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 7. BANKING AND SECURITIES

PART 2. TEXAS DEPARTMENT OF BANKING

CHAPTER 15. CORPORATE ACTIVITIES

The Finance Commission of Texas (the commission), on behalf of the Texas Department of Banking (the department), adopts amendments to Chapter 15 of Title 7 of the Texas Administrative Code, concerning loans and investments by state banks. Sections 15.1, 15.3, 15.4, 15.5, 15.6, 15.7, 15.103, 15.121, and 15.122 are the affected sections. These amendments are adopted without changes to the proposed text as published in the December 29, 2023, issue of the *Texas Register* (48 TexReg 8077). The amended rules will not be republished.

The amendments conform these rules to changes in applicable Texas law, federal regulation, and accounting standards. The amendments do not materially change the requirements of the rules.

The department received no comments regarding the proposed amendments.

SUBCHAPTER A. FEES AND OTHER PROVISIONS OF GENERAL APPLICABILITY

7 TAC §§15.1, 15.3 - 15.7

The amendments are adopted pursuant to Finance Code §11.301, which authorizes the commission to adopt rules applicable to state banks, and Finance Code, §31.003, which authorizes the commission to adopt rules necessary to preserve or protect the safety and soundness of state banks.

This adoption affects the statutes administered and enforced by the department's commissioner with respect to state banks, contained in Finance Code, Subtitle A. No other statutes are affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 21, 2024.

TRD-202400730
Robert K. Nichols, III
General Counsel
Texas Department of Banking
Effective date: March 12, 2024
Proposal publication date: December 29, 2023
For further information, please call: (512) 475-1301

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SUBCHAPTER F. APPLICATIONS FOR MERGER, CONVERSION, AND PURCHASE OR SALE OF ASSETS

7 TAC §15.103

The amendments are adopted pursuant to Finance Code §11.301, which authorizes the commission to adopt rules applicable to state banks, and Finance Code, §31.003, which authorizes the commission to adopt rules necessary to preserve or protect the safety and soundness of state banks.

This adoption affects the statutes administered and enforced by the department's commissioner with respect to state banks, contained in Finance Code, Subtitle A. No other statutes are affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Robert K. Nichols, III
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Texas Department of Banking
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For further information, please call: (512) 475-1301

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SUBCHAPTER G. CHARTER AMENDMENTS AND CERTAIN CHANGES IN OUTSTANDING STOCK

7 TAC §15.121, §15.122

The amendments are adopted pursuant to Finance Code §11.301, which authorizes the commission to adopt rules applicable to state banks, and Finance Code, §31.003, which authorizes the commission to adopt rules necessary to preserve or protect the safety and soundness of state banks.

This adoption affects the statutes administered and enforced by the department's commissioner with respect to state banks, contained in Finance Code, Subtitle A. No other statutes are affected by this adoption.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Robert K. Nichols, III
General Counsel
Texas Department of Banking
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For further information, please call: (512) 475-1301

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TITLE 13. CULTURAL RESOURCES

PART 1. TEXAS STATE LIBRARY AND ARCHIVES COMMISSION

CHAPTER 2. GENERAL POLICIES AND PROCEDURES

The Texas State Library and Archives Commission (commission) adopts amendments to §§2.1, Definitions; 2.2, Responsibilities of Commission and the Director and Librarian; 2.3, Procedures of Commission; 2.5, Advisory Committees; General Requirements; 2.7, Library Systems Act Advisory Board (LSA Board); 2.8, Texas Historical Records Advisory Board (THRAB); 2.9, TexShare Library Consortium Advisory Board (TexShare Advisory Board); 2.46, Negotiated Rulemaking; 2.48, Petition for Adoption of Rules; 2.53, Service Complaints; 2.55, Protest Procedure; 2.56, Training and Education of Staff; 2.60, Friends Groups; 2.70, Vehicle Fleet Management; 2.77, Contract Approval Authority and Responsibilities; 2.111, General Selection Criteria; 2.112, Eligible and Ineligible Expenses; 2.113, Peer Review; 2.114, Funding Decisions; and 2.120, Applicant Eligibility; and new §§2.54, HUB Program; 2.110 Scope of Subchapter and Standards; and 2.115, Grant Recommendation and Award Process. The amendments and new sections are adopted without changes to the proposed text as published in the November 24, 2023, issue of the *Texas Register* (48 TexReg 6831). The rules will not be republished.

The amendments and new sections were identified as necessary following the commission's recent quadrennial review of the rules as required by Government Code, §2001.039. In general, the changes update, modernize, and clarify the rules, improve grammar and readability, conform the language to *Texas Register* preferences, and align the rules with best practices. The commission also adopts the repeals of several sections within 13 Texas Administrative Code, Chapter 2, to coincide with these amendments and new sections. The adopted repeals are published in this same issue of the *Texas Register.*

Explanation of Adopted Amendments and New Sections

Amendments to §2.1 modify the definition of "commission" to mean the seven-member governing body of the Texas State Library and Archives Commission and add a definition of "agency" to mean the Texas State Library and Archives Commission as an agency of the state of Texas, including the staff, collections, archives, operations, programs, and property of the Texas State Library and Archives Commission.

Amendments to §§2.2, 2.3, 2.5, 2.46, 2.48, 2.55, 2.56, 2.60, 2.70, and 2.77 change "commission" to "agency," "chairman" to "chair," and "vice chairman" to "vice-chair" as necessary. Additional amendments to these sections delete unnecessary language and improve existing language. An amendment to §2.5 also updates language regarding reporting by advisory committees to the commission and the commission's evaluation of advisory committees. An amendment to §2.53 updates and simplifies the agency's process for receiving, reviewing, and responding to complaints. An amendment to §2.56 changes the person responsible for approving employee training to the director and librarian or designee.

Amendments to §§2.7, 2.8, and 2.9 continue the commission's advisory committees for another four years.

Amendments to §2.111 make minor wording improvements to the section.

Amendments to §2.112 update the list of items that are generally ineligible for funding through competitive grants to mirror the requirements as stated in TSLAC's Notices of Funding Opportunities, which are written in compliance with federal and state guidelines. An additional amendment updates a citation.

Amendments to §2.113 change the title of the section to Selection Process and fold in the requirements of previous §2.117 (relating to Grant Review and Award Process) to the amended rule. Additional amendments update and clarify the language. As amended, §2.113 outlines TSLAC staff's review of grant applications and the process for staff in working with grant applicants on their applications; authorizes and explains the process for peer review panels; and outlines the process for the scoring of applications.

Amendments to §2.114 make minor language updates and move the language previously codified at §2.115 (relating to Awarding of Grants) to new subsection (e).

Amendments to §2.120 make a minor wording update.

New §2.54 updates the commission's HUB Program rule to reference the correct citations. New §2.110 updates the chapter's scope to establish guidelines applicable to the awarding of grants and other rules necessary to the administration of TSLAC's grant programs. An amendment to this section also adopts the Uniform Grant Management Standards and the Texas Grant Management Standards as published by the Texas Comptroller of Public Accounts. This provision was previously a stand-alone section, §2.116 (relating to Texas Grant Management Standards). New §2.115 is titled Grant Recommendation and Award Process and consists of the language formerly codified at §2.118 (relating to Decision Making Process).

SUMMARY OF COMMENTS. The commission received comments from one individual on the proposed amendments and new sections.

COMMENT. The individual commented that §2.2(b)(7) does not appear to be functioning as written, noting her recent experience requesting an appeal to the commission.

RESPONSE. The commission acknowledges the comment and understands that the commenter disagrees with the actions taken by the agency in response to her complaint. However, the commission disagrees that §2.2(b)(7) does not function as written and declines to make a change to this section. Under

Government Code, §441.002, the director and librarian is the executive and administrative officer of the commission and shall discharge the administrative and executive functions of the commission. The fact that the commenter disagrees with how a complaint was handled does not provide justification to change a rule regarding the commission's role as a final board of appeals for certain matters.

COMMENT. The individual commented in relation to §2.3, Procedures of the Commission, that transparency regarding the work of the commission would be greatly increased, as would the ability for individuals to participate publicly, if the commission and committee meetings were routinely published on the agency's website. The individual also suggested that recordings be made of advisory committee meetings, noting that minutes are the "lowest possible bar allowed by law" and suggesting in relation to §2.5, Advisory Committees; General Requirements, that the commission consider the recent adoption of House Bill 4611, 88th Legislature, Regular Session (2023) (HB 4611).

RESPONSE. The commission acknowledges the comment and notes that all commission and committee meetings are posted with the Secretary of State in compliance with Government Code, Chapter 551, Subchapter C and on the agency's website. Commission meeting agendas are also posted on the agency's website. In addition, though not required, the commission routinely allows participation in commission and committee meetings by videoconference, which increases public participation. The commission keeps minutes of its open meetings in compliance with Government Code, §551.021, which requires a governmental body to prepare and keep minutes *or* make a recording of each open meeting of the body. Government Code, §551.022 provides that the minutes and recordings of an open meeting are public records and shall be available for public inspection and copying *on request to the governmental body's chief administrative officer or the officer's designee*. After a meeting, any member of the public may request recordings and other records related to commission meetings under the Public Information Act. Finally, Government Code, Chapter 522, as added by HB 4611 applies to the Texas Health and Human Services Commission. Therefore, the commission declines to make a change in response to this comment.

COMMENT. The individual commented in relation to §2.53, Service Complaints, that the complaint system is not functioning according to the state law regarding customer service in the Compact with Texans. The commenter also noted that a review of the complaint process and maintenance of the complaint record should be codified, as only two complaints since 2012 were returned when she made a Public Information Act request, indicating to the commenter that retention of complaint records is not being undertaken.

RESPONSE. The commission disagrees with the comment for several reasons. The Compact with Texans is established in Government Code, §2114.006, which requires each state agency to create a "Compact with Texans" that must be approved by the Governor's Office of Budget and Planning and the Legislative Budget Board. The statute requires each Compact with Texans to set customer service standards and describe customer service principles for the agency that address the following:

1. The agency's procedures for responding to public contacts and complaints;

2. Applicable licensing and certification procedures; and

3. Customer waiting time for access and service delivery and responses to complaints.

The commission's approved Compact with Texans, published on the agency's website at https://www.tsl.texas.gov/customer/compact, outlines procedures for responding to complaints and a timeframe for responding to complaints. Regarding the commenter's allegation that the commission is not retaining records related to complaints, the commission notes that a lack of records is not an indication that records are not being maintained but rather an indication that the commission has not received many complaints from the public. The commission declines to make a change in response to this comment.

SUBCHAPTER A. PRINCIPLES AND PROCEDURES OF THE COMMISSION

13 TAC §§2.1 - 2.3, 2.5, 2.7 - 2.9, 2.46, 2.48, 2.53 - 2.56, 2.60, 2.70, 2.77

STATUTORY AUTHORITY. The amendments and new rules are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code, §441.006, General Powers and Duties, which directs the commission to govern the state library; and Government Code, §441.0065, Advisory Committees, which directs the commission to adopt rules regarding advisory committees.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 21, 2024.

TRD-202400758
Sarah Swanson
General Counsel
Texas State Library and Archives Commission
Effective date: March 12, 2024
Proposal publication date: November 24, 2023
For further information, please call: (512) 463-5460

SUBCHAPTER C. GRANT POLICIES

13 TAC §§2.110 - 2.115, 2.120

STATUTORY AUTHORITY. The amendments and new rules are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; §441.0091, Grant Program for Local Libraries, which authorizes the commission to adopt by rule guidelines for awarding grants; §441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5460

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CHAPTER 2. GENERAL POLICIES AND PROCEDURES

The Texas State Library and Archives Commission (commission) adopts the repeal of §§2.4, Principles; 2.10, Dual Office Holding; 2.58, Use of Technology; 2.54, Bid Procedures and HUB Program; 2.110, Scope of Subchapter; 2.115, Awarding of Grants; 2.116, Texas Grant Management Standards; 2.117, Grant Review and Award Process; 2.118, Decision Making Process; 2.210, Negotiated Grants; 2.211, Resource Sharing--Interlibrary Loan Grants; 2.212, Technical Assistance Grants; 2.213, System Integrated Negotiated Grants; 2.610, Goals and Purposes; 2.611, Eligible Applicants; 2.612, Criteria for Award; 2.810, Goals and Purposes; 2.811, Definitions; 2.812, Eligible Applicants; 2.813, Eligible Expenses; 2.814, Funding Formula; 2.815, Application Review and Awarding Process; 2.910, Goals and Purposes; 2.911, Eligible Applicants; and 2.912, Criteria for Award. The repeals are adopted without changes to the proposed text as published in the November 24, 2023, issue of the *Texas Register* (48 TexReg 6841). The rules will not be republished.

The repeals were identified as necessary during the commission's recent review of the rules in Chapter 2, General Policies and Procedures, as required by Government Code, §2001.039.

Specifically, the repeal of §2.4, Principles, is appropriate because the rule is outdated and does not implement, interpret, or prescribe law or policy or describe a commission procedure or practice requirement. The repeal of §2.10, Dual Office Holding, is appropriate as this requirement is unnecessary and inappropriate in a commission rule. Dual office holding is prohibited by Texas law, based on the Texas constitutional restriction on holding two civil offices of emolument and common-law incompatibility. The repeal of §2.58, Use of Technology, is appropriate because it does not implement, interpret, or prescribe law or policy or describe a commission procedure or practice requirement.

The repeal of §2.110, Scope of Subchapter, is appropriate because the commission is updating the language for this section. Rather than amend the existing rule, the commission determined it was more efficient to repeal the existing rule and propose a new rule in its place. New §2.110 is published in this same issue of the *Texas Register.*

The repeal of §§2.115, Awarding of Grants; 2.116, Texas Grant Management Standards; 2.117, Grant Review and Award Process; and 2.118, Decision Making Process, is necessary because the commission is reorganizing the rules within Subchapter C (Grant Policies), Division 1 (General Grant Guidelines). The amended and new sections are published in this same issue of the *Texas Register.*

Lastly, the repeal of §§2.210, Negotiated Grants; 2.211, Resource Sharing--Interlibrary Loan Grants; 2.212, Technical Assistance Grants; 2.213, System Integrated Negotiated Grants; 2.610, Goals and Purposes; 2.611, Eligible Applicants; 2.612, Criteria for Award; 2.810, Goals and Purposes; 2.811, Definitions; 2.812, Eligible Applicants; 2.813, Eligible Expenses; 2.814, Funding Formula; 2.815, Application Review and Awarding Process; 2.910, Goals and Purposes; 2.911, Eligible Applicants; and 2.912, Criteria for Award is necessary because each of these sections relate to grant programs the commission no longer administers. Furthermore, the rules are unnecessary, as the commission's general grant rules apply to all of the commission's grant programs and individual rules pertaining to specific grant programs are not necessary, unless required by statute. In this case, none of the specific grant programs described in the repealed sections are required in statute to be adopted by rule.

SUMMARY OF COMMENTS. The commission received comments from one individual on the proposed repeals.

COMMENT. The individual commented that she was surprised to find that §2.4, Principles, was proposed for repeal, noting that the rule appeared to codify upright behavior when discussing access and nondiscrimination. The commenter also noted that aspects of the rule are assurances promised as a requirement of funding from the Library Services Technology Act (LSTA), which, she stated, requires "those things" to be codified through state law. The commenter questioned whether removing the rule would cause problems with funding from the LSTA.

RESPONSE. The commission appreciates the comment. However, as noted in the preamble proposing the repeals, §2.4 does not implement, interpret, or prescribe law or policy or describe a commission procedure or practice requirement. Rather, it restates requirements noted elsewhere in state law, states requirements that are not necessary in agency rule, or describes internal agency management or organization. In addition, the commission provides annual assurances and certifications to the Institute of Museum and Library Services for funding under the LSTA. As such, the commission declines to make a change in response to this comment.

COMMENT. The individual commented that the repeal of §2.10, Dual Office Holding, seemed to be eliminating an important mechanism of enforcement for Article XVI of the Texas Constitution.

RESPONSE. As noted in the preamble proposing the repeals, dual office holding is prohibited by Texas law, based on the Texas constitutional restriction on holding two civil offices of emolument and common-law incompatibility. In some cases, acceptance of a second public office can result in automatic resignation from a person's current public office. Furthermore, any violation of the prohibition on dual office holding would not be a matter of enforcement by the commission but would have to be challenged through a civil action in a district court. As such, the commission declines to make a change in response to this comment.

SUBCHAPTER A. PRINCIPLES AND PROCEDURES OF THE COMMISSION

13 TAC §§2.4, 2.10, 2.54, 2.58

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; and Government

Code, §441.006, General Powers and Duties, which directs the commission to govern the state library.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5460

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SUBCHAPTER C. GRANT POLICIES

DIVISION 1. GENERAL GRANT GUIDELINES

13 TAC §§2.110, 2.115 - 2.118

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code, §441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and Government Code, §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5460

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DIVISION 2. NEGOTIATED GRANTS

13 TAC §§2.210 - 2.213

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code, §441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and Government Code, §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
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For further information, please call: (512) 463-5460

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DIVISION 6. LIBRARY SERVICES AND TECHNOLOGY ACT, GUIDELINES FOR LIBRARY SYSTEMS

13 TAC §§2.610 - 2.612

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code, §441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and Government Code, §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
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For further information, please call: (512) 463-5460

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DIVISION 8. LOAN STAR LIBRARIES GRANT PROGRAM, GUIDELINES FOR PUBLIC LIBRARIES

13 TAC §§2.810 - 2.815

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code,

§441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and Government Code, §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
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For further information, please call: (512) 463-5460

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DIVISION 9. IMPACT GRANTS FOR LIBRARY INNOVATION AND IMPROVEMENT

13 TAC §§2.910 - 2.912

STATUTORY AUTHORITY. The repeals are adopted under Government Code, §2001.004, which requires state agencies to adopt rules of practice stating the nature and requirements of all available formal and informal procedures; Government Code, §441.135, Grants, which directs the commission to adopt by rule the guidelines for awarding grants; and Government Code, §441.136, Rules, which directs the commission to adopt rules necessary to the administration of the program of state grants.

CROSS REFERENCE TO STATUTE. Government Code, Chapter 441.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Sarah Swanson
General Counsel
Texas State Library and Archives Commission
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For further information, please call: (512) 463-5460

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TITLE 22. EXAMINING BOARDS

PART 5. STATE BOARD OF DENTAL EXAMINERS

CHAPTER 111. STANDARDS FOR PRESCRIBING CONTROLLED SUBSTANCES AND DANGEROUS DRUGS

22 TAC §111.5

The State Board of Dental Examiners (Board) adopts this amendment to 22 TAC §111.5, concerning electronic prescribing waivers without changes to the proposal as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7280). The rule willl not be republished. The adopted amendment removes the requirement that a dentist must submit a written statement and supporting documentation describing the circumstances necessitating a waiver, and instead requires a dentist to attest to the circumstances necessitating a waiver. This amendment will make it less burdensome on the dentist when submitting a waiver request to the Board, and it will make the Board's waiver process more efficient.

The Texas Dental Association (TDA) provided a written comment in support of adoption of the rule as proposed. No changes to the proposed rule were made as a result of the comment.

This rule is adopted under Texas Occupations Code §254.001(a), which gives the Board authority to adopt rules necessary to perform its duties and ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 16, 2024.

TRD-202400691
Lauren Studdard
General Counsel
State Board of Dental Examiners
Effective date: March 7, 2024
Proposal publication date: December 15, 2023
For further information, please call: (512) 305-8910

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CHAPTER 114. EXTENSION OF DUTIES OF AUXILIARY PERSONNEL--DENTAL ASSISTANTS

22 TAC §114.8

The State Board of Dental Examiners (Board) adopts this new rule 22 TAC §114.8, concerning the retired status of a dental assistant registration, without changes to the proposal as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7281) and will not be republished. This rule will allow registered dental assistants to apply to the Board to retire their registrations and also to reinstate their retired registrations.

The Texas Dental Association (TDA) provided a written comment in support of adoption of the rule as proposed. No changes to the proposed rule were made as a result of the comment.

This rule is adopted under Texas Occupations Code §254.001(a), which gives the Board authority to adopt rules

necessary to perform its duties and ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 16, 2024.

TRD-202400692
Lauren Studdard
General Counsel
State Board of Dental Examiners
Effective date: March 7, 2024
Proposal publication date: December 15, 2023
For further information, please call: (512) 305-8910

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22 TAC §114.13

The State Board of Dental Examiners (Board) adopts this new rule 22 TAC §114.13, concerning the reinstatement of a cancelled registration, without changes to the proposal as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7283) and will not be republished. This rule will allow registered dental assistants to apply to the Board to reinstate a cancelled registration.

The Texas Dental Association (TDA) provided a written comment in support of adoption of the rule as proposed. No changes to the proposed rule were made as a result of the comment.

This rule is adopted under Texas Occupations Code §254.001(a), which gives the Board authority to adopt rules necessary to perform its duties and ensure compliance with state laws relating to the practice of dentistry to protect the public health and safety.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TRD-202400693
Laren Studdard
General Counsel
State Board of Dental Examiners
Effective date: March 7, 2024
Proposal publication date: December 15, 2023
For further information, please call: (512) 305-8910

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PART 8. TEXAS APPRAISER LICENSING AND CERTIFICATION BOARD

CHAPTER 151. GENERAL ADMINISTRATION

22 TAC §§151.1 - 151.7

The Texas Appraiser Licensing and Certification Board (TALCB) adopts new rules 22 TAC §151.1, Definitions, §151.2, Charges for Copies of Public Information, §151.3, Employee Training and Education, §151.4, Historically Underutilized Businesses Program, §151.5, Bid Opening and Tabulation, §151.6, Negotiation and Mediation of Certain Contract Disputes, and §151.7, Vendor Protest Procedures.

The new rules are adopted without changes to the proposed text as published in the November 24, 2023, issue of the *Texas Register* (48 TexReg 6847) and will not be republished.

The new rules create a General Administration Chapter for rules of general applicability to TALCB's administration. The changes create a new definitions section in §151.1 for ease of reading and terminology consistent with terms utilized by both the Texas Real Estate Commission and TALCB. In §151.2, the new rule outlines TALCB's approach to fees related to the production of documents in response to public information requests. In §151.3, the new rule addresses the Board's payment of education and training for TALCB employees. Finally, in §151.4, Historically Underutilized Businesses Program; §151.5, Bid Opening and Tabulation; §151.6, Negotiation and Mediation of Certain Contract Disputes; and §151.7, Vendor Protest Procedures, the new rules relate TALCB's contracting and procurement processes.

No comments were received regarding adoption of the new rules.

The new rules are adopted under Texas Occupations Code §1103.151, which authorizes TALCB to adopt rules related to certificates and licenses that are consistent with applicable federal law and guidelines adopted by the AQB; §1103.152, which authorizes TALCB to prescribe qualifications for appraisers that are consistent with the qualifications established by the Appraiser Qualifications Board; §1103.154, which authorizes TALCB to adopt rules relating to professional conduct; and §1103.156 which authorizes TALCB to establish reasonable fees to administer Chapter 1103, Texas Occupations Code; and Texas Occupations Code §1104.151, which authorizes TALCB to adopt rules necessary to administer the provisions of Chapter 1104, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 26, 2024.

TRD-202400828
Kathleen Santos
General Counsel
Texas Appraiser Licensing and Certification Board
Effective date: March 17, 2024
Proposal publication date: November 24, 2023
For further information, please call: (512) 936-3652

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

22 TAC §153.12, §153.16

The Texas Appraiser Licensing and Certification Board (TALCB) adopts amendments to 22 TAC §153.12, Criminal History Checks and §153.16, License Reinstatement.

The amendments are adopted without changes to the proposed text as published in the November 24, 2023, issue of the *Texas Register* (48 TexReg 6849) and will not be republished.

The amendments to §153.12 accurately reflect the process of criminal history checks. The amendments to §153.16 refine the requirements related to the reinstatement of an expired license. Specifically, the amendments remove reexamination as a requirement for reinstatement, clarify that the requirements are consistent with that of the Appraisal Qualifications Board, and specify the circumstances when an applicant must demonstrate experience in compliance with USPAP.

No comments were received regarding adoption of the amendments.

The amendments are adopted under Texas Occupations Code §1103.151, which authorizes TALCB to adopt rules related to certificates and licenses that are consistent with applicable federal law and guidelines adopted by the AQB; §1103.152, which authorizes TALCB to prescribe qualifications for appraisers that are consistent with the qualifications established by the Appraiser Qualifications Board; and §1103.154, which authorizes TALCB to adopt rules relating to professional conduct.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 159. RULES RELATING TO THE PROVISIONS OF THE TEXAS APPRAISAL MANAGEMENT COMPANY REGISTRATION AND REGULATION ACT

22 TAC §159.110

The Texas Appraiser Licensing and Certification Board (TALCB) adopts amendments to 22 TAC §159.110, AMC National Registry.

The amendments are adopted without changes to the proposed text as published in the November 24, 2023, issue of the *Texas Register* (48 TexReg 6851) and will not be republished.

The amendments allow for greater flexibility in addressing AMCs that fail to pay the AMC registry fee.

One comment was received, but it did not pertain to the amendments as published.

The amendments are adopted under Texas Occupations Code §1104.151, which authorizes TALCB to adopt rules necessary to administer the provisions of Chapter 1104, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Texas Appraiser Licensing and Certification Board
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PART 15. TEXAS STATE BOARD OF PHARMACY

CHAPTER 283. LICENSING REQUIREMENTS FOR PHARMACISTS

22 TAC §283.9

The Texas State Board of Pharmacy adopts amendments to §283.9, concerning Fee Requirements for Licensure by Examination, Score Transfer and Reciprocity. These amendments are adopted without changes to the proposed text as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7288). The rule will not be republished.

The amendments clarify how the board calculates the fee for failing to timely submit the initial renewal application and license fee for a license to practice pharmacy and correct grammatical errors.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 16, 2024.

TRD-202400686

Daniel Carroll, Pharm.D.
Executive Director
Texas State Board of Pharmacy
Effective date: March 7, 2024
Proposal publication date: December 15, 2023
For further information, please call: (512) 305-8033

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22 TAC §283.12

The Texas State Board of Pharmacy adopts amendments to §283.12, concerning Licenses for Military Service Members, Military Veterans, and Military Spouses. These amendments are adopted without changes to the proposed text as published in the December 22, 2023, issue of the *Texas Register* (48 TexReg 7745). The rule will not be republished.

The amendments clarify that the requirements for obtaining an interim license for a military service member or military spouse do not affect rights that may be provided under federal law.

The Board received comments from the Texas Medical Association suggesting the phrase "federal law" be replaced with the more specific phrase "Sec. 705A of the Servicemembers Civil Relief Act (50 U.S.C. § 4025A)." The Board declined to make this change.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 291. PHARMACIES
SUBCHAPTER D. INSTITUTIONAL PHARMACY (CLASS C)

22 TAC §291.74

The Texas State Board of Pharmacy adopts amendments to §291.74, concerning Operational Standards. These amendments are adopted with changes to the proposed text as published in the December 22, 2023, issue of the *Texas Register* (48 TexReg 7748). The rule will be republished.

The amendments specify prepackaging and labeling requirements for a participating provider to dispense donated prescription drugs under Chapter 442, Health and Safety Code, in accordance with House Bill 4332.

The Board received comments from George Wang, Ph.D., with SIRUM in support of the amendments and suggesting the addition of an omitted word for consistency with statutory language. The Board agreed and added "written" as an option for the signature of the prepacker in the recordkeeping requirements to align with the language in §442.0515, Health and Safety Code.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

§291.74. Operational Standards.

(a) Licensing requirements.

(1) A Class C pharmacy shall register annually or biennially with the board on a pharmacy license application provided by the board, following the procedures specified in §291.1 of this title (relating to Pharmacy License Application).

(2) A Class C pharmacy which changes ownership shall notify the board within 10 days of the change of ownership and apply for a new and separate license as specified in §291.3 of this title (relating to Required Notifications).

(3) A Class C pharmacy which changes location and/or name shall notify the board of the change as specified in §291.3 of this title.

(4) A Class C pharmacy owned by a partnership or corporation which changes managing officers shall notify the board in writing of the names of the new managing officers within 10 days of the change following the procedures in §291.3 of this title.

(5) A Class C pharmacy shall notify the board in writing within 10 days of closing, following the procedures in §291.5 of this title (relating to Closing a Pharmacy).

(6) A fee as specified in §291.6 of this title (relating to Pharmacy License Fees) will be charged for the issuance and renewal of a license and the issuance of an amended license.

(7) A separate license is required for each principal place of business and only one pharmacy license may be issued to a specific location.

(8) A Class C pharmacy, licensed under the Act, §560.051(a)(3), which also operates another type of pharmacy which would otherwise be required to be licensed under the Act, §560.051(a)(1) (Community Pharmacy (Class A)) or the Act, §560.051(a)(2) (Nuclear Pharmacy (Class B)), is not required to secure a license for the such other type of pharmacy; provided, however, such licensee is required to comply with the provisions of §291.31 of this title (relating to Definitions), §291.32 of this title (relating to Personnel), §291.33 of this title (relating to Operational Standards), §291.34 of this title (relating to Records), and §291.35 of this title (relating to Official Prescription Records), contained in Community Pharmacy (Class A), or §291.51 of this title (relating to Purpose), §291.52 of this title (relating to Definitions), §291.53 of this title

(relating to Personnel), §291.54 of this title (relating to Operational Standards), and §291.55 of this title (relating to Records), contained in Nuclear Pharmacy (Class B), to the extent such sections are applicable to the operation of the pharmacy.

(9) A Class C pharmacy engaged in the compounding of non-sterile preparations shall comply with the provisions of §291.131 of this title (relating to Pharmacies Compounding Non-sterile Preparations).

(10) Class C pharmacy personnel shall not compound sterile preparations unless the pharmacy has applied for and obtained a Class C-S pharmacy.

(11) A Class C pharmacy engaged in the provision of remote pharmacy services, including storage and dispensing of prescription drugs, shall comply with the provisions of §291.121 of this title (relating to Remote Pharmacy Services).

(12) A Class C pharmacy engaged in centralized prescription dispensing and/or prescription drug or medication order processing shall comply with the provisions of §291.123 of this title (relating to Central Prescription Drug or Medication Order Processing) and/or §291.125 of this title (relating to Centralized Prescription Dispensing).

(13) A Class C pharmacy with an ongoing clinical pharmacy program that proposes to allow a pharmacy technician to verify the accuracy of work performed by another pharmacy technician relating to the filling of floor stock and unit dose distribution systems for a patient admitted to the hospital if the patient's orders have previously been reviewed and approved by a pharmacist shall make application to the board and submit any information specified on the application.

(14) A rural hospital that wishes to allow a pharmacy technician to perform the duties specified in §291.73(e)(2)(D) of this title (relating to Personnel), shall make application to the board and submit any information specified on the application.

(A) A rural hospital may not allow a pharmacy technician to perform the duties specified in §291.73(e)(2)(D) of this title until the board has reviewed and approved the application and issued an amended license to the pharmacy.

(B) Every two years, in conjunction with the application for renewal of the pharmacy license, the pharmacist-in-charge shall update the application for pharmacy technicians to perform the duties specified in §291.73(e)(2)(D) of this title and shall attest as required on the application.

(b) Environment.

(1) General requirements.

(A) The institutional pharmacy shall have adequate space necessary for the storage, compounding, labeling, dispensing, and sterile preparation of drugs prepared in the pharmacy, and additional space, depending on the size and scope of pharmaceutical services.

(B) The institutional pharmacy shall be arranged in an orderly fashion and shall be kept clean. All required equipment shall be clean and in good operating condition.

(C) A sink with hot and cold running water exclusive of restroom facilities shall be available to all pharmacy personnel and shall be maintained in a sanitary condition at all times.

(D) The institutional pharmacy shall be properly lighted and ventilated.

(E) The temperature of the institutional pharmacy shall be maintained within a range compatible with the proper storage of drugs. The temperature of the refrigerator and/or freezer shall be maintained within a range compatible with the proper storage of drugs.

(F) If the institutional pharmacy has flammable materials, the pharmacy shall have a designated area for the storage of flammable materials. Such area shall meet the requirements set by local and state fire laws.

(G) The institutional pharmacy shall store antiseptics, other drugs for external use, and disinfectants separately from internal and injectable medications.

(2) Security requirements.

(A) The institutional pharmacy shall be enclosed and capable of being locked by key, combination or other mechanical or electronic means, so as to prohibit access by unauthorized individuals. Only individuals authorized by the pharmacist-in-charge shall enter the pharmacy.

(B) Each pharmacist on duty shall be responsible for the security of the institutional pharmacy, including provisions for adequate safeguards against theft or diversion of dangerous drugs, controlled substances, and records for such drugs.

(C) The institutional pharmacy shall have locked storage for Schedule II controlled substances and other drugs requiring additional security.

(c) Equipment and supplies. Institutional pharmacies distributing medication orders shall have the following equipment:

(1) data processing system including a printer or comparable equipment; and

(2) refrigerator and/or freezer and a system or device (e.g., thermometer) to monitor the temperature to ensure that proper storage requirements are met.

(d) Library. A reference library shall be maintained that includes the following in hard-copy or electronic format and that pharmacy personnel shall be capable of accessing at all times:

(1) current copies of the following:

(A) Texas Pharmacy Act and rules;

(B) Texas Dangerous Drug Act and rules;

(C) Texas Controlled Substances Act and regulations; and

(D) Federal Controlled Substances Act and regulations (or official publication describing the requirements of the Federal Controlled Substances Act and regulations);

(2) at least one current or updated reference from each of the following categories:

(A) drug interactions. A reference text on drug interactions, such as Drug Interaction Facts. A separate reference is not required if other references maintained by the pharmacy contain drug interaction information including information needed to determine severity or significance of the interaction and appropriate recommendations or actions to be taken;

(B) a general information reference text;

(3) a current or updated reference on injectable drug products;

(4) basic antidote information and the telephone number of the nearest regional poison control center;

(5) metric-apothecary weight and measure conversion charts.

(e) Absence of a pharmacist.

(1) Medication orders.

(A) In facilities with a full-time pharmacist, if a practitioner orders a drug for administration to a bona fide patient of the facility when the pharmacy is closed, the following is applicable:

(i) Prescription drugs and devices only in sufficient quantities for immediate therapeutic needs may be removed from the institutional pharmacy;

(ii) Only a designated licensed nurse or practitioner may remove such drugs and devices;

(iii) A record shall be made at the time of withdrawal by the authorized person removing the drugs and devices. The record shall contain the following information:

(I) name of patient;

(II) name of device or drug, strength, and dosage form;

(III) dose prescribed;

(IV) quantity taken;

(V) time and date; and

(VI) signature (first initial and last name or full signature) or electronic signature of person making withdrawal;

(iv) The original or direct copy of the medication order may substitute for such record, providing the medication order meets all the requirements of clause (iii) of this subparagraph; and

(v) The pharmacist shall verify the withdrawal of drugs from the pharmacy and perform a drug regimen review as specified in subsection (g)(1)(B) of this section as soon as practical, but in no event more than 72 hours from the time of such withdrawal.

(B) In facilities with a part-time or consultant pharmacist, if a practitioner orders a drug for administration to a bona fide patient of the facility when the pharmacist is not on duty, or when the pharmacy is closed, the following is applicable:

(i) Prescription drugs and devices only in sufficient quantities for therapeutic needs may be removed from the institutional pharmacy;

(ii) Only a designated licensed nurse or practitioner may remove such drugs and devices;

(iii) A record shall be made at the time of withdrawal by the authorized person removing the drugs and devices; the record shall meet the same requirements as specified in subparagraph (A)(iii) and (iv) of this paragraph;

(iv) The pharmacist shall verify the withdrawal of drugs from the pharmacy after a reasonable interval, but in no event may such interval exceed seven days; and

(v) The pharmacist shall perform a drug regimen review as specified in subsection (g)(1)(B) of this section as follows:

(I) If the facility has an average daily inpatient census of ten or less, the pharmacist shall perform the drug review after a reasonable interval, but in no event may such interval exceed seven (7) days; or

(II) If the facility has an average inpatient daily census above ten, the pharmacist shall perform the drug review after a reasonable interval, but in no event may such interval exceed 96 hours.

(vi) The average daily inpatient census shall be calculated by hospitals annually immediately following the submission of the hospital's Medicare Cost Report and the number used for purposes of subparagraph (B)(v)(I) and (II) of this paragraph shall be the average of the inpatient daily census in the report and the previous two reports for a three year period.

(2) Floor stock. In facilities using a floor stock method of drug distribution, the following is applicable:

(A) Prescription drugs and devices may be removed from the pharmacy only in the original manufacturer's container or prepackaged container.

(B) Only a designated licensed nurse or practitioner may remove such drugs and devices.

(C) A record shall be made at the time of withdrawal by the authorized person removing the drug or device; the record shall contain the following information:

(i) name of the drug, strength, and dosage form;

(ii) quantity removed;

(iii) location of floor stock;

(iv) date and time; and

(v) signature (first initial and last name or full signature) or electronic signature of person making the withdrawal.

(D) The pharmacist shall verify the withdrawal of drugs from the pharmacy after a reasonable interval, but in no event may such interval exceed seven days.

(3) Rural hospitals. In rural hospitals when a pharmacy technician performs the duties listed in §291.73(e)(2)(D) of this title, the following is applicable:

(A) the pharmacy technician shall make a record of all drugs distributed from the pharmacy. The record shall be maintained in the pharmacy for two years and contain the following information:

(i) name of patient or location where floor stock is distributed;

(ii) name of device or drug, strength, and dosage form;

(iii) dose prescribed or ordered;

(iv) quantity distributed;

(v) time and date of the distribution; and

(vi) signature (first initial and last name or full signature) or electronic signature of nurse or practitioner that verified the actions of the pharmacy technician.

(B) The original or direct copy of the medication order may substitute for the record specified in subparagraph (A) of this paragraph, provided the medication order meets all the requirements of subparagraph (A) of this paragraph.

(C) The pharmacist shall:

(i) verify and document the verification of all distributions made from the pharmacy in the absence of a pharmacist as soon as practical, but in no event more than seven (7) days from the time of such distribution;

(ii) perform a drug regimen review for all medication orders as specified in subsection (g)(1)(B) of this section and document such verification including any discrepancies noted by the pharmacist as follows:

(I) If the facility has an average daily inpatient census of ten or less, the pharmacist shall perform the drug review as soon as practical, but in no event more than seven (7) days from the time of such distribution; or

(II) If the facility has an average daily inpatient census above ten, the pharmacist shall perform the drug review after a reasonable interval, but in no event may such interval exceed 96 hours;

(iii) review any discrepancy noted by the pharmacist with the pharmacy technician(s) and make any change in procedures or processes necessary to prevent future problems; and

(iv) report any adverse events that have a potential for harm to a patient to the appropriate committee of the hospital that reviews adverse events.

(D) The average daily inpatient census shall be calculated by hospitals annually immediately following the submission of the hospital's Medicare Cost Report and the number used for purposes of subparagraph (C)(ii)(I) and (II) of this paragraph shall be the average of the inpatient daily census in the report and the previous two reports for a three year period.

(f) Drugs.

(1) Procurement, preparation and storage.

(A) The pharmacist-in-charge shall have the responsibility for the procurement and storage of drugs, but may receive input from other appropriate staff of the facility, relative to such responsibility.

(B) The pharmacist-in-charge shall have the responsibility for determining specifications of all drugs procured by the facility.

(C) Institutional pharmacies may not sell, purchase, trade or possess prescription drug samples, unless the pharmacy meets the requirements as specified in §291.16 of this title (relating to Samples).

(D) All drugs shall be stored at the proper temperatures, as defined in the USP/NF and in §291.15 of this title (relating to Storage of Drugs).

(E) Any drug bearing an expiration date may not be distributed beyond the expiration date of the drug.

(F) Outdated and other unusable drugs shall be removed from stock and shall be quarantined together until such drugs are disposed of properly.

(2) Formulary.

(A) A formulary shall be developed by the facility committee performing the pharmacy and therapeutics function for the facility. For the purpose of this section, a formulary is a compilation of pharmaceuticals that reflects the current clinical judgment of a facility's medical staff.

(B) The pharmacist-in-charge or pharmacist designated by the pharmacist-in-charge shall be a full voting member of the committee performing the pharmacy and therapeutics function for the facility, when such committee is performing the pharmacy and therapeutics function.

(C) A practitioner may grant approval for pharmacists at the facility to interchange, in accordance with the facility's formulary, for the prescribed drugs on the practitioner's medication orders provided:

(i) the pharmacy and therapeutics committee has developed a formulary;

(ii) the formulary has been approved by the medical staff committee of the facility;

(iii) there is a reasonable method for the practitioner to override any interchange; and

(iv) the practitioner authorizes pharmacists in the facility to interchange on his/her medication orders in accordance with the facility's formulary through his/her written agreement to abide by the policies and procedures of the medical staff and facility.

(3) Prepackaging of drugs.

(A) Distribution within a facility.

(i) Drugs may be prepackaged in quantities suitable for internal distribution by a pharmacist or by pharmacy technicians or pharmacy technician trainees under the direction and direct supervision of a pharmacist.

(ii) The label of a prepackaged unit shall indicate:

(I) brand name and strength of the drug; or if no brand name, then the generic name, strength, and name of the manufacturer or distributor;

(II) facility's unique lot number;

(III) expiration date based on currently available literature; and

(IV) quantity of the drug, if the quantity is greater than one.

(iii) Records of prepackaging shall be maintained to show:

(I) name of the drug, strength, and dosage form;

(II) facility's unique lot number;

(III) manufacturer or distributor;

(IV) manufacturer's lot number;

(V) expiration date;

(VI) quantity per prepackaged unit;

(VII) number of prepackaged units;

(VIII) date packaged;

(IX) name, initials, or electronic signature of the prepacker; and

(X) name, initials, or electronic signature of the responsible pharmacist.

(iv) Stock packages, prepackaged units, and control records shall be quarantined together until checked/released by the pharmacist.

(B) Distribution to other Class C (Institutional) pharmacies under common ownership.

(i) Drugs may be prepackaged in quantities suitable for distribution to other Class C (Institutional) pharmacies under common ownership by a pharmacist or by pharmacy technicians or phar-

macy technician trainees under the direction and direct supervision of a pharmacist.

(ii) The label of a prepackaged unit shall indicate:

(I) brand name and strength of the drug; or if no brand name, then the generic name, strength, and name of the manufacturer or distributor;

(II) facility's unique lot number;

(III) expiration date based on currently available literature;

(IV) quantity of the drug, if the quantity is greater than one; and

(V) name of the facility responsible for prepackaging the drug.

(iii) Records of prepackaging shall be maintained to show:

(I) name of the drug, strength, and dosage form;

(II) facility's unique lot number;

(III) manufacturer or distributor;

(IV) manufacturer's lot number;

(V) expiration date;

(VI) quantity per prepackaged unit;

(VII) number of prepackaged units;

(VIII) date packaged;

(IX) name, initials, or electronic signature of the prepacker;

(X) name, initials, or electronic signature of the responsible pharmacist; and

(XI) name of the facility receiving the prepackaged drug.

(iv) Stock packages, prepackaged units, and control records shall be quarantined together until checked/released by the pharmacist.

(v) The pharmacy shall have written procedure for the recall of any drug prepackaged for another Class C pharmacy under common ownership. The recall procedures shall require:

(I) notification to the pharmacy to which the prepackaged drug was distributed;

(II) quarantine of the product if there is a suspicion of harm to a patient;

(III) a mandatory recall if there is confirmed or probable harm to a patient; and

(IV) notification to the board if a mandatory recall is instituted.

(4) Sterile preparations prepared in a location other than the pharmacy. A distinctive supplementary label shall be affixed to the container of any admixture. The label shall bear at a minimum:

(A) patient's name and location, if not immediately administered;

(B) name and amount of drug(s) added;

(C) name of the basic solution;

(D) name or identifying code of person who prepared admixture; and

(E) expiration date of solution.

(5) Distribution.

(A) Medication orders.

(i) Drugs may be given to patients in facilities only on the order of a practitioner. No change in the order for drugs may be made without the approval of a practitioner except as authorized by the practitioner in compliance with paragraph (2)(C) of this subsection.

(ii) Drugs may be distributed only from the original or a direct copy of the practitioner's medication order.

(iii) Pharmacy technicians and pharmacy technician trainees may not receive oral medication orders.

(iv) Institutional pharmacies shall be exempt from the labeling provisions and patient notification requirements of §562.006 and §562.009 of the Act, as respects drugs distributed pursuant to medication orders.

(B) Procedures.

(i) Written policies and procedures for a drug distribution system (best suited for the particular institutional pharmacy) shall be developed and implemented by the pharmacist-in-charge, with the advice of the committee performing the pharmacy and therapeutics function for the facility.

(ii) The written policies and procedures for the drug distribution system shall include, but not be limited to, procedures regarding the following:

(I) pharmaceutical care services;

(II) handling, storage and disposal of cytotoxic drugs and waste;

(III) disposal of unusable drugs and supplies;

(IV) security;

(V) equipment;

(VI) sanitation;

(VII) reference materials;

(VIII) drug selection and procurement;

(IX) drug storage;

(X) controlled substances;

(XI) investigational drugs, including the obtaining of protocols from the principal investigator;

(XII) prepackaging and manufacturing;

(XIII) stop orders;

(XIV) reporting of medication errors, adverse drug reactions/events, and drug product defects;

(XV) physician orders;

(XVI) floor stocks;

(XVII) drugs brought into the facility;

(XVIII) furlough medications;

(XIX) self-administration;

(XX) emergency drug supply;

(XXI) formulary;

(XXII) monthly inspections of nursing stations and other areas where drugs are stored, distributed, administered or dispensed;

(XXIII) control of drug samples;

(XXIV) outdated and other unusable drugs;

(XXV) routine distribution of patient medication;

(XXVI) preparation and distribution of sterile preparations;

(XXVII) handling of medication orders when a pharmacist is not on duty;

(XXVIII) use of automated compounding or counting devices;

(XXIX) use of data processing and direct imaging systems;

(XXX) drug administration to include infusion devices and drug delivery systems;

(XXXI) drug labeling;

(XXXII) recordkeeping;

(XXXIII) quality assurance/quality control;

(XXXIV) duties and education and training of professional and nonprofessional staff;

(XXXV) procedures for a pharmacy technician to verify the accuracy of work performed by another pharmacy technician, if applicable;

(XXXVI) operation of the pharmacy when a pharmacist in not on-site; and

(XXXVII) emergency preparedness plan, to include continuity of patient therapy and public safety.

(6) Discharge Prescriptions. Discharge prescriptions must be dispensed and labeled in accordance with §291.33 of this title (relating to Operational Standards) except that certain medications packaged in unit-of-use containers, such as metered-dose inhalers, insulin pens, topical creams or ointments, or ophthalmic or otic preparation that are administered to the patient during the time the patient was a patient in the hospital, may be provided to the patient upon discharge provided the pharmacy receives a discharge order and the product bears a label containing the following information:

(A) name of the patient;

(B) name and strength of the medication;

(C) name of the prescribing or attending practitioner;

(D) directions for use;

(E) duration of therapy (if applicable); and

(F) name and telephone number of the pharmacy.

(7) Redistribution of Donated Prepackaged Prescription Drugs.

(A) A participating provider may dispense to a recipient donated prescription drugs that are prepackaged and labeled in accordance with §442.0515, Health and Safety Code, and this paragraph.

(B) Drugs may be prepackaged in quantities suitable for distribution to a recipient only by a pharmacist or by pharmacy technicians or pharmacy technician trainees under the direction and direct supervision of a pharmacist.

(C) The label of a prepackaged prescription drug a participating provider dispenses to a recipient shall indicate:

(i) brand name and strength of the drug; or if no brand name, then the generic name, strength, and name of the manufacturer or distributor;

(ii) participating provider's lot number;

(iii) participating provider's beyond use date; and

(iv) quantity of the drug, if the quantity is greater than one.

(D) Records of prepackaged prescription drugs dispensed to a recipient shall be maintained to show:

(i) name of the drug, strength, and dosage form;

(ii) participating provider's lot number;

(iii) manufacturer or distributor;

(iv) manufacturer's lot number;

(v) manufacturer's expiration date;

(vi) quantity per prepackaged unit;

(vii) number of prepackaged units;

(viii) date packaged;

(ix) name, initials, or written or electronic signature of the prepacker; and

(x) written or electronic signature of the responsible pharmacist.

(E) Stock packages, repackaged units, and control records shall be quarantined together until checked/released by the pharmacist.

(g) Pharmaceutical care services.

(1) The pharmacist-in-charge shall assure that at least the following pharmaceutical care services are provided to patients of the facility:

(A) Drug utilization review. A systematic ongoing process of drug utilization review shall be developed in conjunction with the medical staff to increase the probability of desired patient outcomes and decrease the probability of undesired outcomes from drug therapy.

(B) Drug regimen review.

(i) For the purpose of promoting therapeutic appropriateness, a pharmacist shall evaluate medication orders and patient medication records for:

(I) known allergies;

(II) rational therapy--contraindications;

(III) reasonable dose and route of administration;

(IV) reasonable directions for use;

(V) duplication of therapy;

(VI) drug-drug interactions;

(VII) drug-food interactions;

(VIII) drug-disease interactions;

(IX) adverse drug reactions;

(X) proper utilization, including overutilization or underutilization; and

(XI) clinical laboratory or clinical monitoring methods to monitor and evaluate drug effectiveness, side effects, toxicity, or adverse effects, and appropriateness to continued use of the drug in its current regimen.

(ii) The drug regimen review shall be conducted on a prospective basis when a pharmacist is on duty, except for an emergency order, and on a retrospective basis as specified in subsection (e)(1) or (e)(3) of this section when a pharmacist is not on duty.

(iii) Any questions regarding the order must be resolved with the prescriber and a written notation of these discussions made and maintained.

(iv) The drug regimen review may be conducted by remotely accessing the pharmacy's electronic data base from outside the pharmacy by an individual Texas licensed pharmacist employee of the pharmacy, provided the pharmacy establishes controls to protect the privacy of the patient and the security of confidential records.

(C) Education. The pharmacist-in-charge in cooperation with appropriate multi-disciplinary staff of the facility shall develop policies that assure that:

(i) the patient and/or patient's caregiver receives information regarding drugs and their safe and appropriate use; and

(ii) health care providers are provided with patient specific drug information.

(D) Patient monitoring. The pharmacist-in-charge in cooperation with appropriate multi-disciplinary staff of the facility shall develop policies to ensure that the patient's response to drug therapy is monitored and conveyed to the appropriate health care provider.

(2) Other pharmaceutical care services which may be provided by pharmacists in the facility include, but are not limited to, the following:

(A) managing drug therapy as delegated by a practitioner as allowed under the provisions of the Medical Practice Act;

(B) administering immunizations and vaccinations under written protocol of a physician;

(C) managing patient compliance programs;

(D) providing preventative health care services; and

(E) providing case management of patients who are being treated with high-risk or high-cost drugs, or who are considered "high risk" due to their age, medical condition, family history, or related concern.

(h) Emergency rooms.

(1) During the times a pharmacist is on duty in the facility any prescription drugs supplied to an outpatient, including emergency department patients, may only be dispensed by a pharmacist.

(2) When a pharmacist is not on duty in the facility, the following is applicable for supplying prescription drugs to be taken home by the patient for self-administration from the emergency room. If the patient has been admitted to the emergency room and assessed by a practitioner at the hospital, the following procedures shall be observed in supplying prescription drugs from the emergency room.

(A) Dangerous drugs and/or controlled substances may only be supplied in accordance with the system of control and accountability for dangerous drugs and/or controlled substances administered or supplied from the emergency room; such system shall be developed and supervised by the pharmacist-in-charge or staff pharmacist designated by the pharmacist-in-charge.

(B) Only dangerous drugs and/or controlled substances listed on the emergency room drug list may be supplied; such list shall be developed by the pharmacist-in-charge and the facility's emergency department committee (or like group or person responsible for policy in that department) and shall consist of dangerous drugs and/or controlled substances of the nature and type to meet the immediate needs of emergency room patients.

(C) Dangerous drugs and/or controlled substances may only be supplied in prepackaged quantities not to exceed a 72-hour supply in suitable containers and appropriately prelabeled (including necessary auxiliary labels) by the institutional pharmacy.

(D) At the time of delivery of the dangerous drugs and/or controlled substances, the practitioner or licensed nurse under the supervision of a practitioner shall appropriately complete the label with at least the following information:

(i) name, address, and phone number of the facility;

(ii) date supplied;

(iii) name of practitioner;

(iv) name of patient;

(v) directions for use;

(vi) brand name and strength of the dangerous drug or controlled substance; or if no brand name, then the generic name, strength, and the name of the manufacturer or distributor of the dangerous drug or controlled substance;

(vii) quantity supplied; and

(viii) unique identification number.

(E) The practitioner, or a licensed nurse under the supervision of the practitioner, shall give the appropriately labeled, prepackaged drug to the patient and explain the correct use of the drug.

(F) A perpetual record of dangerous drugs and/or controlled substances supplied from the emergency room shall be maintained in the emergency room. Such record shall include the following:

(i) date supplied;

(ii) practitioner's name;

(iii) patient's name;

(iv) brand name and strength of the dangerous drug or controlled substance; or if no brand name, then the generic name, strength, and the name of the manufacturer or distributor of the dangerous drug or controlled substance;

(v) quantity supplied; and

(vi) unique identification number.

(G) The pharmacist-in-charge, or staff pharmacist designated by the pharmacist-in-charge, shall verify the correctness of this record at least once every seven days.

(i) Radiology departments.

(1) During the times a pharmacist is on duty, any prescription drugs dispensed to an outpatient, including radiology department patients, may only be dispensed by a pharmacist.

(2) When a pharmacist is not on duty, the following procedures shall be observed in supplying prescription drugs from the radiology department.

(A) Prescription drugs may only be supplied to patients who have been scheduled for an x-ray examination at the facility.

(B) Prescription drugs may only be supplied in accordance with the system of control and accountability for prescription drugs administered or supplied from the radiology department and supervised by the pharmacist-in-charge or staff pharmacist designated by the pharmacist-in-charge.

(C) Only prescription drugs listed on the radiology drug list may be supplied; such list shall be developed by the pharmacist-in-charge and the facility's radiology committee (or like group or persons responsible for policy in that department) and shall consist of drugs for the preparation of a patient for a radiological procedure.

(D) Prescription drugs may only be supplied in prepackaged quantities in suitable containers and prelabeled by the institutional pharmacy with the following information:

(i) name and address of the facility;

(ii) directions for use;

(iii) name and strength of the prescription drug--if generic name, the name of the manufacturer or distributor of the prescription drug;

(iv) quantity;

(v) facility's lot number and expiration date; and

(vi) appropriate ancillary label(s).

(E) At the time of delivery of the prescription drug, the practitioner or practitioner's agent shall complete the label with the following information:

(i) date supplied;

(ii) name of physician;

(iii) name of patient; and

(iv) unique identification number.

(F) The practitioner or practitioner's agent shall give the appropriately labeled, prepackaged prescription drug to the patient.

(G) A perpetual record of prescription drugs supplied from the radiology department shall be maintained in the radiology department. Such records shall include the following:

(i) date supplied;

(ii) practitioner's name;

(iii) patient's name;

(iv) brand name and strength of the prescription drug; or if no brand name, then the generic name, strength, dosage form, and the name of the manufacturer or distributor of the prescription drug;

(v) quantity supplied; and

(vi) unique identification number.

(H) The pharmacist-in-charge, or a pharmacist designated by the pharmacist-in-charge, shall verify the correctness of this record at least once every seven days.

(j) Automated devices and systems.

(1) Automated compounding or counting devices. If a pharmacy uses automated compounding or counting devices:

(A) the pharmacy shall have a method to calibrate and verify the accuracy of the automated compounding or counting device and document the calibration and verification on a routine basis;

(B) the devices may be loaded with unlabeled drugs only by a pharmacist or by pharmacy technicians or pharmacy technician trainees under the direction and direct supervision of a pharmacist;

(C) the label of an automated compounding or counting device container shall indicate the brand name and strength of the drug; or if no brand name, then the generic name, strength, and name of the manufacturer or distributor;

(D) records of loading unlabeled drugs into an automated compounding or counting device shall be maintained to show:

(i) name of the drug, strength, and dosage form;

(ii) manufacturer or distributor;

(iii) manufacturer's lot number;

(iv) expiration date;

(v) date of loading;

(vi) name, initials, or electronic signature of the person loading the automated compounding or counting device; and

(vii) signature or electronic signature of the responsible pharmacist; and

(E) the automated compounding or counting device shall not be used until a pharmacist verifies that the system is properly loaded and affixes his or her signature to the record specified in subparagraph (D) of this paragraph.

(2) Automated medication supply systems.

(A) Authority to use automated medication supply systems. A pharmacy may use an automated medication supply system to fill medication orders provided that:

(i) the pharmacist-in-charge is responsible for the supervision of the operation of the system;

(ii) the automated medication supply system has been tested by the pharmacy and found to dispense accurately. The pharmacy shall make the results of such testing available to the Board upon request; and

(iii) the pharmacy will make the automated medication supply system available for inspection by the board for the purpose of validating the accuracy of the system.

(B) Quality assurance program. A pharmacy which uses an automated medication supply system to fill medication orders shall operate according to a written program for quality assurance of the automated medication supply system which:

(i) requires continuous monitoring of the automated medication supply system; and

(ii) establishes mechanisms and procedures to test the accuracy of the automated medication supply system at least every

six months and whenever any upgrade or change is made to the system and documents each such activity.

(C) Policies and procedures of operation.

(i) When an automated medication supply system is used to store or distribute medications for administration pursuant to medication orders, it shall be operated according to written policies and procedures of operation. The policies and procedures of operation shall establish requirements for operation of the automated medication supply system and shall describe policies and procedures that:

(I) include a description of the policies and procedures of operation;

(II) provide for a pharmacist's review and approval of each original or new medication order prior to withdrawal from the automated medication supply system:

(-a-) before the order is filled when a pharmacist is on duty except for an emergency order;

(-b-) retrospectively within 72 hours in a facility with a full-time pharmacist when a pharmacist is not on duty at the time the order is made; or

(-c-) retrospectively within 7 days in a facility with a part-time or consultant pharmacist when a pharmacist is not on duty at the time the order is made;

(III) provide for access to the automated medication supply system for stocking and retrieval of medications which is limited to licensed healthcare professionals, pharmacy technicians, or pharmacy technician trainees acting under the supervision of a pharmacist;

(IV) provide that a pharmacist is responsible for the accuracy of the restocking of the system. The actual restocking may be performed by a pharmacy technician or pharmacy technician trainee;

(V) provide for an accountability record to be maintained which documents all transactions relative to stocking and removing medications from the automated medication supply system;

(VI) require a prospective or retrospective drug regimen review is conducted as specified in subsection (g) of this section; and

(VII) establish and make provisions for documentation of a preventative maintenance program for the automated medication supply system.

(ii) A pharmacy which uses an automated medication supply system to fill medication orders shall, at least annually, review its written policies and procedures, revise them if necessary, and document the review.

(D) Automated medication supply systems used for storage and recordkeeping of medications located outside of the pharmacy department (e.g., Pyxis). A pharmacy technician or pharmacy technician trainee may restock an automated medication supply system located outside of the pharmacy department with prescription drugs provided:

(i) prior to distribution of the prescription drugs a pharmacist verifies that the prescription drugs pulled to stock the automated supply system match the list of prescription drugs generated by the automated medication supply system except as specified in §291.73(e)(2)(C)(ii) of this title; or

(ii) all of the following occur:

(I) the prescription drugs to restock the system are labeled and verified with a machine readable product identifier, such as a barcode;

(II) either:

(-a-) the drugs are in tamper evident product packaging, packaged by an FDA registered repackager or manufacturer, that is shipped to the pharmacy; or

(-b-) if any manipulation of the product occurs in the pharmacy prior to restocking, such as repackaging or extemporaneous compounding, the product must be checked by a pharmacist; and

(III) quality assurance audits are conducted according to established policies and procedures to ensure accuracy of the process.

(E) Recovery Plan. A pharmacy which uses an automated medication supply system to store or distribute medications for administration pursuant to medication orders shall maintain a written plan for recovery from a disaster or any other situation which interrupts the ability of the automated medication supply system to provide services necessary for the operation of the pharmacy. The written plan for recovery shall include:

(i) planning and preparation for maintaining pharmacy services when an automated medication supply system is experiencing downtime;

(ii) procedures for response when an automated medication supply system is experiencing downtime;

(iii) procedures for the maintenance and testing of the written plan for recovery; and

(iv) procedures for notification of the Board and other appropriate agencies whenever an automated medication supply system experiences downtime for more than two days of operation or a period of time which significantly limits the pharmacy's ability to provide pharmacy services.

(3) Verification of medication orders prepared by the pharmacy department through the use of an automated medication supply system. A pharmacist must check drugs prepared pursuant to medication orders to ensure that the drug is prepared for distribution accurately as prescribed. This paragraph does not apply to automated medication supply systems used for storage and recordkeeping of medications located outside of the pharmacy department.

(A) This check shall be considered accomplished if:

(i) a check of the final product is conducted by a pharmacist after the automated system has completed preparation of the medication order and prior to delivery to the patient; or

(ii) the following checks are conducted by a pharmacist:

(I) if the automated medication supply system contains unlabeled stock drugs, a pharmacist verifies that those drugs have been accurately stocked; and

(II) a pharmacist checks the accuracy of the data entry of each original or new medication order entered into the automated medication supply system before the order is filled.

(B) If the final check is accomplished as specified in subparagraph (A)(ii) of this paragraph, the following additional requirements must be met.

(i) The medication order preparation process must be fully automated from the time the pharmacist releases the medica-

tion order to the automated system until a completed medication order, ready for delivery to the patient, is produced.

(ii) The pharmacy has conducted initial testing and has a continuous quality assurance program which documents that the automated medication supply system dispenses accurately as specified in paragraph (2)(A) and (B) of this subsection.

(iii) The automated medication supply system documents and maintains:

(I) the name(s), initials, or identification code(s) of each pharmacist responsible for the checks outlined in subparagraph (A)(ii) of this paragraph; and

(II) the name(s), initials, or identification code(s) and specific activity(ies) of each pharmacist or pharmacy technician or pharmacy technician trainee who performs any other portion of the medication order preparation process.

(iv) The pharmacy establishes mechanisms and procedures to test the accuracy of the automated medication supply system at least every month rather than every six months as specified in paragraph (2)(B) of this subsection.

(4) Automated checking device.

(A) For the purpose of this subsection, an automated checking device is a fully automated device which confirms, after a drug is prepared for distribution but prior to delivery to the patient, that the correct drug and strength has been labeled with the correct label for the correct patient.

(B) The final check of a drug prepared pursuant to a medication order shall be considered accomplished using an automated checking device provided:

(i) a check of the final product is conducted by a pharmacist prior to delivery to the patient or the following checks are performed by a pharmacist:

(I) the prepackaged drug used to fill the order is checked by a pharmacist who verifies that the drug is labeled and packaged accurately; and

(II) a pharmacist checks the accuracy of each original or new medication order.

(ii) the medication order is prepared, labeled, and made ready for delivery to the patient in compliance with Class C (Institutional) pharmacy rules; and

(iii) prior to delivery to the patient:

(I) the automated checking device confirms that the correct drug and strength has been labeled with the correct label for the correct patient; and

(II) a pharmacist performs all other duties required to ensure that the medication order has been prepared safely and accurately as prescribed.

(C) If the final check is accomplished as specified in subparagraph (B) of this paragraph, the following additional requirements must be met.

(i) The pharmacy has conducted initial testing of the automated checking device and has a continuous quality assurance program which documents that the automated checking device accurately confirms that the correct drug and strength has been labeled with the correct label for the correct patient.

(ii) The pharmacy documents and maintains:

(I) the name(s), initials, or identification code(s) of each pharmacist responsible for the checks outlined in subparagraph (B)(i) of this paragraph; and

(II) the name(s), initials, or identification code(s) and specific activity(ies) of each pharmacist, pharmacy technician, or pharmacy technician trainee who performs any other portion of the medication order preparation process.

(iii) The pharmacy establishes mechanisms and procedures to test the accuracy of the automated checking device at least monthly.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 16, 2024.

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Daniel Carroll, Pharm.D.
Executive Director
Texas State Board of Pharmacy
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Proposal publication date: December 22, 2023
For further information, please call: (512) 305-8033

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CHAPTER 297. PHARMACY TECHNICIANS AND PHARMACY TECHNICIAN TRAINEES

22 TAC §297.10

The Texas State Board of Pharmacy adopts amendments to §297.10, concerning Registration for Military Service Members, Military Veterans, and Military Spouses. These amendments are adopted without changes to the proposed text as published in the December 22, 2023, issue of the *Texas Register* (48 TexReg 7757). The rule will not be republished.

The amendments clarify that the requirements for obtaining an interim registration for a military service member or military spouse do not affect rights that may be provided under federal law.

The Board received comments from the Texas Medical Association suggesting the phrase "federal law" be replaced with the more specific phrase "Sec. 705A of the Servicemembers Civil Relief Act (50 U.S.C. § 4025A)." The Board declined to make this change.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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CHAPTER 315. CONTROLLED SUBSTANCES

22 TAC §315.9

The Texas State Board of Pharmacy adopts amendments to §315.9, concerning Pharmacy Responsibility - Out-of-State Practitioner - Effective September 1, 2016. These amendments are adopted without changes to the proposed text as published in the December 15, 2023, issue of the *Texas Register* (48 TexReg 7289). The rule will not be republished.

The amendments clarify that the requirements for dispensing a Schedule II controlled substance prescription issued by a practitioner in another state apply to an electronic prescription and remove the effective date from the short title.

No comments were received.

The amendments are adopted under §§551.002 and 554.051 of the Texas Pharmacy Act (Chapters 551 - 569, Texas Occupations Code). The Board interprets §551.002 as authorizing the agency to protect the public through the effective control and regulation of the practice of pharmacy. The Board interprets §554.051(a) as authorizing the agency to adopt rules for the proper administration and enforcement of the Act.

The statutes affected by this adoption: Texas Pharmacy Act, Chapters 551 - 569, Texas Occupations Code.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 26. HEALTH AND HUMAN SERVICES

PART 1. HEALTH AND HUMAN SERVICES COMMISSION

CHAPTER 338. DISASTER RULE FLEXIBILITIES FOR LOCAL INTELLECTUAL AND DEVELOPMENTAL DISABILITY AUTHORITIES (LIDDAs)

26 TAC §338.1

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) adopts new §338.1, concerning Disaster Rule Flexibilities for Local Intellectual and Developmental Disability Authorities (LIDDAs). The new §338.1 is adopted with changes to the proposed text as published in the December 8, 2023, issue of the *Texas Register* (48 TexReg 7123). This rule will be republished.

BACKGROUND AND JUSTIFICATION

The purpose of the new rule is to allow LIDDAs to use certain flexibilities to rules when providing services during a declared disaster under Texas Government Code §418.014. LIDDAs provide essential services to individuals with intellectual or developmental disabilities (IDD). This vulnerable population relies on LIDDA staff to assist them in securing the services they need, achieving their desired outcomes and best quality of life. Disaster rule flexibilities for LIDDAs ensure that when a disaster declaration is in effect, HHSC may issue timely guidance and authorize flexibilities for LIDDAs to provide services.

The new rule allows HHSC to notify LIDDAs of certain flexibilities immediately upon a disaster declaration to prevent interruption of service delivery. These flexibilities include allowing service coordination to be delivered via audio-only or audio-visual communication to ensure continuity of services, as well as extending some timeframes for LIDDAs. In addition, the rule requires that LIDDAs follow HHSC guidance related to the rules, comply with all applicable requirements related to security and privacy of information, and notify persons impacted by the flexibilities, if applicable.

COMMENTS

The 31-day comment period ended on January 8, 2024.

During this period, HHSC received no comments regarding the proposed rule.

HHSC made minor editorial changes to correct a cross-reference to another rule in §338.1(c)(2)(B) and add "synchronous" to the definitions of "audio-only" and "audio-visual" to align the definitions with the Medicaid State Plan amendment.

STATUTORY AUTHORITY

The new rule is authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.021, which provides HHSC with the authority to administer federal funds and plan and direct the Medicaid program in each agency that operates a portion of the Medicaid program; Texas Human Resources Code §32.021, which provides that HHSC will adopt necessary rules for the proper and efficient administration of the Medicaid program; and Texas Health & Safety Code §533A.0355(a), which provides that the Executive Commissioner of HHSC shall adopt rules establishing the roles and responsibilities of LIDDAs.

§338.1. Disaster Flexibilities.

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

(1) Audio-only--A synchronous, interactive, two-way audio communication that uses only sound and that meets the privacy requirements of the Health Insurance Portability and Accountability Act. Audio-only includes the use of telephonic communication. Audio-only does not include face-to-face communication.

(2) Audio-visual--A synchronous, interactive, two-way audio and video communication that conforms to privacy requirements under the Health Insurance Portability and Accountability Act. Audio-visual does not include audio-only or in-person communication.

(3) Face-to-face--In-person or audio-visual communication that meets the requirements of the Health Insurance Portability and Accountability Act. Face-to-face does not include audio-only communication.

(4) In-person (or in person)--Within the physical presence of another person. In-person or in person does not include audio-visual or audio-only communication.

(b) The Texas Health and Human Services Commission (HHSC) may allow local intellectual and developmental disability authorities (LIDDAs) to use the flexibilities described in subsection (c) of this section while an executive order or proclamation declaring a state of disaster under Texas Government Code §418.014 is in effect. HHSC will notify LIDDAs when a flexibility is permitted and the date the flexibility must no longer be used, which may be before the declaration of a state of disaster expires.

(c) Subject to the notification by HHSC, the following flexibilities may be available to LIDDAs to the extent the flexibility is permitted by and does not conflict with other laws or obligations of the LIDDA and is allowed by federal and state law.

(1) Service coordination required to be provided in person under 26 TAC §331.11(d) of this title (relating to LIDDA's Responsibilities) may be provided using audio-visual or audio-only communication.

(2) HHSC may extend the timeframes for LIDDAs in the following rules:

(A) the timeframe to request an administrative hearing in 40 TAC §4.156 (relating to Request for an Administrative Hearing);

(B) the timeframe for a person and legally authorized representative (LAR) to request a review of a decision to deny or terminate services in 26 TAC §301.155(e)(3) (relating to Notification and Appeals Process);

(C) the timeframe for a person or the person's parent to comply with the applicable accountability requirement in 40 TAC §2.105(f)(1) (relating to Accountability) in order for the LIDDA to retroactively adjust the person's account; and

(D) the timeframe for a person or parent to submit a request to review a LIDDA's appeal decision to HHSC in 40 TAC §2.109(e)(3) (relating to Payments, Collections, and Non-payment).

(d) LIDDAs that use one or more of the flexibilities allowed under subsection (c) of this section must comply with:

(1) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Community Services Division during the declaration of disaster that is published by HHSC on its LIDDA website or in another communication format HHSC determines appropriate; and

(2) all policy guidance applicable to the rules identified in subsection (c) of this section issued by HHSC Medicaid and CHIP Services.

(e) LIDDAs must ensure audio-only or audio-visual communication complies with all applicable requirements related to security and privacy of information.

(f) LIDDAs must notify the person, the LAR, or the person's parent if the person is younger than 18 years of age, of the extension of timeframes permitted under subsection (c)(2) of this section that apply to the person receiving services.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 26, 2024.

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Karen Ray
Chief Counsel
Health and Human Services Commission
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Proposal publication date: December 8, 2023
For further information, please call: (512) 438-5609

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CHAPTER 556. NURSE AIDES

26 TAC §§556.2, 556.3, 556.5, 556.8

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) adopts amendments §556.2, concerning Definitions; §556.3, concerning NATCEP Requirements; §556.5, concerning Program Director, Program Instructor, Supplemental Trainers, and Skills Examiner Requirements; and §556.8, concerning Withdrawal of Approval of a NATCEP.

The amendments to §§556.2, 556.3, 556.5, and 556.8 are adopted without changes to the proposed text as published in the October 27, 2023, issue of the *Texas Register* (48 TexReg 6332). These rules will be not republished.

BACKGROUND AND JUSTIFICATION

The amended rules stipulate that Nurse Aide Competency Evaluation Programs (NATCEPs) must accept 60 hours of classroom training through HHSC's computer-based training (CBT) for nurse aide candidates seeking to qualify for the Certified Nurse Aide (CNA) exam. The amendments update definitions and references associated with the nurse aide CBT training and clarify related requirements. The amended rules also revise language regarding credentials for NATCEP directors and instructors, making them more consistent with federal requirements. Specifically, the Code of Federal Regulations (CFR) does not differentiate between the credentials required by the NATCEP program director versus the program instructor. It states that the program must train nurse aides under the general supervision of a registered nurse with at least two years of nursing experience, at least one of which must be in providing long term care services. The amended rules remove specific credentialing requirements for NATCEP directors and instructors and replace them with language allowing either or both to meet the federal requirements outlined in the CFR.

COMMENTS

The 31-day comment period ended November 27, 2023. During this period, HHSC received eight comments regarding the

proposed rules from eight commenters: a nursing facility administrator, several NATCEP directors, and a NATCEP consultant.

HHSC received eight general comments on the proposed rule amendments. These comments were not related to a specific rule but rather to the overall amendments.

Comment: Six commenters conveyed a misunderstanding that the CBT would constitute the nurse aide training in full, and that after finishing it, trainees would go into the workforce and begin caring for clients independently.

Response: No rule changes are necessary. The CBT is intended to provide an optional method for nurse aide trainees to complete only the classroom portion of the training. Trainees will still be required to complete the clinical portion of the training, under supervision, as specified by Texas Administrative Code (TAC), Title 26 §556.3(n)(2), and to take and pass the CNA certification exam as specified by 26 TAC §556.6. NATCEPs may continue to provide in-person classroom training. HHSC's CBT is simply an additional option for the classroom component of the preparation for the CNA exam.

Comment: One commenter registered concern that the CBT could negatively impact NATCEPs that cannot offer a virtual classroom or online instruction.

Response: No rule changes are necessary. NATCEPs do not need to offer a virtual classroom. Trainees are not required to complete the CBT in a NATCEP classroom. HHSC will host the CBT on the agency website and trainees can complete the training in any setting.

Comment: Five commenters expressed concern that the CBT will not include direct skills training with residents.

Response: HHSC declines to make changes to the rules in response to these comments. Instruction in direct skills is provided by NATCEPs in the clinical portion of the training.

Comment: Six commenters conveyed concern that the online training would be lower in quality than in-person instruction and could result in a range of unfavorable outcomes, such as lower motivation to learn, less retention of training material in trainees, and reduced graduation rates for NATCEPs.

Response: HHSC declines to make changes to the rules in response to these comments. HHSC is creating the CBT to ensure the curriculum meets regulatory standards. Trainees will be able to choose between CBT training and traditional classroom training based on their own preferred learning styles and methods of motivation. Moreover, the rules already allow NATCEPs to use online training instead of, or in addition to, in-person training.

Comment: Six commenters expressed concern about the financial impact statement of the rule proposal's preamble. They stated that NATCEPs will face a reduction in business revenue due to HHSC's provision of CBT and requirement that NATCEPs accept completion of it as completion of the classroom portion of the nurse aide training.

Response: HHSC recognizes these concerns but declines to make changes to the rules in response to the comments. HHSC does not regulate how private businesses structure their business model or fees. Additionally, some NACTEPs--including those operated by nursing facilities under a Medicaid contract and public high schools--do not charge any fees for the training provided. NATCEPs may choose to operationalize their businesses as they deem appropriate and may make changes to their business practices including any fees associated with the services provided.

Comment: One commenter proposed that HHSC create a NATCEP taskforce.

Response: No changes to the rules are necessary. HHSC has a nurse aide workgroup that provides input on policy and rule and will continue to work with its members.

Comment: One commenter offered to create the CBT.

Response: No changes to the rules are necessary. HHSC is developing the CBT internally as the regulating agency that sets the standards for the curriculum and will release it to the public when it becomes available and the rules regarding it go into effect.

Comment: One commenter stated that the CBT is an excellent idea to keep up with national regulations and remain up to date with technology that will also streamline the process and help to educate more CNAs.

Response: No changes to the rules are necessary. HHSC appreciates this feedback and acknowledges the benefits of the CBT highlighted therein.

Comment: Five commenters asked how they would be able to verify authenticity of the CBT completion certificates from HHSC. One commenter requested that HHSC consider adding a feature to the Texas Unified Licensure Information Portal (TULIP) to allow a NATCEP director to confirm a trainee's CBT completion.

Response: No changes to the rules are necessary. HHSC will issue guidance about determining the authenticity of CBT certificates. CBT scores will be retained in a learning management system for trainees, not in TULIP.

Comment: One commenter asked if the CBT would be mandatory.

Response: No changes to the rules are necessary. A NATCEP is not required to use the CBT--only to accept the results of those applicants who do choose to use it. NATCEPs may still utilize the classroom training for trainees who opt for that instead of the CBT.

Comment: One commenter asked what benefits would be conferred by offering the option of CBT without a change to pay or promotional education.

Response: No changes to the rules are necessary. The benefits are to provide more flexibility and a free option for part of the training, at the trainee's own pace.

Comment: One commenter asked who would develop the CBT and what the passing standards for it would be.

Response: No changes to the rules are necessary. HHSC is developing the CBT and is not changing the passing standards for the written portion of the training.

Comment: One commenter requested clarification regarding credentialing requirements for a NATCEP instructor and program director.

Response: No changes to the rules are necessary. These requirements are delineated at §556.5(a) - (d).

Comment: One commenter asked how long the CBT would be valid for.

Response: No changes to the rules are necessary. As required in §556.3(n), the NATCEP must ensure that the trainee completes the classroom portion of the training within the preceding 12 months.

Comment: Four commenters suggested indicating in the rules who nurse aide trainees should contact for technical assistance with the CBT.

Response: The rulemaking process does not encompass including information on technical assistance in the rules. HHSC will publish resources for troubleshooting technical issues.

Comment: One commenter had a concern regarding amended §556.3(n), stating that holding NATCEPs responsible for ensuring that trainees complete 60 hours of classroom training in CBT appears to be unfair, as the NATCEP would not provide this.

Response: HHSC declines to make changes to the rule in response to this comment. The NATCEP is responsible for determining that a trainee has completed the CBT by obtaining and retaining the trainee's certificate of CBT completion.

Comment: Four commenters requested that HHSC include in amended §556.3(n) that a NATCEP may, at its discretion, require a nurse aide trainee to demonstrate competency in the classroom portion of the training.

Response: HHSC declines to make this change. If trainees complete the CBT and provide the NATCEP their certificate of CBT completion, this demonstrates their competency in the training's classroom portion.

Comment: Four commenters requested an addition to amended §556.3(n) to state that if trainees request to be re-trained in the didactic portion, fail competency assessment, or fail the written exam, then the NATCEP may re-train them at a cost decided by the NATCEP.

Response: HHSC declines to make this change to the rule. The rule does not prohibit a nurse aide trainee from requesting re-training that is not CBT. If a trainee requests re-training from the NATCEP, this is a business decision between the trainee and the NATCEP.

Comment: Regarding amended §556.3(n)(1)(B), four commenters asked HHSC to consider requiring the nurse aide trainee to engage or select a NATCEP for the clinical portion of the training upon enrollment in the CBT, to ensure that the NACTEP follows up with the trainee.

Response: No changes to the rule are necessary. HHSC will issue guidance, including a recommendation that trainees select and contact a NATCEP for the clinical training upon starting the CBT.

Comment: Four commenters advocated adding to amended §556.3(n)(2) that a portion of the 40 hours of clinical training include skills training must be in a laboratory or classroom setting, such as the NATCEP itself.

Response: HHSC declines to make this change. HHSC allows the use of laboratory settings in clinical training in certain circumstances, as described in §556.3(e). The NATCEP may structure its program as it deems appropriate, within the parameters described in Chapter 556. The rules do not prohibit using a variety of training methods.

Comment: One commenter proposed that HHSC include a statement in §556.3(n)(2) that a NATCEP may charge for the clinical portion of the training.

Response: HHSC does not require NATCEPs to charge any fees and declines to change the rule in response to this comment. HHSC does not regulate how private businesses structure their business model or fees. Additionally, some NACTEPs--including those operated by nursing facilities under a Medicaid contract and public high schools--do not charge any fees for the training provided. NATCEPs may choose to operationalize their businesses as they deem appropriate and may make changes to their business practices including any fees associated with the services provided.

Comment: One commenter expressed concern regarding proposed §556.3(q), asserting that requiring a NATCEP to accept trainees who have completed the CBT is not allowing the NATCEP to determine who it admits to its program. The commenter asked that HHSC remove this language.

Response: HHSC declines to make this change. If trainees pass the CBT and opt to complete their clinical training at a NATCEP, the NATCEP cannot deny admitting them because they made use of the CBT option.

STATUTORY AUTHORITY

The amendments are adopted under Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies, and Texas Health and Safety Code §250.0035(d), which stipulates that the Executive Commissioner of HHSC shall adopt rules necessary to implement §250.0035, related the issuance and renewal of certificates of registration and the regulation of nurse aides as necessary to protect the public health and safety.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 26, 2024.

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Health and Human Services Commission
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Proposal publication date: October 27, 2023
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TITLE 28. INSURANCE

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

CHAPTER 133. GENERAL MEDICAL PROVISIONS

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts amended 28 TAC §§133.10, 133.20, 133.200, and 133.502, concerning billing and reimbursement for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and maximum

medical improvement (MMI) evaluations and impairment rating (IR) examinations by treating and referred doctors. The amendments implement Texas Labor Code Chapters 408 and 413, which govern workers' compensation benefits, including medical examinations required to establish benefit entitlements, and medical review to ensure compliance with DWC rules for health care, including medical policies and fee guidelines. The DWC medical advisor recommended the amendments to the commissioner of workers' compensation under Labor Code §413.0511(b). The amendments to §§133.10, 133.20, and 133.502 are adopted with three changes to the proposed text published in the December 29, 2023, issue of the *Texas Register* (48 TexReg 8153). The changes clarify the effective dates in §§133.10(l), 133.20(o), and 133.502(g). These rules will be republished. Section 133.200 is adopted without changes and will not be republished.

REASONED JUSTIFICATION. Amending §§133.10, 133.20, 133.200, and 133.502 is necessary to attract and retain designated doctors, required medical examination doctors, and doctors that perform MMI evaluations and IR examinations by addressing billing and reimbursement issues, reducing disputes, and decreasing the administrative burden of participating in the program. Labor Code Chapter 408 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Specifically, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. To help determine the health care that meets those standards, the designated doctor program established under Chapter 408 provides for commissioner-ordered medical examinations to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues. Maintaining a viable program that ensures that injured employees can access examinations in a timely way is essential to meeting the statutory mandate of providing health care for injured employees.

Having too few doctors in the program has a negative impact on the doctors that remain in the system, on injured employees, and on insurance carriers. When there are too few doctors able to conduct the examinations needed to determine benefit levels, injured employees must often wait longer and travel farther to attend an examination, which can delay dispute resolution and other essential processes. DWC last adjusted reimbursement rates for workers' compensation-specific services in January 2008 (33 TexReg 364). Over the past 14 years, DWC has experienced a decline in the numbers of doctors providing workers' compensation-specific services. This decline has been particularly pronounced among designated doctors certified under Labor Code §408.1225 and providing designated doctor examinations as Labor Code §408.0041 requires, and especially among licensed medical doctors and doctors of osteopathy. In December 2022, for the entire state of Texas, there were only 63 available medical doctors, 10 doctors of osteopathic medicine, 177 doctors of chiropractic, and no doctors of podiatry, dental science, or optometry. Yet in that month, there were 1,259 designated doctor appointments for those 250 designated doctors to cover.

DWC held stakeholder meetings in March, September, and December 2022 to discuss issues with declining participation in the designated doctor program, including issues with billing logistics and reimbursement rates. DWC invited public comments on three separate informal drafts posted on DWC's website in August 2022, November 2022, and June 2023. In addition, DWC conducted a stakeholder survey to gather information about anticipated implementation costs and benefits in September 2023. DWC considered the comments it received at the meetings and on the informal drafts when drafting the proposal. DWC also considered comments it received in a public hearing on the proposal on January 23, 2024, as well as written comments it received by the January 29, 2024, deadline, when drafting this adoption order.

In April 2023, after gathering data about the program and soliciting input from system participants about how to maintain and increase participation in the designated doctor program and allow better access to specialized examinations, DWC adopted amendments to Chapter 127 of this title, concerning designated doctor procedures and requirements, and §180.23 of this title, concerning division-required training for doctors. Those rules addressed certification, training, and procedures for designated doctors and were required to address administrative and logistical inefficiencies, and to improve access to examinations, to make participation in the program possible and attractive for more doctors. They were one part of the project to ensure the designated doctor program's viability, in compliance with the Labor Code. After their adoption, DWC saw a near-immediate increase in the numbers of doctors applying to the program, which was very encouraging.

However, the common theme throughout the input-gathering process about how to improve the program was billing and reimbursement for certain workers' compensation-specific services, especially designated doctor examinations. Nearly every comment DWC received mentioned some combination of issues about the fees for designated doctor examinations--that they were insufficient, had not been adjusted for inflation or other economic factors in over a decade, did not take into account missed appointments or the time spent reviewing injured employees' medical records, and other similar issues. In adopting the amendments to Chapter 127 and §180.23, DWC stated that billing and reimbursement issues would be addressed in a separate rule project. As a result, the changes in this rule proposal are another part of the project and are necessary to account for past and future inflation, examination complexity, and other economic factors that affect participation in the designated doctor program.

The amendments to §§133.10, 133.20, 133.200, and 133.502 require an assignment number in the prior authorization field of the medical billing forms to identify designated doctor-associated billing. DWC expects the format of the assignment number to be 12345678DD01. The numbers on the left would be the DWC claim number. The "DD" would denote a designated doctor-associated examination. The numbers on the right would indicate whether it is the first, second, third, and so forth, ordered examination for the claim. The DWC-provided assignment number is for identification purposes and does not create a preauthorization or utilization review requirement. The current rules do not provide a billing mechanism to distinguish designated doctor examinations or any additional testing or referral evaluations that result from a designated doctor examination. This produces confusion and delays in payment. For example, under Labor Code §408.1225, insurance carriers must pay for designated doctor examinations, and §127.10(c) of this title requires a designated doctor to perform additional testing and refer an injured

employee to other health care providers when necessary to resolve the issue in question. Any required additional testing or referral is not subject to preauthorization requirements and cannot be denied retrospectively based on medical necessity, extent of injury, or compensability. However, if the insurance carrier cannot easily see that an examination is a designated doctor examination or a referral from a designated doctor examination, processing the bill could be unnecessarily delayed, which creates additional work and expense. Requiring an assignment number in the preauthorization field addresses this problem by linking the designated doctor examination and any additional testing or referral evaluations to the DWC-provided assignment number that distinguishes them as designated doctor examinations.

In addition, the amendments clarify that the 95-day period for timely submission of a designated doctor examination bill, where the designated doctor has referred the injured employee for additional testing or evaluation, begins on the date of service for the additional testing or evaluation. This ensures that any delays in scheduling or performing the additional testing or evaluation do not penalize the designated doctor by making compliance with the billing timeline impossible, which could make the bill unpayable. It gives the designated doctor time to complete the examination report.

The amendments also correct a typographical error in a rule reference and include nonsubstantive editorial and formatting changes throughout that make updates for plain language and agency style to improve the rule's clarity.

Section 133.10. The amendments to §133.10 require an assignment number in the prior authorization field of the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500), Uniform Bill 04 (UB-04), Statement of Pharmacy Services (DWC Form-066), and 2006 American Dental Association Dental Claim Form (ADA 2006) for DWC-ordered designated doctor examinations, and for additional testing or evaluation that a designated doctor refers. They also clarify the dates that apply to the additional testing or evaluation. Amending §133.10 is necessary to better identify that a bill is for a designated doctor examination, and to help associate a bill for additional testing or evaluation that occurs as a result of a designated doctor examination with the original designated doctor examination. These amendments will help insurance carriers and bill review agents identify these types of bills and associate them with the proper examination types, and they will increase the likelihood that the bills will be paid without unnecessary administrative delay.

Section 133.20. The amendments to §133.20 clarify that the 95-day period for timely submission of a bill for additional testing or evaluation under §127.10 of this title begins on the date of service of the additional testing or evaluation. They also require a designated doctor that refers an injured employee for additional testing or evaluation to provide the assignment number to the health care provider performing the testing or evaluation, and they require a designated doctor or a health care provider performing additional testing or evaluation to include the assignment number on the medical bill to conform with amended §133.10. Amending §133.20 is necessary to ensure consistency in billing deadlines, to allow the designated doctor time to complete the designated doctor report after receiving the results from the additional testing or evaluation, and to prevent the designated doctor from being penalized unfairly if scheduling or performing the additional testing or evaluation takes more than a few weeks.

Section 133.200. The amendments to §133.200 correct an incorrect reference to §133.10. Amending §133.200 is necessary to ensure the reference's accuracy.

Section 133.502. The amendments to §133.502 apply the requirement to include the assignment number in the prior authorization field in §133.10 and §133.20 to professional, institutional or hospital, dental, and pharmacy electronic medical bills. Amending §133.502 is necessary to ensure consistency in billing between paper and electronic formats, and to allow DWC to better identify designated doctor and designated doctor referral billing in the DWC database of medical charges.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received 30 written comments by the January 29, 2024, deadline, and three oral comments at the January 23, 2024, hearing. Because DWC published the Chapter 133 proposal and the Chapter 134 proposal at the same time and discussed both proposals in the hearing, some commenters submitted comments specifically on both proposals, while others acknowledged both proposals but only commented specifically on one. Twenty-two individuals acknowledged both proposals in their comments but did not specifically state a position on the Chapter 133 proposal. Commenters specifically in support of the Chapter 133 proposal were: the Office of Injured Employee Counsel; the Texas Chiropractic Association; the Insurance Council of Texas; Texas Independent Evaluators, LLC; and three individuals. Commenters specifically in support of the Chapter 133 proposal with changes were: Texas Mutual Insurance Company. No commenters were against the Chapter 133 proposal.

Comments on Chapter 133. Seven commenters stated that they supported the proposal. One commenter expressed support and appreciation for DWC’s efforts to provide free training for insurance carriers and health care providers on the new billing requirements and reimbursement rates.

Agency Response to Comments on Chapter 133. DWC appreciates the comments.

Comments on Chapter 133 (assignment number). One commenter stated that the assignment number was for clarity purposes. One commenter stated that they support and appreciate DWC’s clarification on the format for designated doctor order numbers, which will allow insurance carriers to distinguish a designated doctor order number in the preauthorization field of a medical bill from a preauthorization number.

Agency Response to Comments on Chapter 133. DWC appreciates the comments and agrees.

Comment on §133.20 (95-day period). One commenter asked DWC to clarify the start of the 95-day period for timely submission of a designated doctor exam bill.

Agency Response to Comment on §133.20 (95-day period). DWC appreciates the comment. Under §133.10, when a designated doctor refers an injured employee for additional testing or evaluation, the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation. Under §133.20, the 95-day period for timely submission of a bill for additional testing or evaluation begins on the date of service of the additional testing or evaluation (the "To" date in the dates of service field in the CMS-1500/field 24A).

Comment on Chapter 133 (effective dates). One commenter recommended that references to effective dates throughout Chapter 133 be changed to say "effective for services provided on or after (insert final effective date)" to correspond with the applicability date references in §134.209(b) of this title.

Agency Response to Comment on Chapter 133 (effective dates). DWC appreciates the comment and has added to the text in §§133.10(l), 133.20(o), and 133.502(g) to clarify the effective dates for medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after the effective date of the rule.

Comment on §133.10 (health care provider type). One commenter recommended that DWC add a health care provider type "AP" for advanced practice registered nurse to the list of provider types in §133.10(i).

Agency Response to Comment on §133.10 (health care provider type). DWC appreciates the suggestion but declines to make the change because it is out of scope for this rule. If DWC later initiates a rule project to review all of the health care provider types in §133.10, DWC will consider recommendations for additions or deletions at that time.

Comment on §133.10 and §133.502 (pharmacy). One commenter recommended that DWC remove any new billing guidance for additional designated doctor-ordered testing or evaluation services on pharmacy bills. The commenter requested, alternatively, that DWC provide clarification regarding how an insurance carrier would treat such a bill received from a pharmacy.

Agency Response to Comment on §133.10 and §133.502 (pharmacy). DWC appreciates the suggestion but declines to make the change. It is conceivable that a pharmacy provider could need to complete and bill for designated doctor-ordered testing or evaluation services, and omitting pharmacy providers from the billing guidance could inadvertently create confusion in that situation. An insurance carrier would handle the bill through its normal billing process. DWC will address general questions about the normal billing process through training.

Comment on §133.20 (reference to §126.9). One commenter recommended that DWC revise §133.20(l) to include a reference to §126.9 of this title as an additional condition under which a health care provider may bill an injured employee.

Agency Response to Comment on §133.20 (reference to §126.9). DWC appreciates the suggestion but declines to make the change because it is out of scope for this rule. If DWC later initiates a rule project to review the conditions under which a health care provider may bill an injured employee, DWC will consider recommendations for additions or deletions at that time.

SUBCHAPTER B. HEALTH CARE PROVIDER BILLING PROCEDURES

28 TAC §133.10, §133.20

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §133.10 and §133.20 under Labor Code §§408.004, 408.0041, 408.021, 408.023, 408.0251, 408.0252, 408.1225, 413.007, 413.011, 413.012, 413.015, 413.0511, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.004 provides that the commissioner may require an employee to submit to medical examinations to resolve any question about the appropriateness of the health care the employee receives, or at the request of the insurance carrier after the insurance carrier has tried and failed to get the employee's permission and concurrence for the examination. It also requires the insurance carrier to pay for those examinations, as well as the reasonable expenses incident to the employee in submitting to them.

Labor Code §408.0041 provides that, at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues.

Labor Code §408.021 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

Labor Code §408.023 requires in part that the commissioner by rule establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, IR testing, and disclosure of financial interests; and for monitoring of those doctors and health care providers. It also requires a doctor, including a doctor who contracts with a workers' compensation health care network, to comply with the IR training and testing requirements in the rule if the doctor intends to provide MMI certifications or assign IRs.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §408.0252 provides that the commissioner of workers' compensation may, by rule, identify areas of this state in which access to health care providers is less available, and adopt appropriate standards, guidelines, and rules about the delivery of health care in those areas.

Labor Code §408.1225 requires the commissioner of workers' compensation to develop a process for certifying designated doctors, which requires DWC to evaluate designated doctors' educational experience, previous training, and demonstrated ability to perform the specific designated doctor duties in §408.0041. It also requires standard training and testing for designated doctors.

Labor Code §413.007 requires DWC to maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the commissioner in adopting the medical policies and fee guidelines, and by DWC in administering the medical policies, fee guidelines, or rules. The database must contain information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols, and must be able to be used in a meaningful way to allow DWC to control medical costs.

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 with minimal modifications to those reimbursement methodologies as needed to meet occupational injury requirements. It requires the commissioner to adopt the most current methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting; and allows the commissioner to modify documentation requirements as needed to meet the requirements of §413.053. It also requires the commissioner, in determining the appropriate fees, to develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of §413.011(d); and requires the commissioner to provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commissioner rules. The commissioner may not adopt the Medicare fee schedule or conversion factors or other payment adjustment factors based solely on those factors as developed by the federal CMS. Fee guidelines must be fair and reasonable, and designed to ensure the quality of medical care and achieve medical cost control. They may not provide for payment of a fee that exceeds 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. When establishing the fee guidelines, §413.011 requires the commissioner to consider the increased security of payment that Subtitle A, Title 5, Labor Code affords. It allows network contracts under Insurance Code §1305.006. It specifically authorizes the commissioner and the commissioner of insurance to adopt rules as necessary to implement §413.011.

Labor Code §413.012 requires the medical policies and fee guidelines to be reviewed and revised at least every two years 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 is conducted.

Labor Code §413.015 requires insurance carriers to pay appropriate charges for medical services under Subtitle A, Title 5, Labor Code, and requires the commissioner by rule to review and audit those payments to ensure compliance with the adopted medical policies and fee guidelines. The insurance carrier must pay the expenses of the review and audit.

Labor Code §413.0511 requires DWC to employ or contract with a medical advisor. The medical advisor must be a doctor, as defined in §401.011. The medical advisor's duties include making recommendations about the adoption of rules and policies to: develop, maintain, and review guidelines as provided by §413.011, including rules about IRs; reviewing compliance with those guidelines; regulating or performing other acts related to medical benefits as required by the commissioner; and determining minimal modifications to the reimbursement methodology and model used by the Medicare system as needed to meet occupational injury requirements.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§133.10. Required Billing Forms/Formats.

(a) Health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit medical bills for payment in an electronic format in accordance with §133.500 and §133.501 of this title (relating to Electronic Formats for Electronic Medical Bill Processing and Electronic Medical Bill Processing), unless the health care provider or the billed insurance carrier is exempt from the electronic billing process in accordance with §133.501 of this title.

(b) Except as provided in subsection (a) of this section, health care providers, including those providing services for a certified workers' compensation health care network as defined in Insurance Code Chapter 1305 or to political subdivisions with contractual relationships under Labor Code §504.053(b)(2), must submit paper medical bills for payment on:

(1) the 1500 Health Insurance Claim Form Version 02/12 (CMS-1500);

(2) the Uniform Bill 04 (UB-04); or

(3) applicable forms prescribed for pharmacists, dentists, and surgical implant providers specified in subsections (c), (d), and (e) of this section.

(c) Pharmacists and pharmacy processing agents must submit bills using the division form DWC-066. A pharmacist or pharmacy processing agent may submit bills using an alternate billing form if:

(1) the insurance carrier has approved the alternate billing form prior to submission by the pharmacist or pharmacy processing agent; and

(2) the alternate billing form provides all information required on the division form DWC-066.

(d) Dentists must submit bills for dental services using the 2006 American Dental Association (ADA) Dental Claim form.

(e) Surgical implant providers requesting separate reimbursement for implantable devices must submit bills using:

(1) the form prescribed in subsection (b)(1) of this section when the implantable device reimbursement is sought under §134.402 of this title (relating to Ambulatory Surgical Center Fee Guideline); or

(2) the form prescribed in subsection (b)(2) of this section when the implantable device reimbursement is sought under §134.403 or §134.404 of this title (relating to Hospital Facility Fee Guideline--Outpatient and Hospital Facility Fee Guideline--Inpatient).

(f) All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.

(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:

(A) patient's Social Security number (CMS-1500/field 1a) is required;

(B) patient's name (CMS-1500/field 2) is required;

(C) patient's date of birth and gender (CMS-1500/field 3) is required;

(D) employer's name (CMS-1500/field 4) is required;

(E) patient's address (CMS-1500/field 5) is required;

(F) patient's relationship to subscriber (CMS-1500, field 6) is required;

(G) employer's address (CMS-1500, field 7) is required;

(H) workers' compensation claim number assigned by the insurance carrier (CMS-1500/field 11) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(I) date of injury and "431" qualifier (CMS-1500, field 14) are required;

(J) name of referring provider or other source is required when another health care provider referred the patient for the services; no qualifier indicating the role of the provider is required (CMS-1500, field 17);

(K) referring provider's state license number (CMS-1500/field 17a) is required when there is a referring doctor listed in CMS-1500/field 17; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number;

(M) diagnosis or nature of injury (CMS-1500/field 21) is required; at least one diagnosis code and the applicable ICD indicator must be present;

(N) prior authorization number (CMS-1500/field 23) is required in the following situations:

(i) Preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the requesting health care provider. Include the approval number in the prior authorization field (CMS-1500/field 23).

(ii) The division ordered a designated doctor examination and provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(iii) The designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number. Include the assignment number in the prior authorization field (CMS-1500/field 23).

(O) date or dates of service (CMS-1500, field 24A) is required;

(i) If the designated doctor referred the injured employee for additional testing or evaluation, the "From" date is the date of the designated doctor examination, and the "To" date is the date of service of the additional testing or evaluation.

(ii) If the designated doctor did not refer the injured employee for additional testing or evaluation, the "From" and "To" dates are the date of the designated doctor examination.

(P) place of service code or codes (CMS-1500, field 24B) is required;

(Q) procedure/modifier code (CMS-1500, field 24D) is required;

(R) diagnosis pointer (CMS-1500, field 24E) is required;

(S) charges for each listed service (CMS-1500, field 24F) is required;

(T) number of days or units (CMS-1500, field 24G) is required;

(U) rendering provider's state license number (CMS-1500/field 24j, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number;

(W) supplemental information (shaded portion of CMS-1500/fields 24d - 24h) is required when the provider is requesting separate reimbursement for surgically implanted devices or when additional information is necessary to adjudicate payment for the related service line;

(X) billing provider's federal tax ID number (CMS-1500/field 25) is required;

(Y) total charge (CMS-1500/field 28) is required;

(Z) signature of physician or supplier, the degrees or credentials, and the date (CMS-1500/field 31) is required, but the signature may be represented with a notation that the signature is on file and the typed name of the physician or supplier;

(AA) service facility location information (CMS-1500/field 32) is required;

(BB) service facility NPI number (CMS-1500/field 32a) is required when the facility is eligible for an NPI number;

(CC) billing provider name, address, and telephone number (CMS-1500/field 33) is required;

(DD) billing provider's NPI number (CMS-1500/Field 33a) is required when the billing provider is eligible for an NPI number; and

(EE) billing provider's state license number (CMS-1500/field 33b) is required when the billing provider has a state license number; the billing provider must enter the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX').

(2) The following data content or data elements are required for a complete institutional medical bill related to Texas workers' compensation health care:

(A) billing provider's name, address, and telephone number (UB-04/field 01) is required;

(B) patient control number (UB-04/field 03a) is required;

(C) type of bill (UB-04/field 04) is required;

(D) billing provider's federal tax ID number (UB-04/field 05) is required;

(E) statement covers period (UB-04/field 06) is required;

(F) patient's name (UB-04/field 08) is required;

(G) patient's address (UB-04/field 09) is required;

(H) patient's date of birth (UB-04/field 10) is required;

(I) patient's gender (UB-04/field 11) is required;

(J) date of admission (UB-04/field 12) is required when billing for inpatient services;

(K) admission hour (UB-04/field 13) is required when billing for inpatient services other than skilled nursing inpatient services;

(L) priority (type) of admission or visit (UB-04/field 14) is required;

(M) point of origin for admission or visit (UB-04/field 15) is required;

(N) discharge hour (UB-04/field 16) is required when billing for inpatient services with a frequency code of "1" or "4" other than skilled nursing inpatient services;

(O) patient discharge status (UB-04/field 17) is required;

(P) condition codes (UB-04/fields 18 - 28) are required when there is a condition code that applies to the medical bill;

(Q) occurrence codes and dates (UB-04/fields 31 - 34) are required when there is an occurrence code that applies to the medical bill;

(R) occurrence span codes and dates (UB-04/fields 35 and 36) are required when there is an occurrence span code that applies to the medical bill;

(S) value codes and amounts (UB-04/fields 39 - 41) are required when there is a value code that applies to the medical bill;

(T) revenue codes (UB-04/field 42) are required;

(U) revenue description (UB-04/field 43) is required;

(V) HCPCS/Rates (UB-04/field 44):

(i) HCPCS codes are required when billing for outpatient services and an appropriate HCPCS code exists for the service line item; and

(ii) accommodation rates are required when a room and board revenue code is reported;

(W) service date (UB-04/field 45) is required when billing for outpatient services;

(X) service units (UB-04/field 46) is required;

(Y) total charge (UB-04/field 47) is required;

(Z) date bill submitted, page numbers, and total charges (UB-04/field 45/line 23) is required;

(AA) insurance carrier name (UB-04/field 50) is required;

(BB) billing provider NPI number (UB-04/field 56) is required when the billing provider is eligible to receive an NPI number;

(CC) billing provider's state license number (UB-04/field 57) is required when the billing provider has a state license number; the billing provider must enter the license number and jurisdiction code (for example, '123TX');

(DD) employer's name (UB-04/field 58) is required;

(EE) patient's relationship to subscriber (UB-04/field 59) is required;

(FF) patient's Social Security number (UB-04/field 60) is required;

(GG) workers' compensation claim number assigned by the insurance carrier (UB-04/field 62) is required when known, the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(HH) preauthorization number (UB-04/field 63) is required when:

(i) preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.

(II) principal diagnosis code and present on admission indicator (UB-04/field 67) are required;

(JJ) other diagnosis codes (UB-04/field 67A - 67Q) are required when these conditions exist or subsequently develop during the patient's treatment;

(KK) admitting diagnosis code (UB-04/field 69) is required when the medical bill involves an inpatient admission;

(LL) patient's reason for visit (UB-04/field 70) is required when submitting an outpatient medical bill for an unscheduled outpatient visit;

(MM) principal procedure code and date (UB-04/field 74) is required when submitting an inpatient medical bill and a procedure was performed;

(NN) other procedure codes and dates (UB-04/fields 74A - 74E) are required when submitting an inpatient medical bill and other procedures were performed;

(OO) attending provider's name and identifiers (UB-04/field 76) are required for any services other than nonscheduled transportation services, the billing provider must report the NPI number for an attending provider eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX');

(PP) operating physician's name and identifiers (UB-04/field 77) are required when a surgical procedure code is included on the medical bill; the billing provider must report the NPI number for an operating physician eligible for an NPI number and the state license number by entering the '0B' qualifier and the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(QQ) remarks (UB-04/field 80) is required when separate reimbursement for surgically implanted devices is requested.

(3) The following data content or data elements are required for a complete pharmacy medical bill related to Texas workers' compensation health care:

(A) dispensing pharmacy's name and address (DWC-066/field 1) is required;

(B) date of billing (DWC-066/field 2) is required;

(C) dispensing pharmacy's National Provider Identification (NPI) number (DWC-066/field 3) is required;

(D) billing pharmacy's or pharmacy processing agent's name and address (DWC-066/field 4) is required when different from the dispensing pharmacy (DWC-066/field 1);

(E) invoice number (DWC-066/field 5) is required;

(F) payee's federal employer identification number (DWC-066/field 6) is required;

(G) insurance carrier's name (DWC-066/field 7) is required;

(H) employer's name and address (DWC-066/field 8) is required;

(I) injured employee's name and address (DWC-066/field 9) is required;

(J) injured employee's Social Security number (DWC-066/field 10) is required;

(K) date of injury (DWC-066/field 11) is required;

(L) injured employee's date of birth (DWC-066/field 12) is required;

(M) prescribing doctor's name and address (DWC-066/field 13) is required;

(N) prescribing doctor's NPI number (DWC-066/field 14) is required;

(O) workers' compensation claim number assigned by the insurance carrier (DWC-066/field 15) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(P) dispensed as written code (DWC-066/field 19) is required;

(Q) date filled (DWC-066/field 20) is required;

(R) generic National Drug Code (NDC) code (DWC-066/field 21) is required when a generic drug was dispensed or if dispensed as written code '2' is reported in DWC-066/field 19;

(S) name brand NDC code (DWC-066/field 22) is required when a name brand drug is dispensed;

(T) quantity (DWC-066/field 23) is required;

(U) days supply (DWC-066/field 24) is required;

(V) amount paid by the injured employee (DWC-066/field 26) is required if applicable;

(W) drug name and strength (DWC-066/field 27) is required;

(X) prescription number (DWC-066/field 28) is required;

(Y) amount billed (DWC-066/field 29) is required;

(Z) preauthorization number (DWC-066/field 30) is required when:

(i) preauthorization, voluntary certification, or an agreement was approved, and the insurance carrier provided an approval number to the requesting health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.

(AA) for billing of compound drugs, refer to the requirements in §134.502 of this title (relating to Pharmaceutical Services).

(4) The following data content or data elements are required for a complete dental medical bill related to Texas workers' compensation health care:

(A) type of transaction (ADA 2006 Dental Claim Form/field 1);

(B) preauthorization number (ADA 2006 Dental Claim Form/field 2) is required when:

(i) preauthorization, concurrent review, or voluntary certification was approved, and the insurance carrier provided an approval number to the health care provider; or

(ii) a designated doctor referred the injured employee for additional testing or evaluation, and the division provided an assignment number to the designated doctor.

(C) insurance carrier name and address (ADA 2006 Dental Claim Form/field 3) is required;

(D) employer's name and address (ADA 2006 Dental Claim Form/field 12) is required;

(E) workers' compensation claim number assigned by the insurance carrier (ADA 2006 Dental Claim Form/field 15) is required when known; the billing provider must leave the field blank if the workers' compensation claim number is not known by the billing provider;

(F) patient's name and address (ADA 2006 Dental Claim Form/field 20) is required;

(G) patient's date of birth (ADA 2006 Dental Claim Form/field 21) is required;

(H) patient's gender (ADA 2006 Dental Claim Form/field 22) is required;

(I) patient's Social Security number (ADA 2006 Dental Claim Form/field 23) is required;

(J) procedure date (ADA 2006 Dental Claim Form/field 24) is required;

(K) tooth number or numbers or letter or letters (ADA 2006 Dental Claim Form/field 27) is required;

(L) procedure code (ADA 2006 Dental Claim Form/field 29) is required;

(M) fee (ADA 2006 Dental Claim Form/field 31) is required;

(N) total fee (ADA 2006 Dental Claim Form/field 33) is required;

(O) place of treatment (ADA 2006 Dental Claim Form/field 38) is required;

(P) treatment resulting from (ADA 2006 Dental Claim Form/field 45) is required; the provider must check the box for occupational illness/injury;

(Q) date of injury (ADA 2006 Dental Claim Form/field 46) is required;

(R) billing provider's name and address (ADA 2006 Dental Claim Form/field 48) is required;

(S) billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) is required if the billing provider is eligible for an NPI number;

(T) billing provider's state license number (ADA 2006 Dental Claim Form/field 50) is required when the billing provider is a licensed health care provider; the billing provider must enter the license type, license number, and jurisdiction code (for example, 'DS1234TX');

(U) billing provider's federal tax ID number (ADA 2006 Dental Claim Form/field 51) is required;

(V) rendering dentist's NPI number (ADA 2006 Dental Claim Form/field 54) is required when different than the billing provider's NPI number (ADA 2006 Dental Claim Form/field 49) and the rendering dentist is eligible for an NPI number;

(W) rendering dentist's state license number (ADA 2006 Dental Claim Form/field 55) is required when different than the billing provider's state license number (ADA 2006 Dental Claim Form/field 50); the billing provider must enter the license type, license number, and jurisdiction code (for example, 'MDF1234TX'); and

(X) rendering provider's and treatment location address (ADA 2006 Dental Claim Form/field 56) is required when different from the billing provider's address (ADA Dental Claim Form/field 48).

(g) If the injured employee does not have a Social Security number as required in subsection (f) of this section, the health care provider must leave the field blank.

(h) Except for facility state license numbers, state license numbers submitted under subsection (f) of this section must be in the following format: license type, license number, and jurisdiction state code (for example 'MDF1234TX').

(i) In reporting the state license number under subsection (f) of this section, health care providers should select the license type that most appropriately reflects the type of medical services they provided to the injured employees. When a health care provider does not have a state license number, the field is submitted with only the license type and jurisdiction code (for example, DMTX). The license types used in the state license format must be one of the following:

(1) AC for Acupuncturist;

(2) AM for Ambulance Services;

(3) AS for Ambulatory Surgery Center;

(4) AU for Audiologist;

(5) CN for Clinical Nurse Specialist;

(6) CP for Clinical Psychologist;

(7) CR for Certified Registered Nurse Anesthetist;

(8) CS for Clinical Social Worker;

(9) DC for Doctor of Chiropractic;

(10) DM for Durable Medical Equipment Supplier;

(11) DO for Doctor of Osteopathy;

(12) DP for Doctor of Podiatric Medicine;

(13) DS for Dentist;

(14) IL for Independent Laboratory;

(15) LP for Licensed Professional Counselor;

(16) LS for Licensed Surgical Assistant;

(17) MD for Doctor of Medicine;

(18) MS for Licensed Master Social Worker;

(19) MT for Massage Therapist;

(20) NF for Nurse First Assistant;

(21) OD for Doctor of Optometry;

(22) OP for Orthotist/Prosthetist;

(23) OT for Occupational Therapist;

(24) PA for Physician Assistant;

(25) PM for Pain Management Clinic;

(26) PS for Psychologist;

(27) PT for Physical Therapist;

(28) RA for Radiology Facility; or

(29) RN for Registered Nurse.

(j) When resubmitting a medical bill under subsection (f) of this section, a resubmission condition code may be reported. In reporting a resubmission condition code, the following definitions apply to the resubmission condition codes established by the Uniform National Billing Committee:

(1) W3 - Level 1 Appeal means a request for reconsideration under §133.250 of this title (relating to Reconsideration for Payment of Medical Bills) or an appeal of an adverse determination under Chapter 19, Subchapter U of this title (relating to Utilization Reviews for Health Care Provided Under Workers' Compensation Insurance Coverage);

(2) W4 - Level 2 Appeal means a request for reimbursement as a result of a decision issued by the division, an independent review organization, or a network complaint process; and

(3) W5 - Level 3 Appeal means a request for reimbursement as a result of a decision issued by an administrative law judge or judicial review.

(k) The inclusion of the appropriate resubmission condition code and the original reference number is sufficient to identify a resubmitted medical bill as a request for reconsideration under §133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title provided the resubmitted medical bill complies with the other requirements contained in the appropriate section.

(l) Effective Date.

(1) This section is effective for medical bills submitted on or after June 1, 2024.

(2) For medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024, the provisions of subsection (f) of this section are effective on and after June 1, 2024.

§133.20. Medical Bill Submission by Health Care Provider.

(a) The health care provider must submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.

(b) Except as provided in Labor Code §408.0272(b), (c), or (d), a health care provider must not submit a medical bill later than the 95th day after the date the services are provided.

(1) If a designated doctor refers an injured employee for additional testing or evaluation under §127.10 of this title, the 95-day period for timely submission of the bill begins on the date of service of the additional testing or evaluation.

(2) In accordance with subsection (c) of the statute, the health care provider must submit the medical bill to the correct workers' compensation insurance carrier no later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill.

(3) A health care provider who submits a medical bill to the correct workers' compensation insurance carrier must include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied. The medical bill submitted by the health care provider to the correct workers' compensation insurance carrier is subject to the billing, review, and dispute processes established by Chapter 133, including §133.307(c)(2)(A) - (H) of this title (relating to MDR of Fee Disputes), which establishes the generally acceptable standards for documentation.

(c) A health care provider must include correct billing codes from the applicable division fee guidelines in effect on the date or dates of service when submitting medical bills.

(d) The health care provider that provided the health care must submit its own bill, unless:

(1) the health care was provided as part of a return-to-work rehabilitation program in accordance with the division fee guidelines in effect for the dates of service;

(2) the health care was provided by an unlicensed individual under the direct supervision of a licensed health care provider, in which case the supervising health care provider must submit the bill;

(3) the health care provider contracts with an agent for purposes of medical bill processing, in which case the health care provider agent may submit the bill; or

(4) the health care provider is a pharmacy that has contracted with a pharmacy processing agent for purposes of medical bill processing, in which case the pharmacy processing agent may submit the bill.

(e) A medical bill must be submitted:

(1) for an amount that does not exceed the health care provider's usual and customary charge for the health care provided in accordance with Labor Code §§413.011 and 415.005; and

(2) in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care.

(f) Health care providers must not resubmit medical bills to insurance carriers after the insurance carrier has taken final action on a complete medical bill and provided an EOB except in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills).

(g) Health care providers may correct and resubmit as a new bill an incomplete bill that has been returned by the insurance carrier.

(h) Not later than the 15th day after receipt of a request for additional medical documentation, a health care provider must submit to the insurance carrier:

(1) any requested additional medical documentation related to the charges for health care rendered; or

(2) a notice the health care provider does not possess requested medical documentation.

(i) The health care provider must indicate on the medical bill if documentation is submitted related to the medical bill.

(j) The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill or bills. Such billing is subject to the following:

(1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:

(A) prompt payment, as provided by Labor Code §408.027;

(B) interest for delayed payment as provided by Labor Code §413.019; and

(C) medical dispute resolution as provided by Labor Code §413.031.

(2) When a health care provider bills the employer, the health care provider must submit an information copy of the bill to the insurance carrier, which clearly indicates that the information copy is not a request for payment from the insurance carrier.

(3) When a health care provider bills the employer, the health care provider must bill in accordance with the division's fee guidelines and §133.10 of this chapter (relating to Required Billing Forms/Formats).

(4) A health care provider must not submit a medical bill to an employer for charges an insurance carrier has reduced, denied, or disputed.

(k) A health care provider must not submit a medical bill to an injured employee for all or part of the charge for any of the health care provided, except as an informational copy clearly indicated on the bill, or in accordance with subsection (l) of this section. The information copy must not request payment.

(l) The health care provider may only submit a bill for payment to the injured employee in accordance with:

(1) Labor Code §413.042;

(2) Insurance Code §1305.451; or

(3) §134.504 of this title (relating to Pharmaceutical Expenses Incurred by the Injured Employee).

(m) A designated doctor must include the assignment number on the medical bill in accordance with §133.10 of this title (relating to Required Billing Forms/Formats).

(n) A designated doctor who refers the injured employee for additional testing or evaluation under §127.10 must provide the assignment number to the health care provider performing the testing or evaluation. The health care provider performing the testing or evaluation must include the assignment number on the medical bill in accordance with §133.10.

(o) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an

examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 23, 2024.

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Kara Mace
General Counsel
Texas Department of Insurance, Division of Workers' Compensation
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For further information, please call: (512) 804-4703

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SUBCHAPTER C. MEDICAL BILL PROCESSING/AUDIT BY INSURANCE CARRIER

28 TAC §133.200

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §133.200 under Labor Code §§413.053, 402.00111, 402.00116, and 402.061.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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Kara Mace
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SUBCHAPTER G. ELECTRONIC MEDICAL BILLING, REIMBURSEMENT, AND DOCUMENTATION

28 TAC §133.502

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the amendments to §133.502 under Labor Code §§408.0251, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

§133.502. Electronic Medical Billing Supplemental Data Requirements.

(a) In addition to the data requirements and standards adopted under §133.500(a) of this title (relating to Electronic Formats for Electronic Medical Bill Processing), all professional, institutional or hospital, and dental electronic medical bills submitted before January 1, 2012, must contain:

(1) the telephone number of the submitter;

(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";

(3) the injured employee's Social Security number as the subscriber member identification number;

(4) the injured employee's date of injury;

(5) the rendering health care provider's state provider license number;

(6) the referring health care provider's state provider license number;

(7) the billing provider's state provider license number, if the billing provider has a state provider license number;

(8) the attending physician's state medical license number, when applicable;

(9) the operating physician's state medical license number, when applicable;

(10) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill; and

(11) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission.

(b) In reporting the injured employee Social Security number and the state license numbers under subsection (a) of this section, health care providers must follow the data content and format requirements contained in §133.10 of this title (relating to Required Billing Forms/Formats).

(c) In addition to the data requirements contained in the standards adopted under §133.500(c) of this title, all professional, institutional or hospital, and dental electronic medical bills submitted on or after January 1, 2012, must contain:

(1) the telephone number of the submitter;

(2) the workers' compensation claim number assigned by the insurance carrier or, if that number is not known by the health care provider, a default value of "UNKNOWN";

(3) the injured employee's date of injury;

(4) the claim supplemental information, when electronic documentation is submitted with an electronic medical bill;

(5) the resubmission condition code, when the electronic medical bill is a duplicate, request for reconsideration, or other resubmission; and

(6) for a designated doctor and a health care provider performing a test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

(d) In addition to the data requirements contained in the standards adopted under §133.500 of this title, all pharmacy electronic medical bills must contain:

(1) the dispensing pharmacy's National Provider Identification number;

(2) the prescribing doctor's National Provider Identification number; and

(3) for a health care provider performing a test or evaluation as a result of a designated doctor's referral, the assignment number in the prior authorization field.

(e) In reporting the resubmission condition code under this section, the resubmission condition codes must have the definitions specified in §133.10(j) of this title.

(f) This section does not apply to paper medical bills submitted for payment under §133.10(b) of this title.

(g) This section is effective for medical bills submitted on or after June 1, 2024, including medical bills submitted as a result of an examination that was ordered or referred as the result of an order issued on or after June 1, 2024.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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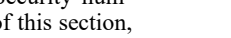

CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts the repeal of 28 TAC §§134.235, 134.239, and 134.240; and new and amended 28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, and 134.260, concerning medical fee guidelines for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and maximum medical improvement (MMI) evaluations and impairment rating (IR) examinations by treating and referred doctors. The sections implement Texas Labor Code Chapters 408 and 413, which govern workers' compensation benefits, including medical examinations required to establish benefit entitlements, and medical review to ensure compliance with DWC rules for health care, including medical policies and fee guidelines. The DWC medical advisor recommended the changes to the commissioner of workers' compensation under Labor Code §413.0511(b). The repealed, new and amended sections are adopted without changes to the proposed text published in the December 29, 2023, issue of the *Texas Register* (48 TexReg 8165). The rules will not be republished.

REASONED JUSTIFICATION. The changes in the new and amended sections adjust the billing methodology and reimbursement rates for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors. They adjust the fees once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024, and then after the initial adjustment, adjust the fees annually on January 1 by applying the MEI percentage adjustment factor in §134.203(c)(2), which is how most other professional fees are adjusted annually in the system. They round the fees to whole dollars to simplify calculations and reduce errors. They eliminate unnecessary billing modifiers, eliminate a required sequence for modifiers, and replace the diagnosis-related estimate and range of motion billing methods with a single method of billing. They also create a $100 missed appointment fee and a $300 specialist fee. In addition, they eliminate tiering. For designated doctors and required medical examination doctors, all issues addressed within one examination will be paid at the established fee and not reduced.

The changes include restructuring and reorganization to move the requirements for each type of examination into a section that is specific to that type of examination, which will help to reduce the need for system participants to look in multiple different rules to find out what their obligations are. To that end, the changes repeal and replace: §134.235 to address billing and reimbursement for required medical examinations, §134.239 to clarify that the requirements for billing for work status reports align across the ordered examinations, and §134.240 to address

billing and reimbursement for designated doctor examinations. The changes amend and restructure §134.250, concerning MMI and IR examinations by treating doctors, to conform with the other sections; and add new §134.260, concerning MMI and IR examinations by referred doctors, to clarify the specific provisions that apply to examinations that are conducted by authorized doctors as a result of a referral from a treating doctor under §130.1 of this title, concerning certification of MMI and evaluation of permanent impairment.

The changes are necessary to attract and retain doctors that perform certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors, by addressing billing and reimbursement issues, reducing disputes, and by decreasing the administrative burden of participating in the program. Labor Code Chapter 408 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Specifically, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. To help determine the health care that meets those standards, the treating doctor manages and coordinates the injured employee's health care for the compensable injury, including referring the employee to a doctor authorized to determine MMI and to assign IRs when needed. The designated doctor program established under Chapter 408 provides for commissioner-ordered medical examinations to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues. Maintaining a viable program that ensures that injured employees can access examinations in a timely way is essential to meeting the statutory mandate of providing health care for injured employees.

Having too few doctors in the program has a negative impact on the doctors that remain in the system, injured employees, and insurance carriers. When there are too few doctors able to conduct the examinations needed to determine benefit levels, injured employees must often wait longer and travel farther to attend an examination, which can delay dispute resolution and other essential processes. DWC last adjusted reimbursement rates for workers' compensation-specific services in January 2008 (33 TexReg 364). Over the past 14 years, DWC has experienced a decline in the numbers of doctors providing workers' compensation-specific services. This decline has been particularly pronounced among designated doctors certified under Labor Code §408.1225 and providing designated doctor examinations as Labor Code §408.0041 requires, and especially among licensed medical doctors and doctors of osteopathy. In December 2022, for the entire state of Texas, there were only 63 available medical doctors, 10 doctors of osteopathic medicine, 177 doctors of chiropractic, and no doctors of podiatry, dental science, or optometry. Yet in that month, there were 1,259 designated doctor appointments for those 250 designated doctors to cover.

DWC held stakeholder meetings in March, September, and December 2022 to discuss issues with declining participation in the designated doctor program, including issues with billing logistics and reimbursement rates. DWC invited public comments on three separate informal drafts posted on DWC's website in August 2022, November 2022, and June 2023. In addition, DWC conducted a stakeholder survey to gather information about anticipated implementation costs and benefits in September 2023. DWC considered the comments it received at the meetings and on the informal drafts when drafting the proposal. DWC also considered comments it received in a public hearing on the proposal on January 23, 2024, as well as written comments it received by the January 29, 2024, deadline, when drafting this adoption order.

In April 2023, after gathering data about the program and soliciting input from system participants about how to maintain and increase participation in the designated doctor program and allow better access to specialized examinations, DWC adopted amendments to Chapter 127 of this title, concerning designated doctor procedures and requirements, and §180.23 of this title, concerning division-required training for doctors. Those rules addressed certification, training, and procedures for designated doctors and were required to address administrative and logistical inefficiencies, and to improve access to examinations, to make participation in the program possible and attractive for more doctors. They were one part of the project to ensure the designated doctor program's viability, in compliance with the Labor Code. After their adoption, DWC saw a near-immediate increase in the numbers of doctors applying to the program, which was very encouraging.

However, the common theme throughout the input-gathering process about how to improve the program was billing and reimbursement for certain workers' compensation-specific services, especially designated doctor examinations. Nearly every comment DWC received mentioned some combination of issues about the fees for designated doctor examinations--that they were insufficient, had not been adjusted for inflation or other economic factors in over a decade, did not take into account missed appointments or the time spent reviewing injured employees' medical records, and other similar issues. In adopting the amendments to Chapter 127 and §180.23, DWC stated that billing and reimbursement issues would be addressed in a separate rule project. As a result, the changes in this rule proposal are another part of the project, and are necessary to account for past and future inflation, examination complexity, and other economic factors that affect participation in the designated doctor program.

Labor Code Chapter 408 governs workers' compensation benefits. It entitles an injured employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. It requires a variety of workers' compensation-specific services, including required medical examinations; designated doctor examinations; MMI evaluations and IR examinations; and return-to-work and evaluation of medical care examinations.

Labor Code Chapter 413, Subchapter B, Medical Services and Fees, requires in part that the commissioner of workers' compensation adopt health care reimbursement policies and guidelines, develop one or more conversion factors or other payment adjustment factors, and provide for reasonable fees for the evaluation and management of care. Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Medical policies and guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control; designed to enhance a timely and appropriate return to work; and consistent with §§413.013, 413.020, 413.052, and 413.053.

The changes are necessary to comply with the mandates for administering the workers' compensation benefit and fee system in Labor Code Chapters 408 and 413. They also include nonsubstantive editorial and formatting changes throughout that make updates for plain language and agency style to improve the rule's clarity.

Section 134.209. The amendments to §134.209 add references to new §134.260 and clarify that the new and amended sections apply to workers' compensation-specific codes, services, and programs provided on or after June 1, 2024. Amending §134.209 is necessary to conform §134.209 to the new and amended sections and ensure that the rules are accurate.

Section 134.210. The amendments to §134.210 clarify that reimbursement for a missed appointment under §134.240 does not qualify for the 10% incentive payment for services performed in designated workers' compensation underserved areas. The amendments provide that fees established in §§134.235, 134.240, 134.250, and 134.260 of this title will be:

- adjusted once by applying the MEI percentage adjustment factor for the period 2009 - 2024;

- adjusted annually by applying the MEI percentage adjustment factor in §134.203(c)(2);

- rounded to whole dollars; and

- effective on January 1 of each new calendar year.

The amendments clarify that, for services provided under §§134.235, 134.240, 134.250, or 134.260, health care providers must bill and be reimbursed the maximum allowable reimbursement (MAR).

In addition, the amendments simplify the modifiers that health care providers must use when billing professional medical services for correct coding, reporting, billing, and reimbursement based on procedure codes. The amendments add modifier 25 and specify that it must be added to Current Procedural Terminology (CPT) code 99456 for designated doctor examinations involving one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title, including traumatic brain injuries, spinal cord injuries and diagnoses, severe burns, complex regional pain syndrome, joint dislocation, one or more fractures with vascular injury, one or more pelvis fractures, multiple rib fractures, complicated infectious diseases requiring hospitalization or prolonged intravenous antibiotics, chemical exposure, and heart or cardiovascular conditions. The amendments add modifier 52 and specify that it must be added to CPT code 99456 when DWC ordered the designated doctor to perform an examination of an injured employee, and the injured employee failed to attend the examination. The amendments correct an error that listed the incorrect CPT code for multiple IRs. The amendments delete the RE, SP, TC, and WP modifiers. The amendments realign the "V" modifiers that must be added to CPT code 99455 by deleting V1 and V2 and replacing the more subjective descriptors ("minimal," "self-limited," "minor," "low to moderate," and "moderate to high severity") with references to CPT code standards. For example, per the amendments, modifier V3, treating doctor evaluation of MMI, must now be added to CPT code 99455 when the office visit level of service is equal to CPT code 99213. The amendments also include CPT code 97546 for modifiers WC (work conditioning) and WH (work hardening).

Amending §134.210 is necessary to decrease administrative burdens by eliminating unnecessary billing modifiers and eliminating a required sequence for modifiers, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system. As fees were last adjusted in 2008, an increase to account for the intervening years of inflation is indicated, and the amendment to §134.210 that adjusts fees annually to account for future inflation is necessary to align with the annual updates in §134.203 of this chapter, concerning the medical fee guideline for professional services.

Section 134.235. New §134.235 renames the section "Required Medical Examinations" to capture the types of examinations more accurately than just the previous title of "Return to Work/Evaluation of Medical Care." It contains statutory references, requires that each examination and its individual billable components be reimbursed separately, and describes the billing methods and reimbursement amounts for a required medical examination (RME) doctor examining an injured employee for MMI or IR. Those billing methods and requirements were previously in §134.250 of this title, but have been moved to new §134.235 to allow RME doctors to find their billing requirements in one section. In addition, new §134.235 describes what the MMI or IR examination must include, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the American Medical Association (AMA) guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. New §134.235 sets increased rates for examinations to determine extent of injury, disability, return to work, other similar issues, and appropriateness of health care. In addition, for required medical examination doctors, all issues addressed within one examination will be paid at the established fee and not reduced. Finally, new §134.235 sets billing and reimbursement requirements for when the RME doctor refers testing to a specialist. It also requires documentation of the referral.

Repealing §134.235 and adopting new §134.235 is necessary to consolidate RME doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Section 134.239. New §134.239 states that work status reports may not be billed or reimbursed separately when they are completed as a component of an ordered examination. Repealing §134.239 and adopting new §134.239 is necessary to update references to conform with the restructured sections and clarify the language. The change does not affect how work status reports are billed in practice.

Section 134.240. New §134.240 specifies billing and reimbursement requirements for designated doctor examinations. It contains statutory references, provides for a $100 missed appointment fee, requires that each examination and its individual billable components be reimbursed separately, and describes the billing methods and reimbursement amounts for a designated doctor examination. In addition, new §134.240 sets the total MAR for an MMI or IR examination, describes what the MMI or IR examination must include and how it must be billed and reimbursed, specifies increased reimbursement rates for MMI eval-

uations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. New §134.240 sets increased rates for examinations to determine extent of injury, disability, return to work, and other similar issues. New §134.240 also sets billing and reimbursement requirements for when the designated doctor refers testing to a specialist, and it requires documentation of the referral. It specifies that the 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation, and that the designated doctor and any referral health care providers must include the DWC-provided assignment number in the prior authorization field, per §133.10(f)(1)(N) of this title. In addition, for designated doctors, all issues addressed within one examination will be paid at the established fee and not reduced. Finally, new §134.240 sets a $300 specialist fee in addition to the examination fee for certain specialized diagnoses.

Based on feedback from many designated doctors in the system, DWC included the missed appointment fee to recognize and compensate, at least in part, designated doctors that schedule an examination appointment with an injured employee, do the required medical record review, prepare for the examination, travel to the appointment, and then have the injured employee not attend the appointment. In the current system, those designated doctors would not be compensated for that missed appointment or the work they performed to prepare for it. The missed appointment fee acknowledges the work the designated doctors are required to do to prepare for an examination.

The specialist fee also acknowledges designated doctors' time and effort spent in gaining specialty certifications and expertise. It reimburses board-certified physicians that participate in the designated doctor program and examine injured employees with certain complex injuries or diagnoses. DWC expects that the specialist fee will help increase the numbers of board-certified physicians in the program, which will reduce delays in examinations for employees with complex injuries or diagnoses and contribute to overall system health and efficiency.

Repealing §134.240 and adopting new §134.240 is necessary to consolidate designated doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors. It is also necessary to put in place a missed appointment fee to compensate designated doctors for the time and expense they incur in reviewing medical records and traveling to the exam location when the injured employee does not attend the examination; and to set a specialist fee for examinations that require particular board certifications and expertise. In addition, repealing §134.240 and adopting new §134.240 is necessary to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines. It is also necessary to attract and retain doctors in the system.

Section 134.250. The amendments to §134.250 rename the section "Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors" to reflect the restructuring in this rule. The amendments move the requirements for required medical examinations into new §134.235, for designated doctors into new §134.240, and for referred doctors into new §134.260. The amendments make §134.250 specific to treating doctors, so treating doctors will be able to find their billing requirements in one section. They specify the billing methods and reimbursement requirements for MMI and IR examinations, and they permit a treating doctor that is not authorized to assign an IR to refer the injured employee to an authorized doctor for the examination and certification of MMI and IR, specifying that the referred doctor must bill under §134.260. In addition, the amendments to §134.250 specify increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, require billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for examination by the treating doctor. Finally, the amendments increase the reimbursement rate for a treating doctor reviewing the certification of MMI and assignment of IR performed by another doctor (referred doctor). Amending §134.250 is necessary to consolidate treating doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Section 134.260. New §134.260 concerns MMI evaluations and IR examinations by referred doctors. It describes what the MMI or IR examination must include, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. Adopting new §134.260 is necessary to consolidate referred doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received 30 written comments by the January 29, 2024, deadline, and three oral comments at the January 23, 2024, hearing. Because DWC published the Chapter 133 proposal and the Chapter 134 proposal at the same time and discussed both proposals in the hearing, some commenters submitted comments specifically on both proposals, while others acknowledged both proposals but only commented specifically on one. Three acknowledged both proposals in their comments but did not specifically state a position on the Chapter 134 proposal. Commenters specifically in support of the Chapter 134 proposal were: the Office of Injured Employee Counsel and two individuals. Commenters specifically in support of the Chapter 134 proposal with changes were: Texas Mutual Insurance Company; the Insurance Council of Texas; the Texas Chiropractic Association; Texas Independent Evaluators, LLC; and 19 individuals. No commenters were against the Chapter 134 proposal. Some commenters included logistical or practical questions or examples about how the rules will function once adopted. DWC will address those questions in the upcoming training sessions about how to comply with the updated rules.

Comment on Chapter 134 (notice of examination). A commenter stated that DWC should send an automated text and email in addition to a physical letter to claimants about the designated doctor examination, and that the days of snail mail are over.

Agency Response to Comment on Chapter 134 (notice of examination). DWC appreciates the comment but declines to make this change because it is out of scope for this rule project.

Comment on §134.240 (missed appointment fee). A commenter stated that the missed appointment fee should be recouped from the injured employee's temporary income benefits (TIBs), and that the insurance carrier should not be financially responsible for the claimant's choice to not attend.

Agency Response to Comment on §134.240 (missed appointment fee). DWC appreciates the comment. The missed appointment fee is necessary to compensate designated doctors for the work they are required to do in advance of an ordered examination, even if the injured employee does not attend the appointment. Section 127.25 of this title, Failure to Attend a Designated Doctor Examination, allows an insurance carrier to suspend TIBs if an injured employee fails, without good cause, to attend a designated doctor examination or a referral examination under §127.10(c) of this title, General Procedures for Designated Doctor Examinations.

Comments on §134.240 (missed appointment fee). Two commenters stated that they appreciated the new no-show fee.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments.

Comments on §134.240 (missed appointment fee). Three commenters stated that the no-show fee should be higher. One stated that the minimum amount should be $200. Another stated that the minimum amount should be $250.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments but declines to make the change at this time because of the significant one-time fee increases and annual inflation adjustments in this rule.

Comments on §134.240 (missed appointment fee). Fourteen commenters stated that DWC should provide a broken or missed appointment fee for all designated doctors, required medical examination doctors, treating doctors, and referral doctors. Three of those commenters also stated that DWC should include the same increase for MMI, IR, and other services.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments but declines to make the change. DWC's rules do not require travel to appointments, missed or attended. In addition, designated doctors are the only ones that are required by rule to review medical records from the treating doctor and insurance carrier before conducting the examination. That is distinct from an MMI or IR examination, where the examination itself includes a review of the records and films. The missed appointment fee is intended to compensate designated doctors for the work the rule requires them to perform before they go to perform the examination, only to find that they cannot perform the examination--and get paid for it--because the injured employee is not there.

Comment on §134.240 (missed appointment fee). One commenter stated that the $100 missed appointment fee proposed in §134.240 is consistent with the amount of the missed appointment fee proposed as part of House Bill (HB) 2702, 88th Legislature, Regular Session (2023), which failed to pass. The commenter stated that because the proposed rules include significant fee increases for all examinations, which will have a sizable cost impact on the workers' compensation system, the commenter did not support a fee amount greater than that which was proposed.

Agency Response to Comment on §134.240 (missed appointment fee). DWC appreciates the comment and agrees that the $100 missed appointment fee is appropriate.

Comments on Chapter 134 (record review fee). Three commenters stated that DWC needs to adopt a record review fee. One of those commenters stated that the fee should be $25 per 50 pages for records totaling more than 200 pages, and suggested that insurance carriers should have to pay extra for sending duplicated, useless, and out-of-order pages.

Agency Response to Comments on Chapter 134 (record review fee). DWC appreciates the comments but declines to make the change. DWC explored that option during the informal draft process, but found that a record review fee is not logistically feasible at this time. In addition, penalizing insurance carriers for sending duplicate pages is not in the scope of this rule. If an insurance carrier is not complying with the requirement to send records, or is abusing the system by sending voluminous, nonresponsive material, DWC encourages the doctor to file a complaint.

Comment on Chapter 134 (print fee). A commenter recommended that DWC allow a designated doctor to bill a print fee for medical records.

Agency Response to Comment on Chapter 134 (print fee). DWC appreciates the comment but declines to make the change, as it is not in scope for this rule. In addition, printing is not necessary to comply with the review requirement in the rule.

Comment on Chapter 134 (retroactive effect). A commenter asked DWC to consider making the fee schedule increase retroactive to January 1, 2024.

Agency Response to Comment on Chapter 134 (retroactive effect). DWC appreciates the comment but declines to make the change. System participants need to be able to program their systems and prepare for compliance in advance of the effective date. Making medical billing changes retroactive would increase medical fee disputes exponentially. In addition, the system does not have a practical way to process amended bills on that scale retroactively.

Comments on Chapter 134 (fee amounts). Two commenters stated that fee amounts should be higher.

Agency Response to Comments on Chapter 134 (fee amounts). DWC appreciates the comments but declines to make the change, as this rule has already increased fees significantly across the board to ensure fair compensation, and the fees will be adjusted annually to account for inflation.

Comments on Chapter 134 (fee amounts). Three commenters stated that the fee increases are fair as proposed. One of those commenters would not support a fee increase greater than what was proposed, and that going forward, the application of the annual adjustment factor will ensure that fees are adjusted as needed in the future. One commenter expressed support for increasing designated doctor compensation via the MEI, adjusting compensation annually to reflect changes in the MEI, and compensating multiple examinations performed concurrently without a discount.

Agency Response to Comments on Chapter 134 (fee amounts). DWC appreciates the comments and agrees.

Comments on Chapter 134 (extent of injury). Fifteen commenters stated that extent-of-injury examinations should be paid more. Thirteen of those commenters recommended reimbursing $50 for each condition after the initial fee when a designated doctor or a required medical examination doctor is required to answer extent-of-injury questions. One of those commenters recommended that for each disputed condition that has to be addressed after the initial condition, an additional $150 should be allowed.

Agency Response to Comments on Chapter 134 (extent of injury). DWC appreciates the comments but declines to make the changes at this time. As proposed, the rule already increased the fees for extent-of-injury examinations significantly, and the fees will be adjusted annually to account for inflation. In addition, the rule eliminates the tiering discount for designated doctors and required medical examination doctors, ensuring that all issues addressed within one examination will be paid at the established fee and not reduced. DWC believes that these changes will ensure that doctors are compensated fairly for extent-of-injury examinations.

Comments on §134.210 (MEI annual adjustment). Two commenters expressed uncertainty about how the MEI is calculated. One of those commenters was concerned about attaching fees to Medicare and wanted to be sure that, if the Medicare rate trended down in the future, the fees would not decrease.

Agency Response to Comments on §134.210 (MEI annual adjustment). DWC appreciates the comments, and offers the following explanation of the MEI, but declines to adjust the rule to remove the MEI factor. DWC sets its own fee schedule and modifies it based on the MEI to allow the fees to increase in relation to changes in the prices of goods and services, including physician-specific costs and compensation.

The MEI is a measure of practice cost inflation that was developed in 1975 and is updated quarterly to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates. It consists of two categories: physician practice costs and physician compensation. The physician practice costs portion of the current MEI includes components for nonphysician compensation, such as fringe benefits; medical supplies; professional liability insurance; and other expenses, including other professional services. Medicare assigns each component a weight and uses various proxy indices to estimate price changes. The physician compensation category of the MEI reflects increases in general earnings and is currently proxied by changes in the wages and benefits of professional occupations in the United States from the Bureau of Labor Statistics. Medicare then adjusts the change in the combined practice costs and physician compensation components by the 10-year average of multifactor productivity for the economy.

Comments on §134.210 (MEI annual adjustment). Fourteen commenters stated that DWC should retroactively include the MEI percentage adjustment factor for the years 2004 - 2008.

Agency Response to Comments on §134.210 (MEI annual adjustment). DWC appreciates the comments but declines to make the change. When DWC adopted amended medical reimbursement policies and medical fee guidelines in §§134.203 and 134.204 (proposed 32 TexReg 6966, October 5, 2007, with corrections at 32 TexReg 7329, October 12, 2007, and adopted 33 TexReg 364, January 11, 2008), the order stated that the commissioner adopted them 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. DWC, in consultation with the medical advisor, considered the change in the MEI from 2002 to 2007 and found that, at the time of adoption, the fee for designated doctor activities was fair and reasonable, after consideration of duties involved, including the additional duties HB 7, 79th Legislature, Regular Session (2005) added to Labor Code §408.0041.

Comment on §134.210 (MEI annual adjustment). One commenter stated, "While we understand the methodology for the one-time increase to account for the lack of fee increases since 2009, some members have expressed concern about the one-time large fee increase referenced in proposed 28 TAC 134.210(a)(1)(A). In addition to DDs, this increase would also apply to all RMEs under new rule 134.235. The purpose of this increase is because of a decline in DDs between 2009 - 2023. However, the proposed revisions in new rule 134.210(a)(1)(A) require an increase for current doctors using a MEI percentage adjustment for all years between 2009 - 2024. This is an average increase of 56% and seems to conflict with statutory provisions requiring DWC adjustment of fees every two years. See Labor Code 413.012."

Agency Response to Comment on §134.210 (MEI annual adjustment). DWC appreciates the comment but disagrees with the assertion that the one-time and annual adjustments are inappropriate or excessive and conflict with Labor Code §413.012. For the affected programs, DWC estimates that based on calendar year (CY) 2022 activity, the total system impact from the changes will be about $9 million over CY 2022 reimbursement. That includes a one-time initial adjustment in rates based on the accrued changes in the MEI since the rates were last adopted, plus costs associated with removing tiering, adding the missed appointment fee, and adding the specialist fee. For the past five years, the annual change in the MEI has ranged from 1.4% to 4.6%, averaging 2.8%. Based on this estimated average future year over previous year percentage, DWC estimates the increase in reimbursement to be a little more than $1 million per year. To help offset costs for teaching and training staff on the changes, DWC expects to provide free training presentations with specific billing examples after the rule is adopted but before it becomes effective.

The one-time adjustment is necessary to achieve fair and reasonable fees, and the annual inflation adjustment is necessary to ensure that future one-time large increases won't be needed. Labor Code §413.012 requires DWC to review medical policies and fee guidelines *at least* every two years to reflect fair and reasonable fees and medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision is conducted. DWC reviewed billing methodologies and reimbursement amounts to ensure that these medical policies and fee guidelines align with the need to attract and retain an adequate number of qualified designated doctors, RME doctors, and MMI and IR-certified doctors participating in the workers' compensation system.

Comment on §134.240 (specialist fee). Two commenters asked DWC to clarify what the $300 specialist fee is. Another commenter thought that DWC had confused "specialist" with "complex exam."

Agency Response to Comment on §134.240 (specialist fee). DWC appreciates the comment. The specialist fee is in §134.240(g)(3). It applies when DWC orders a designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title, Qualification Standards for Designated Doctor Examinations.

Comments on §134.240 (specialist fee). Three commenters recommended that DWC eliminate the additional $300 for specialists in §134.240(g)(3).

Agency Response to Comments on §134.240 (specialist fee). DWC disagrees with the recommendation. The specialist fee acknowledges designated doctors' time and effort spent in gaining specialty certifications and expertise. It reimburses board-certified physicians that participate in the designated doctor program and examine injured employees with certain complex injuries or diagnoses. The specialist fee is a necessary incentive for board-certified physicians to participate in the program, which reduces delays in examinations for employees with complex injuries or diagnoses and contributes to overall system health and efficiency.

Comments on §134.240 (specialist fee and tiering). One commenter stated that the extra costs incurred for specialist declaration should be compensated accordingly at an appropriate rate. With regard to eliminating tiering, the commenter stated that it is unfair to compensate differently for the same work product based on title (unless it is a specialist fee, as noted above). Another commenter expressed support for compensating multiple examinations performed concurrently without a discount.

Agency Response to Comments on §134.240 (specialist fee and tiering). DWC appreciates the comment and agrees that the specialist fee is necessary and appropriate. DWC also agrees that eliminating tiering is necessary so that, for designated doctors and required medical examination doctors, all issues addressed within one examination are paid at the established fee and not reduced.

Comment on Chapter 134 (tiering). One commenter recommended that DWC retain tiered reimbursement as set out in current rule §134.240, which provides that the first issue examined by a DD beyond MMI or IR will be paid at 100% of the fee guideline, the second issue will be paid at 50% of the fee guideline, and subsequent issues will be paid at 25% of the fee guideline.

Agency Response to Comment on Chapter 134 (tiering). DWC appreciates the comment but declines to make the change. Eliminating tiering is necessary so that, for designated doctors and required medical examination doctors, all issues addressed within one examination are paid at the established fee and not reduced. Compensating designated doctors and required medical examination doctors for the actual work performed, instead of imposing a discount for examining an issue just because the patient happens to have other issues as well, is fair and reasonable, in addition to being necessary to encourage participating providers to remain in the program and entice more providers to participate.

Comment on Chapter 134 (IR spine and MMI). One commenter stated that the fee for IR spine is too low. The commenter said that sometimes they have cases with multiple fusions that also fail back surgery, and that the fee should be higher because they have to use the diagnosis-related estimate model but still have to do all range of motion of the spine. The commenter also stated that the fee for "none MMI" evaluation should be much higher--more than just $350--since they have to do the examination, make a decision at the end, and review all the records.

Agency Response to Comment on Chapter 134 (IR spine and MMI). DWC appreciates the comment but declines to make the changes. The rule replaces the diagnosis-related estimate and range-of-motion billing methods with a single method of billing. In addition, the rules provide for a significant one-time increase in the fees established in §§134.235, 134.240, 134.250, and 134.260 by applying the MEI percentage adjustment factor for the period 2009 - 2024, as well as an annual MEI adjustment in those fees going forward. DWC made those adjustments to comply with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Comment on Chapter 134 (clarification letter). One commenter asked DWC to consider a small fee of $50 for a clarification letter. The commenter stated that in federal cases for any clarification letter they have a fee of $75 to resolve issues with any clarification response.

Agency Response to Comment on Chapter 134 (clarification letter). DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project. In addition, clarification letters are not part of an examination, and DWC does not find it appropriate to charge for clarifying a report that should have been written clearly.

Comment on Chapter 134 (car accidents). One commenter asked whether there is a better system for payment in the case of patients in a car accident where workers' compensation applies. The commenter stated that those accidents always show multiple body parts, such as shoulder, elbow, wrist, knee, hip, and spine, and today the system is only based on three body parts maximum.

Agency Response to Comment on Chapter 134 (car accidents). DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project. In addition, changing the payment system for car accidents in workers' compensation would create many medical fee disputes and would be inconsistent with the way all other examinations are paid.

Comment on Testing. One commenter stated that DWC should continue to require doctors to test, instead of accepting all doctors who took the test some 10 years ago.

Agency Response to Comment on Testing. DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project.

Comment on Chapter 134 (effective date). One commenter estimated that a minimum of 90 days after the rules become effective will be needed to implement the proposed changes.

Agency Response to Comment on Chapter 134 (effective date). DWC appreciates the comment and has attempted to ensure a minimum of 90 days' lead time between publication of the order and the date the rules become effective.

Comment on Chapter 134. One commenter expressed support and appreciation for DWC's efforts to provide free training for insurance carriers and health care providers on the new billing requirements and reimbursement rates.

Agency Response to Comment on Chapter 134. DWC appreciates the comment.

Comment on §134.210 (incentive payment). One commenter stated that they support the proposed amendments to §§134.210 and 134.240, which would exclude the proposed designated doctor missed appointment fee from the §134.2 incentive payment. The commenter requested that DWC clarify that the HPSA incentive payment, the physician scarcity bonus, and the §134.2 incentive payment be exempted from application to all designated doctor examination fees, including fees provided for in §134.240(g)(3) authorizing a $300 additional fee for examinations involving diagnoses listed in §127.130(b)(9)(B) - (I) and the missed appointment fees provided for in §134.240. The commenter stated that without this clarification, insurance carriers would be left to interpret the existing statute and rules without guidance, which could lead to unnecessary medical fee disputes.

Agency Response to Comment on §134.210 (incentive payment). DWC appreciates the comment but declines to make this change. Section 134.210(b)(3), as proposed and adopted, applies the 10% incentive payment to the maximum allowable reimbursement (MAR) for services that are performed in designated workers' compensation underserved areas and that are outlined in §§134.220 (case management services), 134.225 (functional capacity evaluations), 134.235 (required medical examinations), 134.240 (designated doctor examinations), 134.250 (MMI and IR examinations by treating doctors), 134.260 (MMI evaluations and IR examinations by referred doctors), and §134.210(d), which refers to services in §§134.215, 134.220, 134.225, and 134.230 where there is no negotiated or contracted amount that complies with Labor Code §413.011. It specifically exempts reimbursement for a missed appointment under §134.240 from the 10% incentive payment.

Comment on §134.210 (annual adjustment factor). One commenter expressed support for the addition of an annual adjustment factor, but stated that the annual adjustment factor should not be applied to the missed appointment fee and the §127.130 expert exam fees. The commenter recommended that §134.210 be revised to exclude the application of the annual adjustment factor to reimbursements for expert examinations under §134.240(g)(3) and the missed appointment fees provided for in §134.240. The commenter also recommended that DWC publish the MEI-adjusted designated doctor, required medical examination doctor, treating doctor, and referral doctor examination fees each year in the same way it publishes the MEI adjuster professional fee conversion factors to ensure that all insurance carriers pay the correct reimbursement rates.

Agency Response to Comment on §134.210 (annual adjustment factor). DWC appreciates the comment but declines to exclude the specialist fee in §134.240(g)(3) from the annual adjustment based on the MEI, because it would increase the complexity of the bill and could lead to more errors. The missed appointment fee, unlike the specialist fee, is a one-time, one-line fee that would not apply to every examination and would not be billed as part of the examination. For example, if the designated doctor in the underserved area is also evaluating MMI and IR, and the injury is a traumatic brain injury, so the $300 specialist fee applies, excluding the 10% incentive payment from the specialist fee but not from other components of the examination would be confusing and time-consuming. In addition, the purpose of the annual adjustment is to ensure that payments keep pace with inflation, preventing the need for another comprehensive update to the fees in the future, and excepting the $300 specialist fee does not accomplish this goal. To the commenter's other recommendation, which does not require a change in the rule text--DWC agrees and plans to publish the MEI-adjusted designated doctor, required medical examination doctor, treating doctor, and referral doctor examination fees each year in the same way it publishes the MEI adjuster professional fee conversion factors.

Comment on §134.235 (reference). One commenter suggested that §134.235(a) be revised to include a reference to Labor Code §408.0044.

Agency Response to Comment on §134.235 (reference). DWC appreciates the comment but declines to make the change because Labor Code §408.004 lists §§408.0043 and 408.0045, but does not list §408.0044.

Comment on Chapter 134 (modifiers). One commenter recommended that DWC create modifiers for various types of required medical examinations and retain the current modifier for appropriateness of health examinations.

Agency Response to Comment on Chapter 134 (modifiers). DWC appreciates the comment but declines to make those changes at this time. DWC understands that the suggested modifier, RE, exists, but is not used explicitly for required medical exams; and if it were required as the commenter suggests, it would not be used in billing, but instead only in an internal tracking system. One of DWC's goals in updating the billing and reimbursement rules in Chapters 133 and 134 has been to reduce administrative burdens by simplifying the modifiers. Adding new modifier requirements would be counter to this goal.

SUBCHAPTER C. MEDICAL FEE GUIDELINES

28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, 134.260

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts amended §§134.209, 134.210, and 134.250; and new §§134.235, 134.239, 134.240, and 134.260 under Labor Code §§408.004, 408.0041, 408.021, 408.023, 408.0251, 408.0252, 408.1225, 413.007, 413.011, 413.012, 413.015, 413.0511, 413.053, 402.00111, 402.00116, and 402.061.

Labor Code §408.004 provides that the commissioner may require an employee to submit to medical examinations to resolve any question about the appropriateness of the health care the employee receives, or at the request of the insurance carrier after the insurance carrier has tried and failed to get the employee's permission and concurrence for the examination. It also requires the insurance carrier to pay for those examinations, as well as the reasonable expenses incident to the employee in submitting to them.

Labor Code §408.0041 provides that, at the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work; or other similar issues.

Labor Code §408.021 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery,

or enhances the ability of the employee to return to or retain employment.

Labor Code §408.023 requires in part that the commissioner by rule establish reasonable requirements for doctors, and health care providers financially related to those doctors, regarding training, IR testing, and disclosure of financial interests; and for monitoring of those doctors and health care providers. It also requires a doctor, including a doctor who contracts with a workers' compensation health care network, to comply with the IR training and testing requirements in the rule if the doctor intends to provide MMI certifications or assign IRs.

Labor Code §408.0251 requires the commissioner of workers' compensation, in cooperation with the commissioner of insurance, to adopt rules about the electronic submission and processing of medical bills by health care providers to insurance carriers and establish exceptions. It also requires insurance carriers to accept electronically submitted medical bills in accordance with the rules, and it allows the commissioner of workers' compensation to adopt rules about the electronic payment of medical bills by insurance carriers to health care providers.

Labor Code §408.0252 provides that the commissioner of workers' compensation may, by rule, identify areas of this state in which access to health care providers is less available, and adopt appropriate standards, guidelines, and rules about the delivery of health care in those areas.

Labor Code §408.1225 requires the commissioner of workers' compensation to develop a process for certifying designated doctors, which requires DWC to evaluate designated doctors' educational experience, previous training, and demonstrated ability to perform the specific designated doctor duties in §408.0041. It also requires standard training and testing for designated doctors.

Labor Code §413.007 requires DWC to maintain a statewide database of medical charges, actual payments, and treatment protocols that may be used by the commissioner in adopting the medical policies and fee guidelines, and by DWC in administering the medical policies, fee guidelines, or rules. The database must contain information necessary to detect practices and patterns in medical charges, actual payments, and treatment protocols, and must be able to be used in a meaningful way to allow DWC to control medical costs.

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 with minimal modifications to those reimbursement methodologies as needed to meet occupational injury requirements. It requires the commissioner to adopt the most current methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting; and allows the commissioner to modify documentation requirements as needed to meet the requirements of §413.053. It also requires the commissioner, in determining the appropriate fees, to develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of §413.011(d); and requires the commissioner to provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commissioner rules. The commissioner may not adopt the Medicare fee schedule or conversion factors or other payment adjustment factors based solely on those factors as developed by the federal CMS. Fee guidelines must be fair and reasonable, and designed to ensure the quality of medical care and achieve medical cost control. They may not provide for payment of a fee that exceeds 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. When establishing the fee guidelines, §413.011 requires the commissioner to consider the increased security of payment that Subtitle A, Title 5, Labor Code affords. It allows network contracts under Insurance Code §1305.006. It specifically authorizes the commissioner and the commissioner of insurance to adopt rules as necessary to implement §413.011.

Labor Code §413.012 requires the medical policies and fee guidelines to be reviewed and revised at least every two years 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 is conducted.

Labor Code §413.015 requires insurance carriers to pay appropriate charges for medical services under Subtitle A, Title 5, Labor Code, and requires the commissioner by rule to review and audit those payments to ensure compliance with the adopted medical policies and fee guidelines. The insurance carrier must pay the expenses of the review and audit.

Labor Code §413.0511 requires DWC to employ or contract with a medical advisor. The medical advisor must be a doctor, as defined in §401.011. The medical advisor's duties include making recommendations about the adoption of rules and policies to: develop, maintain, and review guidelines as provided by §413.011, including rules about IRs; reviewing compliance with those guidelines; regulating or performing other acts related to medical benefits as required by the commissioner; and determining minimal modifications to the reimbursement methodology and model used by the Medicare system as needed to meet occupational injury requirements.

Labor Code §413.053 requires the commissioner by rule to establish standards of reporting and billing governing both form and content.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Filed with the Office of the Secretary of State on February 23, 2024.

TRD-202400816

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Texas Department of Insurance, Division of Workers' Compensation
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Proposal publication date: December 29, 2023
For further information, please call: (512) 804-4703

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28 TAC §§134.235, 134.239, 134.240

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the repeal of §§134.235, 134.239, and 134.240 under Labor Code Chapter 408; Chapter 413, Subchapter B; and §§402.00111, 402.0016, and 402.061.

Labor Code Chapter 408 governs workers' compensation benefits. It entitles an injured employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. It requires a variety of workers' compensation-specific services, including required medical examinations; designated doctor examinations; MMI evaluations and IR examinations; and return-to-work and evaluation of medical care examinations.

Labor Code Chapter 413, Subchapter B, Medical Services and Fees, requires in part that the commissioner of workers' compensation adopt health care reimbursement policies and guidelines, develop one or more conversion factors or other payment adjustment factors, and provide for reasonable fees for the evaluation and management of care. Fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. Medical policies and guidelines must be designed to ensure the quality of medical care and to achieve effective medical cost control; designed to enhance a timely and appropriate return to work; and consistent with §§413.013, 413.020, 413.052, and 413.053.

Labor Code §402.00111 provides that the commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority under Title 5 of the Labor Code.

Labor Code §402.00116 provides that the commissioner of workers' compensation shall administer and enforce this title, other workers' compensation laws of this state, and other laws granting jurisdiction to or applicable to DWC or the commissioner.

Labor Code §402.061 provides that the commissioner of workers' compensation shall adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 37. PUBLIC SAFETY AND CORRECTIONS

PART 15. TEXAS FORENSIC SCIENCE COMMISSION

CHAPTER 651. DNA, CODIS, FORENSIC ANALYSIS, AND CRIME LABORATORIES
SUBCHAPTER C. FORENSIC ANALYST LICENSING PROGRAM

37 TAC §§651.207 - 651.209

The Texas Forensic Science Commission ("Commission") adopts amendments to 37 Texas Administrative Code Chapter 651, §651.209 Forensic Analyst and Forensic Technician License Expiration, Reinstatement, and Procedure for Denial of Initial Application and Reconsideration is adopted without changes. Section 651.207 Forensic Analyst and Forensic Technician License Expiration and §651.208 Forensic Analyst and Forensic Technician License Renewal are adopted with changes to the text as published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 7029). Section 651.209 will not not be republished. Sections 651.207 and 651.208 are adopted with changes and will be republished. The adopted amendments change the Commission's forensic analyst and forensic technician license expiration dates to expire on the licensee's birthdate.

Reasoned Justification for Rule Adoption. Under the adopted rules, forensic analyst and forensic technician licenses will expire on the last day of the licensee's birth month after each two-year license cycle, rather than every two years from their initial application. Prior to these changes and the inception of the Commission's forensic analyst licensing program on January 1, 2019, a majority of the Commission's licenses expired at the same time in the even-numbered years in the Fall, placing a heavy administrative burden both on Commission staff and licensees waiting on their licenses to be renewed at the same time. The adopted changes also include a monthly proration of the required fees and continuing forensic education requirements for current and first-time license applicants depending on the number of months in the applicant's first license term. The changes also require all new license applicants to complete the Commission's Mandatory Legal and Professional Responsibility Course.

Public Comment. Pursuant to § 2001.029 of the Texas Government Code, the Commission gave all interested persons a reasonable opportunity to provide oral and/or written commentary concerning the adoption of the rules. The public comment period began on December 1, 2023, and ended on January 5, 2024. The Commission did not receive any comments from the public.

Statutory Authority. The rules are adopted under the general rulemaking authority provided in Code of Criminal Procedure, Article 38.01 § 3-a and its authority to license forensic analysts under Article 38.01 § 4-a(b). This rule has been reviewed by legal counsel and found to be within the state agency's authority to adopt.

Cross-reference to statute. The adopted rules affect Tex. Code Crim. Proc. art. 38.01.

§651.207. Forensic Analyst and Forensic Technician Licensing Requirements, Including Initial License Term and Fee, Minimum Education and Coursework, General Forensic Examination, Proficiency Monitoring and Mandatory Legal and Professional Responsibility.

(a) Issuance. The Commission may issue an individual's Forensic Analyst License under this section.

(b) Application. Before being issued a Forensic Analyst or Forensic Technician License, an applicant must:

(1) demonstrate that he or she meets the definition of Forensic Analyst or Forensic Technician set forth in this subchapter;

(2) complete and submit to the Commission a current Forensic Analyst or Forensic Technician License Application form;

(3) pay the required fee(s) as applicable:

(A) Initial Application fee of $220 for Analysts and $150 for Technicians for the twenty-four months of the Initial License Term. If the Analyst or Technician's Initial License Term under subsection (b) of this section exceeds twenty-four months, the Analyst or Technician shall pay an additional prorated amount of $8.33 per month (for Analysts) and $5.42 per month (for Technicians) for each month exceeding two years. If the Analyst or Technician's Initial License Term under subsection (b) of this section is less than twenty-four months, the Analyst or Technician shall pay a prorated amount of $8.33 per month (for Analysts) and $5.42 per month (for Technicians) for each month in the Initial License Term;

(B) Temporary License fee of $100;

(C) Provisional License fee of $110 for Analysts and $75 for Technicians; An applicant who is granted a provisional license and has paid the required fee will not be required to pay an additional initial application fee if the provisional status is removed within one year of the date the provisional license is granted;

(D) License Reinstatement fee of $220;

(E) *De Minimis* License fee of $200 per ten (10) licenses;

(F) Uncommon Forensic Analysis License fee of $200 per ten (10) licenses; and/or

(G) Special Exam Fee of $50 for General Forensic Analyst Licensing Exam, required only if testing beyond the three initial attempts or voluntarily taking the exam under the Unaccredited Forensic Discipline Exception described in subsection (g)(5)(C) of this section;

(4) provide accurate and current address and employment information to the Commission and update the Commission within five (5) business days of any change in address or change of employment. Licensees are required to provide a home address, email address, and employer name and address on an application for a license; and

(5) provide documentation that he or she has satisfied all applicable requirements set forth under this section.

(c) Minimum Education Requirements.

(1) Seized Drugs Analyst. An applicant for a Forensic Analyst License in seized drugs must have a baccalaureate or advanced degree in chemical, physical, biological science, chemical engineering or forensic science from an accredited university.

(2) Seized Drugs Technician. An applicant for a Forensic Analyst License limited to the seized drug technician category must have a minimum of an associate's degree or equivalent.

(3) Toxicology (Toxicology Analyst (Alcohol Only, Non-interpretive), Toxicology Analyst (General, Non-interpretive), Toxicologist (Interpretive)). An applicant for a Forensic Analyst License in toxicology must have a baccalaureate or advanced degree in a chemical, physical, biological science, chemical engineering or forensic science from an accredited university.

(4) Toxicology Technician. An applicant for a Forensic Analyst License limited to the toxicology technician category must have a minimum of an associate's degree or equivalent.

(5) Forensic Biology (DNA Analyst, Forensic Biology Screener, Nucleic Acids other than Human DNA Analyst, Forensic Biology Technician). An applicant for any category of forensic biology license must have a baccalaureate or advanced degree in a chemical, physical, biological science or forensic science from an accredited university.

(6) Firearm/Toolmark Analyst. An applicant for a Forensic Analyst License in firearm/toolmark analysis must have a baccalaureate or advanced degree in a chemical, physical, biological science, engineering or forensic science from an accredited university.

(7) Firearm/Toolmark Technician. An applicant for a Forensic Analyst License limited to firearm/toolmark technician must have a minimum of a high school diploma or equivalent degree.

(8) Materials (Trace) Analyst. An applicant for a Forensic Analyst License in materials (trace) must have a baccalaureate or advanced degree in a chemical, physical, biological science, chemical engineering or forensic science from an accredited university. A Materials (Trace) Analyst performing only impression evidence analyses must have a minimum of a high school diploma or equivalent degree.

(9) Materials (Trace) Technician. An applicant for a Forensic Analyst License limited to materials (trace) technician must have a minimum of a high school diploma or equivalent degree.

(10) Foreign/Non-U.S. degrees. The Commission shall recognize equivalent foreign, non-U.S. baccalaureate or advanced degrees. The Commission reserves the right to charge licensees a reasonable fee for credential evaluation services to assess how a particular foreign degree compares to a similar degree in the United States. The Commission may accept a previously obtained credential evaluation report from an applicant or licensee in fulfillment of the degree comparison assessment.

(11) If an applicant does not meet the minimum education qualifications outlined in this section, the procedure in subsection (f) or (j) of this section applies.

(d) Specific Coursework Requirements.

(1) Seized Drugs Analyst. An applicant for a Forensic Analyst License in seized drugs must have a minimum of sixteen-semester credit hours (or equivalent) in college-level chemistry coursework above general coursework from an accredited university. In addition to the chemistry coursework, an applicant must also have a three-semester credit hour (or equivalent) college-level statistics course from an accredited university or a program approved by the Commission.

(2) Toxicology. An applicant for a Forensic Analyst License in toxicology must fulfill required courses as appropriate to the analyst's role and training program as described in the categories below:

(A) Toxicology Analyst (Alcohol Only, Non-interpretive). A toxicology analyst who conducts, directs or reviews the alcohol analysis of forensic toxicology samples, evaluates data,

reaches conclusions and may sign a report for court or investigative purposes, but does not provide interpretive opinions regarding human performance must complete a minimum of sixteen-semester credit hours (or equivalent) in college-level chemistry coursework above general coursework from an accredited university.

(B) Toxicology Analyst (General, Non-interpretive). A toxicology analyst who conducts, directs or reviews the analysis of forensic toxicology samples, evaluates data, reaches conclusions and may sign a report for court or investigative purposes, but does not provide interpretive opinions regarding human performance must complete a minimum of sixteen-semester credit hours (or equivalent) in college-level chemistry coursework above general coursework that includes organic chemistry and two three-semester credit hour (or equivalent) college-level courses in analytical chemistry and/or interpretive science courses that may include Analytical Chemistry, Chemical Informatics, Instrumental Analysis, Mass Spectrometry, Quantitative Analysis, Separation Science, Spectroscopic Analysis, Biochemistry, Drug Metabolism, Forensic Toxicology, Medicinal Chemistry, Pharmacology, Physiology, or Toxicology.

(C) Toxicologist (Interpretive). A toxicologist who provides interpretive opinions regarding human performance related to the results of toxicological tests (alcohol and general) for court or investigative purposes must complete a minimum of sixteen-semester credit hours (or equivalent) in college-level chemistry coursework above general coursework that includes organic chemistry, one three-semester credit hour (or equivalent) course in college-level analytical chemistry (Analytical Chemistry, Chemical Informatics, Instrumental Analysis, Mass Spectrometry, Quantitative Analysis, Separation Science or Spectroscopic Analysis) and one three-semester credit hour (or equivalent) college-level courses in interpretive science (Biochemistry, Drug Metabolism, Forensic Toxicology, Medicinal Chemistry, Pharmacology, Physiology, or Toxicology).

(D) An applicant for a toxicology license for any of the categories outlined in subparagraphs (A) - (C) of this paragraph must have a three-semester credit hour (or equivalent) college-level statistics course from an accredited university or a program approved by the Commission.

(3) DNA Analyst. An applicant for a Forensic Analyst License in DNA analysis must demonstrate he/she has fulfilled the specific requirements of the Federal Bureau of Investigation's Quality Assurance Standards for Forensic DNA Testing effective September 1, 2011. An applicant must also have a three-semester credit hour (or equivalent) college-level statistics course from an accredited university or a program approved by the Commission.

(4) Firearm/Toolmark Analyst. An applicant must have a three-semester credit hour (or equivalent) college-level statistics course from an accredited university or a program approved by the Commission. No other specific college-level coursework is required.

(5) Materials (Trace) Analyst. An applicant for a Forensic Analyst License in materials (trace) for one or more of the chemical analysis categories of analysis (chemical determination, physical/chemical comparison, gunshot residue analysis, and fire debris and explosives analysis) must have a minimum of sixteen-semester credit hours (or equivalent) in college-level chemistry coursework above general coursework from an accredited university. In addition to chemistry coursework for the chemical analysis categories, all materials (trace) license applicants must also have a three-semester credit hour (or equivalent) college-level statistics course from an accredited university or a program approved by the Commission. An applicant for a Forensic Analyst License in materials (trace) limited to impression evidence is not required to fulfill any specific college-level coursework requirements other than the statistics requirement.

(6) Exemptions from specific coursework requirements. The following categories of licenses are exempted from coursework requirements:

(A) An applicant for the technician license category of any forensic discipline set forth in this subchapter is not required to fulfill any specific college-level coursework requirements.

(B) An applicant for a Forensic Analyst License limited to forensic biology screening, nucleic acids other than human DNA and/or Forensic Biology Technician is not required to fulfill the Federal Bureau of Investigation's Quality Assurance Standards for Forensic DNA Testing or any other specific college-level coursework requirements.

(e) Requirements Specific to Forensic Science Degree Programs. For a forensic science degree to meet the Minimum Education Requirements set forth in this section, the forensic science degree program must be either accredited by the Forensic Science Education Programs Accreditation Commission (FEPAC) or if not accredited by FEPAC, it must meet the minimum curriculum requirements pertaining to natural science core courses and specialized science courses set forth in the FEPAC Accreditation Standards.

(f) Waiver of Specific Coursework Requirements and/or Minimum Education Requirements for Lateral Hires, Promoting Analysts and Current Employees. Specific coursework requirements and minimum education requirements are considered an integral part of the licensing process; all applicants are expected to meet the requirements of the forensic discipline(s) for which they are applying or to offer sufficient evidence of their qualifications as described below in the absence of specific coursework requirements or minimum education requirements. The Commission Director or Designee may waive one or more of the specific coursework requirements or minimum education requirements outlined in this section for an applicant who:

(1) has five or more years of credible experience in an accredited laboratory in the forensic discipline for which he or she seeks licensure; or

(2) is certified by one or more of the following nationally recognized certification bodies in the forensic discipline for which he or she seeks licensure;

(A) The American Board of Forensic Toxicology;

(B) The American Board of Clinical Chemistry;

(C) The American Board of Criminalistics;

(D) The International Association for Identification; or

(E) The Association of Firearm and Toolmark Examiners; and

(3) provides written documentation of laboratory-sponsored training in the subject matter areas addressed by the specific coursework requirements.

(4) An applicant must request a waiver of specific coursework requirements and/or minimum education requirements at the time the application is filed.

(5) An applicant requesting a waiver from specific coursework requirements and/or minimum education requirements shall file any additional information needed to substantiate the eligibility for the waiver with the application. The Commission Director or Designee shall review all elements of the application to evaluate waiver request(s) and shall grant a waiver(s) to qualified applicants.

(g) General Forensic Analyst Licensing Exam Requirement.

(1) Exam Requirement. An applicant for a Forensic Analyst License must pass the General Forensic Analyst Licensing Exam administered by the Commission.

(A) An applicant is required to take and pass the General Forensic Analyst Licensing Exam one time.

(B) An applicant may take the General Forensic Analyst Licensing Exam no more than three times. If an applicant fails the General Forensic Analyst Licensing Exam or the Modified General Forensic Analyst Licensing Exam three times, the applicant has thirty (30) days from the date the applicant receives notice of the failure to request special dispensation from the Commission as described in subparagraph (C) of this paragraph. Where special dispensation is granted, the applicant has 90 days from the date he or she receives notice the request for exam is granted to successfully complete the exam requirement. However, for good cause shown, the Commission or its Designee at its discretion may waive this limitation.

(C) Requests for Exam. If an applicant fails the General Forensic Analyst Licensing Exam or Modified General Forensic Analyst Licensing Exam three times, the applicant must request in writing special dispensation from the Commission to take the exam more than three times. Applicants may submit a letter of support from their laboratory director or licensing representative and any other supporting documentation supplemental to the written request.

(D) If an applicant sits for the General Forensic Analyst Licensing Exam or the Modified General Forensic Analyst Licensing Exam more than three times, the applicant must pay a $50 exam fee each additional time the applicant sits for the exam beyond the three initial attempts.

(E) Expiration of Provisional License if Special Dispensation Exam Unsuccessful. If the 90-day period during which special dispensation is granted expires before the applicant successfully completes the exam requirement, the applicant's provisional license expires.

(2) Modified General Forensic Analyst Licensing Exam. Technicians in any discipline set forth in this subchapter may fulfill the General Forensic Analyst Licensing Exam requirement by taking a modified exam administered by the Commission.

(3) Examination Requirements for Promoting Technicians. If a technician passes the modified General Forensic Analyst Licensing Exam and later seeks a full Forensic Analyst License, the applicant must complete the portions of the General Forensic Analyst Exam that were not tested on the modified exam.

(4) Credit for Pilot Exam. If an individual passes the Pilot General Forensic Analyst Licensing Exam, regardless of his or her eligibility status for a Forensic Analyst License at the time the exam is taken, the candidate has fulfilled the General Forensic Analyst Licensing Exam Requirement of this section should he or she later become subject to the licensing requirements and eligible for a Forensic Analyst License.

(5) Eligibility for General Forensic Analyst Licensing Exam and Modified General Forensic Analyst Licensing Exam.

(A) Candidates for the General Forensic Analyst Licensing Exam and Modified General Forensic Analyst Licensing Exam must be employees of a crime laboratory accredited under Texas law or employed by an agency rendering them eligible for a voluntary license under §651.222 *(Voluntary Forensic Analyst Licensing Requirements Including Eligibility, License Term, Fee and Procedure for Denial of Initial Application or Renewal Application and Reconsideration)* of this subchapter to be eligible to take the exam.

(B) Student Examinee Exception. A student is eligible for the General Forensic Analyst Licensing Exam one time if the student:

(i) is currently enrolled in an accredited university as defined in §651.202 of this subchapter (relating to Definitions);

(ii) has completed sufficient coursework to be within 24 semester hours of completing the requirements for graduation at the accredited university at which the student is enrolled; and

(iii) designates an official university representative who will proctor and administer the exam at the university for the student.

(C) Crime Laboratory Management and Unaccredited Forensic Discipline Exception. An Employee of a crime laboratory accredited under Texas law who is either part of the crime laboratory's administration or management team or authorized for independent casework in a forensic discipline listed below is eligible for the General Forensic Analyst Licensing Exam and Modified General Forensic Analyst Licensing Exam:

(i) forensic anthropology;

(ii) the location, identification, collection or preservation of physical evidence at a crime scene;

(iii) crime scene reconstruction;

(iv) latent print processing or examination;

(v) digital evidence (including computer forensics, audio, or imaging);

(vi) breath specimen testing under Transportation Code, Chapter 724, limited to analysts who perform breath alcohol calibrations; and

(vii) document examination, including document authentication, physical comparison, and product determination.

(h) Proficiency Monitoring Requirement.

(1) An applicant must demonstrate participation in the employing laboratory's process for intra-laboratory comparison, inter-laboratory comparison, proficiency testing, or observation-based performance monitoring requirements in compliance with and on the timeline set forth by the laboratory's accrediting body's proficiency monitoring requirements as applicable to the Forensic Analyst or Forensic Technician's specific forensic discipline and job duties.

(2) A signed certification by the laboratory's authorized representative that the applicant has satisfied the applicable proficiency monitoring requirements, including any intra-laboratory comparison, inter-laboratory comparison, proficiency testing, or observation-based performance monitoring requirements of the laboratory's accrediting body as of the date of the analyst's application, must be provided on the Proficiency Monitoring Certification form provided by the Commission. The licensee's authorized representative must designate the specific forensic discipline in which the Forensic Analyst or Forensic Technician actively performs forensic casework or is currently authorized to perform supervised or independent casework by the laboratory or employing entity.

(i) Mandatory Legal and Professional Responsibility Course:

(1) All Forensic Analyst and Forensic Technician License applicants must complete the current Commission-sponsored mandatory legal and professional responsibility update at the time of their

application or demonstrate that they have taken the training within the 12-month period preceding the date of their application.

(2) Mandatory legal and professional responsibility training topics may include training on current and past criminal forensic legal issues, professional responsibility and human factors, courtroom testimony, disclosure and discovery requirements under state and federal law, and other relevant topics as designated by the Commission.

§651.208. Forensic Analyst and Forensic Technician License Renewal.

(a) Timing of Application for Renewal. The Commission may renew an individual's Forensic Analyst or Forensic Technician License up to 60 days before the expiration of the individual's license term.

(b) Renewal Term. The renewal date of a Forensic Analyst or Forensic Technician License will be every two years on the last day of the license holder's birth month.

(c) Renewal Fees. The biennial renewal fee is $200 for Forensic Analysts and $130 for Forensic Technicians. Fees for Forensic Analysts and Forensic Technicians seeking to renew their licenses between January 1, 2024 and December 31, 2025, will be pro-rated on a monthly basis depending upon the birth month of the renewing license holder and the number of months in the renewal term as describe in subsection (b) of this section. The pro-rated fee will be assessed at $8.33 per month (for Forensic Analysts) and $5.42 per month (for Forensic Technicians).

(d) Application. An applicant for a Forensic Analyst or Forensic Technician License renewal shall complete and submit to the Commission a current Forensic Analyst or Forensic Technician License Renewal Application provided by the Commission, pay the required fee, attach documentation of fulfillment of Continuing Forensic Education and other requirements set forth in this section.

(e) Proficiency Monitoring Certification Form for Renewal Applicants Employed by an Accredited Laboratory. An applicant for a Forensic Analyst or Forensic Technician License renewal must provide an updated copy of the Commission's Proficiency Monitoring Certification form demonstrating the applicant participates in the laboratory's process for intra-laboratory comparison, inter-laboratory comparison, proficiency testing, or observation-based performance monitoring requirements in compliance with and on the timeline set forth by the laboratory's accrediting body's requirements as applicable to the Forensic Analyst or Forensic Technician's specific forensic discipline and job duties. The form must be:

(1) signed by the licensee's authorized laboratory representative; and

(2) designate the specific forensic discipline in which the Forensic Analyst or Forensic Technician actively performs forensic casework or is currently authorized or currently participating in a training program to become authorized to perform supervised or independent forensic casework.

(f) Proficiency Monitoring Certification Form for Renewal Applicants Not Employed at an Accredited Laboratory or at an Accredited Laboratory in a Forensic Discipline Not Covered by the Scope of the Laboratory's Accreditation.

(1) An applicant for a Forensic Analyst or Forensic Technician license renewal who is employed by an entity other than an accredited laboratory or performs a forensic examination or test at an accredited laboratory in a forensic discipline not covered by the scope of the laboratory's accreditation must provide:

(A) an updated copy of the Commission's Proficiency Monitoring Certification form demonstrating the applicant participates in the laboratory or employing entity's process for intra-laboratory comparison, inter-laboratory comparison, proficiency testing, or observation-based performance monitoring requirements in compliance with and on the timeline set forth by the laboratory or employing entity's Commission-approved process for proficiency monitoring as applicable to the Forensic Analyst or Forensic Technician's specific forensic discipline and job duties:

(i) signed by the licensee's authorized laboratory representative; and

(ii) designating the specific forensic discipline in which the Forensic Analyst or Forensic Technician actively performs forensic casework or is currently authorized to perform supervised or independent forensic casework;

(B) written proof of the Forensic Science Commission's approval of the laboratory or employing entity's proficiency monitoring activities or exercise(s) as applicable to the applicant's specific forensic discipline and job duties; and

(C) written documentation of performance in conformance with expected consensus results in compliance with and on the timeline set forth by the laboratory or employing entity's Commission-approved proficiency monitoring activities or exercise(s) as applicable to the applicant's specific forensic discipline and job duties.

(g) Continuing Forensic Education Including Mandatory Legal and Professional Responsibility:

(1) Forensic Analyst and Forensic Technician Licensees must complete a Commission-sponsored mandatory legal and professional responsibility update by the expiration of each two-year license cycle as provided by the Commission. Forensic Technicians are not required to complete any other continuing forensic education requirements listed in this section.

(2) Mandatory legal and professional responsibility training topics may include training on current and past criminal forensic legal issues, professional responsibility and human factors, courtroom testimony, disclosure and discovery requirements under state and federal law, and other relevant topics as designated by the Commission.

(3) All forensic analysts shall be required to satisfy the following Continuing Forensic Education Requirements by the expiration of each two-year license cycle:

(A) Completion of thirty-two (32) continuing forensic education hours per 2-year license cycle.

(B) Sixteen (16) hours of the thirty-two (32) must be discipline-specific training, peer-reviewed journal articles, and/or conference education hours. If a licensee is licensed in multiple forensic disciplines, at least eight (8) hours of discipline-specific training in each forensic discipline are required, subject to the provisions set forth in subsection (f) of this section.

(C) The remaining sixteen (16) hours may be general forensic training, peer-reviewed journal articles, and/or conference education hours that include hours credited for the mandatory legal and professional responsibility training.

(4) Continuing forensic education programs will be offered and/or designated by the Commission and will consist of independent, online trainings, readings, and participation in recognized state, regional, and national forensic conferences and workshops.

(5) Approved continuing forensic education hours are applied for credit on the date the program and/or training is delivered.

(h) Timeline for Exemption from Supplemental Continuing Forensic Education Requirements. Where a current licensee adds a forensic discipline to the scope of his or her license, the following continuing forensic education requirements apply for the supplemental forensic discipline:

(1) If the supplemental forensic discipline is added less than six (6) months prior to the expiration of the analyst's current license, no additional discipline-specific training is required for the supplemental forensic discipline.

(2) If the supplemental forensic discipline is added six (6) months or more but less than eighteen (18) months prior to the expiration of the analyst's current license, four (4) additional discipline-specific training hours are required for the supplemental forensic discipline.

(3) If the supplemental forensic discipline is added eighteen (18) months or more prior to the expiration of the analyst's current license, eight (8) additional discipline-specific training hours are required for the supplemental forensic discipline.

(i) If an applicant fails to fulfill any or all of the requirements pertaining to license renewal, continuing forensic education and the mandatory legal and professional responsibility update, the applicant may apply to the Commission for special dispensation on a form to be provided on the Commission's website. Upon approval by the Commission, the applicant may be allowed an extension of time to fulfill remaining continuing forensic education requirements.

(j) Temporary Exception to Continuing Forensic Education Requirements During January 2024 to December 2026 Transition from Application to Birthdate-Based Renewal Terms. For any licensee who has less than two years to complete the continuing forensic education requirements in subsection (g) of this section as a result of the transition from application-based renewal to birthdate-based renewal, the number of required continuing education hours in subsection (g)(3)(A) and (B) of this section for license renewal shall be pro-rated based on the number of months in the renewal term.

(k) Subsections (j) and (k) of this section expire on December 31, 2026.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 936-0661

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SUBCHAPTER F. DNA QA DATABASE; STORAGE AND REMOVAL OF CERTAIN DNA RECORDS

37 TAC §§651.501 - 651.503

The Texas Forensic Science Commission (Commission) adopts new §651.501 and §651.503, Subchapter F DNA QA Database; Storage and Removal of Certain DNA Records without changes, §651.502 is adopted with changes to the text as published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 7036). Sections §651.501 and §651.503 will not be republished. Section 651.502 will be republished. The adopted amendments are responsive to the 88th Texas Legislature's passage of HB 3506, which requires the Commission to adopt prescribed rules for the removal of elimination sample DNA records from a crime laboratory's deoxyribonucleic acid (DNA) Quality Assurance (QA) database, a database maintained by a crime laboratory and used to identify possible contamination or other quality assurance events with respect to a DNA sample.

Reasoned Justification for Rule Adoption. Under the new rules, the Commission, in accordance with HB 3506: (1) requires all crime laboratories that maintain a DNA QA database to maintain the database separately from any other local, state, or federal database, including the CODIS DNA database established by the Federal Bureau of Investigation; (2) prohibits crime laboratories from uploading or storing a DNA record created from an elimination sample, or any other information derived from that record, in any database other than the DNA QA database maintained by the crime laboratory; and (3) requires each crime laboratory that maintains a DNA QA database to, not later than three months after the date on which a forensic DNA analysis of an elimination sample is completed, remove from the DNA QA database the DNA record created from the elimination sample and any other information derived from that record that is contained in the database.

Public Comment. Pursuant to § 2001.029 of the Texas Government Code, the Commission gave all interested persons a reasonable opportunity to provide oral and/or written commentary concerning the adoption of the rules. The public comment period began on December 1, 2023, and ended on January 5, 2024. The Commission did not receive any comments from the public.

Statutory Authority. The new rules are adopted under the Commission's general rulemaking authority provided in Code of Criminal Procedure, Article 38.01 § 3-a and its authority to regulate crime laboratories under Article 38.01 § 3-b(a). It also conforms to changes made by HB 3506. This adoption has been reviewed by legal counsel and found to be within the state agency's authority to adopt.

Cross-reference to statute. The adopted rules affect Tex. Code Crim. Proc. art. 38.01.

§651.502. Definitions.

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

(1) DNA--deoxyribonucleic acid.

(2) DNA QA Database--a database maintained by a crime laboratory and used to identify possible contamination or other quality assurance events with respect to a DNA sample.

(3) Elimination sample--a blood sample or other biological sample or specimen voluntarily provided by the victim of an offense or another individual not involved in the alleged offense whose DNA is likely to be present at the scene of the crime to isolate and identify the DNA of a potential perpetrator.

(A) The designation of any sample as an "elimination sample" is based upon factual information provided by the submitting law enforcement or other investigative agency.

(B) Samples maintained by a crime laboratory for the purpose of administering a blind proficiency testing program are not considered elimination samples subject to this subchapter.

(4) QA--quality assurance system in a crime laboratory.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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TITLE 43. TRANSPORTATION

PART 1. TEXAS DEPARTMENT OF TRANSPORTATION

CHAPTER 2. ENVIRONMENTAL REVIEW OF TRANSPORTATION PROJECTS

The Texas Department of Transportation (department) adopts the repeal of §2.132 concerning Gulf Intracoastal Waterway Projects and new §§2.351 - 2.364 concerning Gulf Intracoastal Waterway Projects. The repeal of §2.132 and new §§2.351 - 2.364 are adopted without changes to the proposed text as published in the November 10, 2023, issue of the *Texas Register* (48 TexReg 6574) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The purpose of this rulemaking is to reorganize and clarify the rules of the Texas Transportation Commission (commission) concerning the requirements for state participation in dredge disposal plans and projects for the beneficial use of dredged materials related to the Gulf Intracoastal Waterway. The rulemaking also removes references in the rules to the Gulf Intracoastal Waterway Advisory Committee, which has been abolished.

Section 2.132, Gulf Intracoastal Waterway Projects, is repealed and the substance of that section is revised and moved to new Subchapter J of Chapter 2, which consists of new §§2.351 - 2.364.

New §2.351, Definitions, provides the defined terms used in Subchapter J.

New §2.352, Maintenance and Sponsorship of GIWW, is derived from §2.132(b) and clarifies that the State of Texas is the non-federal sponsor of the GIWW and the commission serves as the state's designee.

New §2.353, Disposal Plans, is a non-substantive revision of §2.132(c)(1) and (2).

New §2.354, State Participation in Beneficial Use Project, is a non-substantive revision of §2.132(c)(3).

New §2.355, Interagency Coordination, is derived from §2.132(a)(2) and (c)(4). The section clarifies that the U.S. Army Corps of Engineers is responsible for overseeing and initiating coordination of projects for the beneficial use of dredged material.

New §2.356, Investigation of Proposed Disposal Plan or Beneficial Use Project, is derived from §2.132(c)(5). The section recognizes that investigations will be led by the interagency coordination team rather than the department and that membership of interagency coordination team is determined by the U.S. Army Corps of Engineers.

New §2.357, Preparation of Environmental Review Document and Public Participation, is a non-substantive revision of §2.132(d).

New §2.358, Notification of and Assistance to Property Owners, is a non-substantive revision of §2.132(f)(1)(A) - (C). The new section clarifies that the department gives notification and assistance to the owners of real property that is being acquired for a dredged material placement area and if requested, meets with other affected real property owners.

New §2.359, Public Meeting, is a non-substantive revision of §2.132(f)(1)(D) and (2). The new section clarifies that the department may hold one or more public meetings on a proposed dredged material placement area and clarifies where notice of all meetings held under the section must be published.

New §2.360, Procedures for State Acquisition of Real Property, is a non-substantive revision of §2.132(e)(1). The new section clarifies that the procedures provided by the section apply to a proposal to use the real property as a dredged material placement area. It also clarifies where notice of a plan, proposal, or project to which the section applies must be published.

New §2.361, Commission approval, is derived from §2.132(a)(5) and (e)(2). The new section replaces the requirement that a beneficial use project demonstrate "substantial" local support with a requirement that the project demonstrate local support evidenced by an official document from the governing body with jurisdiction over the project. The definition of "jurisdiction" is deleted, and its substance is integrated into the section to clarify the way in which local support is to be shown. The new section does not include the limitation of current §2.132(e)(2)(B)(vi)(I) and (II), which prohibits the department from contributing more than 50 percent of the difference between the federal share and the cost of a beneficial use project, because such a limitation is unnecessarily restrictive. The new section expressly provides that it applies to a proposal to use the real property as a dredged material placement area.

New §2.362, Agreement to Participate in Beneficial Use Project, is a non-substantive revision of §2.132(e)(3).

New §2.363, Participation in Existing Beneficial Use Project, provides the procedure for state participation in an existing beneficial use project. There is no corresponding provision in §2.132.

New §2.364, Prohibition on Use of Funds, is a non-substantive revision of §2.132(e)(2)(B)(vi)(III).

COMMENTS

No comments on the proposed repeal and new sections were received.

SUBCHAPTER F. REQUIREMENTS FOR SPECIFIC TYPES OF PROJECTS AND PROGRAMS

43 TAC §2.132

STATUTORY AUTHORITY

The repeal is adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and, more specifically, Transportation Code, §51.009, which requires the commission to establish eligibility criteria for a project to beneficially use dredge material.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapter 51.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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For further information, please call: (512) 463-3164

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SUBCHAPTER J. GULF INTRACOASTAL WATERWAY PROJECTS

43 TAC §§2.351 - 2.364

STATUTORY AUTHORITY

The new sections are adopted under Transportation Code, §201.101, which provides the commission with the authority to establish rules for the conduct of the work of the department, and, more specifically, Transportation Code, §51.009, which requires the commission to establish eligibility criteria for a project to beneficially use dredge material.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Transportation Code, Chapter 51.

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CHAPTER 4. EMPLOYMENT PRACTICES

SUBCHAPTER B. JOB APPLICATION PROCEDURES

43 TAC §4.10, §4.15

The Texas Department of Transportation (department) adopts amendments to §4.10 and §4.15, concerning to Job Application Procedures. The amendments to §4.10 and §4.15 are adopted without changes to the proposed text as published in the December 1, 2023, issue of the *Texas Register* (48 TexReg 7037) and will not be republished.

EXPLANATION OF ADOPTED AMENDMENTS

The purpose of the amendments is to align the rules with changes made by Senate Bill No. 1376, Acts of the 88th Legislature, Regular Session, 2023, relating to employment preferences for members of the military and their spouses. S.B. 1376 amended Government Code, Chapter 657, by expanding the state's employment preference for veterans to the spouse of a member of the United States armed forces or Texas National Guard serving on active duty as well as the spouse of a veteran if the spouse is the primary source of income for the household and the veteran has a total disability rating based either on having a service-connected disability with a disability rating of at least 70 percent or on individual unemployability. The bill grants the spouse priority in the order of preference after a veteran, with or without a disability, but before a qualifying surviving spouse or qualifying orphan of a veteran. The bill also replaces references to veteran's employment preference with references to a military employment preference and includes military members and their dependents.

Amendment to §4.10, Purpose, replaces the reference to employment preference for veterans with employment preference for military related service to align with the new terminology that was added by Senate Bill 1376, Acts of the 87th Legislature, Regular Session, 2023.

Amendment to §4.15, Preferences, updates the heading of Government Code, Chapter 657.

COMMENTS

No comments on the proposed amendments were received.

STATUTORY AUTHORITY

The amendments are adopted under Transportation Code, §201.101, which provides the Texas Transportation Commission (commission) with the authority to establish rules for the conduct of the work of the department.

CROSS REFERENCE TO STATUTES IMPLEMENTED BY THIS RULEMAKING

Government Code, Chapter 657.

The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

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