and non-network payment structures are a natural process for setting benchmarks, there is no mandated relationship between these two reimbursement systems. There is no reason to believe that an increase or decrease in non-network regulated fee schedules should hinder network negotiations of schedule fees.

Comment: Commenters support a conversion factor that is higher than the proposed conversion factor. For non-surgical care, commenters' recommendations include 140 percent, 150 percent, 155, 175 percent, and 200 percent. For surgical care, some commenters recommend 175 percent and others recommend 190 percent. Commenters state that the recommended 155 percent of Medicare for evaluation and management services and the recommended 190 percent of Medicare are based on national averages from a comprehensive WCRI study, "Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006," Workers' Compensation Research Institute (WCRI Report) that examined all states with workers' compensation fee guidelines.

Commenters state the proposed conversion factors are too low for physicians to continue to treat complex injured worker cases. Other commenters state the proposed conversion factors are too low to bring doctors back into the workers' compensation system. The commenters assert that it is difficult to find physicians willing to treat workers' compensation patients and are concerned that the proposed conversion factors will affect injured worker's access to quality care. The commenters note that patients frequently have to be referred out of town for specialty care because local specialists will not take workers' compensation patients. One commenter states dermatology, neurology, psychiatry, and orthopedic surgery are in short supply. The commenter expresses additional concern with the nationwide shortage and similar experience in San Antonio of family practice physicians. The commenter states that for the last 3-5 years, residency programs are only filling 50 percent of their slots in favor of finding other, more lucrative and less administratively burdensome, patient practices.

Another commenter asserts that it will stop treating workers' compensation patients if the proposed conversion factors are adopted. A commenter notes that in other states workers' compensation reimbursement rates are set higher than commercial payors such as United Healthcare and Humana.

Other commenters assert that conversion factors higher than the proposed conversion factors will help alleviate barriers to keeping the workforce healthy and safe, restore balance, encourage good non-operative care, and will ensure orthopedic surgeons continue to treat workers' compensation patients. One commenter says that conversion factors recommended by the Texas Medical Association will improve medical fees to a level that will significantly improve access to care by re-engaging the surgical and primary care foundation of the workers' compensation system.

The commenters state that physicians not currently in the system, who may not have adequate staff to accommodate the workers' compensation patient population, need sufficient financial inducement in the form of higher reimbursement fees to take on the added costs. The commenters advise that it is the steep administrative burden that impacts the physician's operating costs and erodes the fee received for the medical services provided to workers compensation patients. One commenter notes there are many burdens, such as documentation, reporting, preauthorization, electronic billing requirements, treatment and return to work guidelines, treatment planning, and coordination with employers, adjusters and case managers. Some commenters also reference compensability and disability issues as factors contributing to administrative costs, as well as denial of legitimate medical care. A commenter notes that these requirements place demands on physician time and often require specially trained staff or consultants to manage the unique reporting and communications intrinsic to workers compensation. A commenter states that it takes twice the time and effort to treat a workers' compensation patient as it does for the same treatment provided to a group health patient.

Agency Response: The Division disagrees that the adopted conversion factors are inadequate and need to be higher. In determining "fair and reasonable" reimbursement levels the Division must look at several factors. The Division is tasked with several rigorous statutory requirements that must be balanced. Section 413.011(d) of the Act requires that a fair and reasonable standard must be met and fees must be "designed to ensure the quality of medical care and to achieve effective medical cost control." In addition, the statute provides that, "The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

In reviewing the conversion factors from §134.202 to determine whether the conversion factors should be adjusted to meet the fair and reasonable standard, the Division considers the change in the MEI from 2002 to 2007. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. The increases in these practice expenses have not been recognized in the Medicare conversion factor due to other factors in the Medicare's sustainable growth rate (SGR) that effectively negate it. The other components of the SGR serve as major restraints in Medicare's budget neutrality requirements, and do not directly relate to workers' compensation reimbursements. Consequently, the MEI, a direct reflection of physician costs, has increased 15.7 percent since 2002, but Medicare's conversion factor is essentially unchanged from 2002 to 2007.

In addition to the medical practice expenses, the Division examined the administrative requirements of the Texas workers' compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL, but must continue with training requirements related to types of injured employee examinations (e.g., MMI, IRs, and functional restoration). Doctors now must comply with the Division's adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is presumed medically necessary. Treatment outside or in excess

of the guidelines must be preauthorized. Beginning January 1, 2008, providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Comment: Commenters recommend retaining the current 125 percent conversion factor for all services. The commenters state dual conversion factors further encourage the use of more intensive approaches to care when compared to conservative management. It also contributes to medical graduates choosing more lucrative surgical specialties over primary care or non-procedural specialties resulting in shortages of internists, family doctors, neurologists, etc.

The commenters state the current 125 percent conversion factor rate is both fair and reasonable for medical providers and has provided injured workers with ready access to quality medical care. One commenter believes that with the exception of a few isolated cases that would apply to any system, whether it is Medicare or commercial health insurance, employers are not complaining of difficulty in their injured employees finding access to health care. The commenters also state that the current rate, which has been affirmed by the Texas court system, was based on access to care, impact on return to work objectives, special training requirements for medical providers of the workers' compensation system, and the administrative complexity and requirements for medical providers. In addition, one commenter notes that the current conversion factor was based on various workers' compensation specific factors. The commenter states three of those factors have now disappeared or are in the process of disappearing: paper billing, fear of sustainable growth rates reduction in Medicare rates, and transitional considerations. The commenter believes these factors should be taken out of the equation, which would reduce the current 140 percent proposal back to 125 percent of Medicare.

Agency Response: The Division agrees that reimbursement rate of 125 percent of Medicare's conversion factor was fair and reasonable when it was affirmed by the courts in 2003. The Division has maintained this fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. For example, insurance carriers and employers now have new tools in the form of treatment and return to work guidelines that will aid them in cost containment. Additionally, the network market is envisioned to continue growing and to gain deeper state-wide penetration, and these networks also feature increased management of claims and other cost control measures. In addition, during the intervening period, the practice expenses for HCPs providing health care services to injured employees has increased as reflected by the MEI. With these system changes over the intervening four years and with the experienced decline in health care providers, particularly the decrease in access to specialists, the Division now determines it timely to establish new benchmarks to build upon.

The Division's new benchmark is the MEI, which is a component of Medicare's Sustainable Growth Rate (SGR), only without the other components of the SGR that serve as restraints necessary to implement Medicare's budget neutrality requirement. Medicare Payment Advisory Commission has recommended to Congress since 2002 that Congress replace the SGR as a methodology to update physician payments. "Replacing the SGR system could allow updates more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look not only at adjusting payment updates, but at controlling volume growth directly." The American Medical Association also has requested that Congress eliminate the SGR calculation, and instead calculate changes in the physician update based on the MEI. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. Building on the MEI, in general, would allow the conversion factor to increase in relation to changes in the prices of such goods and services as measured by the MEI. With the allowed annual adjustment to the MEI, the Division's conversion factor changes and associated cost increases, as described in the proposal preamble for these rules, will more accurately reflect the increases in costs of providing health care than the previous index to Medicare. Because of the budget neutrality provisions, the expenses are not directly reflected in the Medicare conversion factor. The new benchmark will improve the financial viability of providers to participate in the Texas workers' compensation system.

Comment: Commenter states there is no justification for raising the non-surgical conversion factor above the current conversion factor. The commenter further states that if the differential between the proposed surgical and non-surgical conversion factor is adopted, the surgical conversion factor should be adjusted to 156 percent.

Agency Response: The Division disagrees. Labor Code §413.011 requires the Commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care, and to provide reasonable fees for the evaluation and management of care as required by Labor Code §408.025(c) and Division rules. If surgery is necessary, availability of specialty surgeons is paramount for the prompt and appropriate surgical and follow up treatment of the injured employee. Surgery is only performed, if and when it has been determined to be medically necessary by the insurance carrier. If a health care provider performs surgery in a facility, the provider must seek preauthorization.

Additionally Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies but to also consider the standardized reimbursement structures found on other health care delivery systems. As noted in the certified network surveys conducted by the Department's Research and Evaluation Group and in the WCRI reports it is common for payors to provide a differential for surgical services.

The Division disagrees that the surgical conversion factor should be adjusted to 156 percent of the Medicare rate. The Division has determined that the appropriate differential for surgical services is 25.5 percent over the non-surgical rate. This rate is based on the Division's calculation of the average differential between surgical and non-surgical services as listed in WCRI Report.

§134.203(c)(1)

Comment: Commenter states the proposal preamble's public benefit/cost note makes it sound as though total costs are only increasing to fully account for MEI, but the addition of the surgical conversion should apply to approximately 10 percent of the procedures, driving the weighted average of the conversion factors to 143.5 percent. If it is the Division's intent to limit the increase in costs to the MEI increases, then the surgical conversion factor would be 170.7 percent, the non-surgical conversion factor

would be 136.6 percent, and the weighted average of the conversion factor would be 140 percent.

Agency Response: The Division disagrees that the non-surgical rate should be recalculated. The Division did not predetermine the impact of the MEI increase. Based upon the court decision finding the 2002 baseline conversion factor fair and reasonable, the Division applies the annual MEI adjustment activity year-to-year beginning with the baseline year of 2002. This calculation establishes the adoption conversion factor for non-surgical services at $52.83. The Division applies the differential for surgical versus non-surgical services, based on the WCRI report, to the $52.83 conversion factor. The MEI is not applied using a weighted average due to the Labor Code 413.011(b), which states in part, "The commissioner may also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules." A weighted average approach would not reflect the actual increases in medical practice expenses.

Comment: Commenter states the proposed increase for surgery codes is higher than any contract negotiation based on commenter's cumulative experience of working in various capacities of provider contracting. On average, many of the surgical contracts were negotiated lower than the 140 percent proposed figure. Commenter believes these proposed rates will adversely affect the initiative to control the rising medical costs in the workers' compensation system.

Agency Response: The Division disagrees. Labor Code §413.011 requires the Commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care, and to provide reasonable fees for the evaluation and management of care as required by Labor Code §408.025(c) and Division rules. If surgery is necessary, availability of specialty surgeons is paramount for the prompt and appropriate surgical and follow up treatment of the injured employee. Surgery is only performed, if and when it has been determined to be medically necessary by the insurance carrier. If a health care provider performs surgery in a facility the provider must seek preauthorization.

Additionally Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies and to also consider the standardized reimbursement structures found in other health care delivery systems. As noted in the certified network surveys conducted by the Department's Research and Evaluation Group and in the WCRI reports, it is common for payors to provide a differential for surgical services. The second conversion factor, to be used for surgical procedures when performed in a facility setting, such as a hospital or ASC, is based on the average reimbursement differential between reimbursement rates for surgical services and overall services of those state workers' compensation systems using RBRVS as listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (Workers' Compensation Research Institute, 2006).

Comment: Commenters recommend a single conversion factor so as not to encourage overuse of inappropriate and costly medical treatments. Moving to a multiple conversion factor system defeats the hallmark of the RBRVS system. All internal coherence between medical service categories in a medical fee guideline is achieve only if the guideline has a relative based RVU scale such as RBRVS which values every unique medical procedure or service. Further, the RBRVS system makes reimbursement between different medical procedures and services equitable, and helps discourage inappropriate utilization of health care services. It is important to realize that all extra costs associated with the provision of surgical services are already accounted for in Medicare's RBRVS systems and deviating will seriously jeopardize the medical cost containment measures recently put in place in Texas.

Agency Response: The Division disagrees. Although the Division has adopted two conversion factors, the basic tenets and relationships of the RBRVS system remain in place. Non-surgical services retain their relativities to each other and services within the surgical category generally retain their relativities. Any discrepancy between relativities is based on the differential in the conversion factor and is reflective of the average differential in workers' compensation systems. Because all of the surgeries in a facility setting require preauthorization by the insurance carrier, the Division notes this process as one of the system's utilization control measures to ensure surgeries are not performed if not medically necessary. The preauthorization process encompasses all requests for surgical services in a facility setting. The Division also notes newly adopted treatment guidelines as tools to consistently identify when those treatments and services are appropriate. While it is still too soon to report on outcomes in Texas as a result of the Division's disability management rules applicable for dates of service on or after May 1, 2007, including the Division's adoption of the *Official Disability Guidelines--Treatment in Workers' Comp*, recent analysis of the reforms in California' workers' compensation system reflect some improvements in that state's utilization control. A report, "Analysis of California Workers' Compensation Reforms" (California Workers' Compensation Institute, January 2007) indicates that prior to 2003, there were virtually no limits on the amount of medical services that an injured worker in the California workers' compensation system might receive, as number of visits was often unlimited. With the reforms implemented in 2004, this study reflects some of the benefits of the most notable reforms--mandatory utilization review, adoption of the *American College of Occupational and Environmental Medicine* guidelines, and a cap on the number of physical therapy and chiropractic care visits. In five of the six fee schedule treatment categories, the authors found the implementation of the medical care reforms was associated with declines in medical service utilization, particularly in the use of physical therapy and chiropractic manipulation. The use of medicine section services, surgical procedures, and radiology also declined, but to a lesser degree. As was done in California, the Division anticipates close monitoring and analysis of the implementation of the Texas disability management rules for comparable results in a significant cost control measure that is curtailing over-utilization of medical treatments and services.

Comment: Comments were received on the surgical conversion factor. Commenters recommend the higher conversion factor apply to all procedures in the surgery category, relying on Medicare's relative values to properly weight the payments for facility and non-facility services. The commenters suggest that a single surgery conversion factor would encourage cost-effective care in the appropriate setting, eliminate the choice of setting for economic gain, and ensure the choice of setting is only for quality and safety reasons. Other commenters suggest office-based surgery should be higher than facility reimbursement. One commenter recommends that reimbursement for surgeries should not be dependent on setting to allow health care providers to accept workers' compensation patients and treat them in the most medically appropriate setting.

Agency Response: The Division disagrees. Current billing practices allow the designation of the locality where the surgical procedure was performed (e.g., office versus facility). The Division was initially concerned that this recommendation might incentivize many providers to perform the surgery in a facility setting for the higher reimbursement, and they might then seek preauthorization to perform the surgery in a facility setting. However, Medicare now allows site of service preference deemed by the physician as long as the procedure may be performed safely in that setting. In the Medicare system, the doctor does not have much of an incentive to move a procedure from his office to the ASC or other facility setting, because he would get paid the facility rate, which in most instances is less than the office rate. In the Texas workers' compensation system, the doctor will get paid more in an ASC than in his office because of the Division's conversion factors. The RVUs for the facility rate is less than RVUs for office rate, because the doctor does not encumber the overhead costs of the facility. Consequently, the Division does not agree that surgical services will necessarily shift to a facility setting or cause over-utilization of surgical services. Because all of the surgeries in a facility setting require preauthorization by the insurance carrier, the Division notes this process as one of the system's utilization control measures to ensure surgeries are not performed if not medically necessary. The preauthorization process encompasses all requests for surgical services in a facility setting. The Division also notes newly adopted treatment guidelines as tools to consistently identify when those treatments and services are appropriate.

The Division plans to closely monitor the system's overall medical cost expenditures, review the fee guidelines on a regular basis as required by Labor Code §413.012, and revise the fee guidelines, if the need is indicated.

Comment: Commenter opposes the reimbursement conversion factor for specialty surgical codes and request information be provided regarding how these codes were chosen. The commenter demonstrates this opposition be suggesting codes 20552 and 20553 be removed from the list of codes qualifying for the higher reimbursement, as both can be performed in a doctor's office, and are relatively minor procedures for such a significant increase.

Agency Response: The Division clarifies the adopted rule does not list CPT codes. The informal working draft included CPT codes that would be reimbursed at a higher conversion factor. However, based on public comment and after a review with the Medical Advisor, the CPT codes were deleted from the rule text, and not included in the proposal. The use of specific CPT codes would have resulted in higher administrative burdens due to the changing nature of the CPT codes. Instead, the adopted rule establishes a higher conversion factor for surgical services when performed in a facility setting. The Division notes that the commenter suggests office-based surgery should be higher than facility reimbursement. If a health care provider plans to perform the surgical services, including those listed in the comment, in a facility setting, it would require preauthorization. In the Medicare system, the doctor does not have much of an incentive to move a procedure from his office to the ASC or other facility setting, because he would get paid the facility rate, which in most instances is less than the office rate. In the Texas workers' compensation system, the doctor will get paid more in an ASC than in his office because of the Division's conversion factors. The practice expense RVU is lower for similar services performed in a facility setting rather than in an office setting. The RVUs for the facility rate are less than RVUs for office rate because the doctor does not encumber the overhead costs of the facility.

Comment: Commenter recommends that separate conversion factors not be adopted as RBRVS already accounts for differences in time, cost, skill, risk, etc. The commenter further references the WCRI 2006 study indicating most state fee schedules create financial incentives to under-use primary care and overuse invasive and specialty care.

Agency Response: The Division disagrees. Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies but to also consider the standardized reimbursement structures found on other health care delivery systems. The Division further acknowledges that information contained in the WCRI Report is a study designed to present the comparisons for workers' compensation medical fee schedules to state Medicare fee schedules. The Division disagrees that the purpose of the WCRI Report is to argue one stance over another, such as the use of one or more conversion factors. The study merely compares those states that have one conversion factor versus states that have developed more than one, even those states that have developed their reimbursement structures based on Medicare's RBRVS using one or more conversion factors. In developing new §134.203, the Division carefully considered the potential financial incentive to create over-utilization of invasive specialty care in favor of primary care, but recognizes that the Division has other tools to control over-utilization, such as the Disability Management rules and the preauthorization process for determining medical necessity. Consequently, the second conversion factor adopted by the Division is a relatively minor subset of all treatments and services with integrated carrier controls to monitor utilization and potential misuse. The Division also acknowledges the certified network surveys conducted by the Department's Research and Evaluation Group indicates it is common for payors to provide a differential for surgical services.

Comment: Commenters have varying recommendations regarding the proposed conversion factors and the issue of injured employees' having adequate and appropriate access to health care. One commenter states a key point of Texas public policy is that approximately 75 percent of physicians in the state currently choose not to participate in the workers' compensation system, and accordingly improving reimbursement remains crucial to ensuring that injured employees have access to appropriate care. Another commenter believes an increased reimbursement rate is the only incentive that will keep HCPs in and bring other providers back into the workers' compensation system. To adequately measure access to care, states the commenter, one should examine whether or not patients can seek and find HCPs within a reasonable geographical area, not the number of physicians registered to provide care on the ADL. Other commenters state that their medical association's survey data demonstrates cuts to physicians' fees as a result of the 2003 implementation of §134.202 hurt access to care for injured workers. The data in 2002 overall indicated poor access to care with only 46 percent of physicians accepting workers' compensation. Segmenting the 2002 data by physician specialty showed better access to most surgeon specialties than primary care physicians. These commenters indicate that by 2004, the percentage of physicians who would accept all new patients was reduced to less than a third for almost all specialties, and remains low when based on the medical association's 2006 survey. The effect of market forces on access to health care is different than the effect in other fields because ethical and legal considerations compel physicians to provide care without regard to payment. A commenter criticizes

misleading Division data that makes this loss of access look less astounding as the Division reports reflect providers as participating if they were involved in any single encounter in an emergency room. Documented information in the medical advisor's office should reflect the many thousands of requests to help locate a doctor for an injured employee. One commenter describes his own travel from his office to a neighboring town, and the inability to locate a willing orthopedic surgeon to assist with a new case anywhere between, including a nearby city. Some commenters note that even physicians who limit the services they provide to injured patients will continue to care for them when the relationship began in an emergency circumstance. When patients seek medical care in emergency rooms, it increases the costs for everyone.

Other commenters recommend postponing adoption of rules until the Department's Research Evaluation Group completes their access to health care study as this study is more reliable than the survey completed by a medical association. The commenters state that increasing the rate to 140 percent of Medicare will increase medical costs by $71.6 million, yet no independent studies have been cited regarding an access to quality care problem under the current system. The commenters note that a recent survey conducted by the Division indicates that 86.3 percent of medical doctors on the ADL were still accepting workers' compensation patients, and that recent tort and medical malpractice reforms, have resulted in a sizable influx of new doctors into Texas. Accordingly, the access to care for injured employees in Texas, which is already good and sufficient, should only improve now and in the future. To the extent that local access to health care has been recognized as a public health issue affecting the health of many rural Texans, a commenter asks if it is appropriate for the cost of resolving a broad societal issue should be borne by the employers who voluntarily participate in the Texas workers' compensation system.

Agency Response: The Division acknowledges commenters' concerns on the issue of injured employee access to health care, and determines this to be a complex issue that cannot be summed up with any one set of findings, which also is why the Division declines to postpone adoption of the rules until the latest research effort is completed by the Department's Research Evaluation Group. The Division cites the findings of a previous agency publication in December 2006, "Biennial Report of the Texas Department of Insurance to the 80th Legislature on the Division of Workers' Compensation" that suggested the data does not support the idea that there are widespread access to care problems for all claims or for primary care. However, the report's findings did reveal certain types of providers and certain regions of the state where access can, and probably is, an issue. Additionally as stated in the WCRI Report, "The construction of a medical fee schedule in workers' compensation involves a delicate balance. If rates are set too high, savings will be negligible and the fee schedule will not achieve its cost containment goal. Conversely, setting rates too low makes treating injured workers uneconomical for providers and jeopardizes workers' access to quality care."

The Division believes, however, that perception on the part of HCPs is relevant. For example, it has been well documented that the Texas workers' compensation system is dependent on the providers' perceptions about the administrative burdens and associated costs to participate as compared to the reimbursement rates they receive. Particular emphasis has been placed on both the increasing number of medical bill denials and compensability issues, which are on the increase in our system over the past few years.

The Division's 2006 Biennial Report also noted a high market concentration of workers' compensation providers whose workers' compensation patient volume only represents 25 percent or less of their total patient volume. One of the public policy questions, therefore, is whether the system wants to increase the percentage of health care providers who treat the majority of Texas workers' compensation patients by increasing participation of those low volume providers whose practice is not completely dependent on workers' compensation reimbursements. The Division determines this to be a viable option, and again re-states its message from the proposal preamble, the Division determines the public will benefit from an increase in reimbursements to health care providers after a four year experience of a 25 percent fixed add-on to Medicare's conversion factor that includes all of the sustainable growth factors that are the Medicare system's budget neutrality requirements, and believes the increase in conversion factors via these adopted rules will foster continued access to health care and bring increased stability to the system with the new benchmarks that are still based on the standardized Medicare reimbursement methodologies.

Comment: Commenters recommend numerous factors be included in the consideration of establishing new professional services reimbursement rates. The commenters recommend additional reimbursement consideration be given for other specific workers' compensation driven tasks, and reference as examples the justification to a peer reviewer that more care is required than recommended in treatment guidelines; completion of forms; frequent payment denials, or slow payments; and managing multiple case related phone calls. A commenter explains that outcome expectations for the care of injured individuals are different than caring for other types of patients due to return to work considerations, such as whether they are at MMI, and the use of treatment guidelines. One commenter suggests §134.202, with fee schedule reductions and payment denials, is a failed policy that diminishes the 125 percent of Medicare reimbursement rates. Another commenter recommends the adopted conversion factors show recognition of the economic environment for physicians in Texas as compared to other states, and cites the Texas prohibition of corporate practice of medicine in preventing non-physicians from employing physicians, which ensures the integrity of physicians' medical decisions and without subjugating a professional opinion to accommodate the needs of an employer, and thus, a lower fee schedule.

Agency Response: The Division declines to make the changes, and disagrees that §134.202 is a failed policy. The Division has maintained the fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. In both this and the proposal preamble, the Division has articulated what the factors and considerations are that have formed the policy decision establishing these new conversion factors; new set fees for the responsibility of treating doctors in case management activities and reimbursements for designated doctor examinations. The overall reimbursements have increased as compared to those adopted four years ago in §134.202 and these new rates are not based or reflective of other states' low fee schedules. Additionally, reimbursements for certain required Division forms are addressed in other Division rules.

Comment: Commenters acknowledged that even Medicare doesn't have the rules and regulations that tie up the health care provider's time, as is the case with the workers' compensation patient. One commenter suggested the Brinker study conducted in Houston supports this assertion. The commenters also indicate that the energy and commitment it takes to care for a workers' compensation patient is approximately 250 percent of the overhead as compared to Medicare.

Agency Response: The Division disagrees with the commenters' statement that commission rules and regulations tie up the healthcare providers' time, and that the energy and commitment to care for a workers' compensation patient is approximately 250 percent of the overhead as compared to Medicare. As most healthcare providers are already familiar with the Medicare policies, the continued use of standardized coding, billing, and methodology should facilitate office operations, eliminating the need to maintain separate systems. This standardization should allow physician office practices to achieve consistency in their workers' compensation and all other health care billing practices, thereby reducing time and administrative costs. The Brinker study, The Effect of Payor Type on Orthopaedic Practice Expenses, was a study of a single physician and not necessarily indicative of Medicare or workers compensation costs. In a previous testimony before Congress, Glenn M. Hackbarth, J.D., MedPAC stated, "We lack information on the cost of physician services, so we cannot compare Medicare's payments and costs the way we can for other services, such as hospital care" and "the regulatory burden of the Medicare program is an important concern of physicians. Nevertheless, estimates of the cost of this burden are not available." Without a regulatory burden assessment in the Medicare system, it is difficult to directly compare the administrative burden between the systems. As stated in the June 25, 2001 edition of The American Medical News, published by the AMA, "Some experts argue that Medicare's procedures aren't any worse than any other payers. The programs pay faster than most, and the administrative and clinical challenges are like other managed care demands these days, they say." In the same article Dr. Darren Carter is quoted as saying, "There is really not much difference about the way Medicare has created these rules from other carriers."

Comment: Commenter recommends no distinction be made in terms of access to care between group health and workers' compensation health care models, and adopted workers' compensation reimbursement rates should reflect similar rates paid in group health or other commercial insurance plans.

Agency Response: The Division agrees that access to health care is a universal concern and should not be exclusive to workers' compensation, but notes that no changes are necessary in response to this comment. The Division is adopting higher conversion factors than those established in previous §134.202, in recognition of multiple system concerns and economic issues. As a result, the newly adopted rules should be reflective and proportionate to other payor systems.

Comment: Commenter opines that these rules are geared toward offering incentives to health care providers to join the system, but clarifies that in testimony before the Legislature, providers have stated that issues are more related to the "hassles" or burdens of the system. The commenter suggests there is little evidence that these proposed fees will increase participation or improve quality of care, and instead, based on historical trends, will only push more employers out of the workers' compensation system in Texas.

Agency Response: The Division disagrees. The Division has maintained a fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. For example, insurance carriers and employers now have new tools in the form of treatment and return to work guidelines that will aid them in cost containment. Additionally, the certified network market is envisioned to continue growing and to gain deeper state-wide penetration, and these certified networks also feature increased management of claims and other cost control measures. In addition to the medical practice expenses, the Division examines the administrative requirements of the Texas workers' compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL but must continue with requirements related to types of injured employee examinations (e.g., MMI, IRs, and functional restoration). Doctors now must comply with the Division's adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is presumed medically necessary. Treatment outside or in excess of the guidelines must be preauthorized. Beginning January 1, 2008 providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Thus, the Division determines that with these system improvements over the intervening four years, and the experienced decline in health care providers, particularly the decrease in access to specialists, it is timely to establish new benchmarks to build upon.

Comment: Commenter recommends the categories listed in subsection (c)(1) be made consistent with the current year CPT Code book and recommends deletion of "general medicine," and "physical medicine" as these noted exceptions should be classified as "medicine."

Agency Response: The Division declines to make the change. The categories of services as proposed are the same as in §134.202 and there has been no confusion as to the intent of which services are inclusive on the part of system participants. The Division determines that to consolidate the service categories during this update effort will only serve to confuse participants unnecessarily.

Comment: Commenter observes that 175 percent of Medicare's RBRVS is still far below fee schedules in other states.

Agency Response: The Division disagrees that reimbursement rates in Texas for professional services should be reflective of the rates established by those with higher conversion factors or percentages of Medicare. The median of state reimbursements is 123 percent of Medicare for the 42 states listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (WCRI, 2006). The Division's proposed conversion factor of $66.45 for surgeries when performed in a facility represents an approximate 175 percent of the Medicare conversion factor applied in calendar year 2007. As a reflection of the final MEI annual percentage adjustment of 1.8 percent for calendar year 2008, the Division's adopted conversion factor of $66.32 for surgeries when performed in a facility represents 195 percent of the Medicare conversion factor ($34.0682) for calendar year 2008.

Comment: Commenter recommends that the WCRI conduct an updated study of "The Anatomy of Workers' Compensation Medical Costs and Utilization" with 2008 data, which should also address any access problems so that future decisions on increasing the fee schedule may be based on facts and data and not anecdotal stories. Commenter implies that the study should additionally reflect that if states set their rates too high, savings will be negligible and fee schedules will not achieve the cost containment goal.

Agency Response: The Division clarifies it has no direct purview as to the selected topics and content of studies and reports that are conducted by the WCRI.

Comment: Commenter, as another basis for recommending the retention of current 125 percent of Medicare rates, suggests the current rate is consistent with the experience of several states with a conversion factor lower than a 125 percent rate, such as Hawaii, a state that has not experienced significant access or quality of care problems since adopting 110 percent of Medicare as a reimbursement level in 1995. Pennsylvania and the District of Columbia with 113 percent have not experienced such issues either.

Agency Response: The Division disagrees that reimbursement rates in Texas for professional services should be reflective of the rates established by those states with lower conversion factors or percentages of Medicare. The requirements of the Labor Code, including the requirements for how Texas is to set reimbursement rates, differ from those of other states. The Division is required to follow the mandates of the Labor Code and associated rules, and not those of other states. Additionally, the states noted by the commenter are not representative of the Texas experience or economy, and other states do not have comparable health care practices that are the standard for Texas.

Comment: Commenter asks what fee is proposed for anesthesiologists if they are currently getting paid $47.37 per unit.

Agency Response: The Division clarifies that the adopted conversion factor for anesthesiology for calendar year 2008 is $52.83.

Comment: Commenters recommend that while a separate conversion factor may be indicated for anesthesia services from the one set by Medicare, the proposed anesthesia conversion factor is set too high, over 315 percent of the Medicare 2007 Anesthesia conversion factor for Texas.

Agency Response: The Division disagrees. While the Medicare system utilizes the American Society of Anesthesiologists (ASA) RVU system for anesthesia services, the Medicare anesthesia conversion factor was determined for §134.202 to be more than 50 percent below the 1996 MFG anesthesia conversion factor (§134.201), and a 50 percent reduction in the anesthesia conversion factor would have created a significant negative impact in the entire anesthesia category, and would do so now. Further, a recent 2007 national survey of anesthesia conversion factors used in commercial managed care contracts reflects the volume-weighted national average commercial conversion factor ranges as between $52.16 and $65.06. (American Society of Anesthesiologists NEWSLETTER, Volume 71, Number 7, July 2007) The median is in the $53 to $63 range as compared to Medicare's 2007 anesthesia conversion factor of $16.19. The survey results state, "In anesthesiology third-party payment contracts, conversion factors that do not significantly exceed the Medicare rate are highly implausible. The fact that the Medicare rate is lower in 2007 than it was in 1997, combined with the well-known price competition to attract and retain anesthesia personnel, removes any incentive to provide anesthesiology services other than at a multiple of Medicare." Therefore, as with §134.202, the Division maintains the same conversion factor, $52.83, for anesthesia services that is established for all other service categories (with the exception of surgical procedures when performed in a facility setting) as there is no reason to drop the reimbursement rate below the market.

§134.203(c)(2)

Comment: Commenters support the MEI adjustment for the fee guideline's multiplier and state the chosen methodology for annually updating the fee schedule should provide an effective method for making sure that reimbursement levels remain current in the years ahead, while avoiding issues related to negative changes to the Medicare rates as a result of federal budgetary constraints; it is a reasonable solution to a major public policy problem; and a critical improvement.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenters request that §134.203(c)(2) be deleted. One commenter states the use of the MEI is inappropriate, given the fact that the MEI adjustment is already made to the Medicare base payment. Other commenters state this proposed section is more than a minimal modification to the Medicare system, and will cause an added 4 percent annual average medical impact to the system without due process of allowing system stakeholder input as per the Texas Administrative Procedure Act. The commenters assert that adding an automatic increase to the reimbursement rate is inconsistent with the requirement of §413.011 that the Division's fee guideline achieve medical cost control, and that it is also inconsistent with §413.012, which requires fee guidelines to be reviewed and revised at least every two years. One commenter further suggests that as long as there is no evidence of an access problem and no evidence that the current rate is unfair and unreasonable, the current rate should be reaffirmed during the two year review.

Agency Response: The Division declines to make the change. Medicare's Sustainable Growth Rate, which sets the annual conversion factor adjustment, includes the MEI and other utilization and productivity and reimbursement measures. These measures, other than MEI, are designed to meet the budgetary requirements of the Medicare program. These budgetary constraints are not applicable to workers' compensation. The MEI has increased 15.7 percent since 2002 while the Medicare conversion factor has decreased from $36.1992 to $34.0682, or -5.6 percent.

The Division determines the adopted language in §134.203(c)(2) is the appropriate method of creating new benchmarks and it reminds system participants that the Commissioner is obligated by §413.012 of the Labor Code to review fee guidelines. The Commissioner may also review the estimated MEI change as early as March before the new calendar year, and has the authority to take appropriate action as necessary to prevent an undesired consequence. The Division also notes that at least two other states, Georgia and Maryland, have automatic MEI updates included in their rules.

§134.203(d)

Comment: Commenter supports the 125 percent of Medicare and basing reimbursement on the Medicare Fee Schedule as it is a fair and reasonable process for this complex system.

Agency Response: The Division appreciates the support.

Comment: Commenter recommends that an additional reference should be made to the CMS Medicare Fee for Service Part B Drugs (i.e., 125 percent of this fee schedule). Many diagnostic providers render services to injured workers that require the use of various drugs and/or contrast material that should be reimbursed utilizing the CMS Part B Drug Files.

Agency Response: The Division declines to make the change. The rule language addressing this situation has not changed since the 2003 implementation of §134.202 and the Division has not received any information or data showing there to be a problem in correct billing and reimbursement for these items. Additionally, there were no similar suggestions offered when the Informal Working Draft Rules were posted on the Division's website for system participant input.

§134.203(d), (e), (f) and §134.204(b)

Comment: Commenters recommend rules be further modified, with suggested draft language, to make the MEI applicable to fees for the services and/or supplies rendered via HCPCPS Level II codes and pathology and laboratory services not addressed in the CPT Code service categories, as well as all services identified in §134.204. Additionally a commenter recommends a language addition applying a yearly MEI percentage adjustment that parallels language adopted in §134.203(c)(2). The commenters say that without application of the MEI adjustment to these services, the Division will be required to go through the rulemaking process too often.

Agency Response: The Division declines to make the change. Reimbursement for DME in the Medicare system is not based on the Medicare Physicians Fee Schedule, the SGR, or the MEI. Instead, Medicare bases those reimbursements on a different fee schedule, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule, as was the case with previous §134.202 and adopted new §134.203. Unlike the Medicare conversion factor, the DMEPOS fee schedule is updated quarterly by Medicare, and the Division adopts those changes as they occur. Such an attempt to create a system of reimbursement that takes into consideration the MEI where it is not applicable in the Medicare system would be unnecessary and might not comply with the requirements of §413.011 of the Labor Code.

§134.203(d), (e), (f), and (h)

Comment: Commenters observe that a cynical interpretation of "fair and reasonable" reimbursement determinations by carriers would include a means which is not shared with anyone else, and that carriers manipulate the results to an amount less than the MAR for every service provided by an HCP. Another commenter recommends a new paragraph in subsection (f) of this section that states the Division shall maintain a master record of applicable products and services for which no relative value unit of payment has been assigned. The commenter suggests that these records could be used to resolve medical fee disputes in a timely manner.

Agency Response: The Division disagrees and declines to make the change. The DMEPOS, Medicare Clinical Fee Schedule, and Medicaid fee schedules cover the majority of items used in the treatment of work-related injuries. For those products and services without an established relative value unit or payment amount, §134.203(f) directs the reimbursement to be made in accordance with §134.1(e) of this chapter (relating to Medical Reimbursement), which incorporates a methodology that carriers are to use to assign a relative value. This default fair and reasonable reimbursement methodology has been maintained by the Division since August 2003, the implementation date of §134.202, and allows use of a wide variety of resources to establish a reimbursement that is fair and reasonable. Maintenance of a log of reimbursements for non-valued services would require additional reporting from both providers and carriers, thus increasing administrative burdens for the system.

§134.203(e)

Comment: Commenters recommend substitute language that provides (1) 125 percent for the whole procedure component of services when applicable; (2) 55 percent of the MAR derived from (1) for the technical component; and (3) 45 percent of the MAR derived from (1) for the professional component. One commenter asserts the substituted language is necessary and proper to ensure payment in accordance with Medicare's reimbursement models.

Agency Response: The Division declines to make the requested change. Such a change would significantly decrease reimbursements to the laboratory and pathology community, and would amount to a reduction in payments to 55 percent of the 125 percent total for the technical component of this service. The recommendation is not consistent with the reimbursements maintained within the MFGs in place since 1996 (§134.201) that allows for a professional component of reimbursement to the pathologist, and has been derived as a ratio of professional and technical components of the overall reimbursement rate, and has been maintained to ensure that pathologists are not cut out of the system. At a time when the Division is suggesting incremental increases to this fee guideline, there appears to be no justifiable reason to cut the fees for laboratory and pathology services.

§134.204(e)

Comment: Commenter expresses support for reimbursement for both treating doctors and other health care providers involved in case management, which is a key component of the treatment planning efforts underway at the Division. Since extra time and effort are involved, which takes time away from providing direct patient care; it is only fair that providers be reimbursed a reasonable amount for their time. However, notes the commenter, the proposal to reimburse the other providers 25 percent of the treating doctor amount is not sufficient or fair. The commenter recommends that reimbursement to referral health care providers contributing to the case management activities should be at least 50 percent because, in many cases, the other providers have the most information to provide in the case management process.

Agency Response: The Division appreciates the supportive comment but declines to make the suggested changes. The provisions of subsection (e) of this section enhance the ability of the treating doctor to fulfill the requirements of §408.025 and §408.021 of the Labor Code by recognizing that communication between referral providers and the treating doctor for claims requiring medical case management is a normal business practice, and appropriate communication results in efficient care of the injured employee as well as an efficient medical practice. However, the coordination of this activity is the responsibility of the treating doctor, as the Division emphasized in the adoption of Chapter 137 Disability Management Rules. The Division has recognized the contributions of referral health care providers contributing to the activity, and determines that 25 percent of the amount established for the treating doctor's overall case

management functions is cost effective and adequate compensation. The 25 percent is considered adequate since the referral HCPs do not have the coordination, administrative, and reporting requirements that are required as part of the treating doctor's case management functions.

Comment: Commenters recommend deletion of §134.204(e), as the services listed are included in Division §180.22(c) as responsibilities of the treating doctor and are normal services provided as the medical "standard of care." The "standard of care" includes treatment planning for all patients, whether preauthorization is required or not. A commenter cites statements from the preambles associated with the development and adoption of §134.202 that speak to the increase in reimbursement rates for Evaluation and Management Codes, and support this increase as treating doctors, the gatekeepers in the workers' compensation system, are most often the users of Evaluation and Management Codes. Another commenter's reason for recommending the deletion of subsection (e) is because case management services should be covered by the rule's non-surgical conversion factor. The commenter recommends that, if not deleted, the non-surgical conversion factor should be reduced to remove the costs associated with those services.

Agency Response: The Division declines to make the changes. Except for the establishment of rates where none previously were provided by rule, the provisions of this subsection are not new and the concepts were also contained in §134.202. The doctor's responsibility for case management services are specific Evaluation and Management Codes that are delineated in the 2007 CPT Code book, and consequently they are additionally a necessary component in the workers' compensation system. The rephrasing of these provisions in this rule proposal include the establishment of reimbursement rates that are not valued by the RBRVS system (e.g., left to the individual insurance carrier's determination of a fair and reasonable reimbursement), and further describes the treating doctor's responsibilities that are intended to enhance the ability of the treating doctor to manage workers' compensation cases, and lends certainty of payment for this important function to system participants. The Division notes this is especially necessary since Medicare does not specifically address return to work initiatives. The Division further clarifies that the function of case management in the Texas workers' compensation system is to effectively coordinate care and to facilitate the injured employee's timely and productive return to work. The purpose of the Division's medical fee guidelines are to provide reimbursement for the services that are listed in the Division's §180.22. While §180.22 delineates the role and responsibilities of treating doctors as "primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury," the rule also lists the roles and responsibilities of several other doctor functions in the Texas workers' compensation system but does not list the reimbursement amounts for the services provided by the other doctors. Therefore, to use §180.22 as a basis for deleting case management services and reimbursement in §134.204(e), would imply that the reimbursement for services provided by consulting, referring, required medical examination, and designated doctor functions as listed in that rule should also be deleted.

Comment: Commenter states that Labor Code §413.021(a) gives insurance carriers the option of independently determining whether or not case management is needed. The commenter states this includes the assumption of a right to contract with the case manager to pay a certain amount, and that this provision is not designed to be a contractual arrangement through the treating doctor for case management. The commenter notes that the Division's 2004 Question Resolution Log states that case management is not separately reimbursable regardless of whether the case manager is an independent contractor hired by the physician or a member of the physician's staff.

Agency Response: Labor Code at §413.021(a) provides insurance carriers with a tool to facilitate return to work initiatives, including claims management services and does not relieve the treating doctor of duties to medically manage health care provided to an injured employee. This section revision is not for the purpose of addressing the insurance carrier's claims management processes. Instead, this rule revision addresses medical case management and it is the treating doctor's responsibility to manage the medical care. Additionally this section is a rephrasing of §134.202(e)(3) and adds reimbursements that have been set for the treating doctor's case management responsibilities and with recognition of those referral health care providers contributing to the doctor's case management activities. Subsection (e) contains workers' compensation specific services that are a necessary component in the workers' compensation system and not necessarily addressed by Medicare's payment policies. The case management language included in this section enhances the ability of the treating doctor to manage workers' compensation cases, this is especially necessary since Medicare does not specifically address return to work initiatives. The Division clarifies, as stated in §134.202(e)(3) (and now in §134.204(e)), that case management activities are only reimbursable when performed by the treating doctor and not when done by a team member. Since a contractor hired to do case management would not be the treating doctor, there is no provision for reimbursement for those services.

Comment: Commenter observes that there is no mention of preparing a treatment plan. The commenter recommends that treatment planning activities be included in case management and that a set fee be established.

Agency Response: The Division clarifies that the planning and development of treatment plans are addressed in this §134.204(3)(B), and reimbursement amounts for case management services are listed at (4)(A) - (E). Currently the Division is working with stakeholders to develop treatment planning parameters including reimbursement amounts, which will be addressed in future treatment planning rules. Several carriers have agreed to participate in a treatment planning pilot that is currently underway. The outcome of the pilot will help the Division establish permanent treatment planning policies.

Comment: Commenters recommend added language or clarification that allows for the billing and reimbursement of both a case management activity and an initial evaluation and treatment visit, or any other services that are performed on the same day as a case management activity. The commenters assert that experience has shown that carriers uniformly bundle these services and pay only the main service. Another commenter recommends no additional reimbursement is warranted for a case manager to attend an office visit with the injured employee, as some physician's practices are to refuse to see the case manager in order to be able to work with the case manager on a different date, and be assured of payment for the doctor's role in the case management activity.

Agency Response: The Division declines to make the change. The case management activities are to be documented by the

treating doctor, under the general parameters established by this section, but do not include other basic treating doctor functions, such as referring the injured employee for physical therapy treatments and presuming to bill this as a case management activity. The inclusion of such recommended language would too easily lead to such inappropriate use of the terminology. The function of case management in the context of this section is for HCPs, especially the treating doctor, to effectively coordinate care and to facilitate the injured employee's timely and productive return to work. Under workers' compensation, case management usage is specific regarding time parameters and is limited to the development or revision of treatment plan, altering or clarifying previous instructions, coordination of care for employees with catastrophic or multiple injuries and coordinating with employer, employee and/or assigned case manager. The case management language included in this rule enhances the ability of the treating doctor to manage workers' compensation cases. This is necessary since Medicare does not specifically address return to work initiatives. The Division disagrees that further clarification is required in the rule for case management services since the rule lists CPT codes for specific case management services that are different from other service CPT codes.

§134.204(e)(2)

Comment: Commenter recommends substituted language stating team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of "developing or substantially revising a treatment plan requested by the carrier or any treatment plans required by the Division rules. A team conference or telephone conference call may be held for the purpose of coordinating return to work for the injured employee." The commenter further reasons that treatment plans are not required or necessary for all injuries.

Agency Response: The Division declines to make the change, but agrees that treatment plans are not required or necessary for all injuries. The Division will monitor the case management activities in conjunctions with Division disability management rules to assure compliance with the intent of the statutory requirements.

§134.204(e)(4)

Comment: Commenter recommends rule language modification to require that each HCP that contributes to the case management activity submit documentation to support the services provided and billed.

Agency Response: The Division declines to make the change. The section requires the treating doctor to provide identification of HCPs that contribute to the case management activity as well as documentation listing the purpose and outcome of team conferences or phone calls, thus eliminating this burden from the referral health care providers as well. The reimbursement amount for the treating doctor's services takes into account this responsibility of providing documentation when billing for case management services. Conversely, the lower reimbursement amount allotted to other HCPs participating in the case management activities is reflective of less responsibility in the case management activities, including not having to routinely provide documentation when billing for case management.

Comment: Commenter recommends that the Division amend this subsection to provide a modifier for the referral HCP, which will ensure consistent reimbursement for the service provided and minimize disputes related to inappropriate code-modifier combinations. The commenter notes that in Medicare, the proposed codes all have a status indicator of "B-bundled". Only the treating doctor and the referral provider would be subject to reimbursement provided documentation supports the level of service.

Agency Response: The Division declines to make the change. The section provides for the treating doctor to apply a specific modifier when billing for case management services, and the treating doctor's submitted information is meant to identify those referral HCPs who contributed to the activity. Therefore, the bills submitted by other HCPs should be easily recognizable by the carriers for the appropriate reimbursement.

§134.204(f)

Comment: Commenter requests that the Division clarify the reimbursement provisions for home health services. The commenter notes that the subsection suggests that reimbursement is either Medicaid or the contracted rate or, if there is no contracted rate, the lesser of the MAR, fair/reasonable, or usual and customary. The commenter asks how a provider would know whether Medicaid billing applies versus when billing for non-contracted rates apply, and whether it is the lesser of these two formulas if there is not a contracted rate.

Agency Response: The Division agrees that the reimbursement provisions for home health services should be clarified. The MAR for home health services provided through a licensed home health agency is 125 percent of the published Texas Medicaid fee schedule for home health agencies. Subsection (f) has been revised to clarify this.

§134.204(g)

Comment: Commenter states that the limit of three FCEs, when applied judiciously, could significantly hamper efforts to safely return injured employees to appropriate duty. The commenter requests clarification regarding the limit of three FCEs for each compensable injury, asking who this limit applies to and the statutory right to request an FCE/medical examination.

Agency Response: The Division disagrees the limit of three FCEs may hamper injured employees return to work. Pursuant to Labor Code §413.018(c), the adopted rule recognizes that the Division may require a treating or examining doctor, on the request of the employer, insurance carrier, or Division, to provide a FCE of an injured employee. As such, subsection (g) of the rule specifies that FCEs ordered by the Division do not count toward the three FCEs allowed. This allows injured employees the opportunity to obtain these evaluations as is required by their compensable injury. The Division clarifies that three FCEs are allowed for each compensable injury, unless the FCEs are ordered by the Division. This is true whether the evaluations are performed by different health care providers or the evaluations are requested by different insurance carrier representatives. The limits on the frequency of FCEs are necessary in the provision of this service to ensure only necessary testing is provided to injured employees.

§134.204(h)

Comment: Commenter recommends language change from "should" to ". . . shall meet the specific program standards. . . ," to improve the quality and outcomes of return to work rehabilitation programs.

Agency Response: The Division declines to make the change. In essence, the commenter's recommendation could eliminate many return to work rehabilitation programs that are not accred-

ited by the Commission on Accreditation of Rehabilitation Facilities (CARF) from participating in the Texas workers' compensation system because they may not meet every requirement of CARF specific program standards. Such a significant change from the proposed rules would require the Division to re-propose this recommendation as it would otherwise prevent other system participants from providing input. The Division believes the current language encouraging compliance with CARF standards, and the monitoring of non-CARF accredited programs that requires them to seek preauthorization approval for medical necessity, are all sufficient reasons to encourage programs to meet the highest program standards.

§134.204(i)

Comment: Commenter expresses support for addition of this subsection, stating it will ensure Division-ordered examinations are completed timely and reimbursed correctly.

Agency Response: The Division appreciates the supportive comment.

Comment: Commenter recommends the adoption of §134.204(i) without changes and supports the idea of new modifiers that are associated with the expanded duties and important role of a designated doctor. The commenter commends the Division's efforts to provide additional compensation to treating doctors for new responsibilities as a result of disability management and the adoption of treatment and return to work guidelines.

Agency Response: The Division appreciates the supportive comment.

Comment: Commenter suggests adding a new §134.204(i)(1)(G) to read: "(G) A designated doctor may be reimbursed only for those examination services performed under paragraph (1)(A)-(F) of this subsection that are specified in the Division order. Some practitioners may bill for MMI/IR when the Division's order requires only examination for 'extent of injury' under (C). The carrier should not be liable for the MMI/IR determination in this example."

Agency Response: The Division disagrees. The DWC Form-32 (Request for Designated Doctor) provides spaces to indicate the requested examinations. Designated doctors are not to do examinations other than those requested and by extension are not allowed to bill for examinations other than those requested. Improper billing would subject the designated doctor to possible sanctions under Labor Code §413.044(a) and the provisions of Chapter 415 (Administrative Violations).

§134.204(i) and (k)

Comment: Commenter provided a sampling analysis of 40 designated doctor examinations, which support a conclusion that the proposed rules reduce the overall designated doctor reimbursement fees by an average of 4.6 percent.

Agency Response: The Division appreciates the commenter's information. The commenter presented information at two different stages in the development of the reimbursement rules. In the earlier submission, the commenter, based on a sample of 51 cases, showed that the rules would increase the overall designated doctor reimbursement by an average of 0.5 percent The second submission, based on 40 cases, showed that the overall reimbursement would be reduced by an average of 4.6 percent. The Division considers both of the differences to be within a reasonable variation from the adopted amount.

Comment: Commenter recommends reimbursements for designated doctors be at least comparable to that provided to IROs, who receive $650 with no examination requirements.

Agency Response: The Division disagrees. Certified IROs are governed under Insurance Code Chapter 4202 and 28 TAC §12.01, et seq. Under those requirements, the IRO has mandated requirements that are not placed on the designated doctors. Those requirements contribute to administrative overheads that the designated doctors are not mandated to incur. An example of that would be the requirement that under 28 TAC §12.207 IROs have appropriate personnel reasonably available to utilization review agents by telephone at least 40 hours per week during normal business hours, in both time zones in Texas, if applicable, to discuss patients' care and allow response to telephone review questions. Additionally, IROs are to have a telephone system capable of accepting or recording or providing instructions to incoming calls from utilization review agents during other than normal business hours and shall respond to such calls not later than two working days of the later of the date on which the call was received or the date the details necessary to respond have been received from the caller. While the $650.00 goes to the IRO, only a portion goes to the reviewer. That amount would be determined according to the contract between the IRO and the reviewer. As was noted by the Medical Advisor, the designated doctors often work through an agent that does scheduling for them and as such do not receive the entire amount of the reimbursement for the examinations they perform. While they do that, it is done as a matter of convenience for them rather than as the result of a mandated requirement.

§134.204(i), (j) and (k)

Comment: Commenter recommends that proposed fees for designated doctor activities be increased by 30-45 percent. This recommendation is based on commenter's consultation with Livingstone-Lopez Consulting in the analysis of California's designated doctor fees, which found that Texas fees lag far behind California's.

Agency Response: The Division declines to make the requested changes and disagrees that the adopted reimbursement rates are too low based on expectations of the designated doctor's examinations. The Division, in consultation with the Medical Advisor, determined that the fee for designated doctor activities is fair and reasonable after consideration of duties involved, including the additional duties added by HB 7. While the commenter indicated that the recommendation was made based on an analysis of California's designated doctor fees, the commenter did not provide the Division with the basis for its recommendations or the basis of California's rates. Absent more information that would allow for a detailed comparison, the Division will rely on its understanding of the Texas designated doctor information.

§134.204(j)(1) and (2)

Comment: Commenter recommends that reimbursements overall for MMI and IR examinations be raised based on Consumer Price Index (CPI) adjustments, and observes that since 1996 the reimbursements have remained unchanged, and have steadily declined by 24.8 percent based on the CPI.

Agency Response: The Division disagrees that reimbursements for MMI/IR examinations should be increased. The adoption of §134.202, Medical Fee Guideline, in 2002 changed the reimbursement structure to allow for a net increase in reimbursements for MMI/IR examinations. The CPI is not a cost-of-living

index. It is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The CPI market basket is general and varied. It includes "medical care," but also includes, for example, "food and beverages," "housing," and "transportation." MMI/IR examinations are a very unique service specific to workers' compensation. Increasing MMI/IR reimbursement by the CPI would not be a viable option in observing statutory mandates of controlling medical costs.

§134.204(j)(3)

Comment: Commenter asks if reimbursement for an MMI evaluation is the same reimbursement as the applicable office visit if a modifier V1, V2, V3, V4 or V5 is used in addition to the established patient office visit level.

Agency Response: The Division clarifies that both the appropriate established office visit level and the appropriate modifier that corresponds with the last digit of the applicable office visit are appropriate for determining the reimbursement "for an MMI evaluation performed by the treating doctor. Reimbursement for an MMI evaluation performed by the treating doctor should be equal to the reimbursement of the applicable established patient office visit level associated with the examination." The Division also notes the rule provides for additional reimbursement if an IR is performed as well.

§134.204(j)(4)(C)

Comment: Commenter recommends substitute language that it asserts will improve upon current language that has caused confusion among health care providers as to what they may or may not bill for: "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used to render the impairment rating. (ii) If the range of motion model is used to render impairment rating: (a) $300 for the first musculoskeletal body area; and (b) $150 for each additional musculoskeletal body area."

Agency Response: The Division disagrees with the recommendation. The recommended substitute language deletes the subsection which defines the musculoskeletal body areas that may be billed and reimbursed for an IR. The definition of a musculoskeletal body area is very important in determining overall IR reimbursement and its deletion would result in confusion and an increase in medical disputes.

§134.204(j)(4)(D)

Comment: Commenter supports the continued reimbursement of specialty testing, including psychological testing, at the MFG rate for the services provided. This section maintains a fair reimbursement approach when testing is done for clinical purposes, and allows the examining doctor to refer out for specialty evaluation as required or recommended by AMA Guides and Division rules.

Agency Response: The Division appreciates the supportive comment.

§134.204(k)

Comment: Commenter asks if treating and/or designated doctors are to use both modifiers "RE" and "W8" when performing RTW evaluations.

Agency Response: The Division clarifies that use of both modifiers by a designated doctor is accurate, but a treating doctor is not to use modifier "W8," as it is only to be used by a designated doctor when determining the ability of an employee to return to work. Subsection (b) of this section addresses modifiers and states when two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

Comment: Commenter recommends additional reimbursement for designated doctors who are required to submit letters of clarification for the work performed, and cites such requests occurring on 20-50 percent of cases.

Agency Response: The Division declines to make the requested changes. The reimbursement structure for MMI examinations is one which provides one reimbursement amount for almost all MMI evaluations. The established reimbursement is intended to compensate for the instances where a doctor is required to provide further clarification on a certification.

Comment: Commenter states that designated doctor reimbursements are too low due to the added responsibilities and expectations for potentially referencing MDA, ODG, AMA Guides, etc. The commenter recommends a fee schedule of $500 per seven noted designated doctor responsibilities and areas to evaluate as follows: (1) impairment rating, all body parts included, only if calculated; (2) maximum medical improvement, whether at MMI or not at MMI; (3) return to work; (4) extent of injury; (5) duration of disability; (6) SIBS question; and (7) other. Alternatively, the commenter recommends a cap of $2000 maximum on any single date of examination. The commenter also suggests that additional required testing be billed separately according to CPT code.

Agency Response: The Division disagrees that reimbursement rates are too low based on expectations of the designated doctor's examinations, and declines to make the requested changes. The reimbursement structure for MMI examinations is one which provides one reimbursement amount for almost all MMI evaluations. All MMI/IR determinations (except those performed by treating doctors or referral doctors who have previously been treating the injured employee) maintain a basic reimbursement of $350. Subsection (j) of this section maintains the provision that when performing an IR evaluation, body areas are reimbursed as well, and also maintains an additional reimbursement of $50 for each additional IR calculation when multiple IRs are required as a component of a designated doctor examination.

In establishing the prorated payment method for the four remaining examinations that could also be requested of a designated doctor, the Division, in consultation with the Medical Advisor, determined that the requirements of a designated doctor to perform multiple examinations and be paid accordingly has merit. Subsections (i) and (k) of this section are designed to note and address these newer designated doctor responsibilities, to raise the overall reimbursement rate for these other examinations, and to establish a cap with a prorated payment method for the four remaining examinations that could also be requested of the designated doctor. The increase from $350 (reimbursement rate allowed by §134.202) to $500 for an examination is appropriate and commensurate with the increase in designated doctor examination responsibilities as required by HB 7 and changes to the Labor Code at §408.0041.

Comment: Commenters recommend that return to work (RTW) and extent of medical care (EMC) examinations should not be

reimbursed at 100 percent if there are other concurrent examinations taking place and that there is no separate examination that is needed in order to address the RTW and EMC issue. Additionally, the commenters suggest that no RTW or EMC exam can be used for the purpose of certifying MMI."

Agency Response: The Division agrees with the commenter that RTW and EMC examinations should not be reimbursed at 100 percent if there are other concurrent examinations taking place and there are no separate examinations needed in order to address the RTW and EMC issues. Section 413.204(i)(2) addresses the issue of payments were there are concurrent examinations including RTW and EMC examinations. The only time an RTW or EMC examination would be reimbursed at 100 percent would be if the examination was the only one of the examinations listed under §413.204(i)(1)(C)-(F) performed under the Division order. If both RTW and EMC examinations were done concurrently, only the first would be reimbursed at 100 percent under (i)(2)(A) and the second would be reimbursed at 50 percent under (i)(2)(B).

Comment: Commenter requests clarification of methodology used for increase from $350 to $500. The commenter states that a carrier should not be liable for the MMI/IR determination when practitioners bill for MMI/IR if the Division's order requires only examination for "extent of injury" under (C).

Agency Response: The Division agrees that a carrier should not be liable for an MMI/IR determination when the Division order requires only an examination for "extent of injury" and current practice conforms to that understanding. The DWC Form-32 (Request for Designated Doctor) provides spaces to indicate the requested examinations. Designated doctors are not to do examinations other than those requested and by extension are not allowed to bill for examinations other than those requested. In the case presented, the designated doctor would not be allowed to bill for any examination other than one for "extent of injury."

§134.204(l)

Comment: Commenter states that the proposal makes no mention of reimbursement for TDI required reports (specifically the DWC Form-73, Work Status Report), and further recommends that reimbursement, which historically has been $15, be increased to $20, and recommends this section, or another Division rule, reference this. Another commenter recommends the Division mandate a specific reimbursement amount for required reports such as the DWC Form-73, and further recommend a section in the rules that address payment for required forms that are clearly functions separate and apart from the care of patients, but necessary for all parties to have knowledge of patients' status. The commenters observe that carriers often deny these payments because the rules are unclear and not enforced.

Agency Response: The Division disagrees with the first commenter's statement, noting that the Work Statutes Report referenced by the commenter is mentioned in the rule at §134.204(l). As noted in §134.204(l), a provider billing for a Work Status Report that is not conducted as part of the examinations outlined in §134.204(i) or (j) should refer to Division rule §129.5. Because billing for a Work Status Report that is not conducted as part of the examinations outlined in §134.204(i) or (j) is controlled by Division rule §129.5, it would be inappropriate to set different regulations in §134.204.

The commenters do not specify what other forms should have fees set in a new section. However, addition of a new section would be a substantive change requiring a rule proposal prior to adoption, thus would be inappropriate in this adoption order. If commenters believe additional rule sections are necessary to provide fee guidelines for required reports, they are encouraged to notify the Division of specific reports that should be addressed by a new section.

For: Individuals; Empi, Inc.; Midtown Orthopaedics & Sports Medicine, P.A.; North Texas SpineCare; Orthopaedic Specialists of Austin; ReAble Therapeutics, Inc.; Restora Austin Plastic Surgery Centre; Texas Sports Medicine; and Waco Bone & Joint Clinic.

For, with changes: Individuals; Advanced Sports Medicine and Orthopaedics, American Insurance Association, Arlington Orthopedic Associates, P.A.; Cen-Tex Billing and Professional Services; Churchill Evaluation Centers; Coastal Bend Neurology; Concentra, Inc.; Corridor Medical Clinic; DeTar MedWorks; Glen Lakes Orthopaedic Clinic; Health at Work; Industrial & Family Practice Clinic; Insurance Council of Texas; KSF Orthopedic Associates; Medtronic, Inc.; MES Solutions, Inc.; Mid Valley Physicians Association; Mission Orthopaedics, P.A.; Occupational Orthopaedics Specialists; Office of Injured Employee Counsel; Orthopedic Associates of Corpus Christi; Orthopaedic Center of Mesquite; Progressive Medical, Inc.; Property Casualty Insurers Association of America; the San Antonio Orthopedic Group; SKS Plastic Surgery, P.A.; South Texas Radiology Group, P.A.; Southwest Orthopaedic Group; State Office of Risk Management; Texas Association of Neurological Surgeons; Texas Association of Business; Texas Association of School Boards; Texas Medical Association; Texas MedClinic; Texas Mutual Insurance Company; Texas Neurological Society; Texas Orthopaedic Association; Texas Osteopathic Medical Association; Texas Pain Society; Texas Physical Medicine and Rehabilitation Society; Texas Society of Anesthesiologists; Texas Spine Society; and the Hand and Upper Extremity Institute of South Texas.

Against: Individuals, Angelica Plastic Surgery, the Boeing Company, and Restora Austin Plastic Surgery Centre. Neither For or Against: Individuals; Advanced Orthopaedics & Sports Medicine; Azalea Orthopedics; Bronson Clinic; Healthesystems; North Texas SpineCare; and Tejas Anesthesia, P.A.

SUBCHAPTER A. MEDICAL REIMBURSEMENT POLICIES

28 TAC §134.1, §134.2

The amended rule and new rules are adopted under the Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 408.0252, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061. Section 408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the Commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division for use by the Commissioner and the Division in adopting medical policies, fee guidelines, and rules. Section 413.011 mandates that the Division, by rule, establish medical policies and guidelines. Section 413.012 requires the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and

policies to develop, maintain, and review guidelines as provided by §413.011. Section 408.0252 allows the Commissioner of workers' compensation to identify areas of the state in which access to health care provides is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides for procedures for medical dispute resolution. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§134.1. Medical Reimbursement.

(a) "Maximum allowable reimbursement" (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.

(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.

(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the Division's fee guidelines;

(2) a negotiated contract; or

(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

(g) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.

§134.2. Incentive Payments for Workers' Compensation Underserved Areas.

(a) When required by Division rule, an incentive payment shall be added to the maximum allowable reimbursement (MAR) for services performed in a designated workers' compensation underserved area.

(b) The following list of ZIP Codes comprise the Division designated workers' compensation underserved areas: 75134, 75135, 75161, 75181, 75212, 75410, 75558, 75603, 75630, 75650, 75653, 75654, 75658, 75660, 75663, 75666, 75667, 75672, 75687, 75692, 75704, 75750, 75752, 75763, 75789, 75849, 75915, 75933, 75949, 75964, 75969, 75973, 75980, 76023, 76055, 76060, 76066, 76088, 76119, 76226, 76239, 76247, 76271, 76380, 76443, 76534, 76621, 76640, 76657, 76682, 76711, 76932, 76935, 77033, 77050, 77053, 77078, 77336, 77354, 77363, 77389, 77396, 77466, 77496, 77517, 77561, 77632, 77808, 77905, 77968, 78025, 78123, 78132, 78140, 78141, 78210, 78220, 78239, 78242, 78333, 78335, 78343, 78368, 78370, 78383, 78407, 78535, 78574, 78583, 78590, 78605, 78640, 78669, 78802, 78830, 78836, 78877, 78884, 78935, 78960, 79010, 79107, 79108, 79114, 79118, 79311, 79367, 79408, 79411, 79511, 79521, 79536, 79561, 79563, 79778, 79782, 79836, 79838, 79849, 79901, 79922, 79934.

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

Filed with the Office of the Secretary of State on December 28, 2007.

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Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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Proposal publication date: October 5, 2007
For further information, please call: (512) 804-4288

SUBCHAPTER C. MEDICAL FEE GUIDELINES

28 TAC §134.203, §134.204

The amended rule and new rules are adopted under the Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 408.0252, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061. Section 408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted

by the Commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division for use by the Commissioner and the Division in adopting medical policies, fee guidelines, and rules. Section 413.011 mandates that the Division, by rule, establish medical policies and guidelines. Section 413.012 requires the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by §413.011. Section 408.0252 allows the Commissioner of workers' compensation to identify areas of the state in which access to health care provides is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides for procedures for medical dispute resolution. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§134.203. Medical Fee Guideline for Professional Services.

(a) Applicability of this rule is as follows:

(1) This section applies to professional medical services provided in the Texas workers' compensation system, other than:

(A) workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(2) This section applies to professional medical services provided on or after March 1, 2008.

(3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For professional services provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(6) Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(7) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(8) Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

(2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) - (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent,

resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.

(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

(e) The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title.

(i) Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II HCPCS codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(j) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Division-specific modifiers are identified and shall be applied in accordance with §134.204(n) of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services). When two or more modifiers are applicable to a single CPT code, indicate each modifier on the bill.

§134.204. Medical Fee Guideline for Workers' Compensation Specific Services.

(a) Applicability of this rule is as follows:

(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:

(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.

(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).

(e) Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

(B) CPT Code 99362.

(i) Reimbursement to the treating doctor shall be $198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be $50 when a HCP contributes to the case management activity.

(C) CPT Code 99371.

(i) Reimbursement to the treating doctor shall be $18. Modifier "W1" shall be added.

(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.

(D) CPT Code 99372.

(i) Reimbursement to the treating doctor shall be $46. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management activity shall be $12.

(E) CPT Code 99373.

(i) Reimbursement to the treating doctor shall be $90. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management action shall be $23.

(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

(A) appearance (observational and palpation);

(B) flexibility of the extremity joint or spinal region (usually observational);

(C) posture and deformities;

(D) vascular integrity;

(E) neurological tests to detect sensory deficit;

(F) myotomal strength to detect gross motor deficit; and

(G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(D) static positional tolerance (observational determination of tolerance for sitting or standing).

(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

(1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "MR" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(i) The following shall apply to Designated Doctor Examinations.

(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W6;"

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W7;"

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W8"; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier "W9."

(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) $300 for the first musculoskeletal body area; and

(-b-) $150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and,

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

(5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

(6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(l) The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

(m) The following shall apply to Treating Doctor Examination to Define the Compensable Injury. When billing for this type of examination, refer to §126.14 of this title (relating to Treating Doctor Examination to Define Compensable Injury).

(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs--This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(2) CP, Chronic Pain Management Program--This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.

(3) FC, Functional Capacity--This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

(4) MR, Outpatient Medical Rehabilitation Program--This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.

(5) MI, Multiple Impairment Ratings--This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, Not at Maximum Medical Improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC)--This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed.

(8) SP, Specialty Area--This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(9) TC, Technical Component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(10) VR, Review report--This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.

(11) V1, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.

(12) V2, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.

(13) V3, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.

(14) V4, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.

(15) V5, Level of MMI for Treating Doctor--This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.

(16) WC, Work Conditioning--This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.

(17) WH, Work Hardening--This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.

(18) WP, Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(19) W1, Case Management for Treating Doctor--This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

(21) W6, Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.

(22) W7, Designated Doctor Examination for Disability--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.

(24) W9, Designated Doctor Examination for Other Similar Issues--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

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

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SUBCHAPTER E. HEALTH FACILITY FEES

28 TAC §134.403, §134.404

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division), adopts new §134.403 concerning Hospital Facility Fee Guideline--Outpatient and new §134.404 concerning Hospital Fee Facility Guideline--Inpatient. The new sections are adopted with changes to the proposed text as published in the October 12, 2007, issue of the *Texas Register* (32 TexReg 7214) and error corrections published in the November 2, 2007, issue of the *Texas Register* (32 TexReg 8015).

These new sections are necessary to comply with the requirements of Labor Code §413.011, which requires the commissioner to adopt fee guidelines that are fair and reasonable, designed to ensure the quality of medical care, and achieve effective medical cost control and Labor Code §413.012, which directs the commissioner to review and revise the fee guidelines every two years to reflect fair and reasonable fees.

In developing fee guidelines, Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems, using the most current methodologies, models, values, or weights used by the Centers for Medicare and Medicaid Services (CMS) in order to achieve standardization. Additionally, Labor Code §413.011 requires the commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf, and may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by CMS. Labor Code §413.012 requires a review of medical policies and guidelines every two years to reflect both fair and reasonable fees, and reasonable or necessary medical treatment. Labor Code §413.0511 requires the Medical Advisor to review the fee guideline rules and make recommendations, that are consistent with §413.011. These provisions are considered as the rules are developed.

There is currently no fee guideline that addresses outpatient hospital services. Instead, hospital outpatient services are currently reimbursed on a fair and reasonable basis, as provided by §134.1 of this title (relating to Medical Reimbursement). Adopted new §134.403 provides an outpatient hospital fee guideline, which uses the Medicare system as a framework for the billing and reimbursement methodology and establishes standardized formats used in the group health and Medicare systems.

Reimbursements for acute care inpatient hospital services are currently established by §134.401 of this title (relating to Acute Care Inpatient Hospital Fee Guideline), effective August 1, 1997. Section 134.401 provides instruction for calculating reimbursement amounts for health care provided in acute care inpatient hospitals to injured employees in Texas. The reimbursement amounts in §134.401 provide different methods of reimbursement based on the specific classification of the hospital and the type of services and total charges related to the admission. These methodologies include per diem reimbursement, stop-loss reimbursement, and when required, fair and reasonable reimbursement as initially determined by the carrier. New §134.404 is necessary because current §134.401 was adopted prior to significant statutory changes enacted in 2001 by HB 2600, 76th Legislative Session. HB 2600 amended Labor Code §413.011, creating the requirement that fee guidelines be based on current Medicare reimbursement methodologies. New §134.404 provides a new inpatient hospital fee guideline that applies reimbursement methodologies that reflect current Medicare prospective payment practices, including a Medicare-based outlier methodology to replace the previous charge-based stop-loss methodology. The structure set out in new §134.403 and §134.404 uses the Medicare system as a framework for the billing and reimbursement methodology and establishes fee guidelines that use standardized formats used in the group health and Medicare systems.

MEDICARE

CMS regulates the Medicare and Medicaid programs. CMS has established a Medicare prospective payment system (PPS) for hospital/facility-based services, which include inpatient and outpatient hospital care, ambulatory surgical services, and other facility-based services such as, but not limited to, rehabilitation, psychiatric, and long term care units. Medicare requires a deductible and co-pay from the patient, until the patient reaches

a certain level of expenditures. When setting reimbursement amounts, Medicare considers and includes this deductible and co-pay for facility services. CMS has directed an enormous amount of research into determining facility reimbursements in the Medicare System. Reimbursements are based on a facility's expected cost to provide a service rather than charged amounts, thus reimbursements differ by facility type. CMS establishes a predetermined amount of reimbursement which bundles or packages services; therefore, financial risk is assumed by the health care facility, which encourages efficient delivery of care. CMS updates reimbursements periodically based on a variety of factors, including weights (e.g., intensity), clinical issues, costs, inflation, and federal budget constraints. Reimbursement is based on national average costs with adjustments for geographic and facility specific factors. In addition, billed claims are subject to clinical coding edits Medicare has developed.

Diagnosis Related Groups (DRGs) were adopted by CMS (at that time named the "Health Care Financing Administration") in the early 1980s for the reimbursement of hospital inpatient services, and this methodology is widely used by other payors. DRG groups are based on clinically similar diagnoses requiring similar amounts of resources. Each inpatient stay is grouped into a single DRG, and each stay is reimbursed at a predetermined per discharge rate for the DRG, regardless of billed amount or length of inpatient stay, though CMS makes adjustments called "outliers" to the reimbursement to reflect extraordinarily high cost cases. To determine outliers, the base payment rates are multiplied by individual DRG weights and adjusted for local market conditions, or geographic adjustments. Adjustments for local market conditions are accomplished through the wage index, the capital geographic adjustment factor, and the large urban add-on. The operating and capital payment rates are increased for facilities that operate an approved resident training program, and for facilities that treat a disproportionate share of low-income patients. For some transfer cases, rates are reduced; and for extraordinarily costly cases, outlier payments are added. Separate Medicare payments, unrelated to payment for individual discharges, are made for Direct Graduate Medical Education expenses and Medicare bad debts. In addition, a separate reimbursement is allowed for new technology. Rural and other defined hospitals are exempt from payments under the Inpatient Prospective Payment System (IPPS) and have special payment provisions.

In setting the payment rates in the Outpatient Payment Prospective System (OPPS), CMS covers hospitals' operating and capital costs for the services they furnish. Ambulatory Payment Classifications (APCs) were adopted by CMS in August 2000, and the APC methodology is not as widely used by other payors. There are more than 808 APCs based on clinically similar items and services requiring similar amounts of resources. An outpatient visit may include multiple APCs, each APC having a predetermined rate. CMS determines the payment rate for each service by multiplying the APC relative weight for the service by a conversion factor. The relative weight for an APC measures the resource requirements of the service and is based on the median cost of services in that APC. CMS makes outlier adjustments to reflect unusually high cost cases. Additional payments to the facility are made for pass-through items based on hospital specific cost information (e.g., drugs and implantables). Some outpatient services (e.g., physical therapy, occupational therapy, durable medical equipment, laboratory) are reimbursed using the Medicare physician fee schedules rather than being grouped into an APC.

One exception to CMS's method for setting payment rates is the new technology APCs. CMS assigns services to new technology APCs on the basis of cost information collected from applications for new technology status. New technology APCs encompass cost ranges from $0 - $10 to $9,500 - $10,000. CMS sets the payment rate for a new technology APC at the midpoint of its cost range.

Hospitals can also receive three payments in addition to the standard OPPS payments: (1) pass-through payments for new technologies; (2) outlier payments for unusually costly services; and (3) hold-harmless payments for cancer and children's hospitals and rural hospitals with 100 or fewer beds that are not sole community hospitals.

USE AND COLLECTION OF DATA

Division Data

In maintaining a medical billing database, the Division requires carriers to submit billing and reimbursement information to the Division on a regular basis. The Division implemented a new reporting format in late 2006 to facilitate collection of medical billing and reimbursement data from carriers in conjunction with new electronic billing reporting requirements. The new electronic reporting format is the International Association of Industrial Accident Boards and Commission's (IAIABC) 837 format. Carriers submitted calendar year (CY) 2005 charged and paid data in this new format and the Division has based the primary components of its analysis on CY 2005 information. When the data was made available for use, CY 2005 data was determined to be the most complete set of mature claims data available. The Division prepared a series of reports to have an improved understanding of the types of hospital inpatient and outpatient services provided to injured employees and to understand the billing and reimbursement calculations associated with those services. The Division was also able to review charge and payment activity for specific types of admissions. These admissions were further organized to focus on hospital measures followed by carriers' measures. These measures include trauma admissions, burn admissions, surgical admissions, and charges and payments for "carve-outs," including implanted surgical devices. Additionally, the Division's CY 2005 data showed similarities with comparable Texas Health Care Information Collection/Center for Health Statistics data for CY 2005, as described in the following sections.

Hospital services account for a significant portion of the medical benefits paid in the Texas workers' compensation system. Payments to hospitals for CY 2005 services totaled approximately $205 million, which represents approximately 20 percent of total medical payments. These payments were split relatively evenly between inpatient services ($93 million) and outpatient services ($111 million).

Although inpatient services account for a significant portion of hospital reimbursement, there were less than 10,000 inpatient discharges reported with services provided by 578 hospitals in CY 2005. A little more than a third of the inpatient admissions were made to 23 hospitals that each had more than 100 admissions. On the other end of the spectrum, 411 hospitals had ten or fewer Texas workers' compensation admissions in CY 2005. Hospitals with more than 100 admissions were responsible for 47 percent of inpatient charges and 45 percent of inpatient reimbursements.

Texas Health Care Information Collection/Center for Health Statistics (THCIC)

The THCIC is an entity within the Texas Department of State Health Services, and is governed under the rules and regulations of the State Health and Safety Code. The THCIC develops a statewide health care data collection system to collect health care charges, utilization data, provider quality data, and outcome data to facilitate the promotion and accessibility of cost-effective, quality health care. THCIC data does not build on and does not duplicate other data collection required by state or federal law, by an accreditation organization, or by board rule, and the center works with appropriate agencies to review public health data collection programs in Texas and recommend, where appropriate, consolidation of the programs and any legislation necessary to effect the consolidation. Additionally, THCIC is designed to assure that public use data is made available and accessible to interested persons with defined processes for providers to submit data.

The Division obtained public use data sets from THCIC for CYs 2003, 2004, and 2005. The data includes detailed information regarding every inpatient discharge in Texas. Specific identifiers for low volume providers are summarized to protect patient confidentiality. The Division developed numerous queries of the data, and provided summary analysis to the Data Methodology Committee, a committee described later in this preamble. For example, the following queries were run from the data:

* All workers' compensation discharges for 2004 and 2005;

* Top 25 workers' compensation DRGs for 2004 and 2005;

* All discharge by quarter for the top 5 DRG codes;

* Average dollar amount of charges by quarter for the top 5 DRG codes;

* All discharges for the top 25 Texas workers' compensation DRGs for 2004 and 2005; and

* Average dollar amount of charges, average length of stay by payor type.

The data was further segregated by discharges to separately identify trauma codes, discharges with billed charges less than $40,000, and discharges with billed charges more than $40,000. Additionally, further extractions were made to identify the estimated impact based on revenue codes of "carve-out" payments made under current §134.401.

Milliman Consultants and Actuaries

In July 2007, the Division entered into a professional services agreement with Milliman, a leading consultant to the health insurance and health maintenance organization (HMO) industries. Specifically the agreement sought Milliman's expertise for indexing Texas workers' compensation system inpatient and outpatient facility reimbursement to Medicare facility reimbursement. Milliman has extensive experience in designing and pricing insurance products; helping HMOs, preferred provider organizations (PPOs), and insurance carriers set up managed care networks; researching and analyzing health care systems' claims data and reimbursement analysis and rate setting; developing fee guidelines/schedules; and working with governmental and regulatory entities and projecting financial results for clients.

The Division provided Milliman with the 837 data set for CY 2005, which included information on approximately 12,000 inpatient billing lines and 166,000 hospital outpatient billing lines.

Based on the analysis of the Division's 837 data, Milliman estimated that Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays represented approximately 115 percent of 2007 Medicare allowable levels. This percentage varies significantly by type of service, case, payor, and provider. Most notable is the difference in the percentage between hospital stays with low and high billed charge amounts. For hospital stays with less than $40,000 in billed charges, the Texas workers compensation payments represented 66 percent of Medicare allowable amounts. For hospital stays with $40,000 or more in billed charges, the Texas workers' compensation payments represented 160 percent of Medicare allowable amounts.

Milliman's report included information on surgically implanted devices as a percentage of inpatient reimbursement for all cases and as a percentage of reimbursement for cases with surgically implanted devices. For all cases, surgically implanted devices represented 25 percent of the total reimbursement. For cases with surgically implanted devices, the reimbursement for those devices was 36.5 percent of total reimbursement for inpatient admissions with charges for implants.

Milliman's analysis of CY 2005 outpatient hospital data included 54 percent of the Texas workers' compensation payments for hospital outpatient services. These payments, however, totaled over $60 million. Based on those claims with sufficient data to be analyzed and re-priced using CMS' methodology, Milliman estimated that CY 2005 Texas workers' compensation outpatient facility reimbursement represented approximately 186 percent of Medicare allowable levels for outpatient services. As noted in the inpatient results, this percentage varies significantly by type of service, case, payor, and provider.

Milliman's report included information on surgically implanted devices as a percentage of outpatient reimbursement for all cases and as a percentage of reimbursement for surgical cases. For all cases, surgically implanted devices represented 8.6 percent of the total reimbursement.

MARKET REIMBURSEMENT

Texas Hospital Association (THA) Survey

The Division requested the assistance of the THA in coordinating the collection of billing and reimbursement information for services currently provided by Texas hospitals in the Texas workers' compensation system. THA's survey results are available from the Division upon request, at a cost for reproduction.

The Division provided THA with a list of Medicare DRGs most frequently billed in the Texas workers' compensation system. The DRG list was based upon THCIC's public data file. The Division asked THA to survey its members to provide detailed aggregate charges and reimbursements for these DRGs by payor type in order to have a better understanding of the general reimbursement relationships between Medicare, HMOs, PPOs, commercial indemnity, and Texas workers' compensation plans.

Below are some of THA's inpatient survey results represented in percentages of payments to charges for CYs 2005 and 2006 by payor type:

* CY 2006: Inpatient HMOs and PPOs combined reflected a ratio of 42 percent of payments to charges, Medicare a ratio of 25.4 percent, and workers' compensation a ratio of 35.3 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 28.9 percent, for Medicare a ratio of 21.4 percent, and for workers' compensation a ratio of 38 percent.

* CY 2005: Inpatient HMOs and PPOs combined reflected a ratio of 39 percent of payments to charges, Medicare a ratio of 26.1 percent, and workers' compensation a ratio of 35.9 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 27.4 percent, for Medicare a ratio of 20.8 percent, and for workers' compensation a ratio of 35.4 percent.

The same type of outpatient survey results are as follows:

* CY 2006: Outpatient HMOs and PPOs combined reflected a ratio of 39 percent of payments to charges, Medicare a ratio of 16.4 percent, and workers' compensation a ratio of 46.3 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 8.7 percent, for Medicare a ratio of 13.3 percent, and for workers' compensation a ratio of 10.3 percent.

* CY 2005: Outpatient HMOs and PPOs combined reflected a ratio of 41.4 percent of payments to charges, Medicare a ratio of 17.0 percent, and workers' compensation a ratio of 49.2 percent. The ratio of payments to charges for all implants and carve-outs reflected for HMOs and PPOs combined was 8.7 percent, for Medicare a ratio of 12.6 percent, and for workers' compensation a ratio of 9.8 percent.

Ingenix, Inc.

The previous Texas Workers' Compensation Commission (Commission) entered into a professional services agreement with Ingenix in June 2001, and again in the summer of 2005, to benchmark workers' compensation payments to current health care market reimbursement rates. Ingenix is a professional firm specializing in actuarial and health care information services, and assisted the Commission in developing §134.402, which addresses facility fees for health care services provided in an ambulatory surgery center facility.

When conducting its research, Ingenix analyzed hospital inpatient and outpatient services and ASC services separately. In defining the market, Ingenix utilized commercial payor information that is reflective of the current reimbursement for the various payor types such as HMOs, PPOs, point of service (POS) plans, and traditional fee for service health plans (indemnity plans). Commercial reimbursement reflects, for the most part, negotiated rates based on both carriers' and providers' business plans. The combined Medicare market data and commercial market data reflected the actual reimbursement for services provided in the health care market.

Historical Commission medical claims data provided a Texas workers' compensation mix of services for use in the analysis. This utilization pattern was applied to the commercial market (HMO, PPO, POS, and indemnity plans) and Medicare reimbursement levels, establishing an estimated reimbursement for a workers' compensation case mix.

In a report dated August 29, 2005, Ingenix provided actuarial data regarding the mix of insured people by coverage type (Medicare, HMO, POS, PPO, and indemnity plans); the relative utilization factors for each payor group; and the relative reimbursement for each payor type as a percent of Medicare reimbursement. The combination of covered population and utilization rates yields a market share for each type. When this market share information is combined with relative reimbursement rates, a weighted average for the market is calculated. Depending on the definition of the market, i.e., either including or excluding specific payor types, a range of reimbursement for the market may be developed. Additional analysis provided the ratio to Medicare of each coverage type's payment levels for each year from 2003 through 2008. Based on the information included in the Ingenix reports, the Division estimated the inpatient market between 112 percent and 147 percent of Ingenix projected 2008 Medicare rates. Additionally, the Division estimated the outpatient market between 163 percent and 217 percent of Ingenix projected 2008 Medicare rates.

The Division has not included the payment adjustment factors recommended in the Ingenix original 2002 report due to the age of the recommendations and because the recommendations were specific to the draft proposal inpatient and outpatient guidelines being developed in 2002. However, in preparing the currently adopted rules the Division has considered the applicable market information and projections through 2008 contained in the August 2005 Ingenix update report.

ECONOMIC INDICATORS

Medicare Payment Advisory Commission (MedPAC)

MedPAC is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program such as access to care, quality of care, and other issues affecting Medicare. MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress.

Two reports, issued in March and June each year, are the primary outlet for MedPAC recommendations. In its March 2007 Medicare Payment Policy report to the Congress, MedPAC included a section in Chapter 2 on hospital inpatient and outpatient services which pointed out trends in Medicare margins and data analysis showing that costs have risen faster than the market basket (a group of products or services used specifically to track the progress of inflation in a specific market) in recent years. According to MedPAC, the overall Medicare margin (calculated as payments minus costs, divided by payments) has trended downward since 1997 falling to -3.3 in 2005. However, the 0.2 percentage point decline from 2004 to 2005 was the smallest in the last five years. The Medicare inpatient margin decreased by 0.4 percentage point in 2005 to -0.9 percent while the outpatient margin improved for the second year in a row, though it is still lower than the inpatient margin. MedPAC estimates that the Medicare margin in 2007, reflecting 2008 payment policies other than updates will be -5.4 percent. According to MedPAC, the key factor explaining the forecasted decline in margin for 2007, in addition to policy changes, is preliminary evidence that the rate of growth in hospitals' unit costs will exceed the forecasted growth in the hospital market basket index (inflationary measure of the costs and goods of services purchased by hospitals).

MedPAC states that the weighted average of Medicare inpatient and outpatient costs, unadjusted for changes in case mix, increased by 5.3 percent in 2004 and by 5 percent in 2005. Lowering the number to take reported case-mix increases into account, the weighted average cost increase was 4.6 percent in 2004 and 3.7 percent in 2005. The 3.7 percent rate of cost growth in 2005 was slightly more than the 3.3 percent operating update hospitals received from Medicare in 2005. Looking at inpatient costs separately, MedPAC reports that unadjusted inpatient costs per discharge increased by 5.6 percent in 2004 and 5.1 percent in 2005. Case-mix-adjusted inpatient costs rose 5.4 percent in 2004 and 4.0 percent in 2005. Medicare outpatient cost per unit of service (adjusted for case-mix change) has been relatively low, increasing by only 1.2 percent in 2004 and 2.4 per-

cent in 2005. Data are available on case-mix-adjusted Medicare costs through 2005 but are not yet available for 2006. However, MedPAC reports that a survey sponsored by CMS and MedPAC of about 600 hospitals indicates that unadjusted costs per unit of service grew by approximately 5.2 percent in the fiscal year ending June 2006, slightly higher than the rate of 4.8 percent in the prior year. MedPAC also reviewed financial reports from six large publicly traded hospitals that show that their unadjusted growth in cost averaged 6.4 percent per year in the nine months ending September 2006, relative to 4.8 percent in 2005. MedPAC projected that if one averages data from these two samples, costs per discharge appear on pace to grow roughly 1 percent faster in 2006 than in 2005.

MedPAC explains that one reason 2006 differs from 2005 is that capital costs are increasing more rapidly. According to MedPAC, a second reason is that patient volume grew more slowly than hospital employment in the first half of the year; in contrast to 2005. Additionally, MedPAC provides extensive justification for these two reasons.

In its analysis of Medicare cost report data from CMS and CMS's rules for the acute IPPS, MedPAC reports that costs have risen faster than the market basket in recent years. MedPAC examined cost growth during three periods 1986 - 1992, 1993 - 1999, and 2000 - 2004 and concluded that the rate of increase tended to follow trends in private payor profitability in the same three periods. MedPAC reports that during the first cycle (1986 through 1992) most insurers still paid hospitals on the basis of their charges, with little price negotiation or selective contracting and hospital margins on private payor business increased rapidly. MedPAC further states that in the mid-1990's, HMOs and other private insurers negotiated better and most insurers switched to paying for inpatient services on the basis of DRGs or flat per diem amounts for broad types of services. MedPAC then explains that the payment, cost-to-cost ratio for private payors, declined by 17 percentage points from 1993 through 1999. MedPAC reports that by 2000, hospitals had regained the upper hand in price negotiation due to consolidations and consumer backlash against managed care. Rates for private payors rose rapidly and their payment-to-cost ratio rose by 11 percentage points from 2000 - 2004 and from 2001 - 2004, increases in private payor profitability were accompanied by hospital costs rising at a rate faster than the market basket. MedPAC saw the trend in private payor profit margins leveling off in 2005 and cost growth returning to a level close to the market basket increase.

According to MedPAC, the private sector is not the only potential source of financial pressure on hospitals; Medicare payment rates can also influence cost growth. The report further states that in recent years, Medicare inpatient payments have increased at a rate higher than the hospital market basket (reflecting updates equal to the market basket plus a small additional increase due to case-mix change), but payments have not risen fast enough to accommodate the rapid increase in hospital costs. MedPAC reports that by not fully accommodating growth in hospital costs, Medicare can put some pressure on hospitals to constrain costs.

MedPAC concludes in its report that most of its indicators of payment adequacy for hospital services are positive, although Medicare margins are low and recent cost trends suggest they will fall in 2007. At the same time, MedPAC suggests that hospitals with consistently high costs and low margins that have contributed to the industry-wide Medicare margin falling below zero are a fairly small percentage, fewer than a fifth, and opines that Medicare should put pressure on hospitals to control their costs rather than accommodate the current rate of costs growth. Balancing those considerations, MedPAC recommends that Congress should increase payment rates for the acute inpatient and outpatient PPS in 2008 by the projected rate of increase in the market basket index, concurrent with implementation of a quality incentive program. The inpatient update would apply to fiscal year 2008 and the outpatient update would apply to CY 2008. As of MedPAC's March 2007 Report, CMS' latest forecast of the hospital operating market basket index for fiscal year 2008 is 3.1 percent; it will update the forecast twice before using it to update payments in 2008.

SYSTEM PARTICIPANT INPUT AND RECOMMENDATIONS

Data Methodology Committee

In March 2007 a Data Methodology Committee was established and comprised of members recommended by the hospital and insurance industries to assist the Division with technical aspects of development of the hospital fee guidelines. The committee's focus was on data analysis and modeling as it impacts or explains the use of Medicare methodologies in the Texas workers' compensation system.

The Data Methodology Committee met over the course of five months (March - July) and reviewed and discussed numerous issues, including:

* the research of other states' (California, Colorado, New York, Nebraska, and South Carolina) hospital reimbursement systems, including any noted provisions for surgical implants, or implantables;

* spreadsheets developed by THA that included adjusted base calculations and the range of the adjusted base calculations for Texas hospitals;

* Medicare's outpatient pass-through concept for collecting data to set APCs similar to DRGs used for inpatients, as well as hospitals' cost-to-charge ratios; and

* complexities of implantable devices and the difficulties surrounding hospitals' charge compressions.

The committee also met to hear a presentation by Access MediQuip, L.L.C., a national provider of implantable and specialty surgical devices, who described its working relationship as the go-between for certain carriers, hospital systems, and other states in facilitating the procurement of implantable devices and managing the preauthorization and billing processes.

The Division, as recommended by the committee, conducted research of other states' fee schedules, as well as those states' separate reimbursement methodologies for implantables, and used concepts from that research in the development of the proposed rules. Additionally, the Division invited members from Access MediQuip to meet with the committee members for further rule development concepts.

"Recommendations for a Texas Inpatient Hospital Fee Guideline" Report

Texas Mutual Insurance Company and several other workers' compensation insurance carriers commissioned Research & Planning Consultants, LP (RPC) for the purpose of developing a report that provided information, analysis, and recommendations for use in the rulemaking process. RPC's report, at the cost for copying, is available at the Division upon request. As described in the report's section entitled, "Organization of the

Report," the study includes a detailed description of the Medicare IPPS and discusses the methodology used by Medicare to calculate payment rates with all adjustments to the basic payment rates and any applicable add-on payments included. The report additionally covers:

* types of facilities and services that are subject to special payments or excluded;

* an examination and comparison of payment adjustment factors in four states (California, North Dakota, Ohio, and South Carolina) who have preceded Texas in implementing a Medicare-based inpatient hospital fee guideline;

* description of data sets used to formulate recommendations contained in the report;

* analysis of DRG weights and other considerations, and differences in relative costs by DRGs between workers' compensation and Medicare patients; and

* a series of recommendations, which includes (1) adoption of Medicare's transfer payment policy and the three-policy-based adjustments; (2) a single payment adjustment factor of 105.9 percent applied to Medicare that simply adjusts for the difference between the Medicare payment rates and the costs incurred by hospitals treating workers' compensation patients; and (3) an alternate set of payment adjustment factors that allows for a carve-out for high implant charge DRGs (114.9 percent), and a re-distributed payment adjustment factor of 100.8 percent for all other DRGs.

The RPC Report, including the overview of Medicare's IPPS and data analysis, were utilized for comparative purposes in the development of the adopted rules. Much of the Division's analysis and the adopted payment adjustment factors for §134.404 showed similarities with comparable RPC analysis and recommendations.

Hospital Fee Schedule Proposal by Renaissance Healthcare Systems, Inc. (Renaissance)

Renaissance, a network of community health systems, provided the Division with a "Hospital Fee Schedule Rules Proposal" that described its research of other states' hospital fee guidelines, with a focus on Tennessee, Florida, and California. Renaissance gathered information and determined the percentage of Medicare reimbursement by analyzing the operating room and administrative costs to Renaissance for outpatient services. Additionally, Renaissance added patient day costs for the inpatient calculations. With this determination, Renaissance compared the information to Renaissance actual Medicare reimbursements for each of those services and arrived at the percentage of Medicare that Renaissance determined would provide a 15 percent net profit margin in order to serve health care to the community. Consequently, for inpatient hospital fee reimbursements, Renaissance recommended a range of 155-170 percent of Medicare, and for outpatient hospital fee reimbursements, a range of 225-255 percent of Medicare. Additionally, for inpatient services, Renaissance recommended the adoption of stop-loss provisions to be paid at 75 percent of billed charges, less the charges for implantables, when total billed charges exceed $50,000, after the removal of the charges for implantables.

Other States Research

In preparing for the revision and development of the facility fee guidelines, the Division researched the payment methodologies and reimbursement rates of other states workers' compensation programs. Of primary interest was the general topic of other states' use of the Medicare system as a basis for reimbursement. Although many states refer to the Medicare program, each state's unique legislative requirements result in a diverse set of rules and procedures. Per diem reimbursement, cost-to-charge ratios, discounts from billed charges, and DRG based reimbursements are being used. Some states invoke Medicare and quickly diverge from the Medicare model. Consequently, direct comparisons of the various states to Texas are difficult and may lead to erroneous conclusions. California, South Carolina, North Dakota, and Ohio, use a Medicare based system. The inpatient allowable for these states ranges from 115 percent to 140 percent of Medicare reimbursement. Still each of these states has unique variations that ultimately modify the specific reimbursement for each admission.

Payment for outpatient services reflects the same diversity. Discounts from billed charges and cost-to-charge ratios reimbursement are common. Payment based on Medicare's OPPS is used in California, North Dakota, South Carolina, Tennessee, and Washington. Reimbursement rates vary among these five states. Tennessee is at the upper end of the range with a fee schedule set at 150 percent of Medicare.

For both the inpatient and outpatient settings, states have a wide variety of rules that modify their general payment approach. These include carve-outs for specific items, stop-loss reimbursement, and various other payment exclusions or restrictions.

HOSPITAL FEE GUIDELINES RESULTS/CONCLUSIONS AND EXPLANATIONS

In developing the adopted hospital fee guidelines, the Division has carefully and fully analyzed all of the statutory and policy mandates and objectives and all the facts and evidence gathered and submitted, as well as all informal system participants' input and comments received throughout the development process, including written comments to the proposed inpatient and outpatient guidelines and public hearing testimony on the proposed rules. The Division has utilized the information gathered and submitted, along with its expertise and experience, to develop these hospital fee guidelines in a way that best balances the statutory mandates, including the mandate to ensure that injured employees receive the quality health care reasonably required by the nature of their injury, the mandate to ensure that fee guidelines are fair and reasonable, and the mandate to achieve effective medical cost control.

Setting Payment Adjustment Factors (PAFs)

In adopting PAFs for use in §134.403 and §134.404, the Division has conducted extensive research to understand hospital reimbursement in the current Texas workers' compensation system, including: reimbursement rates, the reimbursement rates as compared to Medicare reimbursement, and the reimbursement rates as compared to non-workers' compensation reimbursement for hospital services.

The Division has also considered economic indicators for hospitals that are particularly relevant to the analysis process. Hospital Medicare margins and hospital market basket information reflect the general increasing costs of hospital care over time.

Overall, CY 2005 Texas workers' compensation reimbursement rates for inpatient and outpatient services as a percentage of billed charges are 33 percent and 37 percent respectively. Additionally, Milliman has reviewed Texas workers' compensation

facility utilization and reimbursement. The report prepared by Milliman did not recommend a PAF, however, it did estimate that for CY 2005 services facilities were paid on average 115 percent of Medicare for inpatient services and on average 186 percent of Medicare for outpatient services. Reimbursement rates at these levels would generally maintain overall system costs at CY 2005 levels.

The Division, however, must consider additional factors in setting the PAFs. The ratio of Medicare reimbursement to reimbursement made by other payors is an important and necessary comparison in order to comply with §413.011. In adopting a PAF, the Division has noted and considered the recommendations made by system stakeholders. Those recommendations range from 100 percent to 170 percent of Medicare for inpatient services, and 100 percent to 266 percent of Medicare for outpatient services. These rates were paired with various adjustments to the overall Medicare reimbursement methodology. Additionally, the Division has considered information provided by Ingenix relating to the market share of inpatient and outpatient services for Medicare, HMO, PPO, POS, and commercial indemnity payor groups and the reimbursement rates of those payors when indexed to Medicare payments. This set of reimbursement rate recommendations and observations provides a general range of rates that is reflective of the current hospital market to consider in adopting a PAF.

The Division considered the issues of medical cost containment as prescribed by Labor Code §413.011. The Division balanced changes in the reimbursement rate with high medical costs per claim and access to care. Research conducted by the Workers' Compensation Research Institute concludes that hospital inpatient payments per episode and hospital outpatient payments per claim in Texas were lower than the 13-state median studied. (Workers' Compensation Research Institute, *Baselines for Evaluating the Impact of the 2005 Reforms in Texas and an Early Look at the Impact of the 2003 Fee Schedule Changes: The Anatomy of Worker's Compensation Medical Costs and Utilization*, (Summary of Major Findings for Texas) 6th Edition, xiii, February 2007))

Medicare's methodology does not include a separate reimbursement for surgically implanted devices, with the exception of new technology; however, separate reimbursement for surgically implanted devices is used in some instances in the commercial market. This fee guideline is developed to both use the most current methodologies, models, values, or weights used by the CMS but also to consider economic indicators in health care and reflect the commercial market's use of separate reimbursement for surgically implanted devices. These fee guidelines adopt separate reimbursement for surgically implanted devices in order to ensure injured employees have access to quality medical care, including surgery where surgically implanted devices are medically necessary. The modification establishes two PAFs in each adopted section. For the Inpatient Hospital Fee Guideline, the adopted PAFs are 143 percent and 108 percent of Medicare. The adopted PAFs for the Outpatient Hospital Fee Guideline are 200 percent and 130 percent of Medicare.

Hospitals will have the option to choose the higher or lower PAF for each guideline. The higher PAF contemplates the inclusion of reimbursement for surgically implanted devices as a part of the DRG. If the hospital chooses the lower PAF, the surgically implanted device(s) will be reimbursed separately at cost plus an administrative expense fee. The administrative expense fee is set at 10 percent or $1,000 per item add-on, whichever is less, but will not exceed $2000 in add-on's per admission. If the hospital is reimbursed the lower PAF, the cost of the surgically implanted device(s), including the administrative expense fee, will not be considered in determining eligibility for outlier payments.

The Division's adopted PAFs take into consideration Milliman's estimate that Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays represented approximately 115 percent of 2007 Medicare allowable levels and the difference in the percentage between hospital stays with low- and high-billed charge amounts.

For inpatient hospital stays with less than $40,000 in billed charges, Milliman estimated Texas workers' compensation payments represented 66 percent of Medicare allowable amounts. For inpatient hospital stays with $40,000 or more in billed charges, Milliman estimated Texas workers' compensation payments represented 160 percent of Medicare allowable amounts.

In determining the adopted PAFs for inpatient hospital stays, the Division adjusted the reimbursement for hospital stays with less than $40,000 to reflect reimbursement at 100 percent of Medicare. This adjustment changes Milliman's estimated Texas workers' compensation reimbursement for CY 2005 inpatient hospital stays reimbursed less than $40,000 from 115 percent to 131 percent of Medicare's allowable reimbursement.

Similarly, reimbursement for inpatient hospital stays with billed charges greater than $40,000 was reviewed. Reimbursement at 160 percent of Medicare allowable reimbursement approximated 35 percent of billed charges. If the commercial standard of approximately 40 percent of billed charges is met for these inpatient hospital stays, overall reimbursement increases to 143 percent of Medicare allowable reimbursement. The Division used this standard as the benchmark for reimbursement.

The estimated reimbursement for all inpatient hospital stays, those with reimbursement less than $40,000, and reimbursement greater than $40,000, changes from 115 percent to 143 percent of Medicare's allowable reimbursement.

In setting a PAF for inpatient hospital stays with a separate reimbursement for surgically implanted devices, the surgically implanted device costs are removed from the higher proposed PAF, 143 percent. To determine the amount of reimbursement to be removed from this PAF, the Division analyzed reimbursements for surgically implanted devices as a percentage of total reimbursement.

Milliman's report included information on surgically implanted devices as a percentage of inpatient reimbursement for all inpatient hospital stays and as a percentage of reimbursement for inpatient hospital stay with surgically implanted devices. For all cases, surgically implanted devices represented 25 percent of the total reimbursement. For cases with surgically implanted devices, the total implantable reimbursement for those devices was estimated to be 28.7 percent of total estimated Medicare inpatient reimbursement.

The Division considered actual implantable reimbursement in determining the offset. Actual reimbursement for inpatient hospital stays with implantables was 35 percent of Medicare's allowable reimbursement. This dollar amount represents reimbursement on a cost-plus basis and the same methodology is carried over the reimbursement methodology. Therefore, the Division's adopted PAF for inpatient stays with separate reimbursement for surgically implanted devices is 35 percentage points less than the higher PAF. This adjustment should insulate hospitals for po-

tential losses as a result of high cost implants by assuring that if costs for an implant exceed 35 percent of the DRG, the hospital has the option of recovering the total cost of the implant.

Milliman's report on outpatient reimbursement indicated CY 2005 Texas workers' compensation reimbursement is approximately 186 percent of Medicare allowable reimbursement. Milliman's report also noted that one workers' compensation payor reimbursed at a significantly lower rate than the average payor. Adjusting for this anomaly, reimbursement moves to approximately 211 percent of Medicare allowable reimbursement. The Division also compared the general benchmark of 40 percent of billed charges which was equal to approximately 200 percent of the Medicare allowable reimbursement. This benchmark is based upon THA survey data.

In determining the PAFs for outpatient hospital stays, the Division considered Medicare's methodology for reimbursing device-dependent services. Medicare establishes a device offset to recognize the average implantable cost as it relates to reimbursement for a specific APC. Milliman's report indicated five APCs with an average implantable devices offset of 70 percent. The entire list of APCs identified as device-dependent by Medicare indicates an average implantable device offset of 75 percent. Since CMS identified the relative reimbursement for these devices, the Division was able to directly remove the 70 percent offset from the overall outpatient reimbursement PAF of 200 percent, resulting in a second PAF of 130 percent for use when billing implantables separately.

Based on all of these factors, the Division adopts PAFs of 143 percent and 108 percent of Medicare reimbursement for use in determining Texas workers' compensation inpatient facility service reimbursement. The Division adopts PAFs of 200 percent and 130 percent of Medicare reimbursement for use in determining Texas workers' compensation outpatient facility service reimbursement.

In response to comments from interested parties, the Commissioner has adopted these sections with some changes to the proposal as published.

§134.403. In subsection (b)(2)(D) and (E), respectively, additional language, "and" as well as "related equipment necessary to operate, program, and recharge the implantable" are changes from proposal as a result of public comments to clarify that implant-related equipment necessary to operate, program, and recharge the actual implantable device should be billable and reimbursable along with the actual implant devices. In subsection (g), additional language, "per billed item, add-on" is a change from proposal as a result of public comment to clarify that the $1,000 limit can potentially extend to multiple implantable items. This limit allows for the recognition of the administrative cost but discourages the unbundling of implantables associated with expensive items. Further, additional language in subsection (g) "but not to exceed $2,000 in add-on's per admission" is also a change from proposal. The limit of per admission should cover the administrative charges in most cases, and prevent an excessive administrative add-on for any individual item. Consequently, in the interests of effective medical cost control, the limit of $2,000 per admission is included in the adopted rules. As proposed, subsection (g) included (g)(4), however, as adopted, the Division changes (g)(4) to new subsection (h) as applicable to the entire section and not just the subsection and re-numbers the subsequent subsections accordingly.

§134.404. In subsection (b)(2) (D) and (E) respectively, additional language, "and" as well as "related equipment necessary to operate, program, and recharge the implantable" are changes from proposal as a result of public comments to clarify that implant-related equipment necessary to operate, program, and re-charge the actual implantable device should be billable and reimburseable along with the actual implant devices. In subsection (g), additional language, "per billed item, add-on" is a change from proposal as a result of public comment to clarify that the $1,000 limit can potentially extend to multiple implantable items. This limit allows for the recognition of the administrative cost but discourages the unbundling of implantables associated with expensive items. Further additional language in subsection (g) "but not to exceed $2,000 in add-on's per admission" is also a change from proposal. The limit of per admission should cover the administrative charges in most cases, and prevent an excessive administrative add-on for any individual item. Consequently, in the interests of effective medical cost control, the limit of $2,000 per admission is included in the adopted rules.

Adopted new §134.403(a) describes the applicability of the section. Adopted new §134.403(a)(1) states that the section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. Adopted new §134.403(a)(2) notes that the section does not apply to professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in the section; and, that it is not applicable to services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

Adopted new §134.403(b) provides definitions for words and terms that are used in the section. Adopted new §134.403(b)(1) defines the term "acute care hospital" to mean a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma. Adopted new §134.403(b)(2) defines the term "implantable" to mean an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and, includes related equipment necessary to operate, program and recharge the implantable. Adopted new §134.403(b)(3) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare. Adopted new §134.403(b)(4) defines the term "outpatient" to mean the patient is not admitted for inpatient or residential care, and includes observation in an outpatient status provided the observation period complies with Medicare policies. Adopted new §134.403(b)(5) defines the term "surgical implant provider" to mean a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

Adopted new §134.403(c) clarifies that a surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of the section and the sections in Chapter 133 of this title (relating to Benefits--Medical Benefits).

Adopted new §134.403(d) requires that for coding, billing, reporting, and reimbursement of health care covered in the section, Texas workers' compensation system participants shall apply Medicare payment policies in effect of the date a services is

provided with any additions or exceptions specified in the section. Adopted new §134.403(d)(1) provides that specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, as taking precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program. Adopted new §134.403(d)(2) provides that Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, as taking precedence in that case only, over any Division rules and Medicare payment policies. Adopted new §134.403(d)(3) provides for the stated inclusion that whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

Adopted new §134.403(e) establishes that regardless of billed amount, reimbursement shall be determined in the following order. The first method is in §134.403(e)(1) and indicates the amount for the service is the amount included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. The second method is in §134.403(e)(2) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount is as described under subsection (f) of the section, including any applicable outlier payment amounts and reimbursement for implantables. The last method is in §134.403(e)(3) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of the section, then reimbursement shall be determined in accordance with §134.1 of this tile (relating to Medical Reimbursement).

Adopted new §134.403(f) requires that the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare OPPS reimbursement formula and factors as published annually in the *Federal Register*, with the minimal modifications noted in the following paragraphs. Adopted new §134.403(f)(1) indicates that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent. Adopted new §134.403(f)(2) establishes that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

Adopted new §134.403(g) addresses the use of implantables, and states, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of the section, implantables shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000, per billed item add-on, whichever is less, but not to exceed $2,000 in add-ons per admission. Adopted new §134.403(g)(1) establishes that a facility or surgical implant provider billing separately for an implantable, shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Adopted new §134.403(g)(2) states that a carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) properly reflects the requirement of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B). Adopted new §134.403(g)(3) provides that nothing in the rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices, and that implantables provided by a surgical implant provider shall be reimbursed according to the subsection.

Adopted new §134.403(h) establishes that for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

Adopted new §134.403(i) clarifies that, notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

Adopted new §134.403(j) provides that a preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement are to be kept by both parties; and, the agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). Adopted new §134.403(j)(1) establishes that the agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and must include the reimbursement amount; a description of the services to be performed under the agreement; any other provisions of the agreement; and the names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement. Adopted new §134.403(j)(2) states that an agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. Adopted new §134.403(j)(3) requires that upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

Adopted new §134.403(k) establishes the severability of this section and states that if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

Adopted new §134.404(a) describes the applicability of the section. Adopted new §134.404(a)(1) states that the section applies to medical services provided in an inpatient acute care hospital

with an admission date on or after March 1, 2008. Adopted new §134.404(a)(2) describes that for admission dates prior to March 1, 2008, the law and the Texas Department of Insurance, Division of Workers' Compensation (Division) rules in effect for those dates of services shall apply. Adopted new §134.404(a)(3) notes the section does not apply to professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; and, it is not applicable to services provided through a workers compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

Adopted new §134.404(b) provides definitions for word and terms that are used in the section. Adopted new §134.404(b)(1) defines the term "acute care hospital" to mean a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma. Adopted new §134.404(b)(2) defines the term "implantable" to mean an object or device that is surgically implanted, embedded, inserted, or otherwise applied, and includes related equipment necessary to operate, program, and recharge the implantable. Adopted new §134.404(b)(3) defines "Medicare payment policy" to mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare. Adopted new §134.404(b)(4) defines the term "outlier payment amount" to mean the amount determined by Medicare's IPPS calculations for unusually costly services. Adopted new §134.404(b)(5) defines the term "surgical implant provider" to mean a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

Adopted new §134.404(c) clarifies that a surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits - Medical Benefits).

Adopted new §134.404(d) requires that for coding, billing, reporting, and reimbursement of health care covered in the section, Texas workers' compensation system participants shall apply Medicare payment policies in effect of the date a services is provided with any additions or exceptions specified in the section. Adopted new §134.404(d)(1) provides that specific provisions contained in the Texas Labor Code or the Division rules take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program. Adopted new §134.404(d)(2) provides for the inclusion of IRO decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title, which are made on a case-by-case basis, as taking precedence in that case only, over any Division rules and Medicare payment policies. Adopted new §134.404(d)(3) provides that whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

Adopted new §134.404(e) establishes that except as provided in subsection (h) of the section, regardless of billed amount, reimbursement shall be determined in the following order. The first method is in §134.404(e)(1) and indicates the amount for the service is the amount included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. The second method is in §134.404(e)(2) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, the MAR amount is as described under subsection (f) of the section, including all applicable outlier payment amounts and reimbursement for implantables. The last method is in §134.404(e)(3) and states that if no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of the section, then reimbursement shall be determined in accordance with §134.1 of this title.

Adopted new §134.404(f) requires that the reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare IPPS reimbursement formula and factors as published annually in the *Federal Register*, with the following minimal modifications applied to it. Adopted new §134.404(f)(1) indicates that the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 143 percent, unless a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of the section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent. Adopted new §134.404(f)(2) establishes that when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of the section.

Adopted new §134.404(g) addresses the use of implantables, and states, that when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of the section, implantables shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts), plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission. Adopted new §134.404(g)(1) establishes that a facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge." Adopted new §134.404(g)(2) states that a carrier may use the audit process under §133.230 of this title to seek verification that the amount certified under paragraph (1) properly reflects the requirement of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title, if that process is properly requested, notwithstanding §133.307(d)(2)(B). Adopted new §134.404(g)(3) provides that nothing in the rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices, and that implantables provided by a surgical implant provider shall be reimbursed according to subsection (g).

Adopted new §134.404(h) establishes that a hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for such a hospital in accordance with to subsections (e) through (g) of the section, that

if the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

Adopted new §134.404(i) clarifies that, notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

Adopted new §134.404(j) provides that a preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request and that copies of the agreement are to be kept by both parties; and, the agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1). Adopted new §134.404(j)(1) establishes that the agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and must include the reimbursement amount; a description of the services to be performed under the agreement; any other provisions of the agreement; and the names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement. Adopted new §134.404(j)(2) states that an agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. Adopted new §134.404(j)(3) requires that upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

Adopted new §134.404(k) establishes the severability of the section and states, if a court of competent jurisdiction holds that any provision of the section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of the section shall remain in full effect.

§134.403: Some commenters appreciate the Division's efforts in adopting an outpatient hospital fee guideline that is compliant with the Texas Labor Code and with the Medicare fee schedule. One commenter notes that thousands of "fair and reasonable" disputes have added considerable litigation costs to the Texas system due to not having an outpatient fee guideline in place.

Agency Response: The Division agrees the adopted rule for hospital outpatient services is needed and appreciates the supportive comments.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter expresses concern about the significant challenges, short-term impact, costs that payers and vendors are likely to face in implementing the rules, developing new technology, and retaining staff in order to comply with the Medicare-based methodology. Some of the increased administrative costs will ultimately be borne by Texas employers, as well as other system participants.

Agency Response: The Division understands the concerns; however, since 2001, the Labor Code at §413.011 has directed the Division to adopt and implement fee schedules based upon the standardization of the most current reimbursement methodologies, models, and values or weights used by CMS. The Division believes these required changes will result in significant improvements in the Texas workers' compensation system, including fewer fee disputes. Although system costs are ultimately borne by Texas employers, the net change in administrative costs will be offset by reduced disputes and standardized reimbursement methodologies, and other recent system improvements, such as billing and disability management concepts and rules.

§134.403 and §134.404: Some commenters support and recommend the adoption of both §134.403 and §134.404, without changes or with minor modifications. One commenter believes the Division has attempted to give an appropriate weight and balance to the various statutory requirements and with a number of modifications the proposed payment methodologies can be supported. Another commenter supports the Division's effort to review and modify the hospital fee guidelines. Another commenter appreciates the Division's effort in moving the existing fee guideline to a more appropriate reimbursement. Another commenter commends the Division for obtaining various independent reports upon which to base the proposed inpatient and outpatient hospital fee guidelines.

Agency Response: The Division appreciates the supportive comments.

§134.403 and §134.404: Some commenters do not support the PAFs designated in §134.403 and §134.404, stating that high medical costs do not necessarily equal better quality care. One commenter has concerns that if an appropriate balance is not reached, this rulemaking could undermine the intended efforts of House Bill (HB) 2600 (passed by the Texas Legislature in 2001) and HB 7 (passed in 2005) to remedy the situation of unsatisfactory care and soaring medical costs.

Agency Response: The Division agrees that high medical costs do not necessarily result in better quality of care. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. In setting the payment adjustment factors, the Division has balanced these requirements to meet the overall needs of the system.

§134.403 and §134.404: In regard to both §134.403 and §134.404, commenter believes that there is no statutory requirement for the Division to consider what hospitals are being paid by a small commercial insurance company, such as one with one-tenth of one percent market share, and average that in with everybody else. Commenter emphasizes that the payment adjustment factor should relate to costs to assure reasonable access as opposed to paying them comparable to what commercial insurance companies may be paying.

Agency Response: The Division must consider all the requirements of the Labor Code §413.011 in developing and adopting fee guidelines. The Division clarifies that it has not set benchmarks on the business practices of any particular carrier. The Division has considered Medicare reimbursement, historical Texas workers' compensation system reimbursement, data from THA's market survey, the Ingenix market analysis, and stakeholder recommendations in arriving at a payment adjustment factor. In considering the economic indicators of health care the Division must consider the requirements of the Labor Code in evaluating

both the Medicare cost benchmark and the actual experience of the market.

§134.403 and §134.404: A commenter opposes the reimbursement amounts provided by §134.403 and §134.404, stating that unnecessary and extreme fluctuations in reimbursement amounts will only drive employers out of the system. In support of the comment, the commenter references a recent survey of employer participation in the Texas workers' compensation system which resulted in 35.4 percent of non-subscribing employers reporting that they are not in the workers' compensation system because premiums are too high.

Agency Response: The Division disagrees. The adopted rules establish standardized reimbursements on an ongoing basis. This is in sharp contrast to the number of disputed cases resulting from previous per diem and stop loss methodology for inpatient hospital claims and the fair and reasonable reimbursement standard applied to hospital outpatient claims. Premiums are one of many factors employers consider when determining whether or not to subscribe to the workers' compensation system. Claim costs are driven by frequency of medical treatments, cost per treatment and length of disability. Recent system changes have provided carriers with new tools to manage claim costs and outcomes. The adopted Division treatment and return to work guidelines should allow providers and carriers to manage overall claim costs.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter supports adequate payment to providers, but warns that setting a rate too high will have the unintended consequence of driving employers out of the system, negatively impacting the viability of certified health care networks by increasing their costs to levels that result in insurers and employees electing to not participate in networks, and creating a crisis in the Texas system caused by out of control medical costs.

Agency Response: The Division disagrees with the implication that fee guidelines will negatively impact the viability of certified health care networks and create a system crisis. The Division clarifies that these rules generally do not apply to certified worker's compensation networks under Chapter 1305, Insurance Code, and do not apply to political subdivisions contracting directly with health care providers or political subdivisions contracting directly with a health benefits pool established under Chapter 172, Local Government Code, pursuant to Labor Code, §504.053 (b)(2) and (c)(3). Although the Division has adopted a fee schedule as required by the Labor Code, Labor Code §413.011 (d-1) allows an insurance carrier or the carrier's authorized agent to use an informal or voluntary network, as those terms are defined by Labor Code §413.015, to obtain a contractual agreement that provides for fees different from the fees authorized under the Division's fee guidelines based on certain requirements.

Labor Code at §413.011 (relating to Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols) establishes the requirements for fee guidelines that are fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011 requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, and values, or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors because "fair and reasonable" is a balance of all the required components of the Labor Code. Certified network issues and regulations are a separate set of laws and rules under the Workers' Compensation Health Care Network Act, which is codified at Texas Insurance Code Chapter 1305, and is not administered by the Division of Workers' Compensation.

§134.403 and §134.404: In regard to both §134.403 and §134.404, some commenters express concern about the proposed reimbursement rate. One commenter recommends that fee guidelines should reflect a reimbursement rate that is at the lower end of the average payment range for states that have adopted medical fee guidelines and not an average payment such as reflected in the Division's proposal. The commenter asserts that during the 80th Texas Legislative Session, the Legislature passed House Bill 473, which requires that by the year 2011 out-of-network care will only be able to contract at or above the fee guideline amount. This statutory change will result in a significant increase in medical costs without even factoring in the cost increases included in the proposed Medical Fee Guideline and the Hospital Fee Guidelines. This is the first time in a rule-making process by the Division or the former Texas Workers' Compensation Commission that this is a factor for fee guidelines and there is no other state with a Medicare-based system in which this limitation exists.

Another commenter states that because of recent legislation, the rates set by the Division will become the floor for all network negotiations and the minimum amount at which networks can contract with healthcare providers. The commenter further states that the Division would want to make certain that the floor would reasonably relate to average hospital costs for the workers' compensation book of business. The commenter concedes that since hospitals should be encouraged to go into networks, they should have an incentive to negotiate for those higher rates while making certain that that those negotiations occur at a level that doesn't result in raising overall system healthcare prices.

Agency Response: The Division disagrees that the reimbursement rate should be specifically set at the lower end of the average payment range for states that have adopted medical fee guidelines. In setting the guidelines, the Division must consider all aspects of Labor Code at §413.011. The Labor Code establishes the requirement that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011 requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, and models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors because "fair and reasonable" is a balance of all the required components of the Labor Code.

Additionally, although HB 473 has set in place changes that will occur in 2011, the Division is directed to review and revise, if indicated, fee guidelines on a regular basis in accordance with the Labor Code §413.012. Consequently, predicting the impact of this fee guideline upon a future requirement of the Labor Code that requires certification of all networks is premature.

§134.403 and §134.404: In regard to both §134.403 and §134.404, a commenter recommends that the Division fully explore all information in order to implement an accurate and workable fee guideline, including the effect of the newly adopted medical severity DRGs.

Agency Response: The Division agrees that it needs to consider all information available when developing or amending fee guidelines, and to this end it has reviewed the information available and solicited informal comments from stakeholders prior to proposal. The Division disagrees that additional research is necessary concerning medical severity DRGs, because the Labor Code requires adoption of the most current CMS weights, values, and measures.

§134.403 and §134.404: In regard to the sections adopted in this order, a commenter recommends that the commissioner put together a training team to travel and teach these rules in order for a smooth implementation, stating that it will take collaboration on the part of all system participants to make these changes work.

Agency Response: The Division agrees that partnering with stakeholders is beneficial. The Division will provide training information to facilitate a smooth implementation.

§134.403 and §134.404: For both §134.403 and §134.404, a commenter recommends that the Division develop tools similar to Trailblazer's "Pricer" tools for the Inpatient Prospective Payment System and the Outpatient Prospective Payment System. Many small community hospital and insurance carrier information systems are not equipped to calculate the Medicare payment rate, so "pricer" tools published on the Division's website would allow system participants to operate in compliance with the new rule. In addition, the tools would dramatically reduce the amount of unnecessary disputes that are bound to occur from errors in calculation with the adoption of a complex reimbursement methodology.

Agency Response: The Division disagrees that unique training tools should be developed by the Division as CMS' tools are readily available at the CMS website, www.cms.gov. In addition, privately-developed software and tools are available and can be customized to meet the individual business needs of system participants.

§134.403(a)(1): A commenter recommends adding the following language to §134.403(a)(1) to provide clarity and reduce potential misinterpretation: "This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008. This section does not apply to services paid in accordance with §134.202."

Agency Response: The Division declines to make the requested change because it would be redundant of §134.403(a)(2).

§134.403(a)(1) and §134.404(a)(1): For both §134.403 and §134.404, a commenter requests a postponement of adoption of the proposed acute care hospital fee guideline for 90 days and provides the following basis for the request: bad timing, no reimbursement provision for medical education or bad debts, the appropriateness of outlier payment methodology needs examining, it is necessary to determine whether 40-percent of commercial billed charges is representative throughout the State of Texas, and the necessity to examine the reimbursement impact of medical severity diagnosis related groups (MS-DRGs).

Agency Response: The Division declines to make the change and notes that the applicability dates for adopted §134.403 and §134.404 are unchanged from proposal. Stakeholders are generally anxious to implement a new inpatient hospital reimbursement system, and prefer a quick transition away from the challenges associated with §134.401. Since hospital outpatient claims are reimbursed on a "fair and reasonable" basis without the benefit of a fee guideline, it is important to implement the APC fee structure without further delay. Stakeholders will benefit from the certainty of the new reimbursement methodologies: facilities should have few implementation requirements relative to appropriate billing. Although carriers may face more implementation challenges, carriers should have some lag time after the applicability date to process these claims. However, carriers must still meet the requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the provider.

§134.403(a)(1) and §134.404(a)(1): A commenter states concern that carriers and vendors may not have sufficient time to complete the necessary system renovations prior to the effective date of the rules as listed in §134.403 and §134.404, and recommends phasing in the rules to minimize the hardship on those entities that will be required to engage in a significant retooling of their operations in order to comply with the new methodology.

Agency Response: The Division notes that the applicability dates for adopted §134.403 and §134.404 are unchanged from proposal. Although carriers may face more implementation challenges, carriers should have some lag time after the applicability date to process these claims. Insurance carriers have assured the Division that they are able to meet the processing requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the carrier.

§134.403(b) and §134.404(b): In §134.403(b) and §134.404(b), a commenter recommends that the Division utilize definitions established by the Texas Department of State Health Services in its Chapter 133 rules regarding hospitals, hospital admissions, and associated services.

Agency Response: Under the rules as proposed and adopted, the Division declines to make the change as CMS' definitions prevail if a term is not defined in the Labor Code or the adopted rules.

§134.403(b) and §134.404(b): A commenter believes only Medicare certified hospitals should be allowed to treat and provide medical services to injured employees in the Texas workers' compensation system because certification indicates that the hospitals have met a high standard of quality health care. The commenter recommends the following language for definition of acute care hospital be added to both §134.403 and §134.404: "Acute care hospital" means an appropriately licensed health care facility that provides inpatient and outpatient medical services to patients who experience acute illness or trauma and are Medicare certified.

Agency Response: The Division declines to make the recommended changes as Labor Code §401.011(22), which defines health care provider, does not require facilities to be Medicare certified. In addition, provisions that might limit the number of facilities available to receive reimbursement pursuant to these fee guidelines might result in a reduction of facilities available to provide care to injured employees, thus, resulting in increased burdens on the workers compensation system.

§134.403(b) and §134.404(b): A commenter recommends inclusion of a definition for "observation period" in both §134.403 and §134.404, and references the Center for Medicare and Medicaid's Manual System, Pub 100-19 Demonstrations, Transmittal 53 which provides information regarding "Extended Stay Services" under "The Frontier Extended Stay Clinic Demonstration Project." Another commenter recommends broadening CMS's

definition of "observation" in the workers' compensation system, which should save money since patients may not need to be admitted to the hospital.

Agency Response: The Division declines to make the changes. Medicare payment policies related to observation are adopted by reference in §134.403(d) and §134.404(d).

§134.403(b)(2) and §134.404(b)(2): A commenter recommends that the definition of implantable devices be amended to include the following language in §134.403(b)(2)(E) and §134.404(b)(2)(E) "and related equipment necessary to operate program and recharge the implantable device." The commenter states this will clarify that implant-related equipment should be billable and reimbursable along with the actual implant devices. The commenter provides examples of items involved in an implant that can vary--for a neurostimulator or intrathecal drug pump the items could include electrical leads, a battery, a programmer, and a recharger among other items that are not actually implanted but are provided to a patient. The cost of these items could exceed $3000. These items are typically individually purchased and allowed to be billed and reimbursed separately along with actual related implantable devices. Under the rule's separate cost plus methodology, these items should be billable and reimbursable per individual item. Without rule clarification, this implant-related equipment may not be separately reimbursed despite the intent of the rule.

Agency Response: The Division agrees and the change is made in subsection (b)(2)(E) of the adopted rules. The Division clarifies that equipment necessary to operate, program, and recharge the implantable device are reimbursed separately and the $1,000 limit is per billed item add-on. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the $1,000 per item cap but not to exceed $2,000 in add-on's per admission.

§134.403(b)(5) and §134.404(b)(5): A commenter expresses support for the rule provisions both §134.403 and §134.404 that clarify a surgical implant provider's ability to work with hospitals and insurance carriers in providing implantable devices and to bill insurance carriers directly.

Agency Response: The Division appreciates the supportive comment.

§134.403(b)(5) and §134.404(b)(5): Some commenters request that the term and definition of "surgical implant provider" be deleted from the §134.403(b)(5) and §134.404(b)(5), because the Division lacks the statutory authority to recognize implant providers as health care providers. A "surgical implant provider" does not meet the definition of "health care provider" found in Texas Labor Code §401.011, and the Texas Legislature has not recognized "surgical implant provider" as a stakeholder in the Texas Workers Compensation System as it has with pharmaceutical processing agents under 413.0111. Surgical implant providers do not provide health care and are not involved in the actual treatment of injured employees but act as distributor of implantable devices; therefore, it is inappropriate to attempt to define surgical implant provider as a health care practitioner or health care facility.

Agency Response: The Division disagrees with the comment and declines to make the suggested change. The Division clarifies that the definition for "surgical implant provider" does not expressly define such an entity as being a health care provider. Rather, §134.403(c) and §134.404(c) state that a surgical implant provider is subject to 28 TAC Chapter 133 (relating to Benefits--Medical Benefits) and is considered a health care provider for purposes of §134.403 and §134.404 and Chapter 133. It has been the Department's position in the past that a company that supplies medical equipment is a facility that provides "health care," and thus can meet the definition of "health care provider" under the Labor Code for purposes of Chapter 133. This interpretation was expressed in the adoption order for §133.1 (concerning Definitions for Chapter 133, Benefits--Medical Benefits) published in the *Texas Register* on March 10, 2000, (25 TexReg 2115 at 2118). Subsequently, the statute changed to include surgical supplies as a form of health care pursuant to Labor Code §401.011(19)(F).

§134.403(b)(5) and §134.404(b)(5): A commenter recommends eliminating the option in §134.403 and §134.404 that allows implant makers to bill carriers directly. The commenter states there is no good rationale for allowing them to do that, any more than allowing blood suppliers, suture manufacturers, or anyone else to bill carriers directly. The commenter explains that there is no contract between the implant manufacturer and the carrier so any negotiated discount that a hospital would have negotiated wouldn't apply to the carrier. A commenter states that a carrier has no ability to become a party to the negotiations between a hospital and an implant manufacturer.

Agency Response: The Division declines to make the deletion. Other suppliers may not bill separately since the Division considers payments for the noted services to be bundled in the DRG and APC payments.

In regard to the commenter's concern regarding a discount amount negotiated by a hospital, the Division notes that if the implant provider is the party billing, then the hospital has not purchased the implant, and there would not be a negotiated discount between the hospital and manufacturer or supplier. Additionally, the Division notes that if an implant is being reimbursed separately, then reimbursement should be at the amount the billing facility paid to the manufacturer, plus the permitted add-on amount.

§134.403(d)(2) and §134.404(d)(2): A commenter expresses belief that the rule provisions in §134.403(d)(2) and §134.404(d)(2) allowing Independent Review Organization (IRO) decisions to take precedence over Division rules and Medicare payment policies is contrary to the intent of the statute which requires that all health care provided to injured employees must be appropriate and medically necessary treatment. Determinations regarding medical necessity must comply with the processes contained in the Texas Department of Insurance and Division rules, including preauthorization, concurrent review, retrospective review, and medical dispute resolution processes. This rule section would allow IRO doctors to ignore Medicare payment policies that address medical necessity and which may be applied appropriately to services that are not specifically subject to prospective medical necessity review as provided in Division rule 134.600(p) and (q) (relating to Preauthorization, Concurrent Review, and Voluntary Certification of Health Care).

Agency Response: The Division disagrees. IROs must consider the Division's adopted treatment guidelines and Medicare payment policies not in conflict with the treatment guidelines. However, IROs must also consider the individual employee's medical needs. IRO decisions take precedence on a case-by-case basis and are based on medical necessity as directed in compliance with the Labor Code.

§134.403(d)(2) and §134.404(d)(2): In regard to both §134.403 and §134.404, a commenter asserts that preauthorization of inpatient hospital services has been required for many years, but preauthorization has never precluded retrospective review of ancillary services provided during a hospital admission. As an example, the commenter notes that when surgical procedures in addition to those preauthorized are performed, the medical necessity of such procedures has historically been questioned in a retrospective review. The commenter believes that contrary to a recently published Commissioner's bulletin, retrospective review of hospital ancillary services and supplies is permissible under the provisions of the Texas Labor Code and the Division's medical auditing rules.

Agency Response: The Division clarifies that the commenter's concerns related to §134.600 and Commissioner's Bulletin #B-0028-07 are outside the authority of these adopted rules.

§134.403(d)(3) and §134.404(d)(3): In regard to both §134.403 and §134.404, some commenters support the minimal modifications of the Medicare payment methodologies and policies as provided in this section of the rule, stating that retrospective payments and refunds would make payment within the Texas workers' compensation system uncertain and would result in carriers and hospitals incurring costs associated with making additional payments or refunding payments.

Agency Response: The Division agrees these minimal modifications will improve the system.

§134.403(d)(3) and §134.404(d)(3): A commenter suggests that there is a risk of errors and disputes with the proposed rule language in §134.403(d)(3) and §134.404(d)(3), and recommends minimizing opportunities for error and disputes by building some lag time into the regulation, such as California has done in a corresponding provision which requires that changes to components of the Medicare program be adopted within 60 days of the date on which they are effective for Medicare. The commenter recommends that the Division issue a bulletin to enforce the change, so as to avoid the fiasco that occurred in 2005 - 2006 when CMS and Congress made changes but many provider bills were not re-audited by carriers for payment of the difference.

Agency Response: The Division disagrees. The adopted rules adopt CMS rules by reference. System participants, including the Division, are responsible for monitoring CMS's proposed and adopted changes to Medicare's system. A delay in implementation defeats the standardization required by the Labor Code.

§134.403(e) and §134.404(e): In regard to both §134.403 and §134.404, a commenter believes that additional workers' compensation costs result when a provider or facility is reimbursed more than the actual billed amount. Additionally, most bill payment systems prevent a payment amount greater than the billed amount as a system accounting check. Additional costs are incurred by stakeholders when manual exception processes or work-arounds must be provided. The commenter makes recommendations to amend the language to read as follows: (e) Reimbursement shall be the lesser of: (1) the billed amount; or (2) the amount for the service that is: (A) included in a specific fee schedule set in a contract between an insurance carrier and a health care provider, if the contract complies with the requirements of §413.011(d-1) of the Labor Code; or (B) if no contracted fee schedule exists that complies with §413.011(d-1) of the Labor Code, the MAR amount under subsection (f).

Agency Response: The Division disagrees and declines to make the change. The adopted rules are based on CMS' prospective payment system. This system is designed to reimburse an efficient facility at an average cost amount. In some instances the reimbursement is below cost and in other instances the reimbursement is above cost. This system encourages a health care facility to provide services in a cost-efficient manner and provides an opportunity to offset losses from unprofitable cases.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, some commenters state that more paperwork and a higher rate of non-payment make the workers' compensation system more costly to provide care than in the Medicare system, and that the rule proposals do not meet the statutory obligation to provide fair and reasonable reimbursements. One commenter states that neither Medicare, nor Medicaid, pay their portion of costs, and as a result, hospitals are participating in a business where they have shifted a number of those costs to the commercial and managed care carriers. The commenter states that the inpatient and outpatient rules establish a level of reimbursement that will not be at a level that would be appropriate for the services provided.

Other commenters recommend that the Division follow the direction of other states with a Medicare-based system that do not carve-out implant reimbursement from DRG or APC codes.

Agency Response: The Division disagrees with the comment. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. The Division considered market reimbursement as reported by THA and as projected by Ingenix. When setting the payment adjustment factors, above the Medicare rates, the Division has balanced these requirements to meet the overall needs of the system. Although implantables can be reimbursed separately, the payment adjustment factor has been reduced to offset the separate reimbursement. While there are states without a carve-out for implantables, the number is limited. The majority of workers' compensation systems reimburse separately for implantables at a cost-plus percentage rate.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, some commenters opine that high costs do not necessarily equal better quality care, and that setting rates too high will have unintended consequences of driving employers out of the system. The commenters state that more paperwork and a higher rate of non-payment make the workers' compensation system more costly to provide care than in the Medicare system, and that the rule proposals do not meet the statutory obligation to provide fair and reasonable reimbursements.

Agency Response: The Division agrees that high medical costs do not necessarily result in better quality of care. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. The Division considered market reimbursement as reported by THA and as projected by Ingenix. When setting the payment adjustment factors, above the Medicare rates, the Division has balanced these requirements to meet the overall needs of the system. Although implantables can be reimbursed separately, the payment adjustment factor has been reduced to offset the separate reimbursement. While there are states without a carve-out for implantables, the number is limited. The majority of workers' compensation systems reimburse separately for implantables at a cost-plus percentage rate.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter opposes the Division's method of determining the appropriate PAFs when based on charges because charge levels vary by facility and by health care systems.

Agency Response: The Division disagrees. The Division did not base the adopted payment adjustment factors on charges. The Division indexed actual workers' compensation reimbursement to Medicare and the commercial market. As a part of the indexing, the Division determined the relationship between billed charges and actual reimbursement when Medicare reimbursement relationships could not be established. Again, the Division considered market reimbursement, Medicare reimbursement and actual workers' compensation reimbursement in setting the adopted payment adjustment factors consistent with the Labor Code requirements.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter asserts that the statute requires the Division to pay no more than Medicare unless the Division can show that the Medicare population does not have a comparable standard of living to the workers' compensation population, thereby, justifying that higher payments are necessary to secure reasonable access to quality medical care for injured employees. The commenter states that where there are two populations with an equivalent standard of living, as with managed group health and workers' compensation, the proper method of reimbursement is to pay the lower rate, and not to average the rates by the two benchmark population.

The commenter states that in setting the payment adjustment factor the Division should determine the average costs that hospitals in Texas incur in serving workers' compensation patients and how that compares to 100 percent of what Medicare would pay the hospitals. Commenter states that if the mix of services was such that Medicare payments covered 100 percent or more of the hospital cost, then it would be difficult to determine the public policy rationale for setting a payment adjustment factor higher than 100 percent since the Division would not need to provide for access.

Agency Response: The Division disagrees that workers' compensation reimbursement should be restricted by the standard of living for Medicare patients. The employed population with health care coverage may be more similar to injured employees than the Medicare population. The Labor Code does not designate the Medicare population as the only similar standard of living the Division should consider. Labor Code §413.011(d) states reimbursement should be no more than the fee charged as opposed to the fee paid--"[T]he guidelines may not provide for payment of a fee *in excess of the fee charged* for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. . . ." [emphasis added]. In setting the PAF the division has considered the reimbursement relationship between Medicare and the commercial market and the specific need of the Texas workers' compensation system. The consideration of Medicare cost is one of several factors in evaluating the market; however, Medicare cost alone may not be completely reflective of a hospital's relative workers' compensation costs, because of volume, service mix, and other inherent differences between the Medicare and workers' compensation populations. Consequently, access requirements in the Texas workers' compensation system are dependent on many factors and not just a facility's reported Medicare cost.

§134.403(f) and §134.404(f): In regard to both §134.403 and §134.404, a commenter states that reimbursement under scenario 1 (PAF with no additional payment for implantables) and under scenario 2 (Lower PAF with separate payment for implantables) of the proposed inpatient and outpatient rules would result in less reimbursement than under the current system, specifically under the proposed inpatient rule as it pertains to some of the surgical procedures. Any reduction in expected reimbursement will have a detrimental effect on facilities and whether or not they make a business decision to participate.

Agency Response: The Division clarifies that in some instances a specific hospital stay may be reimbursed less under the new as compared to the previous rules. Overall the Division anticipates an increase in reimbursement for inpatient care and a slight decrease in overall reimbursement for outpatient care. Each facility will have to make business decisions regarding the provision of care in the Texas workers' compensation system.

§134.403(f)(1): A commenter recommends an outpatient PAF of 265 percent of the Medicare APC, with implants carved-out and paid at 65 percent of billed charges in addition to the payment of the APC, and the Medicare outlier calculation.

Another commenter recommends 250 percent of Medicare, since ambulatory surgical centers are currently paid in the system at 213.3 percent of Medicare, and a hospital's costs are recognized by Medicare to be significantly higher than that of an ASC.

Another commenter recommends 185 to 200 percent, rather than 130 percent of Medicare for the implant carve-out PAF with implantables to be paid at cost plus 10 percent, not to exceed $1000. The commenter says this would allow hospitals to recover costs while also ensuring access to quality medical care and effective cost control.

Agency Response: The Division declines to make a change. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The Division also considered the range of recommendations provided by stakeholders while the Division was soliciting input regarding potential reimbursement options. The adopted payment adjustment factors are well within this range and are reflective of the historic workers' compensation reimbursement, Medicare reimbursement, and current market reimbursement. The reimbursement for ASCs is currently based on the ASC group classifications model, and the ASC payment adjustment factor has no direct relationship to the APC reimbursement payment adjustment factor.

§134.403(f)(1): A commenter recommends rule language that establishes a single PAF for hospital outpatient services at 122 percent of Medicare, stating that this rate will cover the costs associated with providing health care to injured employees in an outpatient setting. The commenter lists statutory requirements for a reimbursement rate, and says that the recommended PAF meets them. The commenter asserts that a higher PAF is not justified by any administrative costs associated with workers' compensation claims, and he notes that as of January 1, 2008, when electronic billing will be allowed, the claim submittal process for workers' compensation claims should not impose greater administrative costs on hospitals than the claim submittal process for Medicare claims. The commenter concludes that the cost, including bad debt, of billing and collecting co-payments and de-

ductibles in Medicare, which does not exist in workers' compensation, exceeds the cost of the preauthorization process in workers' compensation.

Agency Response: The Division disagrees. As noted previously, the adopted PAFs fill the requirements of the Labor Code and provide appropriate reimbursement for facilities.

§134.403(f) - (g) and §134.404(f) - (g): In regard to both §134.403 and §134.404, a commenter states that while theoretically helpful to hospitals in a limited capacity one percent of the time for cases outside the norm, the Medicare outlier provision is simply not a solution that ensures adequate reimbursement for device related cases, or other higher cost cases that fall within the norm. The commenter states Medicare reimbursement levels are often inadequate, at least in part, because the payment methodology does not account for the costs associated with acquiring and billing for high-tech devices; ordering, processing, storage, accounting, collections, etc. While Medicare reimbursement does not account for these costs, commenter believes a thorough understanding and appreciation of these issues and costs is imperative in this discussion in order to draft meaningful solutions.

Agency Response: The Division agrees that a thorough understanding of the issues and costs relative to implantable devices is important in determining a fair and reasonable reimbursement rate for the workers compensation system. The workers compensation patient mix is different than the Medicare patient mix. Musculoskeletal injuries are the predominant diagnosis in the workers' compensation system. Although these types of injuries are present in the Medicare system, other age related diagnoses are prevalent in the Medicare system. Having access to surgically implanted devices for procedures related to these musculoskeletal injuries is crucial in facilitating appropriate and timely treatment and improving return to work outcomes. The costs of surgically implantable devices included in the Medicare DRG system may not fully recognize the costs of specific surgically implantable devices critical for the workers compensation patient mix. As a result the Division has attempted to assure access to and adequate reimbursement for surgically implanted devices by establishing a methodology that identifies and reimburses for the actual cost of the implantable. Additionally, the Division agrees that there are administrative costs associated with ordering, processing and maintaining inventory of these surgically implantable devices. These costs are generally addressed in the add-on allowance for separately billed and reimbursed implantables. When not reimbursed separately these costs and related reimbursements are bundled in the DRG payment and adjusted by the adopted PAF.

§134.403(f) - (g) and §134.404(f) - (g): A commenter opines that both §134.403 and §134.404 deviate from strict Medicare policies in order to meet other statutory goals of establishing fees that are fair and reasonable and designed to ensure continued access to quality care along with appropriate medical cost control. The commenter believes that in order to ensure appropriate patient access is maintained, the Division is well within these statutory provisions to adopt rules that deviate from strict Medicare policy. Commenter cites previously adopted §134.402, Ambulatory Surgical Center Fee Guideline, that utilizes a PAF of 213.3 percent of Medicare, and provides for the additional and separate reimbursement of surgically implanted devices including those that are paid for separately by Medicare and those "bundled" in the facility payment.

Agency Response: The Division agrees.

§134.403(f) - (g) and §134.404(f) - (g): Some commenters oppose the proposed PAFs in §134.403 and §134.404, stating that Medicare already adjusts for inflation and implant costs in their singular APC or DRG reimbursement amount.

Agency Response: The Division disagrees that the payment adjustment factors are inappropriate. The Division has considered the DRG and APC methodologies as required by the Labor Code and adopts a minimal modification to meet the specific needs of the Texas workers' compensation system with regard to patient access to reasonable and necessary medical care and fair and reasonable reimbursement for facilities.

§134.403(f) - (g) and §134.404(f) - (g): In regard to both §134.403 and §134.404, a commenter opines that device manufacturers have been able to participate in a system in which price is of little consequence. The Division's proposal aggravates the problem because hospitals can receive more money for more expensive implants--up to $1000. The commenter states carve-outs encourage abuse, over utilization of implantable devices, and increase costs unnecessarily to the workers' compensation system, while hospitals can recoup the cost of a device regardless of what a device manufacturer charges, and with no incentives to control costs of implants. In this type of payment structure, hospitals willingly give all control to the physicians in choosing the implant, whereas with Medicare patients, hospitals are much more active in the decision making process to encourage cost control.

Agency Response: The Division acknowledges the commenters' concerns. The Division, however, disagrees that price is of little consequence to a purchaser of implant devices. For instance, the 110th Congress is currently considering S. 2221, the *Transparency in Medical Device Pricing Act of 2007*, filed on October 23, 2007. This proposed federal legislation would require medical device manufacturers, as a condition of receiving direct or indirect payments under Medicare, Medicaid, and CHIP, to submit to the Secretary of Health and Human Services, on a quarterly basis, the average and median sale prices for all implantable medical devices used in inpatient and outpatient procedures. Thus, this demonstrates that the cost of implantable devices is not only a specific concern to the workers' compensation system, but a significant concern in other health care payor systems. As such, a facility is concerned with its time and value of money through the purchasing and collection processes. Physicians are responsible for determining the medically appropriate implantable device. The Division plans to closely monitor implantable device costs. This may include a data call to capture specific implantable information, such as the invoice cost and facility charge. In addition, the Division may request other specific implantable information, such as the lot number, model number, serial number of the device, or other identifier used by a manufacturer. The latter identifiers are consistent with medical device tracking requirements imposed on a manufacturer when tracking is ordered by the Food and Drug Administration for a class II or class III medical device pursuant to 21 U.S.C. §360i (e) and 21 C.F.R. §821.1 *et.seq.*

§134.403(f) - (g) and §134.404(f) - (g): In regard to both §134.403 and §134.404, some commenters cite the RAND study of California's workers' compensation system, which is the only state that utilizes a Medicare-based payment system that includes carve-outs. The study found no cost-based justification for the carve-out. As a result of their finding, in 2003, the California Commission on Health and Safety and Workers'

Commission proposed eliminating the carve-out, which was estimated to save the system $60 million annually.

Agency Response: The Division has reviewed the RAND study. The state of California took no action as a result of the RAND recommendations and continues to pay separately for surgically implanted devices related to specific DRGs. The RAND study included other recommendations that would allow separate reimbursement of surgically implanted devices which included revaluing the DRG relative weights. The Division adopts a variation of this re-weighting recommendation by establishing a lower payment adjustment factor when implanted devices are billed and reimbursed separately.

§134.403(f) - (g) and §134.404(f) - (g): Some commenters suggest that allowing hospitals and third parties to carve-out reimbursement for implantable devices in §134.403 and §134.404 could lead to fraud, and that neither the Division nor the Department have the resources or expertise to investigate and prosecute medical device makers, suppliers, or doctors who participate in kickback schemes.

Agency Response: The Division acknowledges the commenter's concerns. The Division can and has cooperated with other health care payor systems and governmental entities to pursue suspected fraud.

§134.403(f) - (g) and §134.404(f) - (g): In regard to both §134.403 and §134.404, a commenter observes that prospective payment systems are useful tools in controlling medical costs because the tools provide incentives for hospitals to be prudent in purchasing goods and services, including implants. Hospitals treat large volumes of Medicare patients without a carve-out for implants. There is no reason to believe hospitals cannot or will not treat workers' compensation patients, which comprise approximately two percent of hospital inpatients in Texas, without a carve-out for implants. Ohio, North Dakota, South Carolina and California have Medicare-based payment systems for workers' compensation hospital inpatients. Of the four, only California has a carve-out for some implants.

Agency Response: The Division acknowledges that prospective payment systems can be useful tools in controlling costs. The Division adopts the prospective payment systems as required by the Labor Code with the specific minimal modification to accommodate the needs of the workers' compensation system. The Division notes that hospitals have consistently stated a reluctance to continue to provide service to workers' compensation patients if payments do not adequately address the high costs of implantable devices. As noted, with relatively few workers' compensation cases, even efficient facilities do not have the ability to recover the costs of expensive implantable through increased volume.

§134.403(f) - (g) and §134.404(f) - (g): Some commenters do not support the proposed PAFs in §134.403 and §134.404, and recommend use of only one PAF.

Some commenters recommend reimbursement rates be set at 120 percent of Medicare for both hospital outpatient and inpatient rules respectively.

One commenter says that he arrived at this recommended PAF of 120 percent of Medicare by recognizing the time lapse between the 2005 data and inpatient and outpatient rules taking effect in 2008. The commenter says that he considered what some of the other states had done and felt no evidence existed showing any problem in access or that hospitals had gone under as a result of these rates. Commenter asserts that the 120 percent recommendation gives an adequate cushion.

Other commenters suggests that a single PAF of 120 percent of Medicare would provide a good starting point for HB 473 in setting the statutory floor in 2011, and notes that no other states with a Medicare based system have such a limitation.

Agency Response: The Division disagrees. The adopted PAFs fulfill the requirements of the Labor Code and provide appropriate reimbursement for facilities. Although 120 percent of Medicare is used in the California workers' compensation system, it is not necessarily a target for the Texas workers' compensation system. Other states have higher reimbursement rates. In all cases each state sets a rate based on its own specific legislative and administrative requirements.

The Division notes that although HB 473 requires all informal and voluntary networks to be certified beginning in 2011, the fee guidelines should be reviewed and/or revised prior to that date. When the Division reviews these rules, it will establish fees that are appropriate for system requirements at that time. The Division clarifies it has adopted a fee schedule as required by the Labor Code, and the Labor Code currently allows providers and carriers to negotiate non-network fees above or below the guideline.

§134.403(f) - (g) and §134.404(f) - (g): A commenter says that if two PAFs are adopted for §134.403 and §134.404, the hospital should be limited to billing for the lower of the two net prices.

Agency Response: The Division disagrees. The suggested approach would defeat the purpose of insulating facilities from providing high cost surgical implants and threaten injured employee access to services requiring these devices.

§134.403(f) - (g) and §134.404(f) - (g): Some commenters say that the proposed PAFs and implant provisions §134.403 and §134.404 violate Labor Code §413.011(a), which requires that the Division adopt the most current reimbursement methodologies, models, and values or weights used by CMS with "minimal modifications." Such PAFs and separate payments for implants are much more than a minimal modification and there is no data to justify such a major modification to ensure the quality of medical care and to achieve effective medical cost control as required by §413.011(d).

Agency Response: The Division disagrees. The Division adopts the most current Medicare reimbursement methodologies as required by the Labor Code. Specifically, the Division adopts minimal modifications to reimbursement methodologies to meet the occupational injury requirements as noted in §413.011(a). In accordance with §413.011(b), it is also clearly within the authority of the commissioner to develop one or more conversion factors or other payment adjustment factors in determining the appropriate fees. The Division adopts payment adjustment factors that provide appropriate reimbursement for facilities and assure injured employee access to procedures requiring surgically implanted devices.

§134.403(f) - (g) and §134.404(f) - (g): A commenter states that having a carve-out for implants in §134.403 and §134.404 violates the Texas Labor Code. The commenter references the proposal preamble as stating that implants can constitute 25 percent of the total cost which is significant. The commenter believes that when a pass-through of those costs is allowed there is no effective medical cost control because hospitals will have no incentive to negotiate implant prices and physicians will have no reason

to consider the cost-effectiveness of one program over another. The commenter states that the carrier is left with no option but to pay whatever the implant manufacturer chooses to charge.

Agency Response: The Division disagrees the option of separate reimbursement of implantables violate the Labor Code. The Division has set payment adjustment factors that balance the requirements §413.011, including the requirement to achieve effective medical cost control. The Division, in adopting a lower conversion factor for cases when implantables are billed separately, has recognized the need for payment restraint. Although implantables may be reimbursed separately, there is no added incentive to maximize charges to reach a stop loss threshold. This is a significant cost containment measure compared to the previous rule. The Division notes that implant costs are a significant concern in the entire health care industry and are not limited to the Texas workers' compensation system. Consequently, the Division is committed to monitoring the use and cost of implantables on an ongoing basis.

§134.403(f) - (g) and §134.404(f) - (g): A commenter says that because implants affect 25 percent of the costs for many cases the Division cannot reasonably regard the carve-out provisions in §134.403 and §134.404 as a minimal modification of Medicare payment policies. Commenter states that Medicare does not carve out implants from the DRG payments.

Agency Response: The Division clarifies that §413.011(a) directs the Commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements. The Labor Code does not limit the Division to the use of Medicare reimbursement structures. In developing these rules the Division's research indicates that most worker's compensation systems and group health plans reimburse separately for implantables.

§134.403(f) - (g) and §134.404(f) - (g) In regard to both §134.403 and §134.404, a commenter recommends setting the payment adjustment factor as necessary to account for the implants but eliminating the option of the cost pass-through. A commenter states that there are too many possibilities for improper business practices with the pass-throughs, both between implant makers and physicians and implant makers and hospitals. The commenter states that the carriers and the Division do not have the means to either detect those improper business practices or to deter them.

Agency Response: The Division declines to make the change. By setting dual conversion factors and allowing separate reimbursement for implantables the Division has developed a methodology that assures access to implantable devices by injured employees. Although a single conversion factor could be adopted to, on average reimburse appropriately for the workers' compensation system, an average rate would not cover cost for many extremely expensive implantables. Without a mechanism to insulate facilities from these potential losses, an injured employee's access to necessary medical care is compromised.

§134.403(f) - (g) and §134.404(f) - (g): In regard to §134.403 and §134.404, a commenter suggests there is no data to support higher PAFs for outpatient care as opposed to inpatient care.

Agency Response: The Division disagrees. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The adopted payment adjustment factors are reflective of this historical differential and current market reimbursement.

§134.403(f) - (g) and §134.404(f) - (g): A commenter opines that §134.401 lacked incentives for hospitals to control costs, and in §134.403 and §134.404, neither the PAFs nor the carve-outs for implants are the appropriate incentives to control costs of implants.

Agency Response: The Division disagrees. The adopted rules are based on the CMS prospective payment systems. The majority of services covered by these two rules will be provided without separate reimbursement for implantables. There is a very direct incentive for facilities to provide services in a cost efficient manner in order to develop a profitable workers' compensation product line. Although implantables may be reimbursed separately, the same prospective payment concepts apply to the remainder of an admission, which is reimbursed at a reduced rate. Since workers' compensation volume for most facilities is relatively low, the necessity to be efficient on every workers' compensation admission is intensified.

§134.403(f)(1) and §134.404(f)(1)(A) - (B): Some commenters make recommendations in regard to §134.403(f)(1) and §134.404(f)(1)(A) - (B). To account for bad debt amounts, a commenter recommends a PAF for non-teaching hospital outpatient services of 202 percent with the inclusion of implantables, or 131 percent with implantables paid separately for non-teaching hospital outpatient services; and the commenter recommends a PAF for non-teaching hospital inpatient services of 144 percent with the inclusion of implantables, or 109 percent with implantables paid separately for non-teaching hospital inpatient services. In regard to inpatient services, the commenter also recommends that the PAF be increased to account for the application of the Medicare transfer rules or that both hospitals be paid the full DRG amount.

Agency Response: The Division disagrees with the recommended payment adjustment factors. Bad debt is paid outside the base methodology and is a part of the cost report reconciliation process, which the Division has not adopted. Additionally, bad debt in the workers' compensation system is limited to those situations that are non-compensable or are not related to the compensable injury and as such are not included in system costs. The patient is responsible if it is determined the claim is not compensable or not related to the injury and the patient and/or patient's group health insurance may be liable for facility services. In regard to the comment concerning Medicare transfer rules, the Division notes that paying both facilities the full DRG in transfer situations would result in significant overpayment for a stay and is contrary to the effective medical cost control provisions of the Labor Code.

§134.403(f)(1)(A) - (B) and §134.404(f)(1)(A) - (B): A commenter expresses appreciation for the effort by the Division to gain the best and most current information available on hospital costs and payments, and its efforts to consider this data and analysis in the establishment of the proposed PAFs in §134.403 and §134.404. The commenter believes it is particularly important that the Division consider the reimbursement amounts that hospitals competitively negotiate with commercial health plans because these reimbursement amounts reflect the market value of hospital services. The commenter further asserts the establishment of payment rates for workers' compensation services that are consistent with other non-governmental payers assures that

employers are not cross-subsidizing inadequate workers' compensation payment rates through increases in their nonworkers' health insurance premiums.

Agency Response: The Division appreciates the supportive comments.

§134.403(f)(1)(A) - (B) and §134.404(f)(1)(A) - (B): To appropriately reflect the added costs for teaching hospitals, a commenter recommends setting PAFs at 212 percent of Medicare with inclusion of implantables, or 137 percent with implantables paid separately for teaching hospital outpatient services. Another commenter recommends setting PAFs for teaching hospital inpatient services at 151 percent of Medicate with inclusion of implantables, or 114 percent with implantables paid separately.

Agency Response: The Division disagrees with the recommendations. The Division determines that additional adjustments should not be made to the payment adjustment factors. Direct medical education is paid outside the base methodology and is a part of the cost report reconciliation process, which the Division has not adopted.

§134.403(f)(1) - (2) and §134.404(f)(1) - (2): Some commenters have various recommendations and questions related to what is contained within the calculations of both §134.403 and §134.404. The commenters ask if examples of the reimbursement calculations will be provided, and request clarification regarding device dependent procedures when they are incorporated into the Medicare payment rates.

Agency Response: The Division declines to provide calculation examples in the adopted rules. The adopted rules adopt Medicare's most current reimbursement methodologies. The Division will provide system participants with training materials facilitating implementation.

§134.403(f)(1) - (2) and §134.404(f)(1) - (2): In regard to both §134.403 and §134.404, a commenter asks if insurance carriers will be able to calculate the payments accurately as it may increase their administrative burden, and suggests this may actually increase the amount of medical fee disputes. Another commenter states that several carriers operating in several states where the outlier methodology is used do not have a problem applying it.

Agency Response: Both carriers and facilities are required to comply with the adopted rules when applicable to specific service dates. This includes the requirements of §133.240 (regarding Medical Payments and Denials) to take final action on a complete medical bill, or determine to audit the medical bill not later than the 45th day after the carrier received a complete medical bill. The Division has been assured by carriers throughout the rule development and public comment periods that carriers will calculate and make payments accurately in accordance with the adopted rules.

§134.403(f)(1) - (2) and §134.404(f)(1) - (2): Some commenters address bad debt in regard to both §134.403 and §134.404. One commenter states that although technically there is no bad debt related to co-pays and deductibles in the workers' compensation system, every time a service is considered a non-compensable injury, upon review it becomes bad debt. Other commenters note that payments for direct medical education (e.g., teaching hospitals) and bad debt allowance are reimbursed separately from the Medicare base rate, and both factors have significant impact on commenter's health care system. The commenters recommend the PAFs be appropriately increased to account for hospitals' bad debt, medical education payments to teaching hospitals, and other costs of separately billed pass-through items that are supplemental payments made by the Medicare fiscal intermediary.

Agency Response: The Division declines to make changes. Bad debt and direct medical education are paid outside the base methodology and are a part of the cost report reconciliation process, which the Division has not adopted. Additionally, as one commenter notes, bad debt in the workers' compensation system is limited to those situations that are non-compensable or are not related to the compensable injury. As such, it is not included in system costs. The patient is responsible if it is determined the claim is not compensable or not related to the injury and the patient and/or patient's group health insurance may be liable for facility services.

§134.403(f)(1) - (2) and §134.404(f)(1) - (2): In regard to both §134.403 and §134.404, a commenter opposes pass-through reimbursements of Medicare as they apply to payments for bad debt and teaching schools because these Medicare payments amount to federal subsidies of hospitals that treat Medicare patients. Further, "bad debt" in the Medicare system is associated with co-payments and deductibles that Medicare patients fail to pay. There is not a provision for the payment of co-payments or deductibles in the Texas workers' compensation system. Additionally, no provision exists in the Texas workers' compensation system to reimburse teaching hospitals for their costs that are related to training and teaching student doctors. The Texas Labor Code only provides for the payment of costs associated with reasonably required and medically necessary health care treatment.

Agency Response: The Division agrees that the Labor Code does not provide for pass-through reimbursements to cover bad debt or teaching schools. For this reason, the Division has adopted CMS's base methodology but not parts related to the cost report reconciliation process that address bad debt and direct medical education.

§134.403(g) and §134.404(g): Some commenters support the implant carve-out approach in §134.403 and §134.404, and offer varying recommendations for tightening the rule language. The commenters state that with the additional rule language recommendation to the definition of an implantable, it will be well understood that each individual item that is implanted and the associated elements to make the device function appropriately (e.g., batteries, programmers, rechargers, etc.), is paid separately.

Agency Response: The Division appreciates the supportive comments and notes changes are made in subsection (b)(2)(E) of the adopted rules. The Division clarifies that equipment necessary to operate, program and recharge the implantable device are reimbursed separately and the $1,000 limit is per billed item add-on. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the $1,000 per item cap but not to exceed $2,000 in add-on's per admission.

§134.403(g) and §134.404(g): A commenter recommends the addition of the words "per billed item" be added to the 10 percent reimbursement for implantables, capped at $1000, in §134.403(g) and §134.404(g). This will allow the cap to apply to each individually billed item rather than cumulatively. Commenter additionally recommends that the cap be raised to $3000 to ensure that acquisition costs are adequately covered.

Agency Response: The Division agrees with the inclusion of "per billed item." The words "per billed item add-on" have been added to subsections (g) of the adopted rules to clarify that the 10 percent reimbursement for implantables applies individually to items billed separately. The Division disagrees to raising the cap per billed item. However, a cap of $2,000 is added to the adopted rules to discourage unbundling of items that exceed the $1,000 proposed per billed item cap.

§134.403(g) and §134.404(g): A commenter supports the rule proposal approach with implantables in §134.403 and §134.404, because it will reduce the number of disputes over payment for implants; however, the commenter suggests the Division consider whether it may be preferable to establish one clear method for reimbursement for implantables.

Agency Response: The Division appreciates the supportive comments; however, believes the adopted methodology as changed from proposal is appropriate for the Texas workers' compensation system.

§134.403(g) and §134.404(g): A commenter suggests that §134.403(g) and §134.404(g), as proposed, exclude any implantable therapy for pain, such as intrathecal infusion systems and neuromodulation techniques, which cost substantially more to manufacture than the proposed upper limit of $1000.

Agency Response: The Division clarifies that the rules do not limit the cost of an item, but limit the add-on reimbursement to 10 percent of the item's cost, or $1,000, whichever is less. The Division additionally has changed subsections (g) of both adopted rules in response to public comment to allow reimbursement for multiple items when a single implantable might exceed the $1,000 per item cap.

§134.403(g) and §134.404(g): A commenter seeks specific clarifications regarding the separate billing of implants in §134.403(g) and §134.404(g). How does the Division believe carriers will specifically determine which payment adjustment factor to apply to the bill without this information or indication under the current proposal? The commenter requests the Division to briefly describe the envisioned flow of this process.

Agency Response: The Division agrees that identifying reimbursement methodologies is important to the successful implementation of the adopted rules. The Division is currently investigating the use of field 80 on UB-04 and the use of the billing note in the ANSI X12 837i transaction set. Specific guidance regarding this process will be available through the Division's outreach and implementation efforts subsequent to the adopted rules.

§134.403(g) and §134.404(g): Some commenters recommend deletion of §134.403 (g) and §134.404 (g). Another commenter recommends eliminating the option for implant makers to bill carriers directly. The commenter says that there is no good rationale for allowing them to do that, any more than allowing blood suppliers, suture manufacturers, or anyone else to bill carriers directly. The commenter explains that since there is no contract between the implant manufacturer and the carrier, any discount negotiated by a hospital would not apply to the carrier. The commenter also notes that a carrier does not have the ability to become a party to the negotiations between a hospital and an implant manufacturer. Some of the commenters recommend that if implants are allowed to be billed separately the rule should require both the facility and implant provider bill to be submitted on UB-04 forms, and submitted concurrently.

Agency Response: The Division declines to make the deletion. The Division clarifies that separate billing for implantables by an implant provider should be submitted on a UB-04 form, and suggests that it is impractical to have the facility and implant provider to submit the bills concurrently. Other suppliers may not bill separately since the Division considers payments for the noted services to be bundled in the DRG and APC payments.

In regard to the commenter's concern regarding a discount amount negotiated by a hospital, the Division notes that if the implant provider is the party billing, then the hospital has not purchased the implant, and there would not be a negotiated discount between the hospital and manufacturer or supplier. Additionally, the Division notes that if an implant is being reimbursed separately, then reimbursement should be at the amount the billing facility paid to the manufacturer, plus the permitted add-on amount.

§134.403(g) and §134.404(g): A commenter recommends that in the event that implants are allowed to be billed separately, that §134.403 and §134.404 be amended to require a hospital to include a code on their medical bill that identifies the method being used to bill for an implantable device. Without such a code, the implantable device could result in unintentional duplicate payment. Another commenter states there is no obvious way for a hospital to indicate to a carrier on the UB-04 billing form whether or not a separate bill for the implants will be coming later from the implant manufacturer, and notes that carriers will not know whether to reimburse the hospital at the higher or lower rate. The commenter states the model in the proposed rules create the potential for significant confusion in the billing and reimbursement process. Requiring that the bills be submitted together and in a consistent billing format will alleviate some of these concerns. Another commenter expresses concern of the administrative issues associated with supplying implant invoices, such as the time factor with reconciling the claim, adjudicating a claim, and adding to the complexity of reimbursement.

Agency Response: The Division clarifies that the billing methodology will be identified in both the eBilling and paper billing processes. Specific guidance regarding this process will be available through the Division's outreach and implementation efforts subsequent to the adopted rules. If separate reimbursement for the surgically implanted device is sought, the instructions will instruct the facility to communicate whether the facility or if an implant provider is sending the invoice to the insurance carrier. For this reason the Division declines to make the change requiring bills to be submitted together.

§134.403(g) and §134.404(g): In regard to both §134.403 and §134.404, a commenter suggests that additional documentation on the billed implant should be specific down to the implant serial number so that this information can be adequately tracked and to provide for sufficient audit opportunity. At a minimum, this should include the invoice, the operative report, and the hospital inventory sheet.

Agency Response: The Division declines to require additional documentation. The Division will closely monitor implant costs. This may include a data call to capture specific implantable information, such as the invoice cost and facility charge. In addition, the Division may request other specific implantable information, such as the lot number, model number, or serial number of the device or other identifier used by a manufacturer. The latter identifiers are consistent with medical device tracking requirements imposed on a manufacturer when tracking is ordered by the Food

and Drug Administration for a class II or class III medical device pursuant to 21 U.S.C. §360i (e) and 21 C.F.R. §821.1 *et.seq.*

§134.403(g) and §134.404(g): In response to both §134.403 and §134.404, a commenter expresses concerns about previous reimbursement methodologies. The commenter states that the previous reimbursement methodologies resulted in payment delays. The commenter states that anything the commissioner would do in terms of setting up rules that provide an opportunity to dispute the fees, to challenge either the payment mechanisms, or to request further information to be provided creates an environment where the hospital then is really in a position to have to continue to defend or support the charge and provide additional information.

Agency Response: The Division appreciates the commenter's concern. The Division believes that the certainty of the adopted prospective payment methodologies will ultimately reduce conflicts over reimbursement. As the rules allow separate reimbursement for implantables, mechanisms for auditing and monitoring this payment option are a necessity. Since no specific triggers are initiated based on charges, payment conflict should be minimized.

§134.403(g) and §134.404(g): In regard to both §134.403 and §134.404, a commenter recommends the "administrative expense fee" paid to the hospital when implants are paid for separately should be no more than $25, because there is no justification for paying the lower of 10 percent of the implant's cost or $1000 simply because the hospital chooses to have the implants paid for separately.

Agency Response: The Division declines to make the change. The Division clarifies that the add-on for separate reimbursement of 10 percent of invoice cost or $1,000, whichever is less, is based upon the entity requesting reimbursement for the separately reimbursed implantable. However, a cap of $2,000 is added to the adopted rules to discourage unbundling of items that exceed the $1,000 proposed per billed item cap. If a surgical implant provider bills separately for the surgical implant, the provider is entitled to the add-on reimbursement. In this situation the facility should receive no additional reimbursement for the items billed separately by the surgical implant provider.

§134.403(g)(1) and §134.404(g)(1): Some commenters suggest clarification in both §134.403(g)(1) and §134.404(g)(1). The commenters recommend the rules clarify that an implant manufacturer may not bill separately for implants, and suggest the proposal preamble and proposed rule language are in conflict. One commenter states that allowing the hospital to "bill separately" for the implants and the hospital services themselves, and, thereby, collect an administrative expense fee of up to $1,000 in addition to the cost of the implants adds nothing but additional cost to the workers' compensation system. The commenter states a savvy hospital could increase its revenues and impose additional costs on the workers' compensation system simply by breaking a bill into two parts when there is no reason to do so, other than to collect the "administrative expense fee" authorized by this rule.

Agency Response: The Division declines to make the change, as the rules intend for the option of separately implanted devices to be billed either by the facility or by the surgical implant supplier as defined in §134.403(b)(5) and §134.404(b)(5). The Division clarifies that the facility will submit only one bill. The PAF for facility reimbursement is determined by the facility based on the separate reimbursement of implantables. This determination will likely be documented in a specified field on the UB-04. When a facility chooses the lower PAF and separate implantable reimbursement option, the facility's bill would include the invoices for the separately implantable devices for which it was seeking separate reimbursement and the appropriate invoice certification required by §134.403(g)(1) and §134.404(g)(1). However, if an implant provider is billing for the implantable device, the carrier would receive two bills. The carrier would receive a bill from the facility for treatment and services provided to the injured worker that are unrelated to the cost of the implant. The carrier would receive a bill from the surgical implant provider specific to the implant that includes the required invoices and certifications. Reimbursement for the implantable and the appropriate add-on amount will be made to the entity that submitted the UB-04 with the required invoice and certification.

§134.403(g)(1) and §134.404(g)(1): A commenter express concern with the certification statement in §134.403(g)(1) and §134.404(g)(1), and says that the certification will conflict with the charges reflected on the facility's charge master and itemized statement.

Agency Response: The Division clarifies that the required certification is related to the invoice amount for which the facility or implant provider is seeking reimbursement. It is not the intent of the Division that certification reconcile a facility's charge master and the requested cost plus reimbursement for implantables.

§134.403(g)(1) - (2) and §134.404(g)(1) - (2): A commenter supports the provisions in §134.403(g)(1) - (2) and §134.404(g)(1) - (2) that allow for surgical implant providers, often used by facilities that do not have the infrastructure required to acquire, to obtain prior authorization for, and to secure payment for implantable devices, and to bill carriers directly for implants.

Agency Response: The Division appreciates the supportive comment and agrees that the Division has attempted to assure access to and adequate reimbursement for surgically implanted devices by establishing a methodology that identifies actual facility costs.

§134.403(g)(1) - (2) and §134.404(g)(1) - (2): In regard to both §134.403 and §134.404, a commenter states that the DRG really does not turn on the specific charges. The commenter states that the way to audit a bill in a DRG system is to basically determine whether the medical records support the coded DRG.

Agency Response: The Division notes that in a prospective payment system reimbursement is not generally dependent on charges and as such auditing requirements are significantly different than in the previous structure of §134.401.

§134.403(g)(1) - (2) and §134.404(g)(1) - (2): Some commenters recommend amendments to §134.403(g)(1) - (2) and §134.404(g)(1) - (2) which read, "I hereby certify under penalty of law that I have personal knowledge of the cost of the surgical implantable and the following is the true and correct actual cost after consideration of any and all rebates, discounts or any other financial incentives associated with the purchase of the surgical implantable." One commenter states that it appears that the certification is designed to avoid billing fraud; however, the facility and surgical implant provider can avoid the risk of fraud by having an employee that does not have knowledge of the cost sign the certification.

Agency Response: The Division disagrees with the recommendation. The language in §134.403(g)(1) - (2) and §134.404(g)(1) - (2) has been used §134.402 (regarding Ambulatory Surgical

Center Fee Guideline) since amendments to that section were adopted in 2005, and the Division has not seen problems in its application or use.

§134.403(g)(1) - (2) and §134.404(g)(1) - (2): A commenter recommends amended language in §134.403(g)(1) - (2) and §134.404(g)(1) - (2) that reads, "Nothing in this rule precludes a health care facility and insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. The health care facility and insurance carrier must both agree to utilizing a surgical implant provider to arrange for the provision of an implantable device."

Agency Response: The Division declines to make the change. Requiring both the facility and carrier to agree to the use of a surgical implant provider would potentially restrict or limit the facility's ability to make business decisions appropriate to its specific financial situation.

134.403(g)(4): A commenter expresses concern that §134.403 requires payment by the Medical Fee Guideline.

Agency Response: The Division clarifies that the other Division fee guidelines, which include the Medical Fee Guideline, are used only when the corresponding Medicare fee schedule is utilized by Medicare to supplement the OPPS.

§134.403(h) & (i): Some commenters support the inclusion of Medicare's restriction of a specific setting for a service and assert that it is consistent with Section 413.011(d)(1) of the Labor Code.

Agency Response: The Division appreciates the supportive comment.

§134.403(h) & (i): A commenter believes that to obtain preauthorization and negotiate the facility fee for an alternative facility would violate Texas Labor Code Section 413.011(a) since it would constitute a major modification from CMS reimbursement methodologies and models. In addition, commenter states this would tend to delay necessary medical treatment, prolong lost time from work, and encourage fee disputes while the parties negotiate the facility fee, violating the legislative goals outlined in House Bill 7 reforms found in Section 402.021(a & b).

Agency Response: The Division disagrees. The language allows for providers and carriers to mutually agree to an alternative place of service. Although the Division adopts the place of service requirements, there may be instances when both providers and carriers believe an alternative setting may be beneficial to the injured employee. This concept has been in place in §134.402 since 2004 with few problems.

§134.403(i)(1-3): A commenter recommends amending rule language in §134.403(i)(1-3) to read as follows: "(1) The agreement between the insurance carrier and the party that requested the alternative facility setting shall be submitted in the form and manner prescribed by the Division. (2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting. (3) In the event of a revision of an agreement, the revised agreement shall be submitted in the form and manner prescribed by the Division."

Agency Response: The Division disagrees that a form is necessary to facilitate this process. The Division has outlined the requirements of the agreement so that no Division mandated form is necessary. Similar direction is in place for §134.402 with good results.

§134.404: A commenter recommends that the Diagnosis Related Groups (DRGs) list in §134.404 remain open and not limited to the Division's judgment, and allow the medical providers to use the proper DRGs when needed.

Agency Response: The Division clarifies that the Texas workers' compensation system utilizes the most current CMS DRG set without limitation.

§134.404: In regard to §134.404, some commenters support the Division's rule proposal action that removes any stop loss provisions.

Agency Response: The Division appreciates the supportive comments.

§134.404(a)(1): A commenter requests an earlier effective date than March 1, 2008, for the inpatient hospital fee guideline. The basis for this request is the concern about the growing number of "stop loss" bills that are being received by insurers.

Agency Response: The Division disagrees and declines to make the requested change. Although some participants may feel anxious to move away from the reimbursement requirements of §134.401, an earlier implementation date for the inpatient hospital fee guideline would not allow a sufficient amount of time for system participants to implement the new reimbursement methodologies. Although facilities should have few implementation requirements relative to appropriate billing, carriers need some preparation prior to processing these claims because they will need to meet the requirements of the Labor Code and Division rules to pay, reduce, deny, or determine to audit a claim within 45 days of the receipt of a clean claim from the provider.

§134.404(f): A commenter states that the proposed reimbursement structures of the inpatient rule do not cover the cost of trauma care that is associated with work related injuries, and this is especially so without a stop loss designation. The proposed rates will only cover those stays that are not trauma related and with shorter lengths of stay.

Agency Response: The Division disagrees that the adopted rates will cover only those stays that are short stay or are not trauma related. The adopted rules require the use of the most current adopted and effective Medicare reimbursement methodologies. Medicare DRGs, which adjust for severity and recognize the intensity of services for specific patients, will apply to services when these rules become effective. The Division notes that the Medicare prospective payment system generally reimburses based on the average cost for a facility to provide services related to a specific DRG. This average reimbursement includes all cases running the gamut from the least to the most extreme resource-intense admissions. Medicare reimbursement in general is designed to cover costs and provide a profit for efficiently managed facilities. This concept extends to the outlier methodology, which allows facilities to recover costs for cases that meet the outlier thresholds. Based on this reimbursement structure, which is integral to the prospective payment system, not all admissions will result in a positive margin. The Division adopts PAFs that reimburse at a rate greater than Medicare and provide some protection to facilities on resource-intensive cases. Additionally, facilities have a choice of reimbursement options relative to implantable devices, which insulate facilities from potential losses due to extremely expensive implantables whose costs may not be fully realized in the Medicare prospective payment system. Although the adopted rules provide for appropriate reimbursement for the

system overall, there is no guarantee that a specific facility will realize a positive margin on any specific admission.

§134.404(f)(1)(A) - (B): A commenter recommends setting inpatient hospital PAFs at 175 percent of the Medicare DRG with implants to be paid at 65 percent of billed charges in addition to the DRG amount. The commenter further recommends setting a stop loss provision for claims over $50,000 in billed charges, and to be paid at 75 percent of the billed charges. Other commenters suggest stop loss provisions at $100,000 and $150,000 in billed charges.)

Agency Response: The Division declines to make the change. The payment adjustment factors are based on historical workers' compensation reimbursement and comparisons to Medicare and the commercial market, including health maintenance organizations, preferred provider organizations, point of service plans, and commercial indemnity plans. The Division also considered the range of recommendations provided by stakeholders while the Division was soliciting input regarding potential reimbursement options. The adopted payment adjustment factors are well within this range and are reflective of the historic workers' compensation reimbursement, Medicare reimbursement, and current market reimbursement. The Division has also determined that development of reimbursement methodologies triggered by a billed charge amount is generally contrary to the concept of effective medical cost control.

§134.404(f)(1)(A) - (B): A commenter is concerned that that the proposed outlier payment is not adequate and hospitals will be reimbursed significantly less than their costs on hospital admissions with extraordinarily long lengths of stay. The commenter does, however, state that he recognizes that the Division's use of the Medicare outlier payment is consistent with the statutory requirements and this type of methodology may overcome some of the complaints expressed by carriers about the existing stop loss provision.

Agency Response: The Division agrees that the adopted methodology is consistent with the requirements of the Labor Code. The Division believes that the prospective payment system and the adopted payment adjustment factors provide appropriate reimbursement for the Texas workers' compensation system. It is unlikely that the adopted reimbursement methodology will provide the exact balance between cost and reimbursement in every case. The prospective payment system allows, on average, efficient hospitals to be profitable but on occasion certain stays may not achieve this standard.

§134.404(f)(1)(A) - (B): A commenter states that a payment adjustment factor is not supposed to guarantee, just like a Medicare DRG, that a hospital makes a profit or, indeed, even covers its costs on every individual case. The commenter believes that the important issue is whether the system covers hospital costs such that it keeps them financially viable and provides reasonable access to workers' compensation patients.

Agency Response: The Division agrees. The Division believes that the prospective payment system and the adopted payment adjustment factors provide appropriate reimbursement for the Texas workers' compensation system. It is unlikely that the adopted reimbursement methodology will provide the exact balance between cost and reimbursement in every case. The prospective payment system allows, on average, efficient hospitals to be profitable but on occasion certain stays may not achieve this standard.

§134.404(f)(1)(A) - (B): A commenter opines with regard to inpatient reimbursement, the Medicare program is specifically designed for a population that is much different from the workers' compensation population. Medicare's Diagnosis Related Group (DRG) system is premised on the fact that hospitals will have a broad-range of cases and that the higher cost, lower paying DRGs, will be offset by those that are reimbursed at a higher rate. In this case, the workers' compensation system is primarily orthopedic cases and will not have the same breadth of treatments. As a result, hospitals will not have the ability to offset losses through higher-margin DRGs.

Agency Response: The Division agrees and, for this reason, has proposed and, adopted separate reimbursement for implantable devices to insulate facilities from potential losses due to high-cost implantable devices.

§134.404(f)(1)(A) - (B): A commenter recommends PAFs of 165 to 200 percent of Medicare, and 130 to 140 percent as more appropriate since those rates would allow hospitals to recover its costs while also ensuring access to quality medical care and effective medical cost control. The commenter opposes the lower PAFs (108%) for hospital inpatient services, and states it reflects an astonishing reduction from the higher 143 percent PAF provided with out carve-outs for implants. The 40 percent difference between the two PAFs is extreme. Medicare does not calculate 40 percent of its payment rates as a means to cover the cost of implants and neither should the Division. Commenter states it is understandable to have a reduced PAF to provide for implant carve-outs, but this reduction is excessive.

Agency Response: The Division declines to make the change. The differential is an offset to the direct workers' compensation costs attributable to implantable devices. In setting the guidelines, the Division must consider all aspects of Labor Code at §413.011. The Labor Code establishes the requirement that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Section 413.011 requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining "fair and reasonable" reimbursement levels, the Division must consider several factors, because "fair and reasonable" is a balance of all the required components of the Labor Code.

§134.404(f)(1)(A) - (B): A commenter asserts that the Division needs to determine other costs not related to implants, such as blood, major drugs, sutures, casting, IV fluids and extra respiratory treatment, for other services for a patient that are not factored into the costs incurred by hospitals. The commenter asserts the Division is basically asking hospitals to make a choice to either sacrifice its costs associated with the implants or to sacrifice its costs associated with the hospital stay and the other remaining services provided.

Agency Response: The Division disagrees that costs other than implantable costs are not considered in the Medicare prospective payment system. The DRG reimbursement methodology includes charges for all services provided for a particular DRG. To the extent that the commenter believes the Medicare reimbursement is inadequate, the Division's adopted rules provide reimbursement rates that are greater than those established by Medicare. The overall reimbursement rate of 143 percent of Medicare is within the range of recommendations by system stakeholders. The Division's adopted rates are more similar to the commercial

market as reported by THA than to the Medicare rates. The Division disagrees that facilities must make a choice between implant reimbursement and remaining services. The hospital has the option to be paid at the higher payment adjustment factor or be reimbursed at the lower rate and recover actual costs for the implantable device. The hospital can determine which payment adjustment factor is more favorable by looking at the ratio of overall costs to implantable costs.

§134.404(f)(1)(A) - (B): A commenter notes the Milliman study of payments under the current system represents approximately 115 percent of Medicare, and opines the proposed rates, that are a 23 percent increase, do no support the statutory objectives.

Agency Response: The Division disagrees that the rates do not support the statutory objectives. In setting fees for the non-network workers' compensation system, the Division must take into consideration all requirements of the Labor Code, including access to and quality of care provided, as well as cost containment and fairness of the overall reimbursement rate. In setting the payment adjustment factors, the Division has balanced these requirements to meet the overall needs of the system. The Division notes that facility rates in the Texas workers' compensation system have not changed since 1997. Between 1995 and 2005 cost for hospitals as reported by MedPAC (June 2007 Data Book on Healthcare Spending and the Medicare Program) increased 38%. The increase referenced by the commenter is significantly less than the increase in MedPAC's reported hospital costs.

§134.404(f)(1)(A) - (B): A commenter states the Division offers no justification for increasing the reimbursement for inpatient stays with less than $40,000 in billed charges, and bases the increase for hospital stays with $40,000 or more in billed charges solely on amounts paid under commercial health plans. The Division has determined that both Medicare patients and managed care patients satisfy that standard. Thus, in setting the ASC fee guideline, the previous Commission calculated a weighted average market payment that considered amounts paid by both Medicare and commercial health plans, not just amounts paid under commercial health plans.

Agency Response: The Division disagrees. The Division is required to consider all the requirements of the act to establish fair and reasonable reimbursement. In setting the inpatient PAF's the Division considered market rates as projected by Ingenix in a 2005 report sponsored by the former Texas Workers' Compensation Commission, market data provided by the Texas Hospital Association at the request of the Division, Medicare reimbursement, historic Texas workers' compensation system payments, and recommendations by system stakeholders throughout the rule development process. Specifically, the Division notes that the Milliman report estimated that inpatient bills with charges less that $40,000 are being paid at approximately 66% of Medicare inpatient rates. If Medicare reimbursement generally is set to on average cover hospitals' costs it follows that 66% of Medicare does not cover these costs or allow a margin for profit. In developing a methodology and subsequently calculating PAF's, it is reasonable for the Division to allow at least the Medicare rate as reimbursement for these claims in its methodology. The adopted PAFs are within the range of the Ingenix market estimates and within the range of recommendations provided by system stakeholders.

§134.404(f)(1)(A) - (B): A commenter recommends that a single PAF for the inpatient hospital fee guideline should be set at 105.9 percent of Medicare. As an alternative to the recommendation of 105.9 percent, the commenter joins other commenters in recommending that the PAF for inpatient hospital care be set at 120 percent of Medicare.

Agency Response: The Division disagrees and declines to make the recommended changes. The adopted PAFs meet the requirements of the Labor Code and establish appropriate reimbursement rates for inpatient services. Setting a reimbursement level of 105.9 percent of Medicare would be nearly an 8% reduction from the estimated workers compensation reimbursement of 115 percent of Medicare. Setting a reimbursement level of 120 percent of Medicare would be less than a 5 percent increase from the estimated workers compensation reimbursement of 115 percent of Medicare. Setting reimbursement at either of the recommended rates is contrary to the requirements of the Division to consider the economic indicators of health in establishing fee guidelines. It is unreasonable to suggest that the Division ignore ten years of inflationary pressures on hospitals in adopting these rules.

§134.404(f)(1)(A) - (B): A commenter recommends that an alternative payment adjustment factor of 175 percent of Medicare be established for hospital admissions that exceed 12 days. Commenter state that the average of twelve days represents more than 2.5 standard deviations above the mean length of stay for all workers' compensation cases and states that the proposed PAF will result in payments that are 32 percent of billed charges, 53 percent of current DWC allowed amounts and 77 percent of costs. Using a higher payment adjustment factor for extraordinarily long hospital stays will help to smooth out some of the payment inequities built into the Medicare outlier payment methodology.

Agency Response: The Division declines to make the change. The adopted rules require the use of the most current adopted and effective Medicare reimbursement methodologies, and reflect a reimbursement greater than Medicare's reimbursement. Medicare DRGs, which adjust for severity and recognize the intensity of services for specific patients, will apply to services when these rules become effective. Establishing a different reimbursement methodology for cases with a length of stay greater than 12 days would realign the relative weights of the DRG methodology and be inconsistent with the prospective payment concepts of the Medicare system. Medicare reimbursement reflects average costs and length of stay, and in general is designed to cover costs and provide a profit for efficiently managed facilities. This concept extends to the outlier methodology. The 43 percent adjustment above Medicare reimbursement should provide some insulation for facilities in these cases. The payment adjustment factors provide further reimbursement to cover the costs of a lengthy stay.

For: Office of Injured Employee Counsel.

For, with changes: Individuals; Access MediQuip, LLC; Arkansas Best Corporation; Coventry Health Care; Hospital Corporation of America; Insurance Council of Texas; Medtronic, Inc.; Memorial Hermann; Property Casualty Insurers Association of America; Renaissance Healthcare Systems, Inc.; Scott and White; Service Lloyds Insurance Group; Texas Association of Business; Texas Hospital Association; Texas Mutual Insurance Company; and Zenith Insurance Company.

Neither For Nor Against: Broadspire and River Oaks Hospital.

The new rules are adopted under the Texas Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061.

Section 408.021 entitles injured employees to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division. Section 413.011 mandates that the Division by rule establish medical policies and guidelines. Section 413.012 directs the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires consultation with the Medical Advisor regarding the adoption of rules and policies to develop, maintain, and review guidelines. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides a procedure for medical dispute resolution. Section 402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§134.403. Hospital Facility Fee Guideline--Outpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an outpatient acute care hospital on or after March 1, 2008.

(2) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) "Outpatient" means the patient is not admitted for inpatient or residential care. Outpatient medical services includes observation in an outpatient status provided the observation period complies with Medicare policies.

(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits--Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this tile (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in

the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 200 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual cost (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding 133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) for medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles, and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, all agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

§134.404. Hospital Facility Fee Guideline--Inpatient.

(a) Applicability of this section is as follows.

(1) This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008.

(2) For admission dates prior to March 1, 2008, the law and Division of Workers' Compensation (Division) rules in effect for those dates of service shall apply.

(3) This section does not apply to:

(A) professional medical services billed by a provider not employed by the hospital, except for a surgical implant provider as described in this section; or

(B) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(b) Definitions for words and terms, when used in this section, shall have the following meanings, unless clearly indicated otherwise.

(1) "Acute care hospital" means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma.

(2) "Implantable" means an object or device that is surgically:

(A) implanted,

(B) embedded,

(C) inserted,

(D) or otherwise applied, and

(E) related equipment necessary to operate, program and recharge the implantable.

(3) "Medicare payment policy" means reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for

Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(4) "Outlier payment amount" means the amount determined through use of the calculations described in subsection (f) of this section.

(5) "Surgical implant provider" means a person that arranges for the provision of implantable devices to a health care facility and that then seeks reimbursement for the implantable devices provided directly from an insurance carrier.

(c) A surgical implant provider is subject to Chapter 133 of this title and is considered a health care provider for purposes of this section and the sections in Chapter 133 of this title (relating to Benefits--Medical Benefits).

(d) For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section, including the following paragraphs.

(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare program.

(2) Independent Review Organization decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(3) Whenever a component of the Medicare program is revised and effective, use of the revised component shall be required for compliance with Division rules, decisions, and orders for services rendered on and after the effective date, or after the effective date or the adoption date of the revised Medicare component, whichever is later.

(e) Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

(1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables.

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

(f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the *Federal Register*. The following minimal modifications shall be applied.

(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

(A) 143 percent; unless

(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

(2) When calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under subsection (g) of this section.

(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.

(1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

(2) A carrier may use the audit process under §133.230 of this title (relating to Insurance Carrier Audit of a Medical Bill) to seek verification that the amount certified under paragraph (1) of this subsection properly reflects the requirements of this subsection. Such verification may also take place in the Medical Dispute Resolution process under §133.307 of this title (relating to MDR of Fee Dispute), if that process is properly requested, notwithstanding §133.307(d)(2)(B) of this title.

(3) Nothing in this rule precludes a health care facility or insurance carrier from utilizing a surgical implant provider to arrange for the provision of implantable devices. Implantables provided by a surgical implant provider shall be reimbursed according to this subsection.

(h) A hospital that is classified by Medicare as a Sole Community Hospital, a Medicare Dependent Hospital, or a Rural Referral Center Hospital, shall initially be paid the amount calculated for such hospital in accordance with subsections (e) through (g) of this section. If the initial payment is less than the cost of the services in question, the hospital may request reconsideration in accordance with §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) and present documentation of any amount it would have been paid under the Medicare regulations in effect when the services were performed. If such a showing is made, the hospital shall be paid the difference between the amount initially paid and the amount Medicare would have paid for the services as adjusted by the appropriate multiplier.

(i) Notwithstanding Medicare payment policies, whenever Medicare requires a specific setting for a service, that restriction shall apply, unless an alternative setting and payment has been approved through the Division's preauthorization, concurrent review, or voluntary certification of health care process.

(j) A preauthorization request may be submitted for an alternative facility setting only if an agreement has already been reached and a copy of the signed agreement is filed as a part of the preauthorization request. Copies of the agreement shall be kept by both parties. This agreement does not constitute a voluntary network established in accordance with Labor Code §413.011(d-1).

(1) The agreement between the insurance carrier and the party that requested the alternative facility setting must be in writing, in clearly stated terms, and include:

(A) the reimbursement amount;

(B) a description of the services to be performed under the agreement;

(C) any other provisions of the agreement; and

(D) names of the entities, titles and signatures of both parties, and names, titles, signatures with dates of the persons signing the agreement.

(2) An agreement for an alternative facility setting may be revised during or after preauthorization by written agreement of the insurance carrier and the party that requested the alternative facility setting.

(3) Upon request of the Division, the agreement information shall be submitted in the form and manner prescribed by the Division.

(k) If a court of competent jurisdiction holds that any provision of this section is inconsistent with any statutes of this state, are unconstitutional, or are invalid for any reason, the remaining provisions of this section shall remain in full effect.

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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For further information, please call: (512) 804-4288

CHAPTER 180. MONITORING AND ENFORCEMENT

SUBCHAPTER A. GENERAL RULES FOR ENFORCEMENT

28 TAC §180.19

The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance, Division of Workers' Compensation (Division) adopts new §180.19 concerning the performance-based oversight (PBO) with changes to the proposed text published in the September 28, 2007, issue of the *Texas Register* (32 TexReg 6749).

In accordance with Government Code §2001.033, the preamble contains a summary of the factual basis of the rule, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rule, and the reasons why the Division agrees or disagrees with some of the comments and proposals.

Changes made to the proposed rule are in response to public comments received in writing and at a public hearing held on October 29, 2007, and are described in the summary of comments and responses section of this preamble. Other changes were made for consistency or to correct typographical or grammatical errors.

Several key recommendations to the Texas Legislature from the *Sunset Advisory Commission Staff Report, April 2004*, on the Texas Workers' Compensation Commission (Commission) focused on creating a new regulatory approach that would emphasize overall compliance and performance-based oversight linked to regulatory outcomes. Generally, key findings from the report recommended the Commission review the overall compliance history and performance of system participants in order to concentrate efforts on those participants whose data indicated compliance issues. A similar recommendation was for the Commission to create incentives to reward high performing system participants that did not cause compliance issues. The 79th Legislature enacted some of these recommendations in HB 7.

New §180.19 is necessary to implement Labor Code §402.075, as added by HB 7, enacted by the 79th Texas Legislature, Regular Session. Labor Code §402.075(a) requires the Commissioner, by rule, to adopt requirements that provide incentives for overall compliance in the workers' compensation system and that emphasize performance-based oversight linked to key regulatory outcomes.

The new rule confirms the key regulatory goals required by §402.075 by listing the regulatory goals applicable to the rule and also requires that assessments be completed once a biennium for system participants.

The Division implemented the new regulatory approach required by Labor Code §402.075 by relying on currently reported or available data for system participants. Section 402.075(c) requires the Division to "examine overall compliance records and dispute resolution and complaint resolution practices to identify insurance carriers and health care providers who adversely impact the workers' compensation system and who may require enhanced regulatory oversight. Labor Code §402.075(c) requires the Division to conduct the assessment through analysis of data maintained by the Division and through self-reporting by insurance carriers and health care providers and does not restrict the manner in which the Division performs the assessment. The Division expects that as the performance of the system participants improves within the areas selected for the initial assessment, the areas selected for future assessments will shift to those requiring more oversight to improve overall compliance.

The new rule provides that there will be three regulatory tiers--high, average, and poor. Placement in a tier is determined by reviewing the assessed participant's degree of compliance and success in meeting the key regulatory goals relative to other assessed participants.

The rule also provides what incentives will be offered to those entities placed into a regulatory tier, including those specifically listed in Texas Labor Code §402.075(f) as required for the high performers, and those available to system participants regardless of tier placement.

New §180.19(a) sets forth the purpose of the rule and the key regulatory goals against which the insurance carriers and health care providers will be assessed. The key regulatory goals of subsection (a) align with the general goals and mission of the workers' compensation system set forth in Labor Code §402.021.

New §180.19(b) states that the assessments based on the key regulatory goals will be conducted at least once each biennium. In April 2007, the Division selected for the initial assessment,

those system participants having a significant impact on the workers' compensation system due to their volume of claims handled, forms filed, premium rate, or other relevant criteria the Division deemed appropriate. With the exception of the win/loss ratios in contested case hearings (CCHs), the Division chose factors to assess the insurance carriers and the health care providers from data that the participants are required to report under the Labor Code and Division rules. The Division employed a modified bell curve in its assessment that allows the workers' compensation industry to have a clear understanding of expected performance goals and effectively distribute participants at both ends of the curve. This method compares a participant performance with another participant performance for the same duty, in the same review period and is a complete distribution control method. It allows for a fair, effective and complete distribution of participants when the actual performance level is higher or lower than the industry level.

New §180.19(c) establishes three regulatory tiers that distinguish among poor, average, and high performers in the system. The subsection further provides that insurance carriers and health care providers who are assessed will be placed in one of the three regulatory tiers based on their performance in relation to other assessed carriers and health care providers. In the initial assessment the Division did not, however, assess all insurance carriers and health care providers because many wrote below a specific level of premium or had other factors that minimized their impact upon the workers' compensation system. Those insurance carriers and health care providers that were not assessed and tiered as high, average or poor performers are not relieved from compliance with statutory and rule related duties or from regulatory oversight.

New §180.19(d) provides that the incentives will be based on the regulatory tier in which the insurance carrier or health care provider is placed after the assessment.

New §180.19(e) provides that the Commissioner, in granting incentives, may consider any other relevant factors that lead to overall compliance or factors which adversely impact the workers' compensation system.

New §180.19(f) sets out the incentives required for high tier performers as set forth in Labor Code §402.075(f). New rule §180.19(g) implements the requirements of Labor Code §402.075(g) and sets out incentives that may be applied to an insurance carrier or health care provider who was assessed and placed in any of the three regulatory tiers.

There are no additional rules or rule amendments anticipated in order to implement the proposed changes.

Comment: Commenter states that the rule will never work because the Division cannot keep up with all insurance companies and health care providers.

Agency Response: The Division disagrees. The Division is currently required to monitor and enforce the compliance of participants in the Texas workers' compensation system. The Division achieves this through audits and enforcement, fraud, education, workers' health and safety, self insurance, return to work, medical quality, legal and dispute resolution programs. The new rule does not change the requirements of the Division to monitor and enforce the compliance of system participants, including insurance carriers and health care providers. The new rule follows the directive of Labor Code §402.075 to establish regulatory tiers and provide incentives to improve the overall compliance of insurance carriers and health care providers in the system and to focus the Division's regulatory oversight on those that are identified as poor performers.

Comment: Commenter recommended that the words "within the system" be replaced with the words "among system participants" in 28 Tex. Admin. Code §180.19(a)(2) which states "increase of timely and accurate communications within the system".

Agency Response: The Division agrees with the recommended change to "among system participants" and modifies the rule language accordingly. The language is consistent with the language appearing in the statute relating to the goals of the Division found at Texas Labor Code §402.021(b)(9).

Comment: Commenters state that the methodology and assessment should be in the rule and requested that the Division delineate the requirements by which parties will be assessed in the rule. Commenters also state that the rule as proposed does not meet the statutory mandate to adopt requirements that provide incentives for compliance and emphasize oversight linked to regulatory outcomes.

Agency Response: The Division disagrees. The specific methodology for assessing the regulatory compliance of insurance carriers and health care providers is not within the scope of the rule. Labor Code §402.075(c) directs the Division to assess the performance of insurance carriers and health care providers through the analysis of data but does not require that a particular methodology be adopted. By comparison, §402.075 is more specific and directs the division to develop regulatory tiers for poor, average, and high performers and to focus its regulatory oversight on those system participants identified as poor performers. The provisions of §402.075(c) provide the Commissioner with the regulatory discretion necessary to adapt the assessment methodology as necessary to assess the performance of the system participants over time. Furthermore, Labor Code §402.00128(b)(12), which states, "The commissioner . . . may . . . exercise other powers and perform other duties as necessary to implement and enforce this title" provides the Commissioner the discretion to select, review, and assess different measures of compliance.

The Division also disagrees with the assertion that the proposed rule does not meet the statutory mandate to adopt requirements that provide incentives for compliance and emphasize oversight linked to regulatory outcomes. The purpose of the new rule, as detailed by statute, is to establish performance based tiers and incentives to increase the overall compliance of insurance carriers and health care providers in the system and to emphasize performance based oversight linked to regulatory outcomes. The Division is required to assess the regulatory outcomes of the insurance carriers and health care providers in order to tier them. The tier into which each insurance carrier and health care provider is placed is directly dependant upon the degree to which the tiered participant complied with the Texas Workers' Compensation Act and the Division rules as compared to all other insurance carriers and health care providers that the Division is required to assess. Insurance carriers and health care providers have a duty to comply with all requirements in the Texas Workers' Compensation Act and the Division Rules and should strive for 100% compliance. Therefore, the areas of compliance that the Division determines to review for assessment purposes and the degree of compliance associated with each tier should be inconsequential to the insurance carriers and health care providers to be assessed and tiered.

Comment: Commenter states there will be no fiscal impact to state or local government regarding the employment or enforcement of the rule.

Agency Response: The Division agrees and thanks the commenter.

Comment: Commenter recommended adding language to the Statutory Authority section of the proposed rule to say, "Section 402.075 requires the Commissioner of Workers' Compensation to provide incentives within each tier to promote compliance and high performance from workers' compensation participants by providing biennial assessment."

Agency Response: The Division disagrees that additional language is needed for the Statutory Authority section of the proposed rule. The suggested comment addresses policy issues which have no impact on the actual rule.

Comment: Commenter objected to the use of the win/loss methodology used by the Division in the first assessment as it did not and cannot assess the full statutory scope and focus as set out in Labor Code §402.075.

Agency Response: The Division disagrees. Although the assessment methodology is not within the scope of this rule and is a procedure for the Division to determined within its sole discretion, assessing the contested case hearing win/loss ratio does assess the full statutory scope and focus of Texas Labor Code §402.075. Labor Code §402.021 states that a goal for the system is to minimize the likelihood of disputes and to resolve them promptly and fairly when identified. Further, a key regulatory goal of the system, as identified in 28 Tex. Admin. Code §180.19(a) is to limit disputes to those appropriate and necessary.

Comment: Commenters state that the proposed rule fails to provide a definition for the three tier levels and requests that the criteria be clearly defined in the rule. Commenters stated that the proposed rule should establish a tier structure.

Agency Response: The Division disagrees with adding tier definitions to the rule. The tier structure of high, average and low is stated in the rule. The specific standards for assessed insurance carriers and health care providers to be placed in a high, average or low tier depend upon the degree to which the individual insurance carriers and health care providers are meeting the regulatory goals established in this rule as compared to the success of other insurance carriers and health care providers being assessed in meeting the same regulatory goals.

Comment: Commenter states that because the rule is "incentive-based" that Division should not publish poor and average tier results.

Agency Response: The Division disagrees. Labor Code §402.075 does not prohibit the publication of all tiers. Stakeholders' input indicated that it would be an incentive for average and poor performers to improve their standing if all tier results were posted.

Comment: Commenters state that penalties for non-compliance must be assessed pursuant to §414 and §415 of the Labor Code. The commenter stated the language as proposed in 28 Tex. Admin. Code §§180.19(g)(2) and (3) contains openly restrictive language respecting penalties, by its terms, penalties may only be 'lower' than normal (only for the 'high performer' tier) or 'reduced' (when self-disclosed in any tier). This is inappropriate and violates both the statute and specific rules more properly dealing with penalties.

Agency Response: The Division agrees that penalties are assessed pursuant to §414 and §415 of the Labor Code. The incentives specified in this rule are discretionary and listed in Labor Code §402.075(e) as possible regulatory incentives for purposes of performance based oversight. This proposed rule is intended to supplement Labor Code §414 and §415 and does not supersedes those statutes.

Comment: Commenter requested that the title of the rule be changed from "Performance Based Oversight Incentives" to "Performance-Based Oversight and Performance Incentives."

Agency Response: The Division disagrees that the title should be changed. The purpose of the rule is to develop incentives and emphasize performance-based oversight linked to regulatory outcomes.

Comment: Commenter states the key regulatory goals for the performance based oversight process should be linked to the compliance categories set forth in 28 Tex. Admin. Code §180.11 and Contested Case Hearing (CCH) outcomes should not be included as key performance goals.

Agency Response: The Division disagrees that the key regulatory goals for the performance based oversight process should be linked to the compliance categories set forth in 28 Tex. Admin. Code §180.11. The compliance categories set forth in 28 Tex. Admin. Code §180.11 were a means to categorize various duties under the Texas Workers' Compensation Act and Division rules and to assist with identifying and calculating administrative penalties assessed for violations occurring prior to September 1, 2005. The Division further disagrees that CCH outcomes should not be included as a key regulatory goal. Labor Code §402.075 requires that the Division, among other things, examine the overall dispute resolution practices of the insurance carriers and health care providers to determine compliance with the key regulatory goals provided in this rule and the general regulatory goals of the Division found in Labor Code §402.021.

Comment: Commenter states the performance standards for each key regulatory goal (as expanded under this concept) should be linked to the compliance standards set forth in 28 Tex. Admin. Code §180.12.

Agency Response: The Division disagrees that the performance standards need to be incorporated into the rule. Participants are required to be compliant with the Labor Code and Division rules. The higher the compliance of an assessed participant relative to other assessed system participants, the higher the system participant will be placed in the tier system. The Division further disagrees that the performance standards for each key regulatory goal should be linked to the compliance standards set forth in 28 Tex. Admin. Code §180.12. Section 180.12 provides for minimal compliance standards that system participants are expected to meet for compliance categories defined in 28 Tex. Admin. Code §180.11. These compliance standards are not those provided in this rule or in Labor Code §402.075 and are typically utilized when the Division conducts an audit of the participant.

Comment: Commenter stated that the Division would find it difficult, if not impossible, to complete their respective review of data associated with the PBO assessment process if all ten compliance categories were included in the review. The rule would need to provide that the Division give insurers notice of a smaller subset of compliance categories that would be considered the key regulatory goals for the upcoming PBO review.

Agency Response: The Division agrees that a review of all ten compliance categories set forth in 28 Tex. Admin. Code §180.11 would be difficult; therefore, these ten compliance categories are not the key regulatory goals. The Division identified six key regulatory goals that aligned with the general goals as the statute (§402.075) indicates. The general goals may be found in §402.021 of the Labor Code.

Comment: Commenters state that the performance of insurer carriers and health care providers should be based upon their actual performance and not incorporate the application of a bell curve as discussed in the Division's concept paper. The Division should use a census methodology that considers data from a specific time period for all future PBO assessments.

Agency Response: The Division disagrees. Labor Code §402.075 does not require that the Division's assessment methodology be provided in rule and, by not doing so, allows the Division the discretion to change its assessment methodology as needed to fulfill the legislative intent. To include the assessment methodology in this rule would restrict the Division's ability to shift its regulatory focus, as needed, to areas of compliance that are, or become, areas that adversely impact the workers' compensation system. Labor Code §402.075 requires that the Division assess the insurance carriers and health care providers using data maintained by the Division. Labor Code §402.075 leaves within the sole discretion of the Division the task of determining the areas upon which to focus its assessment and the methodology by which to analyze the Division maintained data and to conduct the assessment. Furthermore, the statute leaves within the sole discretion of the Division the obligation of determining which assessment methodologies are most effective in accomplishing the legislative intent to increase the assessed participants' overall compliance with the key regulatory goals and to minimize the factors adversely impacting the workers' compensation system. The Division's determinations of the areas of assessment and the most effective methodology to apply are procedural and are not appropriate to include in this rule.

The Division further disagrees that a bell curve should not be used in the assessment. The bell curve is a common methodology that compares performance relative to all the system participants assessed. The Division employed a modified bell curve in its assessment that allows the workers' compensation industry to have a clear understanding of expected performance goals and effectively distribute participants at both ends of the curve. This method compares a participant performance with another participant performance for the same duty, in the same review period and is a complete distribution control method. It allows for a fair, effective and complete distribution of participants when the actual performance level is higher or lower than the industry level. Assessments based upon the actual performance of tiered participants may lessen the incentive to improve performance. For example, if an assessment score of 90 percent moved a system participant into the high performer tier, under the methodology proposed by the commenter, there would be no incentive to improve above that 90 percent. In theory, all the system participants could cluster at 90 percent or slightly above and would be in the high performer tier, but would have no incentive to improve and to reach 100 percent.

Comment: Commenters state that the rule should allow the assessed system participant to request a reassessment at a minimum of six months after the Division has released and published the PBO assessment results and tier rankings. Commenters state there should be an appeal process to the Division staff application of the law or other decisions prior to ranking being published.

Agency Response: The Division disagrees. Labor Code §402.075 provides only for the Division's initial performance assessment and a performance assessment of the insurance carriers and the health care carriers at least every biennium thereafter. There is no statutory provision for a reassessment upon request or an appeal process. Labor Code §402.075 leaves within the Division's sole discretion the ability to determine the need for more frequent performance assessments and whether resources are available to conduct more frequent performance assessments.

Comment: Commenters state the rule should require Division staff to provide insurers with feedback on the data corrections submitted during the time period provided for review of the data that will be used for each insurer's PBO assessment. Commenter(s) request that the proposal rule require the Division to respond as to which changes were accepted and which were not and why.

Agency Response: The Division disagrees that the rule should include requirements that the Division provide insurers with feedback on the data corrections. The Division will make every effort to be available to answer participants' questions regarding the PBO assessment and methodology.

Comment: Commenter states that the identity of the third-party administrator (TPA) should be added to the PBO assessment results so that insurers will be able to use the assessment results as a means to gauge the performance of and to select TPAs.

Agency Response: The Division disagrees. Labor Code §402.075 requires the Division to assess insurance carriers and health care providers and does not provide statutory authority to conduct PBO related assessments of TPAs or report TPAs associated with the tiered insurance carriers. HB 472, enacted by the 80th Legislature and codified, in part, in Insurance Code Chapter 4151, brought workers' compensation TPAs under the regulatory authority of the Texas Department of Insurance.

For: Office of Injured Employee Counsel.

For, with changes: Pamela R. Beachley, Attorney and Counselor at Law; Risk Management Services and the State Office of Risk Management.

Against: Insurance Council of Texas, Service Lloyds Insurance Company, American Insurance Association-Southwest Region, Texas Cotton Ginners' Trust, Property Casualty Insurers Association of America, and Marsha Cooper.

The new rule is adopted under Labor Code §402.061, which authorizes the Commissioner to adopt rules necessary to administer the Act and Labor Code §402.075, which requires the Commissioner, by rule, to adopt requirements that provide incentives for overall compliance in the workers' compensation system and that emphasize performance-based oversight linked to key regulatory outcomes.

§180.19. Incentives.

(a) The purpose of this section is to develop incentives and emphasize performance-based oversight to regulatory outcomes. Regulatory outcomes are assessed for the following key regulatory goals:

(1) provide timely and accurate income and medical benefits;

(2) increase timely and accurate communications among system participants;

(3) encourage safe and timely return of injured employees to productive roles;

(4) promote safe and healthy workplaces;

(5) ensure each injured employee shall have access to prompt, high-quality, cost-effective medical care; and

(6) limit disputes to those appropriate and necessary.

(b) At least once every biennium, the Division shall assess the performance of insurance carriers and health care providers based on the key regulatory goals stated in subsection (a)(1) - (6) of this section.

(c) Insurance carriers and health care providers who are assessed will be placed into one of the following regulatory tiers based upon their level of compliance with the Labor Code and related rules and their performance in meeting the key regulatory goals in §180.19(a) relative to the performance of all other assessed insurance carriers and health care providers:

(1) high performers;

(2) average performers; or

(3) poor performers.

(d) Incentives will be based on the regulatory tier into which the insurance carrier or health care provider was placed after being assessed on the key regulatory goals.

(e) In granting incentives, the Commissioner may also consider any other factors that the Commissioner finds relevant which leads to overall compliance or which may adversely impact the workers' compensation system.

(f) Incentives for insurance carriers and health care providers placed into the high performer regulatory tier are:

(1) public recognition, and

(2) use of that designation as a marketing tool.

(g) Other incentives for insurance carriers and health care providers placed into a regulatory tier may include:

(1) limited audit exemption for insurance carriers and health care providers placed in the average and high performers regulatory tiers, while reserving the Division's discretion to audit an average or high performer if deemed necessary;

(2) penalties which may be lower than normally assessed for insurance carriers and health care providers who have been placed in the high performer regulatory tier;

(3) penalties which may be reduced for insurance carriers and health care providers in any regulatory tier who self-disclose non-compliance;

(4) flexibility for audits and inspections based on performance and placement in any regulatory tier; and

(5) any other incentive the Commissioner may deem appropriate.

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

Filed with the Office of the Secretary of State on December 27, 2007.

TRD-200706636
Norma Garcia
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
Effective date: January 16, 2008
Proposal publication date: September 28, 2007
For further information, please call: (512) 804-4288

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TITLE 40. SOCIAL SERVICES AND ASSISTANCE

PART 1. DEPARTMENT OF AGING AND DISABILITY SERVICES

CHAPTER 10. GUARDIANSHIP SERVICES

SUBCHAPTER C. CONTRACTOR REQUIREMENTS

40 TAC §§10.311, 10.315, 10.321

The Health and Human Services Commission (HHSC), on behalf of the Department of Aging and Disability Services (DADS), adopts amendments to §§10.311, 10.315, and 10.321 in Chapter 10, Guardianship Services, without changes to the proposed text as published in the October 19, 2007, issue of the *Texas Register* (32 TexReg 7430).

The amendments to §10.311 and §10.321 are adopted to update contractor employee qualifications with regard to certification by the Guardianship Certification Board (GCB). Effective September 1, 2007, Texas Government Code, §111.042, requires a guardianship contractor's case manager to be certified by the GCB. Before September 1, 2007, §10.311 allowed a case manager to have a certain level of education or experience as an alternative to certification by the GCB. The pre-September 1, 2007, education and experience criteria are now obsolete and no longer necessary to have in rule.

The amendment to §10.315 is adopted to implement the provisions of Senate Bill (SB) 291, 80th Legislature, Regular Session, 2007, which amended the Texas Probate Code, Section 698. Texas Probate Code, §698(a-1) - (a-3) requires DADS to obtain criminal history record information for anyone who provides guardianship services to a ward of DADS or a ward who is referred by DADS, including someone who is an employee or a volunteer with DADS or a guardianship contractor. The rule previously required a contractor to obtain the criminal history record information and, therefore, an amendment was needed for the rule to conform to state law.

DADS received one written comment from Advocacy, Inc., in support of the amendments.

The amendments are adopted under Texas Government Code, §531.0055, which provides that the HHSC executive commissioner shall adopt rules for the operation and provision of services by the health and human services agencies, including DADS; Texas Human Resources Code, §161.021, which provides that the Aging and Disability Services Council shall study and make recommendations to the HHSC executive commissioner and the DADS commissioner regarding rules governing the delivery of services to persons who are served or regulated by DADS; Texas Human Resources Code, §§161.101

- 161.113, which authorizes DADS to serve as guardian of the person or estate, or both, for an incapacitated individual and, if appropriate, to contract with another entity to provide guardianship services; and Texas Probate Code, §698(a-1) - (a-3), which requires DADS to obtain criminal history record information relating to each individual who is or will be providing guardianship services to a ward of or referred by DADS.

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

Filed with the Office of the Secretary of State on December 31, 2007.

TRD-200706647
Kenneth L. Owens
General Counsel
Department of Aging and Disability Services
Effective date: January 20, 2008
Proposal publication date: October 19, 2007
For further information, please call: (512) 438-3734

IN ADDITION

The *Texas Register* is required by statute to publish certain documents, including applications to purchase control of state banks, notices of rate ceilings issued by the Office of Consumer Credit Commissioner, and consultant proposal requests and awards. State agencies also may publish other notices of general interest as space permits.

Office of the Attorney General

Notice of Amendment and Extension to a Major Consulting Contract

The Office of the Attorney General of Texas (OAG) announces the amendment and extension of contract #07-C0254 with Deloitte Consulting, LLP, an entity with a principal place of business at 400 West 15th Street, Suite 1700, Austin, Texas 78701. Under the amended and extended contract, the contractor will provide "Development and Implementation Continuity Assurance" by preparing, planning, developing and deploying the management and technical infrastructure necessary to implement the recommendations made by Deloitte Consulting pursuant to its consulting contract regarding new processes, organizational changes, performance metrics and supporting technologies identified during the initial term of the contract.

The total value of the contract will not exceed $4,231,521. The contract has been extended to August 31, 2008, unless extended or terminated sooner by the OAG. The contractor must complete and submit all deliverables under the contract to the OAG by August 31, 2008.

TRD-200706632
Stacey Napier
Deputy Attorney General
Office of the Attorney General
Filed: December 21, 2007

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Automobile Burglary and Theft Prevention Authority

Request for Grant Applications under the Automobile Theft Prevention Fund

Notice of Invitation for Applications:

The Automobile Burglary and Theft Prevention Authority is soliciting applications for grants to be awarded for projects under the Automobile Burglary and Theft Prevention Authority (ABTPA) Fund. This grant cycle will be one year in duration, and will begin on September 1, 2008. One or more of the following types of projects may be awarded, depending on the availability of funds:

Law Enforcement/Detection/Apprehension Projects, to establish motor vehicle burglary and theft enforcement teams and other detection/apprehension programs. Priority funding may be provided to state, county, precinct commissioner, general or home rule cities for enforcement programs in particular areas of the state where the problem is assessed as significant. Enforcement efforts covering multiple jurisdictional boundaries may receive priority for funding.

Prosecution/Adjudication/Conviction Projects, to provide for prosecutorial and judicial programs designed to assist with the prosecution of persons charged with motor vehicle burglary and theft offenses.

Prevention, Anti-Theft Devices and Automobile Registration Projects, to test experimental equipment which is considered to be designed for auto theft deterrence and registration of vehicles in the Texas Help End Auto Theft (H.E.A.T.) Program.

Reduction of the Sale of Stolen Vehicles or Parts Projects, to provide vehicle identification number labeling, including component part labeling and etching methods designed to deter the sale of stolen vehicles or parts.

Public Awareness and Crime Prevention/Education/Information Projects, to provide education and specialized training to law enforcement officers in auto burglary and theft prevention procedures, provide information linkages between state law enforcement agencies on auto theft crimes, and develop a public information and education program on theft prevention measures.

Eligible Applicants:

State agencies, local general-purpose units of government, independent school districts, nonprofit, and for profit organizations are eligible to apply for grants for automobile burglary and theft prevention assistance projects. Nonprofit and profit organizations shall be required to provide with their grant applications sufficient documentation to evaluate the credibility and the community support of the organization and the viability of the organization's existing activities in the context of providing automobile burglary and theft prevention assistance.

Contact Person:

Detailed specifications, including selection process and schedule for workshops for applicants will be made available through ABTPA. Copies of the Administrative Guide and the application can be found at www.txwatchyourcar.com. Contact Susan Sampson, Director, Texas Automobile Burglary and Theft Prevention Authority, (512) 374-5101.

Application Workshops:

A mandatory workshop for all applicants that wish to apply for the Texas Automobile Burglary and Theft Prevention Grant funds with at least one (1) representative has been selected to be held:

March 18, 2008, Tuesday, Austin, Texas, 8:00 a.m. - 5:00 p.m., Texas Department of Transportation, 200 East Riverside Drive, Room 1A.1, Austin, Texas 78704, (512) 374-5101. Attendees are responsible for making individual hotel reservations. Registration for the workshops must be done on the ABTPA Website at www.txwatchyourcar.com.

Application Deadline and Submission Requirements: The Authority must receive applications by 5 p.m., Friday, May 9, 2008 or postmarked by May 9, 2008. Each Application must:

1. Include all signed certifications and signature pages.

2. Application must be mailed or delivered to:

Texas Automobile Burglary and Theft Prevention Authority

4000 Jackson Avenue

Austin, Texas 78731

3. Submit one (1) original and four (4) copies of the proposal.

4. Facsimile transmissions will not be accepted.

If mailed, applications must be marked "Personal and Confidential" and addressed to the contact person listed above. If delivered, please leave application with the contact person (or designee) at the address listed.

Selection Process:

Applications will be selected according to rules §§57.2, 57.4, 57.7, and 57.14, as published in Title 43 Chapter 57, Texas Administrative Code.

Grant award decisions by ABTPA are final and not subject to judicial review.

Grants will be awarded on or before September 1, 2008.

TRD-200706644
Susan Sampson
Director
Automobile Burglary and Theft Prevention Authority
Filed: December 28, 2007

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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 the award of a contract under Request for Proposals (RFP #178e), for Domestic Core Fixed Income investment management services for assets held by the Texas Tomorrow Fund.

The Comptroller announces that a contract is awarded to: Advantus Capital Management, Inc., 400 Robert Street North, St. Paul, Minnesota 55101-2098. The term of the contract is December 20, 2007 through August 31, 2012. The Board shall have the right, in its sole discretion, to renew the Contract for up to two (2) additional one (1) year periods, one year (1) at a time. The total amount of the Contract is based on a percentage of the total assets managed.

The Request for Proposals was issued on Friday, June 15, 2007. The notice of the Request for Proposals was published in the June 15, 2007, issue of the *Texas Register* (32 TexReg 3724).

TRD-200706645
Pamela Smith
Deputy General Counsel for Contracts
Comptroller of Public Accounts
Filed: December 28, 2007

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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 and §303.009, Texas Finance Code.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/31/07 - 01/06/08 is 18% for Consumer[1]/Agricultural/Commercial[2]/credit through $250,000.

The weekly ceiling as prescribed by §303.003 and §303.009 for the period of 12/31/07 - 01/06/08 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-200706635
Leslie L. Pettijohn
Commissioner
Office of Consumer Credit Commissioner
Filed: December 27, 2007

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Texas Commission on Environmental Quality

Notice of Opportunity to Comment on Default Orders of Administrative Enforcement Actions

The Texas Commission on Environmental Quality (TCEQ or commission) staff is providing an opportunity for written public comment on the listed Default Orders (DOs). The commission staff proposes a DO when the staff has sent an executive director's preliminary report and petition (EDPRP) to an entity outlining the alleged violations; the proposed penalty; and the proposed technical requirements necessary to bring the entity back into compliance; and the entity fails to request a hearing on the matter within 20 days of its receipt of the EDPRP or requests a hearing and fails to participate at the hearing. Similar to the procedure followed with respect to Agreed Orders entered into by the executive director of the commission, in accordance with Texas Water Code (TWC), §7.075 this notice of the proposed order and the opportunity to comment is published in the *Texas Register* no later than the 30th day before the date on which the public comment period closes, which in this case is **February 11, 2008**. 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 February 11, 2008**. 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: Amy Business, Inc. dba Jrs. Quick Stop; DOCKET NUMBER: 2004-0024-PST-E; TCEQ ID NUMBER: RN101550200; LOCATION: 4800 East Highway 199, Springtown, Parker County, Texas; TYPE OF FACILITY: convenience store with retail sales of gasoline; RULES VIOLATED: 30 TAC §37.815(a) and (b), by failing to demonstrate continuous 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 the underground storage tanks; PENALTY: $3,000; 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.

(2) COMPANY: Opel Business, Inc. dba Garth Road Cleaners aka Garth Road 1.69 Cleaners and dba 1.69 City Cleaners; DOCKET NUMBER: 2006-1365-DCL-E; TCEQ ID NUMBERS: RN104621503 and RN104104336; LOCATIONS: 3413 Garth Road, Suite B and 1601 North Alexander Drive, Suite B, Baytown, Harris County, Texas; TYPE OF FACILITIES: dry cleaning facility and dry cleaning drop station; RULES VIOLATED: 30 TAC §337.11(e) and Texas Health and Safety Code, §374.102, by failing to complete and submit the required registration form to the TCEQ for a dry cleaning facility and

a drop station facility; and 30 TAC §337.14(c) and Texas Water Code, §5.702, by failing to pay dry cleaner registration fees for Account Number 24002250; PENALTY: $2,370; STAFF ATTORNEY: Tracy Chandler, Litigation Division, MC 175, (512) 239-0629; REGIONAL OFFICE: Houston Regional Office, 5425 Polk Street, Suite H, Houston, Texas 77023, (713) 767-3500.

TRD-200800003
Mary R. Risner
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 2, 2008

Notice of Opportunity to Comment on Settlement Agreements 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. Section 7.075 requires that before the commission may approve the AOs, the commission shall allow the public an opportunity to submit written comments on the proposed AOs. Section 7.075 requires that notice of the 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 **February 11, 2008**. Section 7.075 also requires that the commission promptly consider any written comments received and that the commission may withdraw or withhold approval of an AO if a comment discloses facts or considerations that indicate that consent is inappropriate, improper, inadequate, or inconsistent with the requirements of the statutes and rules within the commission's jurisdiction or the commission's orders and permits issued in accordance with the commission's regulatory authority. Additional notice of changes to a proposed AO is not required to be published if those changes are made in response to written comments.

A copy of each proposed AO is available for public inspection at both the commission's central office, located at 12100 Park 35 Circle, Building 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 February 11, 2008**. Comments may also be sent by facsimile machine to the attorney at (512) 239-3434. The designated attorney is available to discuss the AO and/or the comment procedure at the listed phone number; however, §7.075 provides that comments on an AO shall be submitted to the commission in **writing**.

(1) COMPANY: Brad Bolton; DOCKET NUMBER: 2003-1528-OSI-E; TCEQ ID NUMBER: RN103051066; LOCATION: 1876 Farm-to-Market Road 2131, Coleman, Coleman County, Texas; TYPE OF FACILITY: installation of an unauthorized on-site sewage facility (OSSF); RULES VIOLATED: 30 TAC §285.61(1) and Texas Health and Safety Code (THSC), §366.071, by failing to possess a current installer license before beginning construction of an OSSF system; 30 TAC §285.61(4) and THSC, §366.051(c), by failing to obtain the permitting authorities authorization to construct an OSSF system; and 30 TAC §285.61(5) and THSC, §366.054, by failing to notify the permitting authority of the date on which the construction of the OSSF system would begin; PENALTY: $750; 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.

(2) COMPANY: Lide Industries, Inc.; DOCKET NUMBER: 2006-2045-AIR-E; TCEQ ID NUMBER: RN101698439; LOCATION: 1618 West State Highway 84, approximately six miles east of Mexia, Freestone County, Texas; TYPE OF FACILITY: metal tank fabrication plant consisting of three separate facilities; RULES VIOLATED: 30 TAC §101.4 and THSC, §382.085(a) and (b), by failing to prevent dust from migrating onto adjacent property and creating a nuisance condition; 30 TAC §111.201 and THSC, §382.085(b), by failing to comply with outdoor burning rules which prohibit outdoor burning of waste from a business; 30 TAC §116.115(c), THSC, §382.085(b), and Air Permit Number 75952, Special Condition Numbers 3(B) and 9(B), by failing to route all emissions from Emission Point Number (EPN) MINCIN to the thermal oxidizer (TO) and by failing to conduct stack sampling, and other testing within180 days after the start of manufacturing operations to determine the destruction efficiency and the pounds per hour of the volatile organic compounds (VOCs) and exempt solvents emitted into the atmosphere from the TO; 30 TAC §116.155(c), THSC, §382.085(b), and Air Permit Number 75952, Special Condition Numbers 8(A) and (B), by failing to conduct testing within 180 days after the start of manufacturing operations to demonstrate 100% capture efficiency at the two completed spray booths at the Main and East facilities; 30 TAC §116.115(c), THSC, §382.085(b), and Air Permit Number 75952, Special Condition Number 11(B) and (C), by failing to record and maintain on file weekly data of material usage and VOC material and hazardous air pollutant content and data of actual daily hours of operations in order to demonstrate compliance and by failing to compile that data into monthly reports that represent the emissions from each emission point as shown on the Maximum Allowable Emissions Rate Table (MAERT) in pounds per hour on a daily average basis and tons emitted; 30 TAC §116.110(a) and THSC, §382.0518(a) and §382.085(b), by failing to obtain a permit or adhere to the requirements of 30 TAC §106.452(2)(A) at the sandblasting media storage facilities; 30 TAC §116.115(b)(2)(F), THSC, §382.085(b), and Air Permit Number 75952, General Condition Number 9, by failing to comply with the MAERT in Air Permit Number 75952 for EPNs MINCIN, MPTBLDFUG, MPTOUTFUG and EPTOUTFUG; 30 TAC §106.433(6)(A) and (7)(A) and THSC, §382.085(b), by failing to comply with the conditions provided in 30 TAC §106.433 at the Main, East, and West outdoor surface coating facilities by exceeding the six pounds per hour limit of VOC emissions averaged over any five-hour period; 30 TAC §101.4 and THSC, §382.085(a) and (b), by failing to prevent paint over-spray from migrating onto adjacent property and creating a nuisance condition; 30 TAC §116.115(b)(2)(G), THSC, §382.085(b), and Air Permit Number 75952, General Condition Number 9, by failing to maintain the air pollution capture and abatement equipment in good working order and operating properly during normal facility operations; 30 TAC §106.433(7)(A) and THSC, §382.085(b), by failing to comply with the conditions provided in 30 TAC §106.433 at the West facility surface coating facility by exceeding the six pounds per hour limit of VOC emissions averaged over any five-hour period; 30 TAC §116.110(a), Texas Water Code, §7.051(a)(1)(B), THSC, §382.085(b) and §382.0518(a), and TCEQ Agreed Order Docket Number 2006-0905-AIR-E, by failing to comply with Ordering Provision Number 2(c) of Agreed Order Docket Number 2006-0905-AIR-E; 30 TAC §106.452(2)(A) and THSC, §382.085(b), by failing to adhere to the requirements of 30 TAC §106.452(2)(A) at the sandblasting media storage facilities; 30 TAC §106.433(7)(A) and THSC, §382.085(b), by failing to comply with the conditions provided in 30 TAC §106.433 at the West surface coating facility by exceeding the six pounds per hour limit of VOC emissions averaged over any five-hour period; and 30 TAC §106.452(2)(A) and THSC, §382.085(b), by failing to adhere to the requirements of 30 TAC §106.452(2)(A) at the sandblasting media storage facilities; PENALTY: $306,570; Supplemental Environmental Project offset

amount of $153,285 applied to Texas Association of Resource Conservation & Development Areas, Inc. Clean School Bus; STAFF ATTORNEY: Kathleen Decker, Litigation Division, MC 175, (512) 239-6500; REGIONAL OFFICE: Waco Regional Office, 6801 Sanger Avenue, Suite 2500, Waco, Texas 76710-7826, (254) 751-0335.

TRD-200800002
Mary R. Risner
Director, Litigation Division
Texas Commission on Environmental Quality
Filed: January 2, 2008

Texas Health and Human Services Commission

Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission will conduct a public hearing on January 30, 2008, at 1:30 p.m. to receive public comment on the proposed Medicaid payment rates for eye surgery by laser procedure codes listed below. These changes are associated with Medicaid medical policy changes. The public hearing will be held in the Lone Star Conference Room of the Health and Human Services Commission, Braker Center, Building H, located at 11209 Metric Blvd, Austin, Texas. Entry is through Security at the main entrance of the building, which faces Metric Boulevard. The hearing will be held in compliance with Human Resources Code §32.0282 and Texas Administrative Code (TAC) Title 1, §355.201(e)-(f), which require public notice and hearings on proposed Medicaid reimbursements. Persons requiring Americans with Disability Act (ADA) accommodation or auxiliary aids or services should contact Kimbra Rawlings by calling (512) 491-1174, at least 72 hours prior to the hearing so appropriate arrangements can be made.

Proposal. The proposed payment rates will be effective March 1, 2008. The proposed rates are as follows:

Type of Service (TOS)*	Procedure Code**	Proposed Relative Value Units (RVUs)	Proposed Medicaid Rate
2	65772	9.08	$260.05
F	65772		ASC Group 4
2	65775	12.31	$352.56
F	65775		ASC Group 4
F	65450		ASC Group 2
F	66770		ASC Group 3

***Type of Service Code Key:**
2 = surgery
F = ambulatory surgical center (ASC)/hospital-based ASC

*****Required Notice:** The five-character codes included in this notice are obtained from the Current Procedural Terminology (CPT®), copyright 2007 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of this notice should refer to the most recent Current Procedural Terminology, which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply. CPT is a registered trademark of the American Medical Association.*

Methodology and Justification. The proposed payment rates are calculated in accordance with 1 TAC §355.8085, which addresses the reimbursement methodology for physicians and certain other practitioners, and 1 TAC §355.8121, which addresses the reimbursement methodology for ASCs/HASCs.

Briefing Package. A briefing package describing the proposed payment rates will be available on or after January 14, 2008. Interested parties may obtain a copy of the briefing package prior to the hearing by contacting Kimbra Rawlings by telephone at (512) 491-1174; by fax at (512) 491-1998; or by e-mail at Kimbra.Rawlings@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 p.m. the day of the hearing. Written comments may be

sent by U.S. mail to the attention of Kimbra Rawlings, Health and Human Services Commission, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Kimbra Rawlings at (512) 491-1998; or by e-mail to Kimbra.Rawlings@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to Kimbra Rawlings, HHSC, Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

TRD-200800012
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: January 2, 2008

Notice of Public Hearing on Proposed Medicaid Payment Rates

Hearing. The Texas Health and Human Services Commission (HHSC) will conduct a public hearing on January 30, 2008, at 1:30 p.m. to receive public comment on the proposed Medicaid payment rates for bariatric surgery procedure codes listed below. These changes are associated with Medicaid medical policy changes. The public hearing will be held in the Lone Star Conference Room of HHSC, 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. The hearing will be held in compliance with Human Resources Code §32.0282 and 1 Texas Administrative Code (TAC) §355.201(e) - (f), which require public notice and hearings on proposed Medicaid reimbursements. Persons requiring Americans with Disability Act (ADA) accommodation, auxiliary aids, or services should contact Kimbra Rawlings by calling (512) 491-1174, at least 72 hours prior to the hearing so appropriate arrangements can be made.

Proposal. The proposed payment rates will be effective March 1, 2008. The proposed rates are as follows:

Type of Service (TOS)*	Procedure Code**	Proposed Relative Value Units (RVUs)	Proposed Medicaid Rate
2	43644	42.50	$1,159.23
8	43644	6.80	$185.48
F	43644		ASC Group 6
2	43645	45.39	$1,238.08
8	43645	7.26	$198.02
F	43645		ASC Group 6
2	43770	27.44	$748.45
8	43770	4.39	$119.74
F	43770		ASC Group 6
2	43771	31.31	$854.01
8	43771	5.01	$136.65
F	43771		ASC Group 6
2	43772	23.54	$642.08
8	43772	3.77	$102.83
F	43772		ASC Group 6
2	43773	31.30	$853.74
8	43773	5.01	$136.65
F	43773		ASC Group 6
2	43774	23.69	$646.17
8	43774	3.79	$103.38
F	43774		ASC Group 6
2	43842	30.10	$821.01
8	43842	4.82	$131.47
F	43842		ASC Group 6
2	43843	31.38	$855.92
8	43843	5.02	$136.93
F	43843		ASC Group 6
2	43845	50.06	$1,365.44
8	43845	8.01	$218.48
F	43845		ASC Group 6
2	43846	40.39	$1,101.68
8	43846	6.46	$176.20
F	43846		ASC Group 6
2	43847	44.17	$1,207.78
8	43847	7.07	$192.84
F	43847		ASC Group 6
2	43848	47.74	$1,302.16
8	43848	7.64	$208.39
F	43848		ASC Group 6
2	43886	8.23	$224.48
8	43886	1.32	$36.00
F	43886		ASC Group 6
2	43887	7.80	$212.75
8	43887	1.25	$34.10
F	43887		ASC Group 6
2	43888	11.05	$301.40
8	43888	1.77	$48.28
F	43888		ASC Group 6
7	00797	8.00	$133.76

***Type of Service Code Key**:
2 = surgery
F = ambulatory surgical center (ASC)/hospital-based ASC
7 = anesthesia

****Required Notice:** *The five-character codes included in this notice are obtained from the Current Procedural Terminology (CPT®), copyright 2007 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of this notice should refer to the most recent Current Procedural Terminology, which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply. CPT is a registered trademark of the American Medical Association.*

Methodology and Justification. The proposed payment rates are calculated in accordance with 1 TAC §355.8085, which addresses the reimbursement methodology for physicians and certain other practitioners, and 1 TAC §355.8121, which addresses the reimbursement methodology for ASCs/HASCs.

Briefing Package. A briefing package describing the proposed payment rates will be available on or after January 14, 2008. Interested parties may obtain a copy of the briefing package prior to the hearing by contacting Kimbra Rawlings by telephone at (512) 491-1174; by fax at (512) 491-1998; or by e-mail at Kimbra.Rawlings@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 Kimbra Rawlings, HHSC, Rate Analysis, Mail Code H-400, P.O. Box 85200, Austin, Texas 78708-5200; by fax to Kimbra Rawlings at (512) 491-1998; or by e-mail to Kimbra.Rawlings@hhsc.state.tx.us. In addition, written comments may be sent by overnight mail or hand delivered to Kimbra Rawlings, HHSC, Rate Analysis, Mail Code H-400, Braker Center, Building H, 11209 Metric Boulevard, Austin, Texas 78758-4021.

TRD-200800014
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: January 2, 2008

Public Notice

The Texas Health and Human Services Commission announces its intent to submit Transmittal Number 08-003, Amendment Number 807 to the Texas State Plan for Medical Assistance, under Title XIX of the Social Security Act. The purpose of this amendment is to amend the State plan in order to allow the State to implement a Long-Term Care Partnership Insurance program consistent with Section 6021 of the federal Deficit Reduction Act of 2005. Texans who purchase long-term care policies under this program will be eligible for a resource disregard up to the amount of the benefits paid by the private policy should they ever apply for Medicaid long-term care. The same amount of disregarded resources are protected from recovery after the death of the affected recipient.

The Health and Human Services Commission will amend its Medicaid Eligibility chapter by amending §358.432 and adding §358.444 to Title 1, Chapter 358, Subchapter D, of the Texas Administrative Code to be consistent with Section 6021 of the federal Deficit Reduction Act of 2005. The proposed amendment is effective March 1, 2008.

The proposed amendment is estimated to result in annual aggregate costs of $0 for Federal Fiscal Year (FFY) 2008, with approximately $0 in federal funds and $0 in state general revenue. For FFY 2009, there is an estimated annual aggregate cost of $1,200,000, with approximately $600,000 in federal funds and $600,000 in state general revenue.

To obtain copies of the proposed amendment, interested parties may contact Dee Church by mail at the, Texas Health and Human Services Commission, P.O. Box 12668, Mail Code 2090, Austin, Texas 78711-2668; by telephone at (512) 206-5325; by facsimile at (512) 206-5211; or by e-mail at dee.church@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-200706633
Steve Aragón
Chief Counsel
Texas Health and Human Services Commission
Filed: December 21, 2007

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 Texas" indicates that the radioactive material may be used on a temporary basis at job sites throughout the state.

NEW LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Victoria	Crossroads Health Center PLLC	L06130	Victoria	00	12/12/07

AMENDMENTS TO EXISTING LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Amarillo	Baptist St Anthonys Health System	L01259	Amarillo	86	12/11/07
Angleton	Isotherapeutics Group LLC	L05969	Angleton	04	12/07/07
Arlington	Columbia Medical Center of Arlington Subsidiary LP DBA Medical Center of Arlington	L02228	Arlington	66	12/05/07
Arlington	Iran Shah MD	L06109	Arlington	01	12/03/07
Austin	Austin Eye Clinic Association	L01642	Austin	14	12/11/07
Austin	Columbia St Davids Healthcare System LP DBA South Austin Hospital	L03273	Austin	73	12/11/07
Austin	Austin Heart PA	L04623	Austin	49	12/07/07
Austin	ARA Imaging	L05862	Austin	25	12/05/07
Austin	Austin Radiological Association	L00545	Austin	136	12/06/07
Austin	Hospira Inc	L03340	Austin	16	12/07/07
Borger	GPCH LLC DBA Golden Plains Community Hospital	L04369	Borger	12	12/11/07
Corpus Christi	Cardinal Health	L04043	Corpus Christi	38	12/03/07
Cuero	Cuero Community Hospital	L02448	Cuero	25	12/12/07
Dallas	Texas Heart Care PA	L06067	Dallas	02	12/11/07
Dallas	Petnet Solutions Inc	L05193	Dallas	33	12/07/07
Dallas	Medical City Dallas Hospital DBA Medical City	L01976	Dallas	177	12/03/07
Dallas	Texas Oncology PA DBA Sammons Cancer Center	L04878	Dallas	38	12/05/07
Deer Park	Total Petrochemicals USA Inc	L00302	Deer Park	52	12/11/07
Denton	Daniel W Caldwell MD PA	L05984	Denton	03	12/11/07
Denton	Texas Woman's University	L00304	Denton	58	12/11/07
Denton	University of North Texas	L00101	Denton	82	12/11/07
Denton	University of North Texas	L00101	Denton	81	12/06/07
El Paso	El Paso Healthcare System LTD DBA Las Palmas Medical Center	L02715	El Paso	79	12/10/07
El Paso	EP Premier Medical Group PA DBA Premier Diagnostic Center	L05198	El Paso	09	12/05/07
El Paso	Cardiology Care Consultants	L05045	El Paso	07	12/05/07
Fort Worth	Alcon Laboratories Inc William C Conner Research Center	L01281	Fort Worth	42	12/07/07
Fort Worth	Cook Childrens Medical Center	L04518	Fort Worth	15	12/06/07
Fort Worth	Fort Worth Medical Plaza Inc DBA Columbia Plaza Medical Center of Fort Worth	L02171	Fort Worth	52	12/04/07
Fort Worth	Maxum Health Services Corporation DBA Insight Diagnostic Center Eighth Avenue	L05887	Fort Worth	04	11/30/07
Freeport	BASF Corporation	L01021	Freeport	51	11/26/07
Frisco	Tenet Hospital LTD DBA Centennial Medical Center	L05768	Frisco	07	12/05/07
Houston	Southwest Cardiovascular Consultants PA	L05396	Houston	06	12/05/07
Houston	Gulf Coast MRI & Diagnostic	L05333	Houston	13	12/05/07
Houston	Complete Cardiac Care	L05218	Houston	09	12/05/07

AMENDMENTS TO EXISTING LICENSES ISSUED CONTINUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Houston	Yong Yongqi MD PA DBA The Heart Clinic	L05820	Houston	02	12/06/07
Houston	Petnet Houston LLC DBA Petnet Houston LLC	L05542	Houston	16	12/03/07
Houston	Harris County Hospital District DBA LBJ General Hospital	L04412	Houston	34	12/12/07
Houston	Houston Refining LP	L00187	Houston	60	12/05/07
Houston	E+ PET Imaging VII LP DBA PET Imaging of Houston - West	L05806	Houston	06	12/06/07
Houston	Memorial Hermann Hospital System DBA Memorial Hospital Southwest	L00439	Houston	130	11/30/07
Houston	Columbia/HCA Healthcare Corp DBA Spring Branch Medical Center	L02473	Houston	63	11/30/07
Kilgore	Wooley Fishing Tool Inc	L02915	Kilgore	08	12/06/07
Kingwood	E+ PET Imaging XIV LP DBA PET Imaging of Kingwood	L05901	Kingwood	02	12/06/07
Longview	Texas Oncology PA DBA Longview Cancer Center	L05017	Longview	11	12/10/07
Lubbock	Covenant Medical Group DBA Cardiology Associates Convenant Medical Group	L04468	Lubbock	21	12/05/07
Marshall	Harrison County Hospital Association DBA Good Shepherd Medical Center – Marshall	L02572	Marshall	27	12/03/07
McAllen	RGV Preventive Care Inc	L06069	McAllen	01	12/11/07
McKinney	Raytheon Company	L05632	McKinney	03	12/07/07
Nacogdoches	The Heart Doctor Imaging Center	L05894	Nacogdoches	04	12/06/07
Odessa	Smith International Inc DBA Smith Services	L05644	Odessa	03	11/30/07
Palestine	East Texas Physicians Alliance LLP	L05583	Palestine	04	12/03/07
Pasadena	CHCA Bayshore LP DBA Bayshore Medical Center	L00153	Pasadena	82	12/06/07
Pasadena	OXY Vinyls LP	L02257	Pasadena	23	12/04/07
Pasadena	Sunoco Inc R&M DBA Sunoco Chemicals	L02153	Pasadena	35	11/29/07
Plano	Texas Heart Hospital of the Southwest LLP DBA The Heart Hospital Baylor Plano	L06004	Plano	08	12/07/07
Plano	Columbia Medical Center of Plano Subsidiary LP DBA Medical Center of Plano	L02032	Plano	85	12/05/07
Richardson	Richardson Cardiology Associates	L05667	Richardson	07	12/05/07
San Antonio	Schnitzler Cardiovascular Consultants	L05792	San Antonio	06	12/05/07
San Antonio	VHS San Antonio Partners LLC DBA Baptist Health System	L00455	San Antonio	170	12/07/07
San Antonio	Christus Santa Rosa Health Care	L02237	San Antonio	97	12/11/07
San Marcos	Central Texas Center for Cancer Care	L05189	San Marcos	03	12/05/07
Sherman	SCELA Inc DBA Cardinal Health	L05461	Sherman	14	12/03/07
Stafford	Sugar Land Veterinary Specialists PC	L05903	Stafford	04	12/05/07
Sugar Land	Houston Cardiovascular Consultants LLP DBA Houston Cardiovascular Imaging	L05350	Sugar Land	13	12/11/07
Tatum	Luminant Generation Company LLC DBA Luminant Power	L04593	Tatum	13	12/05/07
Temple	Texas A&M University System Health Science Ctr	L05494	Temple	10	12/06/07
Texarkana	International Paper Company	L01686	Texarkana	31	12/05/07
Texas City	INEOS USA LLC	L00354	Texas City	36	11/28/07
The Woodlands	VGX Pharmaceuticals	L05773	The Woodlands	06	12/06/07
Throughout Tx	Team Industrial Services Inc	L00087	Alvin	173	12/05/07

AMENDMENTS TO EXISTING LICENSES ISSUED CONTINUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout Tx	Team Industrial Services Inc	L00087	Alvin	172	12/03/07
Throughout Tx	Team Industrial Services Inc	L00087	Alvin	174	12/10/07
Throughout Tx	Global X-ray & Testing Corp	L03663	Aransas Pass	105	12/11/07
Throughout Tx	N-Spec Quality Services Inc	L05113	Corpus Christi	29	12/12/07
Throughout Tx	OKM Engineering Inc	L05946	Dallas	01	12/07/07
Throughout Tx	Jetstar Energy Services Inc	L06034	Dallas	01	11/29/07
Throughout Tx	Terracon Consultants Inc	L05268	Dallas	23	12/07/07
Throughout Tx	IRISNDT Inc	L04769	Deer Park	44	12/13/07
Throughout Tx	Garner Environmental Services Inc	L05228	Deer Park	02	12/07/07
Throughout Tx	Weatherford US LP	L05291	Fort Worth	17	12/11/07
Throughout Tx	Gray Wireline Service Inc	L03541	Fort Worth	23	12/03/07
Throughout Tx	Professional Service Industries	L04944	Harlingen	09	12/14/07
Throughout Tx	American Diagnostic Tech LLC	L05514	Houston	43	12/06/07
Throughout Tx	Thrubit LLC	L06030	Houston	02	12/12/07
Throughout Tx	Radiographic Specialists Inc	L02742	Houston	56	12/10/07
Throughout Tx	Cardinal Health	L01911	Houston	139	12/05/07
Throughout Tx	QC Laboratories Inc	L04750	Houston	22	11/29/07
Throughout Tx	Lone Star Testing Laboratories	L04013	Humble	15	12/07/07
Throughout Tx	Goolsby Testing Laboratories Inc	L03115	Humble	89	12/06/07
Throughout Tx	American X-ray & Inspection Services Inc DBA AXIS Inc	L05974	Midland	08	12/04/07
Throughout Tx	Tracer-Tech Services	L05375	Midland	08	12/06/07
Throughout Tx	Black Warrior Wireline Corp	L04473	Odessa	22	12/07/07
Throughout Tx	Black Warrior Wireline Corp	L04473	Odessa	23	12/13/07
Throughout Tx	Midwest Inspection Services	L03120	Perryton	103	12/10/07
Throughout Tx	US Ecology Texas Inc	L05518	Robstown	06	12/07/07
Throughout Tx	Geotechnical Consultants Inc	L04819	San Antonio	09	12/04/07
Tomball	Tomball Hospital Authority DBA Tomball Regional Hospital	L02514	Tomball	47	11/29/07
Tyler	East Texas Medical Center	L00977	Tyler	139	12/06/07
Weslaco	Knapp Medical Center	L03290	Weslaco	42	12/11/07
Wichita Falls	Clinics of North Texas LLP	L00523	Wichita Falls	53	12/06/07
Winnsboro	Presbyterian Hospital of Winnsboro	L03336	Winnsboro	21	12/05/07

RENEWAL OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Corpus Christi	Sherwin Alumina LP DBA Sherwin Alumina Company	L00200	Corpus Christi	46	12/03/07
Grand Prairie	Richemont North America Inc	L05047	Grand Prairie	08	12/10/07
Jourdanton	Jourdanton Hospital Corporation DBA South Texas Regional Medical Center	L04966	Jourdanton	13	12/10/07
Pasadena	Kaneka Texas Corporation	L05050	Pasadena	05	12/05/07
Sweeny	ConocoPhillips Company	L00337	Sweeny	50	12/05/07

TERMINATIONS OF LICENSES ISSUED:

Location	Name	License #	City	Amend-ment #	Date of Action
Throughout Tx	Drash Consulting Engineers Inc	L04724	San Antonio	22	12/07/07

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 Title 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, 1100 West 49th Street, Austin, Texas 78756-3189. For information call (512) 834-6688.

TRD-200800010
Lisa Hernandez
General Counsel
Department of State Health Services
Filed: January 2, 2008

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Texas Department of Insurance

Company Licensing

Application for incorporation to the State of Texas by NAFTA INSURANCE COMPANY, a domestic fire and/or casualty company. The home office is in Brownsville, Texas.

Application for admission to the State of Texas by SEMINOLE CASUALTY INSURANCE COMPANY, a foreign fire and/or casualty company. The home office is in Ft. Lauderdale, Florida.

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, M/C 305-2C, Austin, Texas 78701.

TRD-200800013
Gene C. Jarmon
Chief Clerk and General Counsel
Texas Department of Insurance
Filed: January 2, 2008

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Third Party Administrator Applications

The following third party administrator (TPA) applications have been filed with the Texas Department of Insurance and are under consideration.

Application of HEALTHPARTNERS ADMINISTRATORS, INC., a foreign third party administrator. The home office is BLOOMINGTON, MINNESOTA.

Application of UNDERWRITERS SAFETY AND CLAIMS, INC., a foreign third party administrator. The home office is ANCHORAGE, KENTUCKY.

Any objections must be filed within 20 days after this notice is published in the *Texas Register*, addressed to the attention of Matt Ray, MC 107-1A, 333 Guadalupe, Austin, Texas 78701.

TRD-200800011
Gene C. Jarmon
Chief Clerk and General Counsel
Texas Department of Insurance
Filed: January 2, 2008

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Public Utility Commission of Texas

Announcement of Application for an Amendment to a State-Issued Certificate of Franchise Authority

The Public Utility Commission of Texas received an application on December 28, 2007, for an amendment to 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 Time Warner Cable for an Amendment to a State-Issued Certificate of Franchise Authority, Project Number 35182 before the Public Utility Commission of Texas.

The requested amended CFA service area includes the City Limits of Belton, 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 1-888-782-8477. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All inquiries should reference Project Number 35182.

TRD-200800009
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

♦ ♦ ♦

Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On December 21, 2007, SC TxLink filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60732. Applicant intends to reflect a change in ownership/control to Mr. Brian Cox, shareholder.

The Application: Application of SC TxLink for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 35160.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 16, 2008. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 35160.

TRD-200800006
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

Notice of Application for Amendment to Service Provider Certificate of Operating Authority

On December 21, 2007, Covad Communications Company filed an application with the Public Utility Commission of Texas (commission) to amend its service provider certificate of operating authority (SPCOA) granted in SPCOA Certificate Number 60192. Applicant intends to reflect a change in ownership/control whereby CCGI Holding Corporation obtains indirect control of the Applicant.

The Application: Application of Covad Communications Company for an Amendment to its Service Provider Certificate of Operating Authority, Docket Number 35167.

Persons wishing to comment on the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 16, 2008. Hearing and speech-impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 35167.

TRD-200800008
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

Notice of Application for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas an application on December 20, 2007, for waiver of denial by the North American Numbering Plan Administrator (NANPA) Pooling Administrator (PA) of AT&T's request for NXX codes.

Docket Title and Number: Application of Southwestern Bell Telephone Company, doing business as AT&T, for Waiver of Denial of Numbering Resources, Docket Number 35144.

The Application: The Mansfield rate center has an optional two-way extended metro service calling plan that requires a dedicated NPA/NXX to ensure proper routing, billing and rating of both extended metro service and non-extended metro service. The PA denied AT&T's request based on the grounds that it did not meet the month-to-exhaust and utilization threshold necessary in order to obtain growth number resources.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 17, 2008. Hearing and speech-impaired individuals with text telephones (TTY) may contact the Commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 35144.

TRD-200800005
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

Notice of Application for Waiver of Denial of Request for NXX Code

Notice is given to the public of the filing with the Public Utility Commission of Texas an application on December 21, 2007, for waiver of denial by the Pooling Administrator (PA) of Time Warner Telecom of Texas, LP's request for a thousands-block in the Pinehurst, Texas rate center.

Docket Title and Number: Petition of Time Warner Telecom of Texas, LP for Waiver of Denial of Numbering Resources, Docket Number 35166.

The Application: Time Warner Telecom of Texas, LP submitted an application to the PA for a thousands-block in the Pinehurst, Texas rate center in accordance with the current guidelines. The PA denied the request.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 16, 2008. Hearing and speech-impaired individuals with text telephones (TTY) may contact the Commission at (512) 936-7136 or toll free at 1-800-735-2989. All comments should reference Docket Number 35166.

TRD-200800007
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

Notice of Petition for Expanded Local Calling Service

Notice is given to the public of the filing with the Public Utility Commission of Texas of a petition on November 21, 2007, for expanded local calling service (ELCS), pursuant to Chapter 55, Subchapter C of the Public Utility Regulatory Act (PURA).

Project Title and Number: Petition of the LaSara Exchange for Expanded Local Calling Service, Project Number 35056.

The petitioners in the LaSara exchange request ELCS to the exchanges of Elsa-Edcouch, Harlingen, Lyford, and Santa Rosa.

Persons who wish to comment upon the action sought should contact the Public Utility Commission of Texas by mail at P.O. Box 13326, Austin, Texas 78711-3326, or by phone at (512) 936-7120 or toll free at 1-888-782-8477 no later than January 25, 2008. Hearing and speech-impaired individuals with text telephone (TTY) may contact the commission at (512) 936-7136 or toll free at 1-800-735-2789. All comments should reference Project Number 35056.

TRD-200800004

Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: January 2, 2008

Public Notice of Forum on Retail Electric Provider Issues

The staff of the Public Utility Commission of Texas (commission) will hold a forum regarding the provision of retail electric service by retail electric providers, on Tuesday, January 29, 2008, at 9:30 a.m. in the Commissioners' Hearing Room, located on the 7th floor of the William B. Travis Building, 1701 North Congress Avenue, Austin, Texas 78701. Project Number 35165, *Forum on Retail Electric Provider Issues*, has been established for this proceeding. This forum will provide interested persons an opportunity to raise and discuss issues concerning the provision of retail electric service in the competitive market and the customer protection rules that the commission has adopted for such service.

Questions concerning the forum or this notice and requests to make presentations should be referred to Lauren Damen, Director of Retail Markets, at (512) 936-7401. Hearing and speech- impaired individuals with text telephones (TTY) may contact the commission at (512) 936-7136.

TRD-200706639
Adriana A. Gonzales
Rules Coordinator
Public Utility Commission of Texas
Filed: December 28, 2007

Texas Water Development Board

Request for Applications for Planning and Project Grants under the FEMA Flood Mitigation Assistance Program

The Texas Water Development Board (Board), as administrator of the Flood Mitigation Assistance (FMA) Program on behalf of the Federal Emergency Management Agency, requests the submission of applications leading to the possible award of FMA Planning Grants and Project Grants from communities within the State with the legal authority to plan for and mitigate the impacts of flooding, and which participate in the National Flood Insurance Program (NFIP). A community is defined as (a) a political subdivision, including any Indian tribe or authorized native organization, that has zoning and building code jurisdiction over a particular area having special flood hazards, and which is participating in the NFIP, or (b) a political subdivision or other authority that is designated to develop and administer a mitigation plan by political subdivisions, all of which meet the requirements of (a). Eligible applicants from any area of the State may submit applications for FMA Program Planning and Project grants. Eligible applicants for FMA Project Grants must have a FEMA approved Mitigation Action Plan.

Description of FMA Program Purpose and Objectives.

The purpose of the FMA Program is to provide Planning and Project grants to develop or update Flood Mitigation Plans for their planning area, and for implementing flood mitigation projects. The overall goal of the program is to fund cost-effective measures that reduce or eliminate the long-term risk of flood damage to buildings, manufactured homes, and other NFIP-insurable structures. Specific goals include reducing the number of repetitively or substantially damaged structures and associated claims under the NFIP and encouraging long-term comprehensive mitigation planning.

Description of Funding Considerations.

The available allocated amounts for Federal Fiscal Year 2008 are expected to be $250,000 for Planning Grants and $2,500,000 for Project Grants. These grants all require a 25 percent local match, of which not more than one-half (12.5 percent) may be in the form of in-kind services. No award for a Planning Grant may exceed $50,000, and no single community may receive more than one Planning Grant per 5-year period. In addition, there is a $3,300,000 limit for the total amount of Project Grant funds to any single community over a five-year period.

Deadline, Review Criteria and Contact Person for Additional Information.

It is required that applications be submitted electronically through FEMA's web-based Electronic Grants Management System (e-Grants). Applicants must request access into the e-Grants system. Access requests should be directed to Mr. Gilbert Ward at (512) 463-6418, or by e-mail to gilbert.ward@twdb.state.tx.us at least by January 31, 2008. Deadline for submitting applications to the Board for FMA Planning and/or Project Grant funds is 5:00 p.m., February 15, 2008. Applications will be evaluated according to rules provided in 31 TAC Chapter 368, see http://info.sos.state.tx.us/pls/pub/readtac$ext.viewtac (Title 31, Part 10). For additional information on the FMA Program, go to www.fema.gov/government/grant/fma/index . Go to www.fema.gov/government/grant/egrants for additional information on FEMA's e-grant system. Final awards for grant funding will be as approved by FEMA.

TRD-200706637
Ingrid K. Hansen
Acting General Counsel
Texas Water Development Board
Filed: December 27, 2007

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 30 (2005) is cited as follows: 30 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 "30 TexReg 2 issue date," while on the opposite page, page 3, in the lower right-hand corner, would be written "issue date 30 TexReg 3."

How to Research: The public is invited to research rules and information of interest between 8 a.m. and 5 p.m. weekdays at the ***Texas Register*** office, Room 245, James Earl Rudder Building, 1019 Brazos, Austin. Material can be found using ***Texas Register*** indexes, the ***Texas Administrative Code***, section numbers, or TRD number.

Both the ***Texas Register*** and the ***Texas Administrative Code*** are available online through the Internet. The address is: http://www.sos.state.tx.us. The ***Register*** is available in an .html version as well as a .pdf (portable document format) version through the Internet. For website subscription information, call the Texas Register at (800) 226-7199.

Texas Administrative Code

The ***Texas Administrative Code (TAC)*** is the compilation of all final state agency rules published in the ***Texas Register***. Following its effective date, a rule is entered into the ***Texas Administrative Code***. Emergency rules, which may be adopted by an agency on an interim basis, are not codified within the ***TAC***.

The ***TAC*** volumes are arranged into Titles 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 (1-800-356-6548), and West Publishing Company (1-800-328-9352).

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

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

How to Cite: Under the ***TAC*** scheme, each section is designated by a ***TAC*** number. For example in the citation 1 TAC §27.15: 1 indicates the title under which the agency appears in the ***Texas Administrative Code***; ***TAC*** stands for the ***Texas Administrative Code***; §27.15 is the section number of the rule (27 indicates that the section is under Chapter 27 of Title 1; 15 represents the individual section within the chapter).

How to update: To find out if a rule has changed since the publication of the current supplement to the ***Texas Administrative Code***, please look at the ***Table of TAC Titles Affected***. The table is published cumulatively in the blue-cover quarterly indexes to the ***Texas Register*** (January 21, April 15, July 8, and October 7, 2005). If a rule has changed during the time period covered by the table, the rule's ***TAC*** number will be printed with one or more ***Texas Register*** page numbers, as shown in the following example.

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

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