ADVISORY NO. 177

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TOPIC: NEW DESIGNATED DOCTOR RULES

The Commission has adopted two new rules (126.10 and 130.6) regarding designated doctors, which are attached. The rules become effective December 1, 1995. The new rules place increased requirements on designated doctors for their expertise in application of the *AMA Guides*, and are designed to decrease the number of dispute proceedings to resolve the issues of certification of maximum medical improvement and assessment of impairment. In addition, the rules are intended to reduce greatly the number of designated doctor determinations overturned by the appeals panel process. Fewer disputes should result in savings to both insurance carriers and health care providers.

Rule 126.10

Rule 126.10 establishes a list of doctors approved by the Commission and afforded the privilege to perform medical evaluations to make recommendations for resolution of disputes regarding certification of maximum medical improvement and/or assignment of impairment rating. This process of training and qualifying designated doctors is designed to allow the Commission to assemble and maintain a pool of highly qualified designated doctors.

Designated doctors are required by the rule to comply with a list of criteria which include the provisions of new Rule 130.6 (see analysis below), and are required to adhere to time limits set in the rule for scheduling and rescheduling appointments. The time frames for the new rule are designed to expedite the dispute resolution process.

Approved Doctor's List: The new rule requires designated doctors to be active on the "Approved Doctor List" as well as have Commission-approved training in the assignment of impairment ratings. It requires doctors to apply to the Commission for addition to the list of designated doctors and establishes specific criteria for approval, suspension, and removal from the Designated Doctor List. The rule lists items the division may consider in adding, deleting, or suspending a doctor from the Designated Doctor List and allows a waiver of requirements for an out of state doctor to serve as a designated doctor. The rule also establishes a three year active practice criteria for designated doctors, in order to assure that the designated doctor is up-to-date on the latest medical developments, have a working knowledge of medical treatments and diagnoses, and have similar experience as the treating doctor. This requirement also prevents retired doctors, without active practice, from serving as designated doctors.

Conflicts of Interest: Provisions of the rule define and prohibit disqualifying associations, and were enacted to prevent conflicts of interest between the doctor and the claimant. The rule indicates that it is economic associations which may reasonable be perceived as having the

potential to influence the conduct or decision of the designated doctor that are sought to be addressed. The rule also prohibits self-referral of a claimant for treatment or a designated doctor becoming the claimant's treating doctor for the medical condition evaluated by the designated doctor. The designated doctor is allowed to indicate in the narrative report any treatment recommendations for the treating doctor to consider, but should not assist in any manner or facilitate the receipt of the treatment.

Review of Removal or Suspension: Doctors recommended for removal or suspension from the Designated Doctor List will be given notice of the reasons for the removal or suspension and an opportunity to rebut those reasons. This process is designed to afford a doctor any due process which may be required for withdrawal of such a privilege while also ensuring that the Commission has considered the available information.

Rule 130.6

The new Rule 130.6 is designed to clarify the Commission requirements for doctors who serve in the capacity as designated doctors and to clarify the process for assigning designated doctors. The new rule represents a significant change to the prior Rule 130.6, and will also result in changes to claims handling with respect to designated doctors and certification of maximum medical improvement and assessment of impairment.

Outline of Rule: If a dispute relating to either assignment of impairment rating or determination of maximum medical improvement exists, the new rule provides for a designated doctor, either agreed to by the insurance carrier and claimant or appointed by the Commission, to examine the claimant. The new rule requires all designated doctors to meet the conditions set forth by new Rule 126.10. If a doctor is not on the Designated Doctor List, he or she may not serve as a designated doctor for the Commission. The rule provides that to serve in a particular case, a designated doctor must be on the Approved Doctor List, not have previously treated or examined the claimant within the last 12 months; not have any disqualifying associations; to the extent possible, be in the same discipline and licensed by the same board of examiners. The rule also: includes the requirement for Commission staff to notify the claimant of the Commission's requirement to adopt the impairment rating made by a mutually agreed upon designated doctor and to explain when a designated doctor's opinion has presumptive weight; requires the treating doctor and carrier to forward medical records to the designated doctor; limits communication with the designated doctor before and after the examination; requires the designated doctor to perform a physical examination of the claimant; holds the designated doctor responsible for the integrity of testing performed by a referral health care provider; requires submission of the medical evaluation report in accordance with Rule 130.1 (relating to Reports of Medical Evaluation; Maximum Medical Improvement); requires the designated doctor to maintain certain records relating to the examination and referrals; addresses the time frame within which a carrier must begin payment of income benefits after a designated doctor's report; and establishes billing procedures and reimbursement amounts for designated doctor services until such time as the Medical Fee Guideline specifically addresses this issue.

Dispute Process: Rule 130.6 also provides the details of the designated doctor dispute resolution process. The rule sets out the procedure to be followed in the selection of a designated doctor,

either by the agreement of the claimant and the carrier or assignment by the Commission. Time limits are set for each stage of the process to ensure timely resolution of disputes. As a means of expediting dispute resolution, the rule provides for the notice of dispute and the notice of appointment of designated doctor to be issued simultaneously. This procedure allows the time frames for agreement on a designated doctor, for setting appointments for Commission-assigned designated doctors, and for forwarding medical records to the designated doctor to run concurrently, thereby shortening the time required for dispute resolution. According to the Commission, only 2.0% of designated doctors are agreed upon by the claimant and carrier, and therefore, delaying the process to wait for such an agreement is not justified. Under the previous Rule 130.6, time frames for setting and scheduling designated doctor exams overlapped with the time frames for receiving medical records, creating a situation where appointments could be scheduled for a date before the medical records were even supposed to have arrived at the designated doctor's office. The new rule should resolve this conflict. This change in the law will have the immediate result of removing the "10-day" defense carriers have successfully argued to obtain a new designated doctor because the parties had not be afforded the opportunity to agree on a designated doctor.

Selection of Designated Doctor: Subsection (b) of the rule sets out criteria which must be met for a doctor to be assigned as a designated doctor for a particular dispute. The purpose of these provisions is to assure that designated doctors are impartial and also perceived to be impartial in the dispute they are asked to resolve. In response to changes made to Texas Labor Code § 408.122 by House Bill 1089, the new rule also requires that, to the extent possible, a designated doctor should be in the same discipline and licensed by the same board of examiners as the claimant's treating doctor.

Agreed-upon Designated Doctor: Although the statute and rule require that a commission-selected designated doctor be of the same discipline and licensed by the same board of examiners as the claimant's treating doctor, it is not clear that this requirement extends to an agreed-upon designated doctor. It is unlikely that this requirement will be imposed on the parties if they agree on a doctor. However, it is quite clear that the doctor must be on the Approved Doctor List. Regarding the actual agreement, the carrier must notify the Commission that the parties have agreed on a designated doctor. The Commission will not consider any agreement valid if the Commission does not receive a timely and proper notice about the agreement. The Commission must then contact the claimant to confirm the agreement, and inability to confirm will result in a presumption that an agreement was not made, and the initial order directing the claimant to be examined by the Commission-selected designated doctor will remain in effect. If the Commission is able to confirm the agreement, an order will be sent to the parties and the designated doctor canceling the Commission-selected designated doctor appointment, and directing the claimant to be examined by the agreed-upon doctor.

Disputes Involving IR or MMI Only: Several Appeal Panel Decisions have addressed the question of what issues a designated doctor assigned to a case should consider. In a case where the designated doctor is asked to resolve a dispute on assignment of impairment rating, some designated doctors have gone further and rendered a decision on maximum medical improvement. In such cases, the Appeals Panel has allowed Hearing Officers to adopt the date of maximum medical improvement certified by the designated doctor, even though it was not in

dispute prior to the examination. Subsection (j) of the new rule requires the designated doctor to address only the issue in dispute. The rule specifically states that if the impairment rating is the only issue in dispute, the doctor shall assess the rating with out regard to maximum medical improvement. This is a clear departure from Appeals Panel decisions, and is designed to speed the resolution process and prevent re-examination of issues previously resolved or not in dispute. Future Decisions from the Appeals Panel may very well hold that a party will waive its right to dispute the other issue by allowing the process to continue without raising it. To ameliorate against this, it is the policy of some Field Offices (and perhaps the Commission as a whole) that if a party disputes either a certification of maximum medical improvement or assessment of impairment, but not both, a Commission employee will contact the other party to determine if it wishes the designated doctor to address both issues.

Unilateral Contacts and Providing of Medical Records: The Commission has noted that designated doctors have had problems receiving complete medical records prior to their scheduled examination of the claimant. Because designated doctors must review the claimant's medical history to render an opinion on maximum medical improvement, impairment rating, or both, difficulty in receiving records has greatly hindered the designated doctor process. Passage of House Bill 1089, 74th Legislature, 1995, made several changes to the Texas Workers' Compensation Act which address designated doctors. One of these changes is a provision which prohibits communication with the designated doctor by anyone except the claimant and appropriate Commission staff prior to the designated doctor examination. The purpose of this provision is to prevent undue influence on a designated doctor's decisions. Because the mere forwarding of unaltered medical records to a designated doctor does not impose an undue influence on a doctor, in the rule, the word "communication" has been interpreted by the Commission to exclude the forwarding of *unaltered* medical records to the designated doctor. This interpretation avoids the time consuming process of sending records to the treating doctor or the Commission, who would then have to forward them to the designated doctor. Instead, the insurance carrier and the treating doctor can send medical records directly to the designated doctor; however, the records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. Breach of this requirement is a class C ($1,000) administrative violation. Therefore, claims handlers are strongly discouraged from making any marks on medical records when initially received that could later be interpreted as attempts to influence the designated doctor by Compliance and Practices. It is not clear whether "communication" also excludes video tapes of the claimant. It is clear from Appeals Panel Decisions, however, that these are relevant, and are properly considered by designated doctors. Further, it is clear from Appeal Panel Decisions that Commission staff have no discretion to refuse to send relevant and non-duplicative material to the designated doctor for consideration. Until this question is resolved, due to the potential administrative violation, it is recommended that claims handlers continue to forward these tapes to the Commission for transmittal to the designated doctor. In the meantime, any problems in getting these tapes to the designated doctor should be resolved by requesting an expedited benefit review conference. The designated doctor is allowed to initiate communication with any doctor who has previously treated or examined the claimant. This would include carrier-selected RME's, but not peer reviewers who have not actually examined the claimant.

Examinations Involving Specialists: The requirements for a designated doctor examination are set out in the rule, as are provisions for testing by a specialist when necessary. Procedures and time frames for rescheduling a designated doctor examination are included to ensure that the process continues expeditiously. The rule specifically indicates that it is the designated doctor who should perform range of motion, sensory, and straight leg testing, if applicable to the particular injury. However, the rule does allow another qualified health care provider to perform the testing, so the rule is apparently only discretionary. The designated doctor, however, is responsible for the integrity of the entire evaluation process, including the testing component.

Retesting: The Appeals Panel has previously held that retesting of range of motion is not mandated by the *AMA Guides*. Apparently in response to these holdings, the new rule specifically states that if the *AMA Guides* specifies that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first testing unless there is no clinical basis for retesting. In which case, the designated doctor must document the lack of clinical basis in the narrative notes with the clinical explanation for not recommending re-examination. The Commission has specifically indicated that the rule does not allow increasing the time period for retesting to allow time for a muscle spasm or other acute medical condition to resolve. Further, the rule leaves with the designated doctor's medical judgement and the *AMA Guides* the number of retests required. This will also be addressed by the commission-approved training for designated doctors. Presumably, this provision does not change the Appeals Panel Decisions allowing a designated doctor to invalidate range of motion based upon observational non-compliance with the testing, or failure to meet cross-validation criteria. It is also important to note that the rule does not mandate retesting in a situation where the claimant fails to meet the straight leg raising validity criteria. This is a second check, and does not depend upon consistency.

Preauthorization: Subsection (m) exempts designated doctor examinations from the requirements for preauthorization of additional testing when it is required by the *AMA Guides* for determining an impairment rating. This exemption was made for three reasons: (1) preauthorization requires coordination with the claimant's treating doctor who would be required to request the authorization--this process could potentially create a conflict of interest if the treating doctor did not agree with the designated doctor regarding the necessity of the testing, particularly if it is the treating doctor's determination that is being challenged; (2) preauthorization takes time and would cause a delay in the timely resolution of the dispute; and (3) testing ordered by designated doctors will be monitored through the Commission's proposed automated reporting system which will alert the Medical Review division to abuses of the system due to unnecessary testing. In addition, testing necessary to assign an impairment rating will be specified in the *AMA Guides* and therefore, not simply at the discretion of the designated doctor.

Records and Reports: The Commission has determined that accurate record-keeping and timely filing of reports is important in the designated doctor process to enable the Commission to meet its statutory duty to monitor health care providers and ensure compliance with the Act and Commission rules relating to health care, medical policies, fee guidelines, and impairment rating. Therefore, subsection (o) requires designated doctors to keep records regarding, among other things, the circumstances surrounding a cancellation or rescheduling, and the date medical records were received from the treating doctor or carrier. This provision, therefore, mandates

that the designated doctor report a carrier or treating doctor for failure to timely provide medical records to the designated doctor, which may result in administrative violations and, perhaps, removal of the treating doctor from the Approved Doctor List. Subsection (n) requires that the designated doctor complete his report within seven days, excluding extenuating circumstances.

Payment of Accrued Benefits: The new rule maintains the controversial requirement that the insurance carrier must pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issues in dispute, within five days after receipt of the report from the designated doctor. There is no discretion allowed by the carrier, and failure to pay is an administrative violation with a potential penalty of $5,000 per day payment is late. The carrier is not authorized to make a reasonable assessment. This provision was specifically criticized in a comment to the new rule, but the Commission chose to continue this provision, nevertheless. The Commission's response to the comment does indicate, however, that a carrier's dispute of a designated doctor's certification of maximum medical improvement or assessment of impairment is to be set for a benefit review conference on an expedited basis.

Sanctions: In response to changes made to the Texas Labor Code by House Bill 1089, subsection (p) provides sanctions which may be imposed on noncompliant designated doctors. The penalties imposed should encourage compliance. One penalty is the issuance of an order for refund to the carrier of the examination payment if an improper or incomplete examination is performed or improper or incomplete report is submitted. The Commission has indicated that it will use statewide averages as an indicator of the doctor's application and knowledge of the *AMA Guides*. Doctors who fall significantly outside the averages will be closely examined to determine compliance.

Fee Schedule for Examination: The new rule sets the amount that a designated doctor is allowed to charge for an examination until such time that the Medical Fee Guideline specifically addresses the issue. Reimbursements for designated doctor services are to be calculated according to the following formula: Base + Body Area(s) = Reimbursement. Ranges for reimbursement are as follows: (Base Ranges from $200 to $400) + (Body Area(s) Range(s) from $300 to $600) = Total Reimbursement Range from $500 to $1,000. The reimbursement ranges from $500 (with one body area) to $1,000 (with all body areas affected). If the claimant fails to attend the examination or cancels the commission-ordered examination within 24 hours of the appointment, reimbursement is $100. Part of the impetus to set these fees arose as a result of the wide disparity noted by the Commission of charges for designated doctor examinations and perceived bias when some doctors are paid more than others. The methodology for the fee schedule is designed to take into account those components necessary for a designated doctor examination, including length of treatment. The most important part of this concept is to separate the basic examination from the variable component of the number of body areas reviewed. Including length of time from the date of injury in the formula adjusts the fee for the complexity of the injury. In cases where additional testing is required and the designated doctor must incorporate the findings of a specialist into the report, an additional reimbursement is allowed. The monetary value of the component is based on fees for the component services as set in the Commission's Medical Fee Guideline as well as a monetary consideration for factors that only affect designated doctors, such as scheduling and paperwork requirements, imposed by

Commission rules. The fee structure prohibits the fee for impairment ratings performed by more than one health care provider to exceed the fee which would be charged if the designated doctor had performed the complete impairment rating. This provision results from the philosophy that fees should be fair and reasonable, based on the value of the service performed, regardless of the number of health care providers performing the service. The new fee schedule is designed to ensure the quality of medical care by adequately compensating designated doctors and to achieve effective medical cost control by establishing limits. The Commission anticipates that the public benefit, as a result of enforcing the rule, will be possible lower costs for the health care provided because the rule establishes standard reimbursement for the designated doctor services as well as indicates all services which are included in the fee. Previously such services may have been billed for separately.

Rule 126.10: Commission Approved List of Designated Doctors.

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

(1) Designated Doctor List-A list of doctors approved by the commission and afforded the privilege to perform medical evaluations and make recommendations to resolve disputes regarding certification of maximum medical improvement and/or assignment of impairment rating.

(2) AMA Guides-Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association.

(3) Division-The Medical Review Division of the Texas Workers' Compensation Commission.

(4) Disqualifying Association-Any association which may reasonably be perceived as having potential to influence the conduct or decision of the designated doctor.

(A) A disqualifying association between a designated doctor and a party may include:

(i) receipt of income, compensation, or payment of any kind not related to medical services provided by the doctor;

(ii) shared investment or ownership interest;

(iii) contracts or agreements which provide incentives, such as, referral fees, payments based on volume or value, and waiver of beneficiary coinsurance and deductible amounts;

(iv) contracts or agreements for space or equipment rentals, personnel services, management contracts, referral services, or warranties, or any other services related to the management of the doctor's practice; or

(v) personal or family relationships.

(B) Receipt of normal payments rendered for services provided pursuant to managed care/preferred provider contracts or any payment in accordance with the Texas Workers' Compensation Act and rules, is not considered a disqualifying association.

(5) Self-Refer-Treatment by the designated doctor or referral for treatment to another health care provider with which the designated doctor has a disqualifying association.

(6) Party-Any of the following entities including any of their agents or representatives: the insurance carrier, health care provider (including designated doctor and treating doctor) , injured employee, or employer.

(b) Doctors included in the Designated Doctor List shall:

(1) be currently active on the list of approved doctors as set forth in the Texas Labor Code, sec.408.023 (relating to List of Approved Doctors);

(2) meet the following training requirements:

(A) have successfully completed commission-approved training in the proper use of the AMA Guides prior to submission of an application;

(B) successfully complete commission-approved training at least every two years from the date of the last training as required in subparagraph (A) of this paragraph; and

(C) have passed the commission-approved written examination for impairment rating training within the time frame as specified by the division;

(3) schedule appointments to examine employees for a date as set forth in sec.130.6 of this title (relating to Designated Doctor: General Provisions);

(4) reschedule the examination for a date as set forth in sec.130.6 of this title (relating to Designated Doctor: General Provisions) when notified by the injured employee of a scheduling conflict;

(5) within 48 hours of receiving notice of being selected as a designated doctor, notify the commission field office of any disqualifying association;

(6) comply with all the provisions for designated doctors as specified in this rule and sec.130.6 of this title (relating to Designated Doctor: General Provisions);

(7) have maintained for the past three years and continue to maintain routine office hours for the treatment of patients in an active practice; and

(8) not self-refer for treatment or become the injured employee's treating doctor for the medical condition evaluated by the designated doctor. The designated doctor may indicate in the narrative report any treatment recommendations for the treating doctor to consider, but should not assist in any manner or facilitate the receipt of this treatment.

(c) Doctors may request to be on the Designated Doctor List by filing with the division form TWCC-72, Designated Doctor List Application, in the form and manner prescribed by the commission. The division shall notify the doctor of the approval or denial of the application.

(d) The division may, in addition to the documentation submitted with the doctor's request, consider the following in determining whether to add a doctor to the Designated Doctor List:

(1) any impairment ratings previously assessed, compared to like injuries;

(2) accuracy of previously assessed impairment ratings and certification of maximum medical improvement;

(3) non-certification of maximum medical improvement followed by the designated doctor self-referring for treatment;

(4) previous billing or treatment practices;

(5) substantiated complaints against the doctor;

(6) any violation of the Texas Workers' Compensation Act or commission rules; and

(7) any doctor's licensing body or regulatory agency disciplinary action.

(e) When deemed necessary because the injured worker is temporarily located or residing out-of-state, the commission may waive any of the requirements as specified in this rule for an out-of-state doctor to serve as a designated doctor to facilitate a timely resolution of the dispute.

(f) Doctors may be suspended or removed from the Designated Doctor List for noncompli ance with requirements of this section. The division may also consider and take action to suspend or remove a doctor from the Designated Doctor List based on, but not limited to, any of the following:

(1) four refusals within a 90 day period, or four consecutive refusals to perform within the required time frames, a commission requested appointment for which the doctor is qualified;

(2) two untimely or incomplete submissions within a 90 day period of medical evaluation reports in accordance with sec.130.1 of this title (relating to Reports of Medical Evaluation, Maximum Medical Improvement and Permanent Impairment) and sec.130.6 of this title (relating to Designated Doctor: General Provisions);

(3) failure to amend patterns of practice after being advised by the commission of performance requiring correction;

(4) misrepresentation or omission of information in the designated doctor application process;

(5) misrepresentation or omission of pertinent facts in medical evaluation and narrative reports;

(6) unnecessary referrals for the assignment of impairment rating or determination of maximum medical improvement (MMI);

(7) submission of an inaccurate or inappropriate impairment rating due to insufficient examination and analysis of a referred/supervised health care provider's testing results which must be in accordance with the AMA Guides;

(8) failure to timely respond to request for clarification from the commission regarding an examination;

(9) assignments of maximum medical improvement and/or impairment ratings overturned in a contested case hearing, appeals panel decision and/or court decision;

(10) any of the factors listed in subsection (d) of this section; or

(11) failure to successfully complete training requirements as specified in subsection (b)(2) of this section.

(g) The division shall notify a doctor in writing by certified mail, return receipt requested, or by personal delivery with receipt acknowledged, of temporary suspension from the Designated Doctor List pending division action. The notification shall include the division's proposed action, the reasons for the proposed action, details regarding the doctor's opportunity to rebut those reasons and notice if pre-scheduled appointments are canceled or should be performed.

(1) The temporary suspension will be effective from the date of receipt of the notice by the doctor.

(2) A doctor may submit a written rebuttal specifically addressing each reason for the proposed action. The rebuttal must be received by the division within 14 days after the doctor's receipt of the temporary suspension notice and must be sent by certified mail, return receipt requested, or by personal delivery with receipt acknowledged. Failure to respond within the time frame will result in the division's proposed action becoming effective without further notification.

(3) The division shall review the rebuttal and determine the appropriate action to take including: reinstatement to; suspension from; or removal from the Designated Doctor List. The division shall notify a doctor in writing of the action taken.

(4) A doctor who has been suspended or removed from the Designated Doctor List, may submit a written request to the division requesting reinstatement to the Designated Doctor List, and shall include a completed Designated Doctor List Application (TWCC-72), and information regarding corrective measures undertaken to resolve the suspension or removal issue. The division will evaluate the request and make a determination of the doctor's reinstatement to the Designated Doctor List and notify the doctor of approval or denial of the reinstatement request.

Effective Date: December 1, 1995

Rule 130.6: Designated Doctor: General Provisions.

(a) If the commission receives a notice from the employee or the insurance carrier that disputes maximum medical improvement; an assigned impairment rating; or maximum medical improvement and an assigned impairment rating, the commission shall issue a written order assigning a designated doctor, setting up a designated doctor appointment for a date no earlier than 14 days from the date of the commission order and no later than 24 days from the date of the commission order, and notifying the employee and the insurance carrier that the designated doctor will be directed to examine the employee. The commission's written order shall also:

(1) contain the designated doctor's name, license number, practice address and telephone number, and the date and time of the examination;

(2) explain that the injured employee may agree with the carrier on a different designated doctor and notify the commission of the agreement as described in subsection (e) of this section;

(3) state that there is a dispute and that the Texas Labor Code, sec.408.125 requires the commission to adopt the impairment rating made by a mutually agreed upon designated doctor;

(4) explain when the designated doctor's report has presumptive weight with respect to maximum medical improvement and/or impairment ratings as specified in the Texas Labor Code, sec.408.122 and sec.408.125;

(5) notify an unrepresented employee that commission staff are available to explain the contents of an agreement for a designated doctor and the possible effects of such an agreement on future benefits;

(6) order the employee to be examined by the designated doctor on the stated date and time, unless the commission is timely notified of an agreement; and

(7) require the treating doctor and insurance carrier to forward all medical records in compliance with subsection (h) of this section.

(b) In order to be a designated doctor for a dispute, the doctor shall:

(1) be on the Designated Doctor List as described in sec.126.10 of this title (relating to Commission Approved List of Designated Doctors);

(2) not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor;

(3) not have any disqualifying association as specified in sec.126.10(a) of this title (relating to Commission Approved List of Designated Doctors); and

(4) to the extent possible, be in the same discipline and licensed by the same board of examiners as the employee's doctor of choice.

(c) After sending the order to the employee and the insurance carrier as specified in subsection (a) of this section, the commission shall allow the employee and insurance carrier to agree on a designated doctor. If at the end of the tenth day from the date of the order, the commission has not received notification from the insurance carrier or injured employee that a designated doctor has been agreed upon, the commission will presume that an agreement is not possible and the employee is required to attend the commission-selected designated doctor examination as specified in subsection (a) of this section.

(d) If the employee and the insurance carrier agree on a designated doctor, the insurance carrier shall schedule an appointment for the designated doctor to examine the employee on a date no earlier than 14 days from the date of the commission order described in subsection (a) of this section and no later than 24 days from the date of the commission order.

(e) The carrier shall notify the commission field office within ten days of the date of the commission's order as described in subsection (a) when an agreement with the injured employee on the selection of a designated doctor is made. The notice shall include:

(1) the commission's claim file number;

(2) the employee's name, address, and social security number, and if known, the employee's telephone number;

(3) the date of the injury; and

(4) the designated doctor's name, license number, practice address and telephone number, and the time and date of the examination.

(f) Upon timely receipt of the notification from the insurance carrier that the injured employee and the carrier have agreed on a designated doctor, the commission shall contact the employee to confirm the agreement. Upon confirmation by the employee, the commission shall send to the carrier, designated doctor and the injured employee an order confirming the agreement, canceling the commission-selected designated doctor appointment, and directing the employee to be examined by the agreed-upon doctor. The order shall remind the parties of the requirements in the Texas Labor Code, sec.408. 122 and sec.408.125 as specified in subsection (a) of this section and require the treating doctor and insurance carrier to forward medical records in compliance with subsection (h) of this section. The order will supersede the initial order identifying a commission-selected designated doctor. If the commission cannot confirm the agreement with the employee, the commission will presume that an agreement was not made and the initial order directing the employee to be examined by a designated doctor selected by the commission shall remain in effect.

(g) The designated doctor and the injured employee shall contact each other if there exists a scheduling conflict for the designated doctor appointment. The designated doctor or the injured employee who has the scheduling conflict must make the contact at least 24 hours prior to the appointment. The 24 hour requirement will be waived in an emergency situation (such as a death in the immediate family or a medical emergency). The rescheduled examination shall be set for a date within seven days of the originally scheduled examination unless an extension is granted by the field office. Within 24 hours of rescheduling, the designated doctor shall contact the commission field office and the insurance carrier with the time and date of the rescheduled examination.

(h) The treating doctor and insurance carrier are both responsible for sending to the designated doctor all the employee's medical records relating to the medical condition to be evaluated by the designated doctor that are in their possession without a signed release from the employee. The designated doctor is authorized to receive the employee's confidential medical records to assist in the resolution of maximum medical improvement and impairment rating disputes. The medical records must not contain any marks, highlights, or other alterations placed on such records for the purpose of communicating with or influencing the designated doctor. The medical records must be received by the designated doctor at least three days prior to the date of the appointment as specified in the commission order. If the medical records are marked, highlighted, altered, or unrelated to the medical condition to be evaluated by the designated doctor, the designated doctor shall notify the commission and report the noncompliance of the treating doctor and/or insurance carrier. Noncompliance with this subsection is a Class C administrative violation under the Texas Labor Code sec.408.125 and may be subject to an administrative penalty not to exceed $1000. If the designated doctor has not received the medical records at least three days prior to the examination, the designated doctor's office shall notify the commission at the appropriate field office and the appropriate commission staff will send an order to the treating doctor and/or insurance carrier for the delivery of medical records.

(i) To avoid undue influence on a person selected as a designated doctor under the Texas Labor Code, sec.408.125, only the employee or an appropriate member of the staff of the commission may communicate with the designated doctor about the case regarding the employee's medical condition or history prior to the examination of the employee by the designated doctor. After that examination is completed, communication with the designated doctor regarding the employee's medical condition or history may be made only through appropriate commission staff members. An ombudsman is not considered appropriate staff to contact the designated doctor and should communicate with a designated doctor only through appropriate commission personnel. The designated doctor may initiate communication with any doctor who has previously treated or examined the employee for the work-related injury. Noncompliance with this section is a Class C administrative violation under the Texas Labor Code, sec.408.125 and may be subject to an administrative penalty not to exceed $1,000.

(j) The designated doctor shall address the issue(s) in dispute and confine the report as described in subsection (n) of this section to only those issues. When the impairment rating is the only issue in dispute, the doctor shall assess an impairment rating without regard to maximum medical improvement. When maximum medical improvement and impairment rating are in dispute and the designated doctor determines that the employee has not reached MMI, the designated doctor shall not assign an impairment rating. An evaluation or certification under the Guides to the Evaluation of Permanent Impairment, third edition, second printing, dated February 1989, published by the American Medical Association (AMA Guides), shall include a physical examination and evaluation by the designated doctor. Although any doctor or any other provider who has successfully completed the training outlined in sec.126.10(b)(2) of this title (relating to Commission Approved List of Designated Doctors) may compare the clinical findings on a particular patient with the criteria in the AMA Guides, the designated doctor shall conduct a physical evaluation and is responsible for the integrity of the evaluation process. This means the designated doctor must evaluate the complete clinical and non-clinical history of the medical condition(s), perform an examination of the employee, analyze the medical history with the clinical and laboratory findings and assess and certify an impairment rating according to the AMA Guides.

(k) When performing range of motion testing, if the AMA Guides specifies that additional testing be performed because of consistency requirements, the designated doctor shall reschedule testing within seven days of the first testing unless there is no clinical basis for retesting and then the designated doctor must document this in the narrative notes with the clinical explanation for not recommending re-examination.

(l) Range of motion, sensory, and strength testing should be performed by the designated doctor, when applicable. If this testing is not performed by the designated doctor, the health care provider performing the testing must have successfully completed commission-approved training as outlined in sec. 126.10(b)(2) in the proper use of the AMA Guides, must not have previously treated or examined the employee within the past 12 months or with regard to the medical condition being evaluated by the designated doctor, and must complete testing within seven days of the designated doctor's physical examination of the employee.

(m) For testing other than that listed in subsection (l) of this section, the designated doctor may perform additional testing or refer employees to other health care providers when deemed necessary to assess an impairment rating. Any additional testing required by the AMA Guides for the assignment of the impairment rating is not subject to preauthorization requirements in accordance with the Texas Labor Code, sec.413.014 (relating to Preauthorization) and additional testing must be completed within seven days of the designated doctor's physical examination of the employee.

(n) The designated doctor shall complete and file the medical evaluation report in accordance with sec.130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment) unless testing must be rescheduled or the employee is referred to another health care provider as specified in subsections (k)-(m) of

this section, the medical evaluation report shall be completed and filed within seven days of the rescheduled testing or referral appointment date.

(o) The designated doctor shall maintain accurate records to reflect:

(1) the date and time of any designated doctor appointments scheduled with employees;

(2) the circumstances regarding a cancellation, no-show or other situation where the examination did not occur as initially scheduled or rescheduled;

(3) the date of the examination;

(4) the date medical records were received from the treating doctor or any other person or organization;

(5) the date the medical evaluation report was submitted to all parties in accordance with sec.130.1 of this title (relating to Reports of Medical Evaluation: Maximum Medical Improvement and Permanent Impairment); and

(6) the name of all referral health care providers, date of appointments and reason for referral by the designated doctor.

(p) The commission may:

(1) issue an order requiring timely submission of medical evaluation reports or narrative reports;

(2) assess administrative violations;

(3) issue an order for refund to the insurance carrier of the examination payment if an improper or incomplete examination is performed or improper or incomplete report is submitted;

(4) take action to remove a doctor from the Designated Doctor List as described in accordance with sec.126.10 of this title (relating to Commission Approved List of Designated Doctors); and/or

(5) take action to remove a doctor from the Approved Doctor List in accordance with sec.126.8 of this title (relating to Commission Approved Doctor List).

(q) The insurance carrier shall pay any accrued income benefits, and shall begin or continue to pay weekly income benefits, in accordance with the designated doctor's report for the issue(s) in dispute, no later than five days after receipt of the report or upon receipt of an order by the commission, whichever is earlier.

(r) The designated doctor billing and reimbursement will be as established in this subsection until the designated doctor reimbursement is specifically addressed by the Medical Fee Guideline. At such time, the Medical Fee Guideline will supersede this subsection.

(1) The insurance carrier is responsible for paying the reasonable cost of a designated doctor examination as set forth in the fee structure of this subsection. In addition, the carrier shall pay for the reasonable travel expenses for an injured employee to attend a designated doctor appointment.

(2) The reimbursement for determination of maximum medical improvement and/or impairment ratings shall be inclusive of:

(A) the examination;

(B) consultation with the employee;

(C) review of records and films;

(D) the preparation and submission of reports, calculation tables, figures, and worksheets;

(E) range of motion, strength, and sensory testing and measurements; and

(F) other tests used to validate the impairment rating.

(3) Regardless of the maximum allowable reimbursement specified in this subsection, the designated doctor's charge for services should correlate with the actual time and level of service involved with each patient and reimbursement from the carrier shall be the lesser of the charge amount or the fees set forth as follows.

(A) Total reimbursement is equal to the base reimbursement plus the area(s) rated.

(B) The base reimbursement is inclusive of the physical examination, patient consultation and education, detailed narrative report, and factors affecting the service as a designated doctor such as ensuring availability of appointments, timeliness of reports, and responding to the need for further clarification, explanation or reconsideration. Length of time elapsed from date of injury will indicate the base reimbursement as follows.

(i) Greater than or equal to two years is reimbursed at $400 and indicated by using modifier L1 on the billing form.

(ii) Greater than or equal to one year and less than two years is reimbursed at $300 and indicated by using modifier L2 on the billing form.

(iii) Less than one year is reimbursed at $200 and indicated by using modifier L3 on the billing form.

(C) Areas that can be reimbursed when rated include body areas and specialty areas as follows.

(i) The reimbursement for body areas that must be rated because of the compensable injury is inclusive of testing, records reviewed, impairment rating calculations, and documentation. The designated doctor may bill for a maximum of three body areas, defined as the Spine and Pelvis; Upper Extremities and Hands; and, Lower Extremities. The reimbursement for one body area is $300 and each additional body area is $150.

(ii) The reimbursement for specialty areas that must be rated where referred testing is required such as psychological, audiologic and/or ophthalmologic testing, is $50 for incorporating one or more specialists' report information into the final impairment rating. This reimbursement will only be allowed once per examination. The referred specialist will be reimbursed separately from the fees outlined in this rule.

(D) The designated doctor must indicate the number of areas rated in the units column on the billing form with the maximum being four units/areas.

(E) When the outcome of the evaluation is that maximum medical improvement has not been reached, the designated doctor shall receive the base reimbursement as outlined in subparagraph (B) of this paragraph. No additional reimbursement will be allowed.

(F) If the employee fails to attend the examination or cancels the commis sion-ordered examination within 24 hours of the appointment, reimbursement shall be $100.

(4) If testing is performed by a health care provider other than the designated doctor as specified in subsection (l) of this section, each health care provider must bill for their respective services using the code and modifiers as prescribed by the commission. If the technical and professional components of the impairment rating are billed separately, reimbursement will be made at 20% for the technical and 80% for the professional of the total reimbursement as outlined in paragraph (3)(A) of this subsection. When the designated doctor performs all components of the service without any referred testing, the designated doctor shall bill using the code as prescribed by the commission with modifier -WP for the whole procedure.

(5) Additional testing or referrals specified in subsection (m) of this section will be reimbursed in addition to the fees specified in paragraph (3) (A)-(C) of this subsection if the additional testing was required to perform the assignment of impairment rating and/or determination of maximum medical improvement. These services should be billed using the appropriate CPT code as specified in the Medical Fee Guideline.

(6) A carrier's time frame for reimbursement to the designated doctor does not begin until a complete medical evaluation report with required attachments has been received by the insurance carrier.

Effective Date: January 25, 1991

Amended Effective Date: December 1, 1995