# ADOPTED RULES

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

## TITLE 4. AGRICULTURE

## PART 1. TEXAS DEPARTMENT OF AGRICULTURE

### CHAPTER 30. COMMUNITY DEVELOPMENT

The Texas Department of Agriculture (Department) adopts the repeal of Title 4, Part 1, Chapter 30, Subchapter A in its entirety. Specifically, the Department adopts the repeal of Subchapter A, Texas Community Development Block Grant Program, Division 1, §§30.1 - 30.8, relating to General Provisions; Division 2, §§30.20 - 30.31, relating to Application Information; Division 3, §§30.50 - 30.60 and 30.62 - 30.67, relating to Administration of Program Funds; Division 4, §§30.80 - 30.84, relating to Awards and Contract Administration; and Division 5, §§30.100, 30.102, and 30.103, relating to Reallocation of Program Funds. In conjunction with this adopted repeal, the Department adopts new subchapter A, relating to the Texas Community Development Block Grant Program, consisting of §§30.1 - 30.13. The repeal of existing Subchapter A is adopted and new Subchapter A is adopted without changes to the proposed text as published in the June 24, 2022 issue of the *Texas Register* (47 TexReg 3601) and will not be republished.

The Department determined that due to the extensive changes to program rules, repeal of the entire subchapter and replacement with new rules was more efficient than proposing numerous amendments to make the required changes. The changes are necessary in order to simplify the rules, focusing on the most generally applicable program requirements and removing details more efficiently addressed in the Application Guides. The repealed rules contained separate requirements for each program category. The new rules focus on program-wide requirements of general applicability. The new rules will allow the Department flexibility to develop program procedures and guidelines in a more timely and efficient manner to ensure compliance with all statutory and applicable regulatory requirements.

New §30.1 describes the Department's authority to implement and administer the Texas Community Development Block Grant Program (TxCDBG) program.

New §30.2 provides definitions for terms and abbreviations applicable to this subchapter.

New §30.3 provides the method of allocation of grant funds.

New §30.4 describes who is eligible to apply for TxCDBG grants.

New §30.5 outlines the application process and provides that the specific application procedures, requirements, and evaluation criteria will be stated in a Request for Applications.

New §30.6 describes application threshold requirements.

New §30.7 explains the citizen participation process.

New §30.8 provides the appeal process for denial or disqualification of applications.

New §30.9 describes project implementation requirements.

New §30.10 sets out the requirement for grant training.

New §30.11 prescribes the conflict of interest standards for grant recipients.

New §30.12 describes the process for requesting amendments to a grant agreement.

New §30.13 concerns the range of sanctions the Department may impose on grant recipients.

The Department did not receive any comments regarding the repeal of existing rules or the proposed new rules.

### SUBCHAPTER A. TEXAS COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

### DIVISION 1. GENERAL PROVISIONS

**4 TAC §§30.1 - 30.8**

The repeal of Subchapter A, Division 1, §§30.1-30.8 is adopted under Texas Government Code, §487.051, which designates the Department as the agency to administer the federal community development block grant non-entitlement program, and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202942
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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### DIVISION 2. APPLICATION INFORMATION

**4 TAC §§30.20 - 30.31**

The repeal of Subchapter A, Division 2, §§30.20 - 30.31 is adopted under Texas Government Code §487.051, which designates the Department as the agency to administer the federal community development block grant non-entitlement program,

and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202943
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Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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## DIVISION 3. ADMINISTRATION OF PROGRAM FUNDS

**4 TAC §§30.50 - 30.60, 30.62 - 30.67**

The repeal of Subchapter A, Division 3, §§30.50-30.60 and 30.62-30.67 is adopted under Texas Government Code §487.051, which provides the Department authority to administer the state's community development block grant non-entitlement program, and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202944
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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## DIVISION 4. AWARDS AND CONTRACT ADMINISTRATION

**4 TAC §§30.80 - 30.84**

The repeal of Subchapter A, Division 4, §§30.80 - 30.84 is adopted under Texas Government Code §487.051, which provides the Department authority to administer the state's community development block grant non-entitlement program, and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202945
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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## DIVISION 5. REALLOCATION OF PROGRAM FUNDS

**4 TAC §§30.100, 30.102, 30.103**

The repeal of Subchapter A, Division 5, §§30.100, 30.102, and 30.103 is adopted under Texas Government Code §487.051, which provides the Department authority to administer the state's community development block grant non-entitlement program, and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202946
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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## SUBCHAPTER A. TEXAS COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

**4 TAC §§30.1 - 30.13**

The new rules are adopted pursuant to Texas Government Code §487.051, which provides the Department authority to administer the state's community development block grant non-entitlement program, and §487.052, which provides authority for the Department to adopt rules as necessary to implement Chapter 487.

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 August 8, 2022.

TRD-202202947
Skyler Shafer
Assistant General Counsel
Texas Department of Agriculture
Effective date: August 28, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 936-9360

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# TITLE 16. ECONOMIC REGULATION

# PART 4. TEXAS DEPARTMENT OF LICENSING AND REGULATION

## CHAPTER 90. OFFENDER EDUCATION PROGRAMS FOR ALCOHOL AND DRUG-RELATED OFFENSES

The Texas Commission of Licensing and Regulation (Commission) adopts amendments to existing rules at 16 Texas Administrative Code (TAC), Chapter 90, Subchapter A, §90.1; Subchapter B, §90.21; Subchapter D, §90.40; Subchapter E, §§90.51 - 90.54; Subchapter F, §90.80; and Subchapter G, §§90.91 - 90.94; new rules at Subchapter A, §90.10; Subchapter B, §§90.20, 90.22 - 90.28; Subchapter C, §§90.30 - 90.34; Subchapter D, §§90.41 - 90.49; Subchapter E, §90.50; and Subchapter G, §90.95; and the repeal of existing rules at Subchapter A, §90.10; Subchapter B, §§90.20, 90.22 - 90.27; Subchapter C, §§90.30 - 90.34; Subchapter D, §§90.41 - 90.49; and Subchapter E, §90.50 regarding the Court-Ordered Education program, without changes to the proposed text as published in the June 10, 2022, issue of the *Texas Register* (47 TexReg 3375). These rules will not be republished.

The Commission also adopts amendments to existing rules at 16 TAC Chapter 90, Subchapter A, §90.1, and Subchapter G, §90.91 and §90.92, regarding the Court-Ordered Education program, with changes to the proposed text as published in the June 10, 2022, issue of the *Texas Register* (47 TexReg 3375). These rules will be republished.

EXPLANATION OF AND JUSTIFICATION FOR THE RULES

The rules under 16 TAC Chapter 90 implement new Texas Government Code, Chapter 171, relating to the Court-Ordered Education Programs, formerly known as the Offender Education Programs. The rules also implement Texas Transportation Code, Chapter 521, §§521.374 - 521.376, regarding the Drug Offender Education Program.

*Senate Bill 1480*

Senate Bill (SB) 1480, 87th Legislature, Regular Session (2021) changed the landscape of the Court-Ordered Education Programs by consolidating the requirements found in separate statutes previously governing the court-ordered programs into one statutory chapter for easier reference and organization.

This bill represents a significant change in the provision of instruction and the Department's regulatory framework for instructors and program providers associated with delivering court-ordered programs. The court-ordered programs available for persons subject to court orders involving community supervision for drug or alcohol-related offenses under new Texas Government Code, Chapter 171 are: the Alcohol Education Program for Minors (AEPM); the Drug Offender Education Program (DOEP); the DWI Education Program (DWIE) and the DWI Intervention Program (DWII). These programs are referenced under Texas Alcoholic Beverage Code §106.115; Texas Transportation Code §§521.374 - 721.376; Texas Code of Criminal Procedure, Chapter 42A, Articles 42A.403 and 42A.406; and Texas Code of Criminal Procedure, Chapter 42A, Articles 42A.404 and 42A.406, respectively.

Instructors and program providers will experience significant changes as a result of this bill, which is intended to benefit program participants and the general public, including: (A) online provision of course materials and curriculum by program providers, thus allowing court-ordered program instruction to reach participants throughout the state, and increasing business flexibility and cost savings for instructors and providers; (B) creation of a unified program provider license with one program fee for providers with multiple locations creating efficiencies for Department administration resulting in lower costs; (C) repeal of the requirement for program provider branch locations and program headquarters organizational structure; and (D) introduction of new program fees for program providers and instructors related to licensing and court-ordered program endorsement fees.

The adopted rules implement SB 1480 for the Court-Ordered Education Programs by: (1) amending program definitions within the chapter; (2) prescribing eligibility requirements and minimum qualifications for license applicants; (3) setting the minimum requirements and responsibilities for licensed providers and instructors; (4) establishing program provider and instructor endorsement requirements; (5) mandating minimum standards for online and in-person program provider delivery of court-ordered program curriculum; (6) amending and adding program fees for program providers and instructors as provided by the new statute; (7) updating rule terminology to include new license types, program provider structure changes, and court-ordered program endorsements; (8) imposing criminal penalties for violations involving the misuse of certificates of program completion; and (9) updating rule language to recognize repealed statutory references.

The adopted rules in this rulemaking represent the first phase of the implementation of SB 1480. A subsequent rulemaking completing the implementation of SB 1480 shall occur later and include rule changes on court-ordered program curriculum, program provider reporting, audits and inspections, and continuing education.

*Senate Bill 181*

The adopted rules also implement Senate Bill (SB) 181, 87th Legislature, Regular Session (2021). SB 181 overlaps with SB 1480, and both bills amend Transportation Code §§521.374, 521.375, and 521.376. The changes, in part, affect the Drug Offender Education Program approved and administered by the Department. Texas Transportation Code §521.374(a)(1), as amended, provides that a person may successfully complete an in-person or online drug offender educational program approved by the Department under Texas Government Code, Chapter 171. Texas Transportation Code §521.375(a) and (b), as amended, requires the Department to work with the Texas Department of Public Safety (DPS) to jointly adopt rules for the qualification and approval of providers of in-person and online drug offender educational programs approved by the Department. Texas Transportation Code §521.376(a), as amended, assigns certain duties to the Department regarding the in-person and online drug offender educational programs approved by the Department. The adopted rules implement SB 181 and SB 1480 related to the Drug Offender Education Program approved and administered by the Department.

As a result of the legislative changes, the adopted rules include extensive amendments and subsequent repeals and renumbering of rule sections within 16 TAC Chapter 90. Moreover, the adopted rules introduce new rule sections in Subchapters A - E and G to provide greater clarity, interpretation, and implementation of the provisions of SB 1480 and SB 181 relating to the Court-Ordered Education Program.

SECTION-BY-SECTION SUMMARY

*Subchapter A, General Provisions.*

The adopted rules amend §90.1, Authority, by deleting repealed statutory references and including a reference to Texas Government Code, Chapter 171 for court-ordered programs for alcohol and drug-related offenses; and, post-publication, added the word "and" just before the citation to the Code of Criminal Procedure related to the DWI Intervention Program to correct rule language.

The adopted rules add new §90.10, Definitions, which establishes the meaning of the words and terms employed throughout the rule chapter. The new rule replaces existing §90.10 to: (1) include definitions for words and terms introduced by SB 1480; (2) added a definition for "module", (3) delete definitions for "Administrator", "Branch Office/Site", "Course Size", "Drug Offender", and "Program/Provider Headquarters"; (4) modify terminology for existing definitions consistent with SB 1480; (5) renumber the provisions as needed; and (6) correct rule language.

The adopted rules repeal existing §90.10, Definitions.

*Subchapter B, Instructor Requirements.*

The adopted rules add new §90.20, Instructor License Required, which introduce changes to instructor licensing structure and the addition of court-ordered endorsements to the instructor license from SB 1480. The new rule replaces existing rule §90.20 to: (1) amend the section header changing the term "certification" to "license"; (2) update rule language to include use of the term "endorsement" to refer to the court-ordered programs consistent with SB 1480; and (3) include requirements for instructors to hold appropriate license endorsements to teach participants at program provider locations.

The adopted rules repeal existing §90.20, Instructor Certification Required.

The adopted rules amend §90.21, Instructor License - Eligibility Requirements, by updating the section header and rule terms consistent with SB 1480, and correct rule language.

The adopted rules add new §90.22, Instructor License - Application for License and First Endorsement, which describes the Department procedure by which an instructor applicant may apply and obtain for a license and an endorsement to instruct a court-ordered program. The new rule will: (1) update the section header and rule terms consistent with SB 1480; (2) identify the new instructor licensing fee; and (3) update terminology in the section header and rule consistent with SB 1480. This rule replaces existing §90.23 and is relocated to more accurately reflect the Department's current licensing process.

The adopted rules add new §90.23, Instructor License - Instructor Training Course and Examination, which identifies the Department's training course and examination process that instructor applicants must successfully complete prior to licensure. The new rule will update the section header consistent with SB 1480. This rule replaces existing §90.22 and is relocated to more accurately reflect the Department's current licensing process.

The adopted rules add new §90.24, Instructor License - Additional Endorsements, to describe the new procedure introduced by SB 1480 by which an instructor may obtain license endorsements to instruct other court-ordered programs, and the endorsement disposition at time of renewal.

The adopted rules add new §90.25, Instructor License Term; Renewals, which describes the license renewal process for the program. The new rule will: (1) specify the two-year term of the license and the concurrent endorsement; (2) describe the Department procedure for license renewal and late renewal; (3) mandate an instructor hold a current license to instruct a specific court-ordered program(s); and (4) update the section header and rule language. This rule replaces existing §90.24.

The adopted rules add new §90.26, Instructor Continuing Education Requirements, which identifies the continuing education requirements by court-ordered program for instructors to meet prior to license renewal. The new rule will: (1) remove the previous minimum teaching requirement of courses during the instructor licensing period to obtain license renewal; (2) replaces the word "attend" with "complete" to recognize the online provision of court-ordered programs as authorized by SB 1480; and (3) updates the rule language and section header. This rule replaces existing §90.25.

The adopted rules add new §90.27, Instructor Continuing Education Audits - All Programs, which describes the Department auditing system and the responsibilities of the instructor to maintain continuing education records, and details the process for instructor reporting of continuing education hours necessary for license renewal. This rule replaces existing §90.26.

The adopted rules add new §90.28, Instructor Responsibilities, which: (1) requires instructors to report their own criminal convictions or those of other instructors; (2) sets notice requirements for changes in instructor name, mailing address, telephone number or email address; (3) shifts instructor course and provider certification requirements for teaching court-ordered programs to new §90.20 and §90.50; and (4) removes the requirement that an instructor provide his/her certification number and Department complaint information to participants. This rule replaces existing §90.27.

The adopted rules repeal existing §90.22, Instructor Certification - Instructor Training Course and Examination.

The adopted rules repeal existing §90.23, Instructor Certification - Application.

The adopted rules repeal existing §90.24, Instructor Certification Term; Renewals.

The adopted rules repeal existing §90.25, Instructor Teaching and Continuing Education Requirements.

The adopted rules repeal existing §90.26, Instructor Continuing Education Audits - All Programs.

The adopted rules repeal existing §90.27, Instructor Responsibilities.

*Subchapter C, Program Provider License Requirements.*

The existing rules in this subchapter are being repealed to accommodate adopted new rule sections to reflect the licensing changes for program providers in implementing SB 1480.

The adopted rules add new §90.30, Program Provider License Required, which introduce changes to program provider licensing structure and the addition of court-ordered endorsements to the program provider license from SB 1480. The adopted rules allow a program provider to have but one license with up to four court-ordered endorsements to operate. Providers are no longer required to license each location owned. Branch locations have been eliminated by SB 1480. Moreover, providers will now be

able to offer or provider instruction statewide with the ability to deliver online service. The new rule replaces existing rule §90.30 to: (1) require program providers have a current license with the applicable endorsement for each court-ordered program offered or provided to participants; (2) ensure each court-ordered program is taught by licensed instructors with the proper endorsement for the program(s) instructed; (3) require that program providers conduct instruction using the Department-approved instructor manuals and curriculum; (4) delete references to "Program/Provider"; (5) allow a program provider to offer or provide a court-ordered program in-person, online, or both, in accordance with SB 1480; and (6) update the rule language and section heading.

The adopted rules add new §90.31, Program Provider License - Application for License and Endorsements, which describes the Department procedure by which a program provider applicant may obtain for a license and an endorsement to offer or provide a court-ordered program. The new rule replaces existing rule §90.31 to: (1) require program providers be licensed and possess applicable endorsement(s) for each court-ordered program offered or provided; (2) describe the Department procedure for an applicant to obtain a program provider license; (3) delete references to "headquarters", "administrator", "program/provider" and "branch sites" from license requirements; (4) include new standards for a program provider applicant that intends to offer or provider online instruction to participants; and (5) update the rule language and section heading.

The adopted rules add new §90.32, Program Provider License - Additional Endorsements, which describes the new procedure introduced by SB 1480 by which a program provider may obtain additional license endorsements to offer or provide more than one court-ordered program, and the endorsement disposition at time of renewal. The new rule replaces existing rule §90.32 to: (1) implement SB 1480 by requiring a program provider who offers or provides additional court-ordered program types to hold the appropriate endorsement for each program offered or provided to participants; (2) describe the Department procedure for an applicant to obtain additional endorsements; (3) delete licensing requirements associated with branch sites and headquarters; (4) clarify that endorsements renew with the program provider license renewal; and (5) update the rule language and section headers.

The adopted rules add new §90.33, Program Provider License Term; Renewal, which describes the program provider license renewal process. The new rule replaces existing rule §90.33 to: (1) specify the two-year term of the license and the concurrent endorsement; (2) identify the Department procedure for program provider license renewal and late renewal; (3) delete references to "program/provider"; (4) mandate a program provider hold a current license to offer or provide a court-ordered program; (5) clarify that endorsements renew with the program provider license renewal; and (6) update the rule language and section headers.

The adopted rules add new §90.34, Program Provider License - Change of Address, Ownership and Other Information, which describes the program provider's responsibilities to report to the Department when there is a change in specific information affecting business operations. The new rule replaces existing rule §90.34 to: (1) require a licensee to notify the Department within 30 days of any change in program provider information as noted in the rule; (2) define what conditions will constitute a change in ownership of the program provider; (3) delete references to "program/provider"; (4) require that a program provider maintain a registered agent within the state for service of process; and (5) update the rule language and section header.

The adopted rules repeal existing §90.30, Program/Provider Certification Requirement.

The adopted rules repeal existing §90.31, Program/Provider Certification Application - Headquarters.

The adopted rules repeal existing §90.32, Program/Provider Certification Application - Branch Sites and Other Locations.

The adopted rules repeal existing §90.33, Program/Provider Certification Term; Renewal.

The adopted rules repeal existing §90.34, Program/Provider Certification - Change of Address and Providing Information.

*Subchapter D, Program Requirements - Curriculum, Courses, Classrooms, Certificates.*

This subchapter is being revised to add new rules and to make amendments to existing rules. Many of the adopted new rules are like to the existing rules in substance, but the rules are being reorganized and renumbered. The rules in this subchapter will also be part of a subsequent rulemaking regarding court-ordered program curriculum.

The adopted rules amend §90.40, Program Curriculum and Materials - All Programs, to: (1) identify the course curriculum approved for each online and in-person court-ordered program; (2) update rule terms consistent with SB 1480; and (3) correct language.

The adopted rules add new §90.41, Program Rules - Drug Offender Education Program, which addresses the joint rulemaking authority between the Department and the Texas Department of Public Safety (DPS) for the adoption of rules related to the qualification and approval of providers for the Drug Offender Education Program, as required under Transportation Code, Chapter 521, and as amended by SB 1480 and SB 181. This rule replaces existing §90.42.

The adopted rules add new §90.42, General Program and Course Requirements - All Programs, which define the responsibilities for program providers and instructors when presenting instruction to participants for in-person and online court-ordered programs, and updated rule language consistent with SB 1480. This rule replaces existing §90.43.

The adopted rules add new §90.43, Additional Course Requirements for the Drug Offender Education Program, which: (1) renames "class sessions" to "modules"; (2) details the course minimums for class instruction hours, duration and number of daily class modules, and administration of course examinations; and (3) sets the maximum number of participants for the specific court-ordered program. This rule replaces existing §90.44.

The adopted rules add new §90.44, Additional Course Requirements for the Alcohol Education Program for Minors, which: (1) renames "class sessions" to "modules"; (2) details the course minimums for class instruction hours, duration and number of daily class modules, and administration of course examinations; and (3) sets the maximum number of participants for the specific court-ordered program. This rule replaces existing §90.45.

The adopted rules add new §90.45, Additional Course Requirements for the DWI Education Program (DWIE), which: (1) details the course minimums for class instruction hours, (2) prescribes the number of daily hours of instruction and administra-

tion of course examinations; (3) increases the maximum number of participants to 30 for the specific court-ordered program; and (4) addresses the disposition of the certificate of completion to the appropriate court officials and the Texas Department of Public Safety. This rule replaces existing §90.46.

The adopted rules add new §90.46, Additional Course Requirements for the DWI Intervention Programs (DWII), which: (1) renames "class sessions" to "modules"; (2) details the course minimums for class instruction hours, duration and number of daily and weekly class modules; (3) sets the maximum number of participants for the specific court-ordered program; (4) provides for make-up class modules for excused participant absences, and individual participant sessions with exit interviews; and (5) addresses the disposition of the certificate of completion to the appropriate court officials and DPS. This rule replaces existing §90.47.

The adopted rules add new §90.47, In-Person Classroom Facilities and Equipment, which: (1) details the necessary equipment and facilities for an in-person program provider to provide court-ordered program instruction to participants; (2) prohibits licensees from offering, providing, or instructing an in-person court-ordered program out of a private residence; (3) requires instructors to be physically present when providing in-person instruction of a court-ordered program; (4) bars licensees from presenting any recorded or videotaped material as a part of the course presentation; and (5) updates the rule language and section header. This rule replaces existing §90.48.

The adopted rules add new §90.48, Online Program Requirements, which defines the requirements for a program provider when offering newly authorized online court-ordered programs to participants. This adopted new rule is added to: (1) require that online program providers possess sufficient bandwidth and working equipment to allow for instruction of court-ordered programs in real time; (2) mandate that online program providers employ Department-approved curriculum and materials under applicable laws and rules; (3) detail instructor and participant on-camera interaction requirements during instruction sessions, and empower the instructor to remove participants from class who fail to comply with those requirements; (4) prohibit the instructor from admitting a participant without fully functional equipment; and (5) impose responsibility on program providers for the administration of and security for pre-course and post-course examination of participants.

The adopted rules add new §90.49, Certificate of Program Completion for Participants, which describes the program provider's responsibilities surrounding the care, control and issuance of program completion certificates to successful participants taking court-ordered programs. This new rule: (1) details the program provider's responsibilities for delivery of a certificate of program completion of a court-ordered program to each participant; (2) prohibits delivery of the certificate by electronic means; (3) sets the responsibilities for program providers under which they maintain certificate records, and the care, custody and control of program certificates; (4) describes the process by which a provider may issue duplicate certificates and return unassigned certificates; (5) establishes requirements on a program provider to protect unissued certificates and account for missing certificates with the Department; (6) addresses additional requirements for the DWIE and DWII Programs when delivering certificates of program completion to court officials and DPS; and (7) updates and clarifies the rule language. This rule replaces existing §90.49.

The adopted rules repeal existing §90.41, Program Curriculum and Rules - DWI Education Program. The statutory provisions requiring jointly-approved curriculum and rules for the DWI Education program were repealed by SB 1480.

The adopted rules repeal existing §90.42, Program Rules - Drug Offender Education Program (DOEP).

The adopted rules repeal existing §90.43, General Program and Course Requirements - All Programs.

The adopted rules repeal existing §90.44, Additional Course Requirements for the Drug Offender Education Program.

The adopted rules repeal existing §90.45, Additional Course Requirements for the Alcohol Education Program for Minors.

The adopted rules repeal existing §90.46, Additional Course Requirements for the DWI Education Program.

The adopted rules repeal existing §90.47, Additional Course Requirements for DWI Intervention Programs.

The adopted rules repeal existing §90.48, Classroom Facilities and Equipment.

The adopted rules repeal existing §90.49, Course Completion Certificates for Participants.

*Subchapter E, Program Requirements - Administration and Other Responsibilities.*

The adopted rules add new §90.50, Program Administration, which define the parameters of program operation for a program provider. This new rule replaces existing §90.50 to: (1) identify the responsibilities for program providers to set course fees, create course schedules and maintain program records for Department audit; (2) set restrictions on the court-ordered program referral policy for program providers and instructors for inquiring participants; (3) require program providers to resolve participant complaints; (4) instruct program providers to provide participants with notice concerning the complaint filing process with the Department; and (5) update the rule language consistent with SB 1480.

The adopted rules repeal existing §90.50, Program Administration.

The adopted rules amend §90.51, Recordkeeping Regarding Course Participants, to: (1) update rule language consistent with SB 1480; (2) clarify the type of address information the program provider is required to collect from participants for its records; (3) correct rule language; and (4) ease record storage requirements for program providers to respond to Department inspections and audit.

The adopted rules amend §90.52, Annual Reports, to update rule language consistent with SB 1480.

The adopted rules amend §90.53, Confidentiality, to update rule language consistent with SB 1480.

The adopted rules amend §90.54, Discrimination Prohibited, to update rule language consistent with SB 1480.

*Subchapter F, Fees.*

The adopted rules amend §90.80, Fees, which illustrate the new program fees framework established by SB 1480. Under the new framework, (1) initial license and renewal fees are now assessed on instructors, as well as providers; (2) program headquarters and branch location provisions have been eliminated; and (3) the requirements for separate licenses for each court-ordered

program have been eliminated. The adopted rules will require a provider or an instructor to obtain one license with the option to add up to four court-ordered program endorsements, one for each program. The endorsement becomes a part of the license for the provider or instructor, and it renews at the same time with the license.

Under the adopted rules, the provider initial license and renewal fee remain unchanged. However, a provider is only required to obtain one license with the option to add up to four endorsements. A provider with multiple locations pays for one unitary license under which all the other locations will operate. The program headquarters and branch location fees have been eliminated. When the provider renews the license, there is one renewal fee that includes the license and the current endorsement(s).

Instructors, under the adopted rules, are now required to pay initial license and renewal fees, pursuant to SB 1480. However, like the provider license regime, an instructor is only required to obtain one license with the option to add up to four endorsements. When the instructor renews the license, there is one renewal fee that includes the license and the current endorsement(s). Consistent with SB 1480, the existing rule is amended to: (1) update rule language in line with SB 1480; (2) eliminate the fees associated with the headquarters and branch location framework which was repealed by SB 1480; (3) add new licensing and endorsement fees for instructors and program providers which reflect the new fee structure and which recognize one license per provider or instructor with up to four court-ordered endorsements; and (4) correct language.

*Subchapter G, Enforcement.*

The adopted rules amend §90.91, Complaints; Investigations, to update rule language consistent with SB 1480; and, post-publication, added the words "or instructor" to clarify the record provision obligations pursuant to a department complaint investigation for driver education instructors and program providers, and removed repetitive language to clarify and correct language.

The adopted rules amend §90.92, Administrative Penalties and Sanctions, to update statutory citations consistent with SB 1480, and, post-publication, added a period after the words "or both" to correct language.

The adopted rules amend §90.93, Enforcement Authority, to update statutory citations consistent with SB 1480.

The adopted rules amend §90.94, Additional Conduct Subject to Disciplinary Actions, to: (1) update rule language consistent with SB 1480; (2) add additional prohibited conduct for a program provider or instructor pursuant to Chapter 171, Texas Government Code; and (3) clarify rule language.

The adopted rules add new §90.95, Criminal Penalties, to affix Class A Misdemeanor criminal penalties to any unauthorized person who knowingly sells, transfers, issues, possesses or trades a certificate of program completion or certificate number. This change is pursuant to Texas Government Code, Chapter 171.

PUBLIC COMMENTS

The Department drafted and distributed the proposed rules to persons internal and external to the agency. The proposed rules were published in the June 10, 2022, issue of the *Texas Register* (47 TexReg 3375). The public comment period closed on July 11, 2022. The Department did not receive any comments from interested parties on the proposed rules.

COMMISSION ACTION

At its meeting on August 9, 2022, the Commission adopted the proposed rules with changes to the proposed text as published in the *Texas Register.*

## SUBCHAPTER A. GENERAL PROVISIONS

### 16 TAC §90.1, §90.10

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

*§90.1. Authority.*

This chapter is promulgated under the authority of Occupations Code, Chapter 51; Government Code, Chapter 171; Alcoholic Beverage Code, §106.115 (Alcohol Education Program for Minors); Transportation Code, §§521.374 - 521.376 (Drug Offender Education Program); Code of Criminal Procedure, Chapter 42A, Articles 42A.403 and 42A.406 (DWI Education Program); and Code of Criminal Procedure, Chapter 42A, Articles 42A.404 and 42A.406 (DWI Intervention Program).

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 August 12, 2022.

TRD-202203038
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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### 16 TAC §90.10

STATUTORY AUTHORITY

The adopted repeal is adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeal is

also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted repeal are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted repeal.

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 August 12, 2022.

TRD-202203018
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER B. INSTRUCTOR REQUIREMENTS

### 16 TAC §§90.20, 90.22 - 90.27

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeals are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted repeals.

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 August 12, 2022.

TRD-202203019
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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### 16 TAC §§90.20 - 90.28

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

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 August 12, 2022.

TRD-202203042
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER C. PROGRAM/PROVIDER CERTIFICATION REQUIREMENTS

### 16 TAC §§90.30 - 90.34

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeals are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapter 51; Texas

Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted repeals.

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 August 12, 2022.

TRD-202203020
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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**16 TAC §§90.30 - 90.34**

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

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 August 12, 2022.

TRD-202203017
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER D. PROGRAM REQUIREMENTS - CURRICULUM, COURSES, CLASSROOMS, CERTIFICATES

**16 TAC §§90.40 - 90.49**

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

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 August 12, 2022.

TRD-202203011
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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**16 TAC §§90.41 - 90.49**

STATUTORY AUTHORITY

The adopted repeals are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeals are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted repeals are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted repeals.

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 August 12, 2022.

TRD-202203021

Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER E. PROGRAM REQUIREMENTS - ADMINISTRATION AND OTHER RESPONSIBILITIES

### 16 TAC §90.50

STATUTORY AUTHORITY

The adopted repeal is adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted repeal is also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted repeal are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted repeal.

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 August 12, 2022.

TRD-202203022
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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### 16 TAC §§90.50 - 90.54

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

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 August 12, 2022.

TRD-202203012
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER F. FEES

### 16 TAC §90.80

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

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 August 12, 2022.

TRD-202203013
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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## SUBCHAPTER G. ENFORCEMENT

### 16 TAC §§90.91 - 90.95

STATUTORY AUTHORITY

The adopted rules are adopted under Texas Occupations Code, Chapter 51 and Texas Government Code, Chapter 171, which authorize the Texas Commission of Licensing and Regulation, the Department's governing body, to adopt rules as necessary to implement these chapters and any other law establishing a program regulated by the Department. The adopted rules are also adopted under Texas Transportation Code, Chapter 521, §521.375, regarding the joint adoption of rules with the Department of Public Safety for the Drug Offender Education Program.

The statutory provisions affected by the adopted rules are those set forth in Texas Occupations Code, Chapter 51; Texas Government Code, Chapter 171; Texas Alcoholic Beverage Code §106.115; Texas Transportation Code, §§521.371 - 521.377; Texas Code of Criminal Procedure, Articles 42A.403, 42A.404, 42A.406, 42A.407, 42A.514, and 45.051; and Texas Family Code §53.03 and §54.047. No other statutes, articles, or codes are affected by the adopted rules.

*§90.91. Complaints; Investigations.*

(a) Upon verbal or written request from the department, a program provider, instructor, or any person associated with the program, must cooperate with the department and furnish requested information concerning any department investigation of a complaint.

(b) If the department is investigating a complaint, the program provider or instructor must make available or provide to the department upon request at any reasonable time, any of its documents or records, unless otherwise prohibited by law.

*§90.92. Administrative Penalties and Sanctions.*

If a person or entity violates any provision of Texas Occupations Code Chapter 51, Texas Government Code, Chapter 171, the statutory provisions identified in §90.1, this chapter, any rule or order of the executive director or commission, proceedings may be instituted to impose administrative penalties, administrative sanctions, or both.

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 August 12, 2022.

TRD-202203014
Brad Bowman
General Counsel
Texas Department of Licensing and Regulation
Effective date: September 1, 2022
Proposal publication date: June 10, 2022
For further information, please call: (512) 475-4879

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# PART 9. TEXAS LOTTERY COMMISSION

## CHAPTER 401. ADMINISTRATION OF STATE LOTTERY ACT

## SUBCHAPTER D. LOTTERY GAME RULES

### 16 TAC §401.317

The Texas Lottery Commission (Commission) adopts amendments to 16 TAC §401.317 ("Powerball" Draw Game Rule) without changes to the proposed text as published in the June 24, 2022 issue of the *Texas Register* (47 TexReg 3616) and will not be republished.

The amendments to §401.317 align the rule with recently amended Multi-State Lottery Association (MUSL) Powerball game rules. MUSL Powerball game rules were amended on January 6, 2022 to address changes related to the funding of Powerball Guaranteed Grand Prizes.

The Commission received no written comments on the proposed amendments during the public comment period.

These amendments are adopted under Texas Government Code §466.015(c), which authorizes the Commission to adopt rules governing the operation of the lottery, and §467.102, which authorizes the Commission to adopt rules for the enforcement and administration of the laws under the Commission's jurisdiction.

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 August 15, 2022.

TRD-202203037
Bob Biard
General Counsel
Texas Lottery Commission
Effective date: September 4, 2022
Proposal publication date: June 24, 2022
For further information, please call: (512) 344-5324

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# TITLE 19. EDUCATION

# PART 2. TEXAS EDUCATION AGENCY

## CHAPTER 97. PLANNING AND ACCOUNTABILITY

## SUBCHAPTER AA. ACCOUNTABILITY AND PERFORMANCE MONITORING

### 19 TAC §97.1005

The Texas Education Agency (TEA) adopts an amendment to §97.1005, concerning results driven accountability (RDA). The amendment is adopted without changes to the proposed text as published in the June 3, 2022 issue of the *Texas Register* (47 TexReg 3211) and will not be republished. The adopted amendment repeals the 2021 RDA Manual currently included as Figure: 19 TAC §97.1005(b) and replaces it with the 2022 RDA Manual.

REASONED JUSTIFICATION: House Bill 3459, 78th Texas Legislature, 2003, added Texas Education Code (TEC), §7.027, which limits and redirects monitoring done by TEA to that required to ensure school district and charter school compliance with federal law and regulations; financial accountability, including compliance with grant requirements; and data integrity for purposes of the Texas Student Data System Public Education Information Management System (PEIMS) and accountability under TEC, Chapter 39. Legislation passed in 2005 renumbered TEC, §7.027, to TEC, §7.028. To meet this monitoring requirement, TEA developed the Performance Based Monitoring Analysis System (PBMAS) Manual, renamed the RDA Manual in 2019, which is used in conjunction with other evaluation systems to monitor performance of certain populations

of students and the effectiveness of special programs in school districts and charter schools.

TEA has adopted its PBMAS Manual/RDA Manual in rule since 2005. The manual outlines a dynamic system that evolves over time, so the specific criteria and calculations for monitoring student performance and program effectiveness may differ from year to year. The intent is to update §97.1005 annually to refer to the most recently published RDA Manual.

The adopted amendment to §97.1005 updates the current rule by adopting the 2022 RDA Manual, which describes the specific criteria and calculations that will be used to assign 2022 RDA performance levels.

The 2022 RDA Manual includes several changes from the 2021 system. Revisions to the RDA Manual include the following.

Referenced dates relevant to the 2022 RDA indicator data and calculations are updated throughout. Additional explanatory text is added to the RDA Manual overview as well as exemplar data for calculation methodologies demonstration.

*Bilingual Education, English as a Second Language, and Emergent Bilingual (BE/ESL/EB)*

This portion includes a new report only indicator for BE/ESL/EB Indicator #3 (i-iv): Alternative Language Program (ALP) STAAR 3-8 Passing Rate to measure student outcomes in local education agencies (LEAs) who receive waivers under 19 TAC §89.1207(a) or 19 TAC §89.1207(b). It also includes new indicator names: BE/ESL/EB Indicator #1 (i-iv) BE STAAR 3-8 Passing Rate; BE/ESL/EB Indicator #2 (i-iv) ESL STAAR 3-8 Passing Rate; BE/ESL/EB Indicator #4 (i-iv) EB (Not Served in BE/ESL) STAAR 3-8 Passing Rate; BE/ESL/EB Indicator #5 EB Dyslexia STAAR 3-8 Reading Passing Rate; BE/ESL/EB Indicator #6 (i-iv) EB Years-After Reclassification (YsAR) STAAR 3-8 Passing Rate; BE/ESL/EB Indicator #7 (i-iv) EB STAAR EOC Passing Rate; BE/ESL/EB Indicator #8 TELPAS Reading Beginning Proficiency Level Rate; BE/ESL/EB Indicator #9 TELPAS Composite Rating Levels for Students in U.S. Schools Multiple Years; BE/ESL/EB Indicator #10 EB Graduation Rate; BE/ESL/EB Indicator #11 EB Annual Dropout Rate (Grades 7-12); and BE/ESL/EB Indicator #12 EB Dyslexia Representation (Ages 6-21) to parallel with programmatic terminology usage that replaces English learners with emergent bilingual students with no impact to data inclusion or exclusion, and which reflects the elimination of a separate writing assessment subject measurement in applicable indicators. In addition, it eliminates duplicative information and renumeration of data notes.

*Other Special Populations (OSP)*

This portion includes a new indicator name: OSP Indicator #1 (i-iv) OSP STAAR 3-8 Passing Rate, which reflects the elimination of a separate writing assessment subject measurement.

*Special Education (SPED)*

This portion includes new indicator names: SPED Indicator #1 (i-iv) SPED STAAR 3-8 Passing Rate; and SPED Indicator #3 (i-iv) SPED Year-After-Exit (YAE) STAAR 3-8 Passing Rate, which reflects the elimination of a separate writing assessment subject measurement; SPED Indicator #8 SPED Dyslexia Representation (school-aged); SPED Indicator #9 SPED Regular Early Childhood Program Rate (preschool-aged); SPED Indicator #10 SPED Regular Class ≥80% Rate (school-aged); SPED Indicator #11 SPED Regular Class ˂40% Rate (school-aged); and SPED Indicator #12 SPED Separate Settings Rate (school-aged), which defines student-aged inclusion in each applicable indicator.

*Of Note for all RDA Program Areas*

On March 16, 2020, Governor Greg Abbott waived the State of Texas Assessment of Academic Readiness (STAAR®) testing requirements for the 2019-2020 school year due to extensive school closures relating to the COVID-19 nation-wide pandemic event. As a result, indicators specific to STAAR® testing proficiency, participation, or other reliance on non-existing 2019-2020 STAAR® data were assigned an "ND" for no data availability for RDA 2020. Because application of the special analysis (SA) process uses data over the prior two years, impacted STAAR® assessment indicators does not include SA processing for RDA 2022.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began June 3, 2022, and ended July 5, 2022. Two virtual public hearings to solicit testimony and input on the proposed amendment were held on June 7 and 9, 2022. The public comments and agency responses are as follows.

Comment: Texans for Special Education Reform (TxSER) and Texas Parent2Parent expressed a concern with the number of LEAs excluded in assignment of performance levels within the RDA reporting system based on the minimum size requirements (MSR). TxSER requested the MSR be changed from 30 to 25 to align with the accountability rating system authorized under 19 TAC §97.1001.

Response: The agency disagrees. In implementing Guiding Principles of the RDA: Principle 3: Protects Children and Families, maximum inclusion is realized by using appropriate alternatives to analyze the performance of LEAs with small numbers of students. The MSR can be met either in the current year or through the aggregation of numerators and denominators over the most recent two years, if applicable. Furthermore, as outlined on pages 10-13 of the 2020 RDA manual, application of a special analysis for group sizes of 15-29 occurs to ensure maximum inclusion for performance level assignments. TEA recognizes the concern for MSR alignment with the accountability rating system authorized under 19 TAC §97.1001 and is working to align its systems of measurement, including looking at MSR in alignment with other accountability measures, but will continue to apply systems such as "special analysis" to ensure maximum inclusion for school sizes that do not meet the MSR in a single year.

Comment: An individual suggested relaxing the performance level for SPED Indicator #6 to allow students receiving special education and related services to graduate in more than four years.

Response: The agency disagrees. Student graduation from high school with a regular high school diploma is an important indicator of school success and one of the most significant indicators of student college and career readiness. Although students receiving special education and related services are eligible for services through age 21 and may graduate beyond 4 years, TEA includes a comparable measurement and applicable performance levels in four-year graduation rates for special populations of students. This measurement aligns with the Every Student Succeeds Act requirements to provide all children significant opportunity to receive a fair, equitable, and high-quality education and to close educational achievement gaps.

Comment: An individual suggested a change in the risk ratio threshold specific to the significant disproportionality (SD) threshold for autism from 2.5 to 3.0 to prevent incentivizing school districts to keep numbers inaccurately low for this population of students.

Response: The agency disagrees. Federal requirements for measurement and reporting SD stem from an effort to better understand the extent of racial and ethnic overrepresentation in special education and promote consistency in how states determine requirements for LEAs to provide early intervening services. Each of the 14 categories, including autism, are analyzed for over-representation in seven racial and ethnic groups. Although 34 CFR §300.647(b)(1)(ii) allows for states to set standards at different levels for each of the categories described in paragraphs (b)(3) and (4) of the relevant section, states are required to apply reasonable standards subject to monitoring and enforcement for reasonableness by the Secretary of Education consistent with Section 616 of the act. Reasonable standards for each area were based on real data models set through numerous stakeholder engagements and input resulting in the established threshold. The threshold establishes, for this particular category, that an LEA that identifies students with autism in a particular race/ethnicity group (e.g., Asian/autism) at a risk ratio of more than 2.5 times than that of all other race/ethnicities (i.e., total students for all other race/ethnicities identified with autism) would be considered disproportionate for that category of students. An LEA that exceeds the threshold in the same particular category for three consecutive years is determined significant disproportionate and is required to reserve the maximum amount of funds under Section 613(f) of the act to provide comprehensive coordinated early intervening services (CCEIS) addressing factors contributing to the significant disproportionality. CCEIS funds may be used to carry out activities that include professional development and educational and behavioral evaluations, services, and supports, described in 34 CFR §300.646(d)(1)(i). The regulation, specifically 34 CFR §300.646(f), prohibits a state or an LEA to develop or implement policies, practices, or procedures that result in actions that violate federal requirements, including requirements related to child find and ensuring that a free appropriate public education is available to all eligible children with disabilities.

STATUTORY AUTHORITY. The amendment is adopted under Texas Education Code (TEC), §7.021(b)(1), which authorizes the Texas Education Agency (TEA) to administer and monitor compliance with education programs required by federal or state law, including federal funding and state funding for those programs; TEC, §7.028, which authorizes TEA to monitor as necessary to ensure school district and charter school compliance with federal law and regulations, financial integrity, and data integrity and authorizes the agency to monitor school district and charter schools through its investigative process. TEC, §7.028(a), authorizes TEA to monitor special education programs for compliance with state and federal laws; TEC, §12.056, which requires that a campus or program for which a charter is granted under TEC, Chapter 12, Subchapter C, is subject to any prohibition relating to the Public Education Information Management System (PEIMS) to the extent necessary to monitor compliance with TEC, Chapter 12, Subchapter C, as determined by the commissioner of education; high school graduation under TEC, §28.025; special education programs under TEC, Chapter 29, Subchapter A; bilingual education under TEC, Chapter 29, Subchapter B; and public school accountability under TEC, Chapter 39, Subchapters B, C, D, F, and J, and Chapter 39A; TEC, §12.104, which states that a charter granted under TEC, Chapter 12, Subchapter D, is subject to a prohibition, restriction, or requirement, as applicable, imposed by TEC, Title 2, or a rule adopted under TEC, Title 2, relating to PEIMS to the extent necessary to monitor compliance with TEC, Chapter 12, Subchapter D, as determined by the commissioner; high school graduation requirements under TEC, §28.025; special education programs under TEC, Chapter 29, Subchapter A; bilingual education under TEC, Chapter 29, Subchapter B; discipline management practices or behavior management techniques under TEC, §37.0021; public school accountability under TEC, Chapter 39, Subchapters B, C, D, F, G, and J, and Chapter 39A; and intensive programs of instruction under TEC, §28.0213; TEC, §29.001, which authorizes TEA to effectively monitor all local education agencies (LEAs) to ensure that rules relating to the delivery of services to children with disabilities are applied in a consistent and uniform manner, to ensure that LEAs are complying with those rules, and to ensure that specific reports filed by LEAs are accurate and complete; TEC, §29.0011(b), which authorizes TEA to meet the requirements under (1) 20 U.S.C. Section 1418(d) and its implementing regulations to collect and examine data to determine whether significant disproportionality based on race or ethnicity is occurring in the state and in the school districts and open-enrollment charter schools in the state with respect to the: (A) Identification of children as children with disabilities, including the identification of children as children with particular impairments; (B) Placement of children with disabilities in particular educational settings; and (C) Incidence, duration, and type of disciplinary actions taken against children with disabilities including suspensions or expulsions; or (2) 20 U.S.C. Section 1416(a)(3)(C) and its implementing regulations to address in the statewide plan the percentage of schools with disproportionate representation of racial and ethnic groups in special education and related services and in specific disability categories that results from inappropriate identification; TEC, §29.010(a), which authorizes TEA to adopt and implement a comprehensive system for monitoring LEA compliance with federal and state laws relating to special education, including ongoing analysis of LEA special education data; TEC, §29.062, which authorizes TEA to evaluate and monitor the effectiveness of LEA programs and apply sanctions concerning emergent bilingual students; TEC, §29.066, which authorizes PEIMS reporting requirements for school districts that are required to offer bilingual education or special language programs to include the following information in the district's PEIMS report: (1) demographic information, as determined by the commissioner, on students enrolled in district bilingual education or special language programs; (2) the number and percentage of students enrolled in each instructional model of a bilingual education or special language program offered by the district; and (3) the number and percentage of emergent bilingual students who do not receive specialized instruction; TEC, §39.003 and §39.004, which authorize the commissioner to adopt procedures relating to special investigations. TEC, §39.003(d), allows the commissioner to take appropriate action under Chapter 39A, to lower the district's accreditation status or the district's or campus's accountability rating based on the results of the special investigation; TEC, §39.051 and §39.052, which authorize the commissioner to determine criteria for accreditation statuses and to determine the accreditation status of each school district and open-enrollment charter school; TEC, §39.053, which authorizes the commissioner to adopt a set of indicators of the quality of learning and achievement and requires the commissioner to periodically review the indicators for consideration of appropriate revisions;

TEC, §39.054(b-1), which authorizes TEA to consider the effectiveness of district programs for special populations when determining accreditation statuses; TEC, §39.0541, which authorizes the commissioner to adopt indicators and standards under TEC, Chapter 39, Subchapter C, at any time during a school year before the evaluation of a school district or campus; TEC, §39.056, which authorizes the commissioner to adopt procedures relating to monitoring reviews and special accreditation investigations; TEC, §39A.001, which authorizes the commissioner to take any of the actions authorized by TEC, Chapter 39, Subchapter A, to the extent the commissioner determines necessary if a school does not satisfy the academic performance standards under TEC, §39.053 or §39.054, or based upon a special investigation; TEC, §39A.002, which authorizes the commissioner to take certain actions if a school district becomes subject to commissioner action under TEC, §39A.001; TEC, §39A.004, which authorizes the commissioner to appoint a board of managers to exercise the powers and duties of a school district's board of trustees if the district is subject to commissioner action under TEC, §39A.001, and has a current accreditation status of accredited-warned or accredited-probation; or fails to satisfy any standard under TEC, §39.054(e); or fails to satisfy any financial accountability standard; TEC, §39A.005, which authorizes the commissioner to revoke school accreditation if the district is subject to TEC, §39A.001, and for two consecutive school years has received an accreditation status of accredited-warned or accredited-probation, failed to satisfy any standard under TEC, §39.054(e), or failed to satisfy a financial performance standard; TEC, §39A.007, which authorizes the commissioner to impose a sanction designed to improve high school completion rates if the district has failed to satisfy any standard under TEC, §39.054(e), due to high school completion rates; TEC, §39A.051, which authorizes the commissioner to take action based on campus performance that is below any standard under TEC, §39.054(e); and TEC, §39A.063, which authorizes the commissioner to accept substantially similar intervention measures as required by federal accountability measures in compliance with TEC, Chapter 39A.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §§7.021(b)(1), 7.028, 12.056, 12.104, 29.001, 29.0011(b), 29.010(a), 29.062, 29.066, 39.003, 39.004, 39.051, 39.052, 39.053, 39.054(b-1), 39.0541, 39.056, 39A.001, 39A.002, 39A.004, 39A.005, 39A.007, 39A.051, and 39A.063.

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 August 9, 2022.

TRD-202202959
Cristina De La Fuente-Valadez
Director, Rulemaking
Texas Education Agency
Effective date: August 29, 2022
Proposal publication date: June 3, 2022
For further information, please call: (512) 475-1497

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# CHAPTER 109. BUDGETING, ACCOUNTING, AND AUDITING

## SUBCHAPTER EE. COMMISSIONER'S RULES CONCERNING FINANCIAL ACCOUNTING GUIDELINES

### 19 TAC §109.5001

The Texas Education Agency (TEA) adopts an amendment to §109.5001, concerning the financial accountability system resource guide. The amendment is adopted without changes to the proposed text as published in the June 3, 2022 issue of the *Texas Register* (47 TexReg 3214) and will not be republished; however, the *Financial Accountability System Resource Guide* (FASRG) adopted by reference in the rule includes changes to Modules 1 and 5 at adoption. The amendment adopts by reference the updated FASRG, Version 18.0. The FASRG provides accounting rules for school districts, open-enrollment charter schools, and education service centers.

REASONED JUSTIFICATION: The FASRG describes the rules of financial accounting for school districts, charter schools, and education service centers. Requirements for financial accounting and reporting are derived from generally accepted accounting principles (GAAP). School districts and charter schools are required to adhere to GAAP. Legal and contractual considerations typical of the government environment are reflected in the fund structure basis of accounting.

An important function of governmental accounting systems is to enable administrators to assure and report on compliance with finance-related legal provisions. This assurance and reporting means that the accounting system and its terminology, fund structure, and procedures must be adapted to satisfy finance-related legal requirements. However, the basic financial statements of school districts and charter schools should be prepared in conformity with GAAP.

School district and charter school accounting systems shall use the accounting code structure presented in the account code section of the FASRG (Module 1). Funds shall be classified and identified on required financial statements by the same code number and terminology provided in the account code section of the FASRG (Module 1).

The FASRG, Version 18.0, contains six modules on the following topics: Module 1, Financial Accounting and Reporting (FAR) and FAR Appendices; Module 2, Special Supplement - Charter Schools; Module 3, Special Supplement - Non-profit Charter Schools Chart of Accounts; Module 4, Auditing; Module 5, Purchasing; and Module 6, Compensatory Education, Guidelines, Financial Treatment, and an Auditing and Reporting System.

State law provides authority for both the State Board of Education (SBOE) and the commissioner of education to adopt rules on financial accounting. To accomplish this, the SBOE and the commissioner each adopt the FASRG by reference under separate rules. The SBOE adopts the FASRG by reference under 19 TAC §109.41, and the commissioner adopts the FASRG by reference under §109.5001.

During the June 2022 SBOE meeting, the SBOE approved §109.41 for second reading and final adoption. At that time, the SBOE approved changes to Modules 1 and 5 of the FASRG since published as proposed. These changes impact the FASRG adopted by reference in new §109.5001.

Module 1 aligns with current governmental accounting standards. Adopted Module 1 includes the following significant changes. School districts and charter schools are required

to maintain proper budgeting and financial accounting and reporting systems. In addition, school districts are required to establish principles and policies to ensure uniformity in accounting in conformity with GAAP established by the Governmental Accounting Standards Board (GASB) and the Financial Accounting Standards Board (FASB).

In response to public comments, Module 1, FAR and FAR Appendices, were modified at adoption to implement recent changes in accounting and auditing standards, provide clearer guidance, and add clarity through grammatical edits.

Module 2 aligns with current financial and accounting reporting standards. Adopted Module 2 includes the following significant changes. The module establishes financial and accounting requirements for Texas public charter schools to ensure uniformity in accounting in conformity with GAAP. The adopted module also includes current guidance that complements the American Institute of Certified Public Accountants (AICPA) Audit and Accounting Guide, State and Local Governments and supplements the Government Auditing Standards of the United States Government Accountability Office (GAO). These requirements facilitate preparation of financial statements that conform to GAAP established by the FASB.

Module 3 aligns with current governmental accounting standards. Adopted Module 3 includes the following significant changes. Charter schools are required to maintain proper budgeting and financial accounting and reporting systems that are in conformity with Texas Education Data Standards in the Texas Student Data Systems PEIMS. In addition, charter schools are required to establish principles and policies to ensure uniformity in accounting in conformity with GAAP established by the FASB. The adopted module also includes current auditing guidance that complements the AICPA Audit and Accounting Guide, State and Local Governments and supplements the Government Auditing Standards of the United States GAO. These requirements facilitate preparation of financial statements that conform to GAAP established by the FASB.

Module 4 aligns with current governmental auditing standards. Adopted Module 4 includes the following significant changes. The adopted module establishes auditing requirements for Texas public school districts and charter schools and include current requirements from TEC, §44.008, as well as Title 2, Code of Federal Regulations, Part 200, Subpart F, Audit Requirements, that implement the federal Single Audit Act. The adopted module also includes current auditing guidance that complements the AICPA Audit and Accounting Guide, State and Local Governments and supplements the Government Auditing Standards of the United States GAO. These requirements facilitate preparation of financial statements that conform to GAAP established by the GASB.

Module 5 aligns with current purchasing laws and standards. Adopted Module 5 includes the following significant changes. School districts and charter schools are required to establish procurement policies and procedures that align with their unique operating environment and ensure compliance with relevant statutes and policies.

To align with changes made in response to public comments submitted to the SBOE on the proposed amendment to 19 TAC §109.41, Module 5 was modified at adoption to implement recent changes in authoritative guidance, provide guidance for compliance, and add clarity through grammatical edits.

Module 6 aligns with current governmental accounting standards. Adopted Module 6 includes the following significant changes. School districts and charter schools are required to maintain proper budgeting and financial accounting and reporting systems. The module provides current information to assist local school officials' understanding of the numerous options for use of the state compensatory education allotment and provide current guidance for compliance.

The FASRG is posted on the TEA website at https://tea.texas.gov/finance-and-grants/financial-accountability/financial-accountability-system-resource-guide.

SUMMARY OF COMMENTS AND AGENCY RESPONSES: The public comment period on the proposal began June 3, 2022, and ended July 5, 2022. Following is a summary of public comments received and agency responses.

Module 1, FAR Appendices, and Module 3, Special Supplement - Nonprofit Charter School Chart of Accounts

Comment: A school district representative commented that it is unclear why prekindergarten program intent codes (PICs), except for the prekindergarten special education PIC, are being deleted because districts have historical information in the PICs.

Response: The agency agrees that there is historical data reported with the prekindergarten PICs. However, prekindergarten PICs 32 (Prekindergarten), 34 (Services to Prekindergarten Students - State Compensatory Education), and 35 (Services to Prekindergarten Students - Bilingual Education) were removed for more concise and unambiguous reporting of expenditures. The agency can continue to receive sufficient data on prekindergarten services, except for special education, by incorporating prekindergarten data into other PICs. The agency will maintain a separate prekindergarten PIC for special education to collect data necessary for state and federal reporting.

Module 1, FAR and FAR Appendices

Comment: A representative with EdMIS: Education Management Information Systems, Inc. proposed changes regarding right to use leases for Module 1, FAR and FAR Appendices, Appendix A. Specifically, the commenter stated that the GASB 87 determination of the "term" of right to use leases is left out of the presentation in section 1.2.4, Capital Assets and Right to Use Leased Assets, and suggested edits to the section to define and clarify the use of lease terms.

The commenter also stated that there is no discussion of a "capitalization" threshold that should be applied when implementing GASB 87 and suggested edits to section 1.2.4.3, Capitalization of Capital Assets and Right to Use Leased Assets, and section 1.2.5.2, Long-term Liabilities.

Additionally, the commenter suggested edits to various object codes in Module 1, FAR Appendices, Appendix A, to clarify coding for right to use leases.

Response: The agency agrees to the suggested edits for right to use leases. The language in various subsections of section 1.2.4 of Module 1, FAR, has been modified at adoption to define and clarify the lease term and capitalization threshold. Additionally, descriptions for various asset, liability, and expenditure object codes in Module 1, FAR Appendices, have been modified at adoption to clarify right to use lease classifications.

Comment: A school district representative commented that Appendix C in Module 1, FAR Appendices, discusses accounting related to GASB 87 for the lessee side only and that accounting

for the lessor side has not been updated. The school district representative also commented that "Due from Lessor" in Module 1, FAR, Section 1.2.2.2, Other Receivables, is a typo and that the term for the definition should be "Due from Lessee." The commenter also stated that it should be a "receivable" object code 1290 instead of "due from lessee" as mentioned by GASB 87 Implementation Guide.

Response: The agency agrees that the lessee side of accounting was updated to reflect GASB 87 guidance and that there was no addition of the lessor side of accounting to Appendix C of Module 1, FAR Appendices. Currently, the agency maintains language as proposed for journal entries in Appendix C of Module 1, FAR Appendices. Regarding guidance in Module 1, FAR, Section 1.2.2.2, Other Receivables, the agency agrees that the term "Due from Lessor" should be replaced. The term "Due from Lessor" has been replaced at adoption with the term "Lease Receivable."

STATUTORY AUTHORITY. The amendment is adopted under Texas Education Code (TEC), §7.055(b)(32), which requires the commissioner to perform duties in connection with the public school accountability system as prescribed by TEC, Chapters 39 and 39A; TEC, §44.001(a), which requires the commissioner to establish advisory guidelines relating to the fiscal management of a school district; TEC, §44.001(b), which requires the commissioner to report annually to the State Board of Education (SBOE) the status of school district fiscal management as reflected by the advisory guidelines and by statutory requirements; TEC, §44.007(a), which requires the board of trustees of each school district to adopt and install a standard school fiscal accounting system that conforms with generally accepted accounting principles; TEC, §44.007(b),which requires the accounting system to meet at least the minimum requirements prescribed by the commissioner, subject to review and comment by the state auditor; TEC, §44.007(c), which requires a record to be kept of all revenues realized and of all expenditures made during the fiscal year for which a budget is adopted. A report of the revenues and expenditures for the preceding fiscal year is required to be filed with the agency on or before the date set by the SBOE; TEC, §44.007(d), which requires each district, as part of the report required by TEC, §44.007, to include management, cost accounting, and financial information in a format prescribed by the SBOE in a manner sufficient to enable the board to monitor the funding process and determine educational system costs by district, campus, and program; and TEC, §44.008(b), which requires the independent audit to meet at least the minimum requirements and be in the format prescribed by the SBOE, subject to review and comment by the state auditor. The audit must include an audit of the accuracy of the fiscal information provided by the district through the Public Education Information Management System.

CROSS REFERENCE TO STATUTE. The amendment implements Texas Education Code, §§7.055(b)(32), 44.001(a) and (b), 44.007(a)-(d), and 44.008(b).

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 August 9, 2022.

TRD-202202960

Cristina De La Fuente-Valadez

Director, Rulemaking

Texas Education Agency

Effective date: August 29, 2022

Proposal publication date: June 3, 2022

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

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# TITLE 22. EXAMINING BOARDS

## PART 5. STATE BOARD OF DENTAL EXAMINERS

### CHAPTER 104. CONTINUING EDUCATION

**22 TAC §104.2**

The State Board of Dental Examiners (Board) adopts this amendment to 22 TAC §104.2, concerning continuing education providers. The adopted amendment adds Dental Risk Solutions, LLC as a Board approved continuing education course provider to subsection (e)(22). This rule is adopted without changes to the proposed text as published in the July 8, 2022, issue of the *Texas Register* (47 TexReg 3868) and will not be republished.

No comments were received regarding adoption of this rule.

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 August 12, 2022.

TRD-202203030

Lauren Studdard

General Counsel

State Board of Dental Examiners

Effective date: September 1, 2022

Proposal publication date: July 8, 2022

For further information, please call: (512) 305-8910

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### CHAPTER 108. PROFESSIONAL CONDUCT
### SUBCHAPTER B. SANITATION AND INFECTION CONTROL

**22 TAC §108.25**

The State Board of Dental Examiners (Board) adopts this repeal of 22 TAC §108.25, concerning dental health care workers. The adopted rule repeal deletes unnecessary repetitive statutory language found in Chapter 85 of the Texas Health and Safety Code. This rule is adopted with no changes to the proposed text as published in the July 8, 2022 issue of the *Texas Register* (47 TexReg 3869), and will not be republished.

No comments were received regarding adoption of this rule repeal.

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 August 12, 2022.

TRD-202203029
Lauren Studdard
General Counsel
State Board of Dental Examiners
Effective date: September 1, 2022
Proposal publication date: July 8, 2022
For further information, please call: (512) 305-8910

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# PART 23. TEXAS REAL ESTATE COMMISSION

## CHAPTER 537. PROFESSIONAL AGREEMENTS AND STANDARD CONTRACTS

### 22 TAC §§537.21 - 537.23, 537.35, 537.39 - 537.41, 537.44, 537.45, 537.52, 537.54 - 537.57, 537.60, 537.62 - 537.64

The Texas Real Estate Commission (TREC) adopts amendments to 22 TAC §537.21, Standard Contract Form TREC No. 10-6; §537.22, Standard Contract Form TREC No. 11-7; §537.23, Standard Contract Form TREC No. 12-3; §537.35, Standard Contract Form TREC No. 28-2; §537.39, Standard Contract Form TREC No. 32-4; §537.40, Standard Contract Form TREC No. 33-2; §537.41, Standard Contract Form TREC No. 34-4; §537.44, Standard Contract Form TREC No. 37-5; §537.45, Standard Contract Form TREC No. 38-7; §537.52, Standard Contract Form TREC No. 45-2; §537.54, Standard Contract Form TREC No. 47-0; §537.55, Standard Contract Form TREC No. 48-1; §537.56, Standard Contract Form TREC No. 49-1; §537.57, Standard Contract Form TREC No. 50-0; §537.60, Standard Contract Form TREC No. 53-0; and new §537.62, Standard Contract Form TREC No. OP-H, Seller's Disclosure Notice; §537.63, Standard Contract Form TREC No. OP-L, Addendum for Seller's Disclosure of Information on Lead-Based Paint and Lead-Based Paint Hazards as Required by Federal Law; and §537.64, Standard Contract Form TREC No. OP-M, Non-Realty Items Addendum in Chapter 537, Professional Agreements and Standard Contracts, without changes, as published in the May 20, 2022, issue of the *Texas Register* (47 TexReg 3010) and will not be republished.

The amendments and new rules to Chapter 537 are made as a result of the Commission's quadrennial rule review. Texas real estate license holders are generally required to use forms promulgated by TREC when negotiating contacts for the sale of real property. The changes to the existing rules add the title of the form adopted by reference in each rule to the rule title and add clarifying language to specify which forms are for mandatory versus voluntary use by license holders. The new rules pair previously existing forms that were available for voluntary use by license holders with a rule to provide greater clarity about the forms purpose and use.

One comment was received from the Texas Association of Builders (TAB), who believes that the proposed addition of "mandatory" will lead to confusion regarding the right of a property owner to use non-TREC forms in certain transactions, and in turn, may delay these transactions. TAB suggested that where the term "mandatory" has been added to the rules, the statement "unless otherwise permitted under 22 TAC 537.11(a)" be appended. The Commission declines to any make changes at this time in response to TAB's comments. However, the Commission is currently reviewing 22 TAC §537.11, Use of Standard Contract Forms, and plans to present recommended changes to that rule, as well as a new definitions section that would include definitions of "mandatory use" and "voluntary use", at the November Commission meeting for proposal. The Commission believes these revisions will better address TAB's concerns.

The amendments and new rules are adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102 and ensure compliance with Chapters 1101 and 1102.

The agency certifies that legal counsel has reviewed the proposal and found it to be within the state agency's legal authority to adopt.

Filed with the Office of the Secretary of State on August 10, 2022.

TRD-202202988
Abby Lee
Deputy General Counsel
Texas Real Estate Commission
Earliest possible date of adoption: August 30, 2022
For further information, please call: (512) 936-3057

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### 22 TAC §§537.26, 537.27, 537.61

The Texas Real Estate Commission (TREC) adopts amendments to 22 TAC §537.26, Standard Contract Form TREC No. 15-5; §537.27, Standard Contract Form TREC No. 16-5; and new §537.61, Standard Contract Form TREC No. 54-0, Landlord's Floodplain and Flood Notice in Chapter 537, Professional Agreements and Standard Contracts, and the forms adopted by reference, without changes in the rule text, but with the following non-substantive changes to the forms as published in the May 20, 2022, issue of the *Texas Register* (47 TexReg 3013):

-The insertion of lines in the blank following Paragraph 11, Special Provisions, of the Seller's Temporary Residential Lease (TREC No. 15-5) and the Buyer's Temporary Residential Lease (TREC No. 16-5),

-The addition of "to" in the notice of the Buyer's Temporary Residential Lease so that the notice reads "…prior to the closing", and

-The replacement of the term "Property" with "a dwelling" in Paragraph C(2) of the Landlord's Floodplain and Flood Notice.

Texas real estate license holders are generally required to use forms promulgated by TREC when negotiating contacts for the

sale of real property. These forms are drafted and recommended for proposal by the Texas Real Estate Broker-Lawyer Committee, an advisory body consisting of six attorneys appointed by the President of the State Bar of Texas, six brokers appointed by TREC, and one public member appointed by the governor. The Texas Real Estate Broker-Lawyer Committee recommended revisions to the contract forms adopted by reference under the amendments and new rule to Chapter 537 to comply with statutory changes enacted by the 87th Legislature in HB 531.

HB 531 requires a landlord to disclose, in certain situations, whether the landlord is aware that the dwelling is located in a 100-year floodplain or that the dwelling has flooded within the last five years. Because landlords of temporary residential leases are not exempted, the changes create a new flood disclosure notice form and add a new paragraph referencing the notice in the Seller's Temporary Residential Lease (TREC No. 15-5) and the Buyer's Temporary Residential Lease (TREC No. 16-5).

Additionally, the amendments §535.26, Standard Contract Form TREC No. 15-5, and §535.27, Standard Contract Form TREC No. 16-5, contain changes made as a result of the Commission's quadrennial rule review. Those changes add the corresponding standard contract form title to the rule title and add clarifying language to specify that both of the forms adopted by reference in these rules are for mandatory use by license holders.

One comment was received from the Texas Association of Builders (TAB), who believes that the proposed addition of "mandatory" to the rules §535.26 and §535.27 will lead to confusion regarding the right of a property owner to use non-TREC forms in certain transactions, and in turn, may delay these transactions. TAB suggested that where the term "mandatory" has been added to the rules, the statement "unless otherwise permitted under 22 TAC 537.11(a)" be appended. The Commission declines to make any changes at this time in response to TAB's comments. However, the Commission is currently reviewing 22 TAC §537.11, Use of Standard Contract Forms, and plans to present recommended changes to that rule, as well as a new definitions section that would include definitions of "mandatory use" and "voluntary use", at the November Commission meeting for proposal. The Commission believes these revisions will better address TAB's concerns.

The amendments and new rules are adopted under Texas Occupations Code, §1101.151, which authorizes the Texas Real Estate Commission to adopt and enforce rules necessary to administer Chapters 1101 and 1102; and to establish standards of conduct and ethics for its license holders to fulfill the purposes of Chapters 1101 and 1102 and ensure compliance with Chapters 1101 and 1102. The amendments and new rules are also adopted under Texas Occupations Code, §1101.155, which authorizes the Texas Real Estate Commission to adopt rules in the public's best interest that require license holders to use contract forms prepared by the Texas Real Estate Broker-Lawyer Committee and adopted by the Commission.

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 August 10, 2022.

TRD-202202968

Abby Lee

Deputy General Counsel

Texas Real Estate Commission

Effective date: August 30, 2022

Proposal publication date: May 20, 2022

For further information, please call: (512) 936-3057

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## CHAPTER 543. RULES RELATING TO THE PROVISIONS OF THE TEXAS TIMESHARE ACT

### 22 TAC §§543.1 - 543.13

The Texas Real Estate Commission (TREC) adopts the repeal of 22 TAC §543.1, Registration; §543.2, Amendments; §543.3, Fees; §543.4, Forms; §543.5, Violations; §543.6, Complaints and Disciplinary Proceedings; §543.7, Contract Requirements; §543.8, Disclosure Requirement; §543.9, Exemptions; §543.10, Escrow Requirements; §543.11, Maintenance of Registration; and §543.12, Renewal of Registration; §543.13, Assumed Names, in Chapter 543, Rules Relating to the Provisions of the Texas Timeshare Act. The repeals are adopted without changes, as published in the May 20, 2022, issue of the *Texas Register* (47 TexReg 3014), and will not be republished.

The repeal of these sections is made as a result of the Commission's quadrennial rule review, and more specifically, is the result of a proposed new definitions section in this chapter, which will require the renumbering of these sections. TREC will renumber and replace these rules, with some proposed changes.

No comments were received on the proposed repeal as published.

The repeal is adopted under the Texas Property Code, §221.024, which authorizes the Texas Real Estate Commission to prescribe and publish forms and adopt rules necessary to carry out the provisions of The Texas Timeshare 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 August 10, 2022.

TRD-202202985

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Deputy General Counsel

Texas Real Estate Commission

Effective date: August 30, 2022

Proposal publication date: May 20, 2022

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### 22 TAC §§543.1 - 543.14

The Texas Real Estate Commission (TREC) adopts new 22 TAC §543.1, Definitions; §543.2, Registration; §543.3, Amendments; §543.4, Fees; §543.5, Forms; §543.6, Violations; §543.7, Complaints and Disciplinary Proceedings; §543.8, Contract Requirements; §543.9, Disclosure Requirement; §543.10, Exemptions; §543.11, Escrow Requirements; §543.12, Maintenance of Registration; §543.13, Renewal of Registration; and §543.14, Assumed Names, in Chapter 543, Rules Relating to the Provi-

sions of the Texas Timeshare Act. The rules are adopted without changes to the text as published in the May 20, 2022, issue of the *Texas Register* (47 TexReg 3015) and will not be republished.

The adopted new rules to Chapter 543 are made as a result of the Commission's quadrennial rule review. The adopted changes add a new definitions section for ease of reading and update terminology for consistency throughout the chapter. Additionally, new §543.5, Forms, and §543.13, Renewal of Registration, correct a reference to a Commission form.

No comments were received on the proposed new rules as published.

The new rules are adopted under the Texas Property Code, §221.024, which authorizes the Texas Real Estate Commission to prescribe and publish forms and adopt rules necessary to carry out the provisions of The Texas Timeshare 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 August 10, 2022.

TRD-202202986
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Effective date: August 30, 2022
Proposal publication date: May 20, 2022
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# TITLE 28. INSURANCE

## PART 1. TEXAS DEPARTMENT OF INSURANCE

### CHAPTER 12. INDEPENDENT REVIEW ORGANIZATIONS

The Commissioner of Insurance adopts amended 28 TAC §12.4, concerning applicability, and new 28 TAC Subchapter G, §12.601, concerning review of preauthorization exemptions by independent review organizations (IROs). These amended and new sections implement House Bill 3459, 87th Legislature, 2021. The amended and new sections were published in the April 8, 2022, issue of the *Texas Register* (47 TexReg 1854). The Commissioner adopts amended §12.4 with a nonsubstantive change to the proposed text. The Commissioner adopts new §12.601 with changes to the proposed text in response to public comments and other nonsubstantive changes. The rules will be republished.

REASONED JUSTIFICATION. Amended §12.4 and new §12.601, are necessary to conform the Texas Department of Insurance's (TDI) utilization review rules with HB 3459, which allows a health maintenance organization or insurer to rescind an exemption from preauthorization requirements under certain conditions. A physician or provider may appeal an adverse determination regarding a preauthorization to an IRO to review the appropriateness of the rescission determination by the health maintenance organization or insurer.

The amended and new sections are described in the following paragraphs.

*Section 12.4.* The amendments to §12.4(a) replace the phrase "of this subchapter" with "of this title" and add a reference to the section heading for consistency with current agency language preferences and drafting practices. TDI makes a grammatical change to the text of subsection (a) as proposed to remove the comma that follows "managed care entities."

The amendments to §12.4(b) remove obsolete applicability language. New language states that independent reviews of adverse determinations regarding preauthorization exemptions made under Texas Insurance Code Chapter 4201, Subchapter N, must comply with new §12.601.

*Subchapter G. Independent Review of Preauthorization Exemptions.* TDI adds new Subchapter G, which consists of new §12.601. TDI modifies the proposed title of the new subchapter to more clearly describe the contents of the subchapter.

*Section 12.601.* New §12.601 outlines requirements and procedures for appeals of adverse determinations regarding a preauthorization exemption.

New §12.601(a) defines "adverse determination regarding a preauthorization exemption," "issuer," "physician," "preauthorization exemption," and "provider" to clarify these terms, which may have different meanings in other contexts in 28 TAC Chapter 12, and to refer to the preauthorization exemption process in 28 TAC Chapter 19.

New §12.601(b) states that the independent review of an adverse determination regarding a preauthorization exemption, the IRO that performs the review, and the appropriate issuer are subject to Insurance Code Chapter 4201, Subchapter N, and 28 TAC Chapter 12, except as otherwise specified in §12.601.

Section 12.601(c) states that for the purposes of §12.601, a physician or provider should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests.

New §12.601(d) states that an issuer must submit a request for independent review of an adverse determination regarding a preauthorization exemption to TDI on behalf of a physician or provider.

In response to comment, TDI modifies the text of new §12.601(e) as proposed to clarify that the IRO must base its decision on whether to uphold an exemption recission on the total number of claims in the initial random sample and a second random sample, if one was requested under Insurance Code §4201.656(d) and available as provided in 28 TAC §19.1733(e). New §12.601(e) provides that, if a second random sample is requested and available, the IRO must identify the new sample of at least five and no more than 20 claims from the list of eligible claims provided by the issuer. The IRO must review each claim that the issuer retrospectively reviewed and determined did not meet the applicable criteria and, if applicable, each claim included in the second random sample identified by the IRO. The IRO may request any medical records needed to evaluate the claims subject to review and must provide at least three business days for receipt of records.

Section 12.601(f) states that appeals for an adverse determination regarding a preauthorization exemption follow TDI's process for assigning IROs under 28 TAC §12.502, except that TDI will

only provide notice of the appeal to the IRO, the issuer, and the physician or provider.

New §12.601(g) states that 28 TAC §12.206 does not apply to an IRO's independent review of an adverse determination regarding a preauthorization exemption. In response to comment, TDI modifies §12.601(g) to clarify that an IRO must provide timely notice to an issuer regarding its determination consistent with the timeframe provided under Insurance Code §4201.656(c).

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received written comments from 23 commenters, and two commenters spoke at a public hearing on the proposal held on May 12, 2022.

Commenters in support of the proposal were: Texas Healthcare and Bioscience Institute.

Commenters in support of the proposal with changes were: eviCore Healthcare, Pharmaceutical Care Management Association, Quest Diagnostics, Texas Academy of Family Physicians, Texas Association of Health Plans, Texas Chapter of the American College of Cardiology, Texas Chapter of the American College of Physicians Services, Texas College of Emergency Physicians, Texas Medical Association, Texas Neurological Society, Texas Orthopaedic Association, Texas Pain Society, Texas Pediatric Society, Texas Public Policy Foundation, Texas Society for Gastroenterology and Endoscopy, Texas Society of Pathologists, Texas Society of Plastic Surgeons, Texas Urological Society, one individual, two state representatives, and two state senators.

*Comments on Chapter 12 Generally*

Comment. One commenter expresses broad support for the proposal.

Agency Response. TDI appreciates the support.

Comment. One commenter suggests that TDI require providers to be responsible for IRO fees if the IRO upholds an issuer's rescission determination.

Agency Response. TDI declines to make the requested change. Insurance Code §4201.656(b) requires the issuer to pay for any appeal or independent review.

*Comments on §12.601*

Comment. One commenter requests TDI provide clarification on how a random sample is compiled and the number of claims required to be included in the sample. Another commenter requests TDI make an amendment to confirm that (1) the only reason a physician or provider may request a new sample for the IRO is if the issuer based the rescission on cases that were outside the random sample, and (2) that the physician or provider cannot request review of a second random sample without reason.

Another commenter objects to an IRO reviewing only the claims in a second random sample, arguing that Insurance Code §4201.656(d) requires that if another random sample is requested, the IRO must base its determination on both the original random sample and the second random sample.

Several commenters jointly state that they oppose the language in proposed §12.601(e) that references the issuer reviewing claims outside of the original random sample because of concerns with lack of alignment with the statutory language. They recommend that TDI implement the language of Insurance Code §4201.656(d) according to its express terms. The commenters suggest that when a provider requests review of "another random sample," as permitted under Insurance Code §4201.656(d), the IRO should perform a first-time review and not a re-review of claims reviewed by the issuer. Alternatively, the commenters suggest that the plan review additional claims upon the provider's request.

Agency Response. In response to the request for clarification, TDI affirms that an evaluation of a physician's or provider's continued eligibility for an exemption is based on a random sample of five to 20 payable claims that were submitted during the most recent evaluation period.

TDI agrees that an issuer may conduct a retrospective review of a health care service subject to an exemption only as provided in §4201.659(b)(1) and (2) and has modified the text of §12.601 as adopted to permit a provider to request that an IRO review another random sample of claims as long as the notice of rescission identified that at least five additional claims were eligible for review but not included in the original random sample. As adopted, §12.601(e) states that the IRO must identify the second random sample of at least five and no more than 20 claims from the list of eligible claims provided by the issuer. In the case that the issuer did not identify that at least five additional claims were eligible but not included in the original random sample, the IRO would be unable to select an additional random sample that differed from the original sample.

The revisions to §12.601(e) require the IRO to review each claim that the issuer retrospectively reviewed and determined did not meet the applicable medical necessity criteria and, if applicable, each claim included in the second random sample identified by the IRO. The IRO's evaluation of a physician's or provider's continued eligibility for an exemption is based on the total number of claims in the initial random sample and, if applicable, the second random sample, consistent with Insurance Code §4201.656(d).

TDI declines to make the requested amendment to limit the circumstances under which the physician or provider may request a second random sample because such an amendment would be inconsistent with Insurance Code §4201.656.

Comment. Several commenters jointly recommend that an IRO be required to make an independent decision regarding whether there was truly a failure to provide medical records necessary for the issuer to make a determination.

Agency Response. TDI declines to make a change. If a rescission is based on one or more claims in which the issuer determined that the physician or provider failed to provide sufficient records to demonstrate medical necessity, the physician or provider must include the applicable records with the request for an independent review. If an IRO believes additional information is needed, the IRO can request any medical records needed to make a determination.

Comment. Two commenters request clarification on the length of time an IRO has to process a review and return the determination to the issuer. The commenters note that there is no clarification for how long the IRO has to perform and complete the review before returning a verdict to the issuer, and that under §12.601(g), the general IRO notice requirements within §12.206 do not apply. One commenter recommends a requirement for a timely IRO notice to the issuer. The other commenter recommends adding a 30-day limitation on the length of time an IRO has to process an appeal. The commenter says this would en-

sure that a physician denied an exemption experiences no delay in his or her appeal process.

Agency Response. Insurance Code §4201.656(c) clearly states that an IRO must complete its review not later than the 30th day after a physician or provider files the request for a review. TDI modifies the text of §12.601(g) as proposed to clarify that an IRO must provide timely notice to an issuer regarding its determination consistent with the timeframe provided under Insurance Code §4201.656(c).

Comment. One commenter asks that TDI provide clarity on when rescissions become effective.

Agency Response. Consistent with Insurance Code §4201.654, a rescission becomes effective either on the 30th day after the issuer notifies the physician or provider of the rescission determination (as indicated on the notice issued under §19.1732(d)), or, if the physician or provider appeals the determination, on the fifth day after the date the IRO affirms the issuer's determination to rescind the exemption.

## SUBCHAPTER A. GENERAL PROVISIONS

### 28 TAC §12.4

STATUTORY AUTHORITY. The Commissioner adopts the amendments to §12.4 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

*§12.4. Applicability.*

(a) All independent review organizations (IROs) performing independent reviews of adverse determinations made by utilization review agents, health insurance carriers, health maintenance organizations, and managed care entities must comply with this chapter. IROs performing independent reviews of adverse determinations made by certified workers' compensation health care networks and workers' compensation insurance carriers must comply with this chapter, subject to §12.6 of this title (relating to Independent Review of Adverse Determinations of Health Care Provided Under Labor Code Title 5 or Insurance Code Chapter 1305).

(b) All IROs performing independent reviews of adverse determinations regarding preauthorization exemptions made under Insurance Code Chapter 4201, Subchapter N, concerning Exemption From Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services, must comply with §12.601 of this title (relating to Preauthorization Exemptions).

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 August 12, 2022.

TRD-202203027
James Person
General Counsel
Texas Department of Insurance
Effective date: September 1, 2022
Proposal publication date: April 8, 2022
For further information, please call: (512) 676-6587

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## SUBCHAPTER G. EXEMPTIONS FOR INDEPENDENT REVIEW ORGANIZATIONS

### 28 TAC §12.601

STATUTORY AUTHORITY. The Commissioner adopts new §12.601 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

*§12.601. Preauthorization Exemptions.*

(a) In this section, the following words and terms have the following meanings unless context clearly indicates otherwise.

(1) Adverse determination regarding a preauthorization exemption--Has the same meaning as defined in §19.1730 of this title (relating to Definitions).

(2) Issuer--Has the same meaning as defined in §19.1730 of this title.

(3) Physician--Has the same meaning as defined by Insurance Code §843.002, concerning Definitions.

(4) Preauthorization exemption--Has the same meaning as defined in §19.1730 of this title.

(5) Provider--Has the same meaning as defined in Insurance Code §843.002.

(b) An independent review of an adverse determination regarding a preauthorization exemption, the independent review organization (IRO) that performs the review, and the appropriate issuer are subject to Insurance Code Chapter 4201, Subchapter N, concerning Exemption from Preauthorization Requirements for Physicians and Providers Providing Certain Health Care Services, and the associated standards and requirements in this chapter, except as otherwise specified in this section.

(c) For purposes of this section, a physician or provider should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests.

(d) Notwithstanding §12.501 of this title (relating to Requests for Independent Review), an issuer must submit a request for independent review of an adverse determination regarding a preauthorization exemption to the department on behalf of a physician or provider.

(e) If a second random sample is requested under Insurance Code §4201.656(d), concerning Independent Review of Exemption Determination, and available as provided in §19.1733(e) of this title (relating to Retrospective Reviews and Appeals of Preauthorization Exemption Rescissions), the IRO must identify, from the list of eligible claims provided by the issuer, a second random sample of at least five and no more than 20 claims. The IRO must review each claim that the issuer retrospectively reviewed and determined did not meet the applicable medical necessity criteria and, if applicable, each claim included in the second random sample identified by the IRO. Consistent with Insurance Code §4201.656(b), the IRO may request any medical records needed to evaluate the claims subject to review and must provide at least three business days for receipt of records. Based on the total number of claims in the initial random sample and, if applicable, the second random sample, the IRO must determine

whether to affirm or overturn the issuer's determination that less than 90 percent of the claims met the applicable medical necessity criteria.

(f) Appeals for an adverse determination regarding a preauthorization exemption to an IRO follow the department's process for assigning IROs under §12.502 of this title (relating to Random Assignment), except that notification under §12.502(a) will only be made to the IRO, the issuer, and the physician or provider.

(g) Section 12.206 of this title (relating to Notice of Determinations Made by Independent Review Organizations) does not apply to a review by an IRO under this section. An IRO must complete its review and provide timely notice to an issuer regarding its determination, consistent with the timeframe provided under Insurance Code §4201.656(c).

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 August 12, 2022.

TRD-202203028
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Effective date: September 1, 2022
Proposal publication date: April 8, 2022
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## CHAPTER 19. LICENSING AND REGULATION OF INSURANCE PROFESSIONALS

The Commissioner of Insurance adopts amended 28 TAC §19.1710 and new 28 TAC Chapter 19, Subchapter R, Division 2, §§19.1730 - 19.1733, concerning requirements prior to issuing an adverse determination and preauthorization exemptions. These amended and new sections implement House Bill 3459, 87th Legislature, 2021. The Commissioner adopts §19.1710 without changes to the proposed text published in the April 8, 2022, issue of the *Texas Register* (47 TexReg 1856). This section will not be republished. The Commissioner adopts §§19.1730 - 19.1733 with revisions made in response to public comments. These sections will be republished.

REASONED JUSTIFICATION. Amended §19.1710 and new Division 2, §§19.1730 - 19.1733 are necessary to conform the Texas Department of Insurance's (TDI) utilization review rules with HB 3459, which allows an issuer such as a health maintenance organization or insurer to grant, deny, or rescind an exemption from preauthorization requirements under certain conditions. Under the adopted rules, an issuer must provide notice of an initial exemption or denial of an exemption not later than October 1, 2022, based on an evaluation period of January 1, 2022, through June 30, 2022.

The amended and new sections are described in the following paragraphs.

*Section 19.1710.* Amended §19.1710 clarifies that a utilization review agent must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician licensed to practice in Texas. This section follows Insurance Code §4201.206, as amended by HB 3459, in which new language specifies that an agent must provide to a health care provider an opportunity to discuss the health care service in question with a physician licensed to practice medicine "in this state." The section is also amended to add a sentence stating, in accordance with Insurance Code §4201.206, that if the health care service was ordered, requested, or provided by a physician, the opportunity to discuss the health care service in question must be with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the requesting physician. Physicians holding Texas Administrative Medicine Licenses under the Medical Practice Act and Texas Medical Board rule, 22 TAC §172.17, can meet this standard. TDI has historically interpreted §4201.206 to include Texas Administrative Medicine Licenses, and TDI believes that recent changes to Insurance Code §4201.206 do not indicate that this long-standing position should change.

*Division 2. Preauthorization Exemptions.* TDI adds new Division 2, titled "Preauthorization Exemptions," to distinguish §§19.1730 - 19.1733 from existing rules in Subchapter R, which relate to utilization review and preauthorization procedures generally. A new Division 1 with the heading "Utilization Reviews" and consisting of §§19.1701 - 19.1719 has been administratively designated in Chapter 19, Subchapter R to distinguish between the sections that address utilization review and those that address preauthorization exemptions.

*Section 19.1730.* New §19.1730 defines terms used in the new division: "adverse determination regarding a preauthorization exemption," "denial of preauthorization exemption," "eligible preauthorization request," "evaluation," "evaluation period," "issuer," "particular health care service," "physician," "preauthorization," "preauthorization exemption," "provider," "random sample," "rescission of preauthorization exemption," and "treating physician or provider." The definitions clarify:

- the nature of an adverse determination regarding a preauthorization exemption, as compared with the meaning of adverse determination under §19.1703;

- the number of eligible preauthorization requests needed for granting or denying a preauthorization exemption;

- the threshold percentage of accepted claims needed for an issuer to grant, deny, or rescind a preauthorization exemption;

- the nature of an evaluation depending on whether the physician or provider currently has a preauthorization exemption in place;

- the time allowed for evaluation periods; and

- the scope of "particular health care service" to include prescription drugs.

TDI changes the definition of "adverse determination regarding a preauthorization exemption" as proposed to add the word "retrospectively" and include a reference to paragraph (4)(B) of the section, where the applicable evaluation is defined, to add clarity and consistency with other changes made in response to comments.

TDI changes the definition of "denial of preauthorization exemption" as proposed in response to comment to add clarity by inserting a reference to paragraph (4)(A) of the section and adding references to the newly defined term, "eligible preauthorization request."

Along with the proposed defined terms, TDI adopts a new defined term "eligible preauthorization request" in response to comments to clarify which preauthorization requests may be counted as approved or denied for the purposes of an evaluation.

TDI changes the definition of "evaluation" as proposed in response to comments to specify that the evaluation for a continuation or rescission analysis is based on a retrospective review of a random sample of claims. The definition is changed to add references to "eligible" preauthorization requests, "retrospective" review, and "payable" claims. TDI also clarifies that claims submitted "in connection with" a physician or provider are subject to an evaluation of the physician's or provider's continued eligibility for an exemption. TDI adds the word "meeting" to clarify that a determination the claims would have been approved is based on meeting the issuer's applicable medical necessity criteria. TDI makes a grammatical change at the end of the definition of "evaluation," to replace the semicolon with a period.

TDI changes the definition of "provider" as proposed by removing unnecessary text after citing to Insurance Code §843.002.

TDI changes the definition of "rescission of preauthorization exemption" as proposed in response to comments to add a reference to paragraph (4)(B) of the section, where the applicable evaluation is defined, and replace language regarding the physician licensure requirement with a reference to Insurance Code §4201.655(b).

TDI changes the definition of "treating physician or provider" as proposed to reference "health and medical care" in place of "health care for an illness or injury," and add "or ordering" to add clarification and avoid the appearance of unintentionally narrowing the scope of the definition. TDI also replaces "includes" with "can include" to improve the grammatical structure in the second sentence of the definition.

TDI renumbers the paragraphs of the defined terms that follow the new defined "eligible preauthorization request."

*Section 19.1731.* New §19.1731 describes the initial preauthorization exemption process. Subsection (a) clarifies that for purposes of Division 2, a "physician" or "provider" should be identified using the National Provider Identifier (NPI) under which a physician or provider makes preauthorization requests. TDI changes subsection (a) as proposed to add a reference to the abbreviation "NPI."

Subsection (b) states that an issuer must review the outcomes of no fewer than five eligible preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption. TDI specifically sought comments on this minimum threshold for review and in response to comments changes the proposed text to reduce it from 20 preauthorization requests to five eligible preauthorization requests.

Subsection (c) provides the requirements for an issuer to rescind a preauthorization exemption that has already been granted to a physician or provider, which must be rescinded consistent with Insurance Code §4201.655. TDI changes subsection (c) as proposed to add a reference to the definition of evaluation in §19.1730(4)(B).

Subsection (d) clarifies that if a treating physician or provider without a preauthorization exemption relies on another physician's or provider's preauthorization exemption in violation of subsection (d), the physician or provider who has qualified for an exemption may be considered by the issuer as failing to substantially perform the health care service. In that situation, the issuer may reduce or deny payment for that service under Insurance Code §4201.659. In response to comments, TDI changes subsection (d) as proposed to consistently reference a physician "or provider" and clarifies that it is the exempt physician or provider that would be considered to have failed to provide a service if the treating physician or provider inappropriately relied on the exempt physician's or provider's exemption. In response to comments and questions, TDI adds a sentence to subsection (d) that clarifies that supervised providers, such as nurses and physician's assistants, may rely on the supervising physician's exemption in certain circumstances.

Finally, TDI adds new subsection (e) to the text of §19.1731 as proposed to address concerns that issuers would be unable to operationalize exemptions for ordering or referring physicians and providers, unless the rendering and billing provider includes the exempt provider's NPI on the claim form.

*Section 19.1732.* New §19.1732(a) states that an issuer must provide notice to the physician or provider when granting a preauthorization exemption, and it requires that an exemption be in place for at least six months before it can be rescinded. In response to comments, TDI changes subsection (a) as proposed to require the exemption notice to include a plain language explanation of the effect of the preauthorization exemption and any claim coding guidance needed to document the exemption, consistent with §19.1731(e). If an issuer subsequently receives a preauthorization request from the physician or provider for a service for which the physician or provider has been granted an exemption, the issuer must provide notice in accordance with Insurance Code §4201.659(e).

For denials of preauthorization exemptions, new §19.1732(b) states that an issuer must provide notice of the denial to the physician or provider and list the reasons for a denial in accordance with Insurance Code §4201.655(c)(2). In response to comments, TDI changes subsection (b) as proposed to also require a denial notice to include a description of how to appeal the denial using the issuer's complaints and appeals processes and information on how to file a complaint with TDI.

New §19.1732(c) provides a required timeframe for issuing notices of exemption or denial following the initial and subsequent evaluation periods and clarifies that such notices are required with respect to a particular health care service only if the physician or provider had submitted at least five eligible preauthorization requests during the evaluation period. TDI specifically sought comments on this minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified. In response to comments, TDI changes subsection (c) as proposed to clarify that an issuer must provide notice within five days of completing an evaluation, as required by Insurance Code §4201.659(d). Consistent with the change to §19.1731(b) as proposed, TDI also changes the minimum threshold from 20 to five eligible preauthorization requests. To conform with agency style, TDI removes the parenthetical reference following §19.1731(b), since the reference is added as part of the change to subsection (a).

New §19.1732(d) describes the requirements of the notice that must be delivered to a physician or provider when rescinding a preauthorization exemption, the requirements for a physician or provider to appeal a rescission of preauthorization exemption, and notes an example form (LHL011) available on TDI's website. In response to comments, TDI changes the text of subsection (d) as proposed to clarify that rescission notices must be provided during the months specified in Insurance Code §4201.655(a)(1). TDI changes subsection (d)(1) as proposed to specify that the rescission notice must include the date the notice is issued and changes subsection (d)(2) as proposed to clarify that issuers

must allow providers to return appeal forms by mail or electronic means. TDI changes subsection (d)(3) as proposed to provide that the notice must state the total number of eligible claims with respect to the health care service subject to rescission and the number of claims included in the random sample. TDI changes subsection (d)(3)(A) as proposed to remove the reference to retrospective review of additional claims that were not included in the random sample. In response to comment, TDI changes subsection (d)(3)(C)(i) to clarify that the rescission notice must state if the principal reason for a determination is based on a failure to submit specified medical records. TDI makes a grammatical change in subsection (d)(3)(C)(iv) as proposed by replacing "that" with "who," when referencing the physician, doctor, or other health care provider. TDI changes subsection (d)(5) as proposed in response to comment to require the rescission notice to include an instruction for the physician or provider to include applicable medical records with the request for independent review for any determination that was based on a failure to provide medical records.

TDI also adds new subsection (e) to the text of §19.1732 as proposed to require issuers to offer physicians and providers an option to request appeals and receive communications regarding preauthorization exemptions by mail or electronically and a method for physicians and providers to indicate their preferred contact information for these communications.

*Section 19.1733.* New §19.1733(a) clarifies that Insurance Code §4201.305 does not apply to retrospective reviews conducted under Insurance Code §4201.659(b)(1).

New §19.1733(b) provides that a physician or provider has at least 30 days to provide medical records or other documents for the issuer to conduct an evaluation. Medical records can be requested only during an evaluation period or within 90 days following the end of an evaluation period. If the physician or provider does not provide the necessary records for an issuer to make a determination, the issuer may determine that the claim would not have met the screening criteria. In response to comment, TDI changes the text as proposed to add a reference to the applicable definition of evaluation in §19.1730(4)(B). TDI makes a nonsubstantive formatting change to the proposed text to capitalize "Contact" in the reference to "URA Contact." TDI also changes language in subsection (b) as proposed to clarify that medical records requested "in connection with a retrospective review of a random sample of claims as authorized under Insurance Code §4201.659(b)(1) should be limited to no more than 20 claims. . ."

New §19.1733(c) states that a physician or provider may request an independent review of the retrospective review that resulted in the rescission of preauthorization exemption at any time before the rescission is effective. In response to comment, TDI changes the proposed text to clarify that the date of the request must be documented on the form and the form must be sent electronically or postmarked before the date the rescission becomes effective.

New §19.1733(d) provides that a physician or provider must submit to the issuer the form provided by the issuer under §19.1732(c) in order to request an independent review. Upon receipt, the issuer must submit the request for independent review to TDI, consistent with adopted new 28 TAC §12.601 (included in a separate adoption) and 28 TAC §19.1717. In response to comment, TDI changes subsection (d) as proposed to require that a physician or provider include applicable records with any request for independent review where one or more determinations subject to review were based on a failure to provide specified medical records. In the last sentence of subsection (d), TDI clarifies that the requirement for the issuer to submit the request for independent review applies only if the issuer seeks to proceed with the proposed rescission. TDI adds a reference to Insurance Code §4201.402 to clarify the obligation of the issuer to provide information concerning the appeal to the independent review organization (IRO) in a timely manner.

TDI changes new §19.1733(e) as proposed in response to comments. The subsection now states that a physician or provider may request that the IRO review another random sample of claims, as authorized under Insurance Code §4201.656(d), if the notice of rescission of preauthorization exemption identified that at least five additional claims were eligible for review but not included in the original random sample. If the request for a new random sample is made, the issuer must provide a listing of all eligible claims that were not included in the original random sample when submitting the request for independent review to TDI. The listing must be sufficiently detailed to allow the IRO to identify each payable claim to be used in an additional random sample, as provided in conforming changes to §12.601(e), which are discussed in a separate adoption.

New §19.1733(f) states that an issuer must communicate the determination of a review by the IRO to the physician or provider within five days.

New §19.1733(g) states that physicians and providers must continue to maintain medical records adequate to demonstrate that the exempted services they provide meet medical guidelines, in order to retain a preauthorization exemption. Most, if not all, physicians and providers subject to this adopted rule already maintain records for a sufficient amount of time. *See, e.g.,* 22 TAC §76.4(a) (Texas Board of Chiropractic Examiners rule imposing a six-year records retention requirement); 22 TAC §165.1(b)(1) (Texas Medical Board rule imposing a six-year records retention requirement); and 22 TAC §§291.34(a), 291.75(a), and 291.94(a) (Texas State Pharmacy Board rules imposing a two-year records retention requirement). If there are no adequate records for an issuer to use during an evaluation, an exemption may be rescinded.

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: TDI received written comments from 32 commenters, and two commenters spoke at a public hearing on the proposal held on May 12, 2022.

Commenters in support of the proposal were: Texas Healthcare and Bioscience Institute.

Commenters in support of the proposal with changes, were: America's Health Insurance Plans; eviCore Healthcare; Harris Health System; National Infusion Center Association; Oncology Consultants, P.A.; Pharmaceutical Care Management Association; Quest Diagnostics, Sendero Health Plans, Inc.; Texas Academy of Family Physicians; Texas Association of Community Health Plans; Texas Association of Health Plans; Texas Chapter of the American College of Cardiology; Texas Chapter of the American College of Physicians Services; Texas College of Emergency Physicians; Texas Medical Association; Texas Neurological Society; Texas Oncology; Texas Orthopaedic Association; Texas Pain Society; Texas Pediatric Society; Texas Public Policy Foundation; Texas Society for Gastroenterology and Endoscopy; Texas Society of Pathologists; Texas Society of Plastic Surgeons; Texas Urological Society; TSAOG Orthopaedics & Spine; one individual; two state representatives; and two state senators.

*Comments on Chapter 19 Generally*

Comment. One commenter expresses support for the amendments.

Agency Response. TDI appreciates the support.

Comment. One commenter strongly encourages TDI to allow preauthorization requests to be made by clinical laboratories for laboratory services, and permit clinical laboratory claims to be measured to grant or deny preauthorization exemption requests. The commenter suggests that these modifications would ensure that clinical laboratories are evaluated fairly and able to obtain the exemption stated in the law.

Agency Response. TDI disagrees that a change is needed. Preauthorization exemptions are available to any physician or provider who makes preauthorization requests with respect to a particular health care service. The definitions of "provider" and "health care services" in Insurance Code §843.002 are generally broad enough to encapsulate clinical laboratories and laboratory services, respectively.

Comment. One commenter suggests that insurance companies and pharmacy benefit managers may have initiated more denials in anticipation of the rule, so that physicians would be denied access to a prior authorization exemption.

Agency Response. TDI recognizes that the statute may have unavoidable incentives with respect to approvals and denials as implementation became imminent, but TDI is unable to address that issue through rulemaking. TDI will monitor issuers' compliance with the law and rules and take appropriate action as necessary.

*Comments on §19.1710*

Comment. Two commenters support allowing physicians holding administrative medical licenses to discuss the plan of treatment for the enrollee with a physician licensed to practice medicine in Texas. Another commenter expresses support for the proposed amendments and states the language is critical in ensuring justified discussions during utilization review. One commenter states that the amendments may have the unintended consequence of preventing a plan from providing a specialty expert who has a higher level of specialty knowledge than the ordering physician.

Several commenters jointly disagree with TDI's assertion that a full medical license is not needed to act as a utilization review peer. They state that the limitations placed on an administrative medical license make the licensee ill-suited for the functions performed by the Texas-licensed physician who conducts the peer-to-peer call. They further state that the use of a limited license for the practice of administrative medicine is inconsistent with both the statutory intent and public policy goals of HB 3459. They recommend adding a new subsection (b) to §19.1710 that provides that a "physician licensed to practice medicine in Texas" means an individual with a full, unrestricted license to practice medicine in Texas issued by the Texas Medical Board (TMB).

Agency Response. TDI disagrees that a change is needed. In 2005, the Legislature enacted Occupations Code §155.009, which directs TMB to adopt rules on licensure for administrative medicine. In 2010, TMB adopted 22 TAC §172.17, establishing criteria for obtaining a limited license for the practice of administrative medicine. The rules define "administrative medicine" to mean "administration or management utilizing the medical and clinical knowledge, skill, and judgment of a licensed physician, and capable of affecting the health and safety of the public or any person." The rules make clear that a physician who holds an administrative medicine license is subject to the Medical Practice Act and the same rules of the board as a person holding a full Texas medical license. In 2013, TDI updated utilization review rules and added a requirement in 28 TAC §19.1706(a), implementing Insurance Code §4201.153(d) and §4201.252(a) and providing that all health care providers that perform utilization review be appropriately trained, qualified, and currently licensed (including via an administrative license).

In 2019, the Legislature enacted Senate Bill 1742, 86th Legislature, which amended Insurance Code Chapter 4201 in several places to require utilization review to be conducted under the direction of a "physician licensed to practice medicine in this state." In implementing SB 1742, TDI has accepted Texas administrative licenses for those physicians. HB 3459 amended Insurance Code §4201.206 to require that a peer-to-peer discussion (which must be offered before an adverse determination may be issued) must be with "a physician licensed to practice medicine in this state and who has the same or similar specialty as the physician" who ordered, requested, or is to provide the health care service. This change did not alter utilization review more broadly or otherwise exclude administrative medical licensees from participating in the peer-to-peer discussions.

From a practical perspective, TMB rules generally require physicians to be engaged in the active practice of medicine on a "full-time basis" in order to obtain a full medical license. *See* 22 TAC §163.11 ("full-time basis" means "at least 20 hours per week for 40 weeks' duration during a given year). Physicians employed by health plans generally do not meet this standard. Therefore, requiring physicians who perform utilization review and conduct peer-to-peer reviews under Insurance Code §4201.206 to hold a full medical license, rather than an administrative license, would significantly limit the ability of health plans to hire full-time physicians to perform utilization review.

*Comments on §19.1730*

Comment. One commenter suggests a modification to §19.1730(2) to specifically reference the evaluation in the definition of "denial of preauthorization exemption." The suggested change would read "A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation, as defined in [§19.1730(4)(A),] of preauthorization requests and demonstrating that the physician or provider received full and final approval for fewer than 90% of the preauthorization requests made for a particular health care service during the most recent evaluation period."

Agency Response. TDI agrees and has made the suggested change.

Comment. A commenter states that the proposed definition of "denial of preauthorization exemption" in §19.1730(2) may encourage delay as a result of including "full and final approval" as part of the term. The commenter suggests that insurers often include modifications to prior authorization approvals, and that this language may encourage the addition of modifications. The commenter states that these modifications could delay or prevent exemptions, and ultimately delay access to care or pose unnecessary risk if modifications are routine.

Several commenters express concern about what TDI may mean by "full" approval and request clarification. Many prior authorizations are reviewed on the basis of Current Procedural Terminology (CPT) codes, either for a specific CPT code or

for a group of codes. In addition, the commenters state that for a three-drug regimen, each drug should be considered a separate service. They ask whether the language concerning "full" approval is intended to apply so that a denial of any part of a three-drug regimen results in the service not being approved for granting a preauthorization exemption.

Agency Response. TDI agrees that if a preauthorization request is modified with agreement of the provider and approval of the issuer, it should be counted as an approved preauthorization request for the purposes of calculating eligibility for a preauthorization exemption with respect to the service that is approved. TDI modifies the definition of "denial of preauthorization exemption" to remove the words "full and final" and add the term "eligible" before the references to "preauthorization requests." For consistency, TDI modifies the definition of "evaluation" in §19.1730(4)(A) to add the word "eligible" before "preauthorization requests." TDI also adds a definition of "eligible preauthorization request" to clarify that a preauthorization request is eligible for the purposes of an evaluation if the request is submitted by the physician or provider and finalized by the health plan during the evaluation period, is not pending appeal, and has an outcome of either approving the request or issuing an adverse determination. If a preauthorization request includes more than one particular health care service, the outcome for each service must be counted separately for the purposes of an evaluation.

Comment. Several commenters jointly suggest that the definition of "evaluation" in proposed §19.1730(3) (redesignated as §19.1730(4)) be clarified to specify that the retrospective review for a continuation or rescission analysis is based on a retrospective review of a random sample of claims. The commenters express concern that the rule language as proposed could be construed as permitting additional claims selected by the issuer to be reviewed as part of the retrospective review to assess continuation or rescission of a preauthorization exemption. Specifically, they suggest that §19.1730(3)(B) read "with respect to a particular health care service for which a physician or provider has a preauthorization exemption, a retrospective review of a random sample of claims submitted by the physician or provider during the most recent evaluation period to determine the percentage of claims that would have been approved, based on meeting the issuer's applicable medical necessity criteria at the time the service was provided, which is conducted for the purpose of evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption."

Agency Response. TDI agrees that the suggested language better aligns with Insurance Code §4201.655(a)(2) and has made the change.

Comment. One commenter suggests that plans may not have the ability to evaluate exempt providers with fewer than five claims in an evaluation period. The commenter states that this would be a barrier to health plans evaluating quality of care.

Agency Response. TDI understands the commenter's concern but declines to make a change. Insurance Code §4201.655(a) permits an issuer to rescind an exemption "only . . . on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims. . . . " TDI also believes that the minimum threshold for receiving an initial preauthorization exemption provides an adequate method to ensure that preauthorization exemptions are granted to physicians and providers who have demonstrated appropriate clinical judgment.

Comment. One commenter states that, based on the definition of "evaluation" in §19.1730(3)(B) (redesignated as §19.1730(4)(B)), it is possible that a provider who is not the treating provider could become perpetually exempt. Since many referring providers do not perform the treatments and will never submit a claim for the service, there would be no way to pull a sample of claims for exempt referring providers. The commenter also suggests that in situations where the referring and treating providers differ--because of the absence of an existing authorization--health plans cannot approve the claim for a non-exempt treating provider if there is no reference on the claim to the exempt ordering (referring) provider. The commenter recommends that TDI require all claims to include ordering provider information on the claim form - HCFA Box 17 (name) and Box 17B (NPI).

Another commenter states that the term "claims submitted" is broad and could be interpreted to include complete claims, rejected claims, claims denied due to bundling/coding errors, etc. The commenter recommends the language be revised to read "payable claims submitted."

Another commenter asks whether pharmacy benefit managers are expected to determine a provider's rate for each prescription drug, for all requests, for particular drug classes, or for some other grouping of medications.

Agency Response. TDI agrees that to take advantage of a preauthorization exemption, the claim must include information that identifies the physician or provider with the exemption. In response to this comment, TDI adds subsection (e) to §19.1731 to require the treating physician or provider to include the name and NPI of the ordering physician or provider on the claim in fields 17 and 17B of CMS Form 1500, or in fields 76 - 79, or another appropriate field in Form UB-04 or in the corresponding fields for electronic claims using the ASC X12N 837 format. The issuer may provide coding guidance to physicians and providers to ensure this information is appropriately captured on the claim.

Absent this information, an issuer may treat the claim as subject to an otherwise applicable preauthorization requirement. TDI also modifies the definition of "evaluation" in §19.1730(4)(B) by replacing the phrase "claims submitted by the physician or provider during the most recent evaluation period," with "*payable* claims submitted by *or in connection with* the physician or provider during the most recent evaluation period." This change removes the implication that an evaluation of a preauthorization exemption is possible only for claims submitted by the treating provider. All claims that rely on a physician's or provider's exemption are subject to an evaluation to determine continued eligibility for an exemption, whether the claim is submitted by the exempt provider or the claim references the exempt provider's information on the claim as required by §19.1731(e).

With respect to the question of how evaluations must be conducted for prescription drugs, this will depend on the issuer's listing that identifies the particular health care services that are subject to preauthorization. Refer to the definition of "particular health care service" in §19.1730(6).

Comment. Several commenters jointly state they would strongly object to any further delay in defining the initial evaluation period. In addition, the commenters state that it is unclear how TDI intends to implement proposed §19.1730(4)(C) (which TDI redesignates as §19.1730(5)(C)). The commenters state that the rule would permit plan-determined six-month evaluation periods for the rescissions, provided that notice of rescission (in either Jan-

uary or June of the year) is no more than two months after the evaluation period ends. The commenters have concerns about plan-determined evaluation periods, as this could promote issuer manipulation of the preauthorization exemption results and lead to shorter preauthorization exemption durations. The commenters ask that TDI (1) make it clear that a plan cannot duplicate any months from an evaluation period that was already reviewed, and (2) adopt language similar to that in proposed §19.1732.

Another commenter states that the timeframe of auditing denials may require additional attention by TDI. The commenter states concern that the timing of denials does not appear to line up with the six-month look-back period, as denials are only allowed in January and June.

Another commenter states that it appears that the rule gives issuers flexibility to determine a six-month period that could be used for the rescission evaluation period, but that the language is confusing. The commenter requests that TDI clarify the language.

Agency Response. TDI declines to make a change to the evaluation periods. While there are rare circumstances when an evaluation period for a rescission could overlap with a previous evaluation period in which an exemption was granted, this is a result of the statutory requirement that rescissions occur only in January or June of each year. Section 19.1732(a) requires than an exemption be in place for at least six months before it may be rescinded. TDI clarifies that the requirement in Insurance Code §4201.655(a)(1) that rescissions occur only in January or June does not apply to denials. If an exemption is not in place, the issuer must adhere to the evaluation period specified in §19.1730(5)(B). TDI also clarifies that issuers do have some flexibility to determine the six-month evaluation period on which a notice of rescission is based. The phrase "or the subsequent six-month periods that follow" would be relevant if a rescission is not finalized.

Comment. Two commenters specifically assert that TDI has the authority to include drug benefits and prescription drugs in the proposed §19.1730(6) definition of "particular health care service," which TDI redesignates as §19.1730(7). The commenters note that Insurance Code §4201.651 states that terms defined by Insurance Code §843.002, including "health care services," "physician," and "provider," have the meanings assigned by that section. Further, the commenters state that the definition of "health care services" in Insurance Code §843.002 specifically includes pharmaceutical services. Another commenter states that preauthorization exemption provisions of HB 3459 must apply to health care services, including prescriptions.

On the other hand, another commenter states that there are no references to prescription drugs in HB 3459, and a plain language reading of the bill shows the exemption requirements apply only to health care services provided, and not for products such as prescription drugs or devices.

Another commenter also opposes the inclusion of prescription drugs under the definition of a "particular health care service." The commenter suggests that the provisions of HB 3459 contain no language that would expand the purview of these preauthorization exemptions to prescription drugs. Specifically, HB 3459 provides no statutory authority to apply the preauthorization exemption and payment requirements to products like prescription drugs. Under the plain language of the law, the requirements apply only to "health care services." While pharmacy "services" would likely be included, prescription drugs by plain definition are not included within health care "services" or pharmacy "services"--they are supplies and products. So HB 3459's requirements simply do not apply. In the commenter's view, pharmaceutical "services" are not the same thing as prescription drugs. The commenter notes that there are CPT codes specific to pharmaceutical services and procedures, while prescription drugs are billed using different coding systems. The commenter also notes that lawmakers have recognized "pharmacy procedures," such as in Insurance Code §1451.1261, and argues that "services" and "procedures" are different from drugs.

In addition, two commenters state that applying preauthorization exemption requirements to prescription drugs would create a very dangerous and expensive new mandate to cover and pay for prescription drugs, including opioids and other dangerous narcotics, with no ability to check for dangerous drug interactions or to confirm that risky drugs are appropriate for certain patients. One commenter raises further concerns, including that health plans often suggest more appropriate drugs, whether certain high-risk medications ought to be exempted from the program, whether there are allowances for considerations such as clinical appropriateness and patient safety, and how it would work when claims are for opioid drugs. The commenter also asks whether application of the exception would be permitted at the generic-product-identifier level. The commenter asks, too, whether management of formulary exceptions by pharmacy benefit managers should be included in preauthorization exemption evaluations.

Agency Response. TDI declines to make a change. Insurance Code §843.002(13) defines "health care services" as "services provided to an individual to prevent, alleviate, cure, or heal human illness or injury," including pharmaceutical services and medical care, and care or services incidental to pharmaceutical services and medical care. TDI recognizes that in certain circumstances, the term "services" is distinguishable from products or commodities. But in the context of HB 3459, TDI believes the Legislature intended that "pharmaceutical services," as defined in §843.002, includes prescription drugs. *See* Webster's Ninth New Collegiate Dictionary 881 (1987) (the adjective "pharmaceutical" means "of, relating to, or engaged in pharmacy," which in turn means "the art or practice of preparing, preserving, compounding, and dispensing drugs[.]"). This position is consistent with TDI rules implementing SB 1742 (adopted at 46 TexReg 1647).

TDI is also mindful of the real safety concerns that could arise from improper prescribing or unintentional drug interactions and encourages providers and plans to remain vigilant on this issue. However, as noted in the preceding paragraph, TDI believes it was the Legislature's intent that HB 3459 cover prescription drugs. But TDI encourages stakeholders to maintain and provide, as needed, additional information as exemptions are implemented to help policymakers monitor this issue.

Comment. One commenter states that HB 3459's preauthorization exemption provisions must apply to health care services, including prescriptions, supplies, products, and procedures. The commenter recommends that proposed §19.1370(6) (which TDI redesignates as §19.1730(7)) be changed to read "A health care service, as defined by §4201.651(2), Insurance Code, including a prescription drug, lab, x-ray, medical equipment, product, or supply, that is subject to preauthorization as listed on the issuer's website under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred

Provider Benefit Plans)." The commenter suggests that anything less than an expansive application of the term "health care services" would thwart the Legislature's goal of removing unnecessary barriers to patient access to care.

Agency Response. TDI agrees with the commenter's suggestion that the term "health care services" is broad but declines to make a change. The definition of "health care services" in Insurance Code §843.002(13) includes medical care and care or services incidental to medical care. By extension, the definitions of "medical care" in Insurance Code §843.002(19) and "practicing medicine" under Occupations Code §151.002(13) provide additional specificity regarding the meaning of the term "health care services." Collectively, these definitions provide sufficient clarity that the term would include drugs, labs, imaging, and medical equipment and supplies ordered by a physician to diagnose, prevent, and "treat a mental or physical disease or disorder or a physical deformity or injury by any system or method."

Comment. One commenter has concerns that §19.1730(6) as proposed (which TDI redesignates as §19.1730(7)) ties the definition of "particular health care service" to what is posted on the plan's website. The commenter has concerns about transparency and how this affects the implementation of HB 3459's requirements. The commenter notes that various plan websites do not approach preauthorization in a consistent format. The commenter suggests that TDI set clearer parameters on the definition of "particular health care service." The commenter does not necessarily oppose tying the definition of a "particular health care service" to the website posting in theory, but states that TDI needs to adopt clearer regulatory parameters for a "particular health care service" posting to avoid any potential gamesmanship and to promote transparency. The commenter suggests that TDI conduct additional monitoring of plan websites for compliance with statutory and regulatory requirements on the posting of preauthorization requirements to ensure that the goals of HB 3459 would be addressed through this definition.

Another commenter states that the proposed definition of "particular health care service" in §19.1730(6) removes critical patient protections because reasons for requesting a particular health care service can vary. For example, services ordered as a combination of service codes performed at the same time are different clinical services than each code ordered individually. The commenter recommends amending the definition of "particular health care service" to mean "a specific individual or combination of health care services, including prescription drugs, that is subject to preauthorization as listed on the issuer's website, used for a specific clinical indication."

Agency Response. TDI recognizes these concerns related to preauthorization procedures and acknowledges that different plans may have different preauthorization procedures. However, TDI does not agree that changes to the rule text are necessary and declines to amend the rule. TDI is not proposing specific additional regulations that would directly prescribe a singular method or format for preauthorization review. Existing §19.1718(j) provides detailed preauthorization requirements, including (1) information about how the preauthorization requirements must be posted; (2) that the posting must specify a detailed description of the process and procedure; and (3) that it must include an accurate list of the services for which the plan requires preauthorization, as well as specific information on each service subject to preauthorization.

TDI will monitor compliance with the provisions of HB 3459 and other insurance laws and take further regulatory action as necessary, including amendments to the sections included in this adoption order. TDI wishes to balance the efficacy of these rules while remaining mindful of the potential unforeseen consequences of prescribing overly detailed and inflexible procedures. TDI will use market conduct examinations, complaint information, and targeted data collections where necessary to follow implementation of HB 3459 and these rules. In addition, TDI will closely observe implementation and be ready to provide additional guidance as needed.

Comment. One commenter expresses concern about the overall lack of specificity of definitions in §19.1730. The commenter encourages TDI to specifically include clinical laboratories as part of the definition of "provider" and laboratory and pathology services as part of the definition of "particular health care service."

Agency Response. TDI declines to amend the proposed rule to include clinical laboratories as part of the definition of "provider" and laboratory and pathology services as part of the definition of "particular health care service." The definitions are clearly defined under Insurance Code §843.002 and are intended to be as broad as the statute allows.

Comment. A commenter states support for the definition of "preauthorization" in proposed §19.1730(8), which TDI redesignates as §19.1730(9). The commenter approves of not including concurrent utilization review within the scope of preauthorization, consistent with the definition in Insurance Code §4201.651.

Agency Response. TDI appreciates the support.

Comment. One commenter requests that TDI replace the word "privilege" in the proposed definition of "preauthorization exemption" under §19.1730(9), which TDI redesignates as §19.1730(10). The commenter states that there are rights and payment protections associated with a preauthorization exemption granted under the law. The commenter is concerned that the word "privilege" fails to accurately reflect the legal status of an exemption.

Agency Response. TDI declines to make a change, as the wording does not interfere with any of the rights and protections granted under the law.

Comment. Several commenters jointly suggest a change to the definition of "random sample" in proposed §19.1730(11), which TDI redesignates as §19.1730(12). The commenters are concerned that this proposed definition of "random sample" does not sufficiently (1) reflect what a true "random sample" is; (2) set parameters to avoid gamesmanship or cherry-picking in issuer selection of random samples; and (3) address TDI's prior questions regarding what happens when there are fewer than five total claims for a particular health care service during the relevant evaluation period. The commenters suggest TDI modify the language to reflect that the sample must be selected through a method that gives each claim an equal probability of being chosen for the sample.

The commenters suggest the definition be "A collection of at least five but no more than 20 claims for a particular health care service, selected through a method that gives each claim an equal chance of being chosen for the sample, for the purpose of conducting an evaluation, as defined by [§19.1730(4)(B)], of physician's or provider's continued eligibility for or rescission of a preauthorization exemption. The random samples must be selected as follows: (A) If only five to 20 claims were submitted by the physician or provider during the most recent evaluation period, all of the claims submitted by the physician or provider

during the most recent evaluation period will constitute the random sample; (B) If more than 20 claims were submitted by the physician or provider during the most recent evaluation period, 20 of those claims will constitute the random sample but those claims must be selected through simple random sampling, which requires using randomly generated numbers to choose a sample. Specific metrics may not be applied by the issuer in selecting a random sample, such as specific patient cohorts or site of service, which may favor the issuer's decision-making. An issuer must maintain records demonstrating the simple random sampling used for each sample under this paragraph. If an issuer does not maintain records and the physician or provider files a complaint with the department or the department performs an audit or review regarding the sample selection, the department shall presume that the sampling was not random and automatically continue any preauthorization exemption that was being reviewed using a non-random sample."

Agency Response. TDI understands the commenters' concerns but declines to make a change. Insurance Code §4201.655(a)(2) gives issuers discretion regarding the size of the random sample, as long as it includes at least five and no more than 20 claims. The definition of "random sample" as proposed requires that the claims be selected "without method or conscious decision," which is consistent with the meaning of "random."

Comment. Several commenters jointly express concerns with the language in the definition of "rescission of preauthorization exemption" as proposed in §19.1730(12), which TDI redesignates as §19.1730(13). The commenters state that the language as proposed fails to clarify that a rescission must be based on a random sample of claims under Insurance Code §4201.655 and reflect other limitations or conditions imposed on rescissions under the law and the proposed rules. They state that it omits statutory language specifying that if the determination is in regard to an exemption for a physician, then the decision must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician.

The commenters suggest the definition read "An adverse determination regarding a preauthorization exemption's continuation based on an evaluation, as defined in [paragraph (4)(B)] of this section, of a random sample of claims and determination made by an individual licensed to practice medicine in this state in which the issuer would have approved fewer than 90% of claims for a particular health care service. For a determination under this paragraph with respect to a preauthorization exemption held by a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as the physician."

Agency Response. TDI agrees with the comment and has modified the definition of a "rescission of preauthorization exemption" to reference the applicable definition of an evaluation related to a rescission determination and to replace the physician licensure language with a reference to Insurance Code §4201.655(b), in order to fully capture the statutory requirements without restating them unnecessarily. TDI also agrees that a rescission evaluation must be based on a random sample, but in the interest of brevity declines to repeat that in this definition, since it is already clearly stated in §19.1731(c) and Insurance Code §4201.655(a)(2), and incorporated into the referenced definition of "evaluation."

Comment. Several commenters jointly suggest new language for the definition of "treating physician or provider" as proposed in §19.1730(13), which TDI redesignates as §19.1730(14). They state the proposed definition is too restrictive, and that the "primarily responsible" and the "illness" or "injury" language could inappropriately narrow the scope of the law's application. They suggest the definition read "A physician or other provider who is treating or responsible for a patient's health care for an illness, physical or mental condition, disease, or disorder, injury, physical deformity, or providing preventative care. A 'treating physician or provider' includes a rendering physician or provider or a referring or ordering physician or provider."

Another commenter encourages TDI to limit the definition to the referring physician or provider, as the rendering provider generally does not evaluate the patient or determine the course of treatment. The commenter says that precertification exemption must be tied to the primary care physician who evaluated the patient and made the decision to request the service, not the physician who conducted the MRI and did not participate in the clinical decision-making to order the service for the patient.

Another commenter supports the proposed rules, stating that the rule successfully encourages claims payment by defining a treating physician or provider as including "a rendering physician or provider."

Agency Response. TDI agrees to modify the definition of "treating physician or provider" to clarify that care may be broader than in relation to an illness or injury. TDI also modifies the definition by replacing "health care for an illness or injury" with "health and medical care," and expanding the definition to include an "ordering" physician or provider. TDI disagrees with suggestions for further modifying the definition. TDI believes it is unnecessary to exclude a rendering physician or provider from the definition since a preauthorization exemption can be obtained only on the basis of a history of approved preauthorization requests. Also, a treating provider may both order and render the care.

*Comments on §19.1731*

Comment. One commenter suggests that §19.1731(a) be modified to require a physical location, in addition to an NPI, as a means of identifying a facility. The commenter argues that HB 3459 seeks to reduce burdens for providers that are considered exemplary in determining what care is medically necessary and appropriate; since this could vary by hospital location, the exemption should be determined for each location separately.

Agency Response. TDI declines to make a change. Applying the exemption analysis at a more granular level as the commenter suggests would create additional complexity and reduce the amount of data available to inform each exemption.

Comment. TDI specifically sought comment on the minimum number of preauthorization requests needed to qualify for an exemption. Many commenters provided valuable input.

Several commenters support the proposed provision requiring a minimum of 20 preauthorization requests for an exemption. One states that the requirement is sufficiently stringent and is aligned with the principles of HB 3459. Another commenter states the threshold provides guardrails for low-volume providers, who are most likely to benefit from utilization management under the preauthorization process. One of these commenters recommends that the number of the threshold be raised to 30, stating that 30 is considered by statisticians to be the minimum number to have an appropriate confidence interval.

Several commenters disagree with the proposed minimum threshold of 20 claims. One commenter states that the threshold

is too high and would prevent far too many capable physicians from receiving exempt preauthorization status.

Other commenters state that HB 3459, as written and passed, does not contain a minimum number of claims for a particular health care service that must be met for the initial granting of a preauthorization exemption. They say that imposing such a requirement at all, but certainly one that requires a minimum of 20 claims, would undercut the goal of the legislation by reducing the intended scope of its application. The commenters argue that applying a minimum of 20 preauthorization requests would inappropriately limit the number of exemptions. One commenter recommends lowering the minimum threshold for review to five claims. Other commenters recommend removing the language "The evaluation must be based on no fewer than 20 preauthorization requests." The commenters state that TDI's creation of the threshold lacks statutory authority and is contrary to the intended meaning of the statute. The commenters also disagree that the request must be both submitted and finalized during the relevant six-month period.

One commenter states that the proposed threshold would create unintended consequences if each particular health care service required no fewer than 20 preauthorization requests to be reviewed within a six-month period to determine whether the physician or provider qualifies for an exemption. The commenter notes that many providers will not have the minimum number of preauthorization requests of a particular health care service for each insurance carrier. The commenter also requests clarification on services that required preauthorization under the parent insurance carrier.

Several commenters jointly oppose §19.1731(c) as proposed. They state it effectively creates a minimum preauthorization submission threshold of 20 requests for reviewing, granting, or denying, and notifying of a grant or denial of a preauthorization exemption, which is in clear conflict with the plain language of the law and the intent of HB 3459.

Agency Response. TDI agrees to reduce the proposed minimum threshold of 20 preauthorization requests for a particular health care service because it may unintentionally limit the number of exemptions that are granted. As adopted, the rule sets a minimum threshold of five eligible preauthorization requests. TDI also adds a definition of "eligible preauthorization request" to clarify which preauthorization requests are counted in an evaluation. TDI declines to change the requirement that the minimum threshold be based on preauthorization requests submitted and finalized during the six-month evaluation period because this aligns with the basis for an evaluation provided in Insurance Code §4201.653(a).

While the statute does not expressly set a minimum number of preauthorization requests needed to qualify for an exemption, TDI does not believe that deprives the agency of authority to set a reasonable threshold by rule or that such a threshold is inconsistent with the statute. *See Tex. State Bd. of Exam'rs of Marriage & Family Therapists v. Tex. Med. Ass'n,* 511 S.W.3d 28, 33 (Tex. 2017) (A state agency "can adopt only such rules as are authorized by and consistent with its statutory authority.") (internal citations and quotations omitted). A primary purpose of HB 3459 is to reduce the burden of preauthorization requirements for providers who have demonstrated high approval rates and adherence to medical necessity guidelines. When there are fewer than five preauthorization requests, there may be insufficient evidence to warrant an exemption and the continued preauthorization requirement creates only a limited burden. Furthermore, without such a threshold, it could allow for abuse of the system (especially since issuers can only rescind a provider's exemption for a particular health care service if the provider has at least five claims for that service during an evaluation period). Ultimately, TDI believes this rule is in harmony with HB 3459's general objectives. *See id.* (a rule must be "in harmony with the general objectives of the act involved").

Comment. One commenter recommends modifying the rule to prevent exemptions from continuing in perpetuity, even if the provider retires, or if the standard of care evolves. The commenter suggests either requiring a minimum number of services to be provided for an exemption to be retained, or allowing an issuer to rescind an exemption with fewer than five claims after a reasonable length of time has passed without any new claims for the particular health care service.

Agency Response. TDI declines to make a change. Insurance Code §4201.655 provides a process and standards for issuers to rescind an exemption. Furthermore, if a provider is not actively practicing, the exemption would not be in use.

Comment. One commenter notes that some carriers have different preauthorization requirements for each of their plans. The commenter suggests that each provider be reviewed on the basis of all requests in total of all health care provided under a parent insurance company - not by each particular health care service.

Another commenter asks for clarification on whether exemptions are assessed separately for each health plan.

Another commenter asks whether reviews for provider exemption for medical benefit drugs and pharmacy benefit drugs are to be conducted separately if the preauthorization requirements are different and preauthorization determinations are made by a different entity.

Agency Response. TDI agrees that the minimum threshold should apply across each issuer and clarifies that an issuer may not conduct evaluations and grant exemptions separately for different plans offered by the issuer. Affiliated issuers are encouraged to perform a combined exemption analysis, to the extent practical. Likewise, to the extent that an issuer uses similar networks and utilization review processes to administer self-funded plans, TDI encourages issuers to use all applicable data when evaluating a physician's or provider's exemption with respect to a particular health care service.

Reviews for different health care services may occur separately, but a review with respect to a particular health care service must include all applicable data and may not be segmented, even if the issuer uses multiple administrators. TDI disagrees that an exemption review can occur across all health care services, because Insurance Code §4201.653(a) provides for an exemption "for a particular health care service."

Comment. One commenter asks whether the data included in the review to determine exemption eligibility would include claims data and actual preauthorization submissions. The commenter notes that not all payor preauthorization web portals include both the ordering physician NPI and the facility NPI. The commenter also asks for clarification in a situation where a facility requests preauthorization for the facility charges but the facility is not actually ordering the service. The commenter asks whether facilities will be awarded an exemption status of their own, and if not, how an affiliated facility will know of exemption status awarded to physicians. Relatedly, if facilities

will be awarded their own exemptions status, the commenter wants to know how those determinations would be made.

Agency Response. Evaluations for an initial exemption are based on the preauthorization requests submitted by a physician or provider for a particular health care service. The initial review does not include claims data. The exemption would be granted to the physician or provider who makes the preauthorization request. There is nothing in the statutes or rules that prevents a facility from qualifying for a preauthorization exemption. Evaluations for continued eligibility for an exemption are based on claims submitted by, *or in connection with,* a physician or provider for the particular health care service. If the preauthorization exemption is held by a physician or provider who orders but does not render a particular health care service, then the billing provider must obtain information about the exemption and include the ordering physician's or provider's NPI on the claim. Such claims would be evaluated to determine whether to continue or rescind an exemption held by the ordering physician or provider. TDI adds new subsection (e) to §19.1731 to clarify the information that must be included on a claim. Issuers must ensure that their systems enable providers to include all information required to identify exempt providers where needed to operationalize the exemptions.

Comment. Several commenters jointly recommend that TDI change the provision regarding rescissions to underscore that an issuer may, but is not required to, conduct an evaluation to determine whether to rescind an exemption. They also suggest the language clarify what the effect is when there is an insufficient number of claims to constitute a "random sample" of claims and suggest the language cross-reference the definition of "evaluation" to make clear that a rescission is based on a retrospective review of a random sample of claims. They suggest specific language to amend §19.1731(c).

Agency Response. TDI modifies §19.1731(c) to include a reference to the definition of the applicable evaluation under §19.1730(4)(B). TDI declines to make other changes, as Insurance Code §4201.653(c) makes clear that issuers may continue an exemption without performing an evaluation. Likewise, Insurance Code §4201.655(a)(2) makes clear that a rescission is not permitted if the issuer does not evaluate at least five claims. This standard is restated in the definition of "random sample" in §19.1730(12) and in §19.1731(c).

Comment. One commenter supports the provision in proposed §19.1731(d) under which a treating physician or provider who inappropriately relies on another physician's or provider's exemption in violation of the rule may be considered by the issuer as failing to substantially perform the health care service. The commenter also states opposition to the provision allowing a "rendering" provider who does not qualify for an exemption to take advantage of an exemption held by the ordering physician or provider.

Another commenter supports preventing a treating physician or provider who does not have a preauthorization exemption from relying on another physician's or provider's exemption. The commenter expresses strong concern with the proposed rules that allow a non-exempt rendering provider to use the ordering or referring provider's preauthorization exemption. The commenter recommends that a preauthorization exemption should be available only when the ordering provider is the same as the provider providing the direct care of the patient.

One commenter asks whether a referring physician without a preauthorization exemption can rely on the rendering physician's exemption. The commenter asks for additional clarification from TDI on how this would be tracked. Another commenter asks whether the exemption extends to anyone that may submit an authorization under the provider's authority.

Several commenters jointly recommend that §19.1731(d) be modified to also apply to treating providers. The commenters also recommend that TDI strike the last sentence of subsection (d), as providing a service in erroneous reliance on another physician's or provider's exemption is not the same as failure to substantially perform a service from a plain language standpoint. The commenters state that Insurance Code §4201.659, referenced in the proposed section, would imply that a preauthorization exemption is not in effect for--and could not be used by--the physician or provider to whom the issuer attempts to reduce or deny payment. The commenters provide alternate language for §19.1731(d). The commenters state that if TDI does not adopt their suggested language, they strongly recommend the inclusion of additional language, which they offer, to limit the ability of the issuer to utilize Insurance Code §4201.659. In addition, the commenters ask TDI to clarify the intent of the provision and include illustrative examples to aid understanding of the provision's application and impact.

Agency Response. TDI believes that limiting the application of a preauthorization exemption to care ordered and performed by a physician or provider would unintentionally limit the scope of the statute and inappropriately shift the responsibilities for obtaining preauthorization to other physicians and providers rather than reducing the burden of preauthorization when an exemption has been granted. With respect to evaluations and tracking exemptions generally, §19.1731(a) indicates that physicians and providers are identified using the NPI under which they make preauthorization requests. TDI adds new subsection (e) to §19.1731 to clarify how an exempt physician or provider would be identified on a claim for care that they order but do not perform or bill for.

TDI modifies §19.1731(d) in response to comments to consistently reference both physicians and providers, and TDI replaces the phrase "that treating physician" with "the physician or provider who has qualified for the preauthorization exemption." This change more accurately reflects that the exemption and its protections do not extend to care that is not ordered, referred, or provided by the physician or provider who qualifies for the exemption. TDI also adds a sentence to the end of subsection (d) to clarify that it is not a violation for a provider, such as a nurse or physician's assistant who practices under the supervision of a physician, to rely on the supervising physician's exemption if the provider appropriately orders care and requests preauthorization under the supervising physician's NPI.

To clarify this provision, TDI offers the following examples:

1. A nurse and physician's assistant work under the supervision of a physician and submit preauthorization requests under the physician's NPI. The physician qualifies for an exemption. In this case, the nurse and physician's assistant are permitted to rely on the physician's exemption because the physician is supervising the care and is considered to be a treating physician.

2. A physician works in a group practice with other physicians. Each physician in the group practice submits preauthorization requests under their individual NPIs. One physician qualifies for an exemption. In this case, the other physicians are not per-

mitted to rely on their partner's exemption; they must continue submitting preauthorization requests for their own patients. The physician with the exemption is not considered to be a treating physician with respect to the patients of his or her partners.

Comment. One commenter asks whether there will be a data repository that identifies all physicians and providers who have been awarded a preauthorization exemption.

Agency Response. Neither the statute nor the rules require issuers to publish data regarding preauthorization exemptions. However, TDI encourages issuers to consider how best to maintain and share this information with providers, in addition to the notices required under §19.1732.

Comment. One commenter asks if, in a situation where an exempted service is provided and the service transitions into a more complicated service, additional services, or surgery, whether all associated services will also be exempt.

Agency Response. Exemptions apply only with respect to particular health care services. If a service is performed that is not eligible for an exemption, then it could be subject to a retrospective review to evaluate whether it is medically necessary and would not have the protections that are provided in Insurance Code §4201.659.

*Comments on §19.1732*

Comment. One commenter disagrees with the requirement in §19.1732(a) that an exemption must be in place for at least six months before it may be rescinded. The commenter states that it would be cumbersome for both the health plan and provider. The commenter notes that industry standards already issue authorizations for cancer patients and other chronic disease treatments for one year, and the commenter suggests that the preauthorization exemption period be extended to an annual basis. The commenter states this would result in savings both toward patients' benefits premium dollars and the costly work involved in the process for both health plans and providers.

Another commenter also encourages a one-year exemption duration. This cycle would allow predictability around the staffing levels required to perform the administrative functions of preauthorization. The commenter states that having to adjust to a six-month basis and have the appropriate number of staff to support this will be nearly impossible. Another commenter states that the exemption should be determined by an annual evaluation period. The commenter states that, because of the seasonal nature of health care, a physician may perform a procedure or prescribe a treatment that requires preauthorization far more often in one six-month period than another.

Several commenters jointly state that they strongly support requiring the exemption to be in place for at least six months before it can be rescinded and strongly contend that any shorter period would be contrary to both the express language and spirit of the law.

Agency Response. TDI declines to make a change. Since the statute provides that a health plan may rescind a preauthorization exemption only in January or June, TDI does not believe the Legislature anticipated an exemption to have a minimum duration of one year. TDI believes the minimum duration of six months is more consistent with the language and intent of the statute.

Comment. Several commenters jointly ask TDI to expand on the list of statutory elements for the notification letters described in §19.1732. They note that Insurance Code §4201.659(d) requires this notice to "include" certain elements, and that "includes" is a word of enlargement under the Code Construction Act. They suggest that the exemption notice under §19.1732(a) should be required to include (1) a plain language explanation of the impact and meaning of the exemption, and (2) contact information for both TDI and the issuer. In addition, they recommend that TDI standardize these notices and require the use of the form so that the notices are more uniform, easier to identify, and easier to read. They state that the notification of a denial under §19.1732(b) should include notice of the physician's or provider's appeal rights; require the form to state that the issuer is required to pay for any IRO review; and include the email address, fax, and any other electronic method the physician or provider prefers to use to return the form.

The commenters provide some specific recommendations to modify the wording on Form LHL011, and to clarify the rule text regarding the dates that exemption notices are issued, effective, and appealed.

The commenters also ask that TDI clarify that the date the appeal is being requested in the context of Form LHL011 is the same thing as the signature date of the physician completing the appeal form, even if the provider returns the form to the issuer before the date the rescission becomes effective.

Another commenter expresses concern with the level of detail required in the rescission notices, specifically citing the requirement to include the principal reason for the determination, the clinical basis for the determination, a description of the sources of screening criteria used as guidelines, and the specialty of the determining provider. The commentor argues that the rule goes well beyond what is required by the statute.

Another commenter suggests that the notice of the initial exemption be required only for physicians or providers who receive an exemption, and that notification not be required for denial of preauthorization exemption for services that the physician or provider did not expressly request an exemption for.

One commenter states support for the rule that an issuer must provide notice when exemptions are both granted or denied. This protects physicians or providers from mistakenly thinking they are exempt, ordering tests, and not requesting preauthorization.

Agency Response. TDI agrees to modify the notice requirement for exemptions issued under §19.1732 and require notices to include a plain language explanation of the effect of the preauthorization exemption and any claim-coding guidance needed to document the exemption. TDI declines to create standardized forms for exemption and denial notices, or to require the use of TDI's example form for rescission notice. Such requirements would limit the flexibility that issuers have and would be difficult to establish at this early phase of implementation. TDI will instead monitor issuers' implementation of these notices and take future action to improve clarity and uniformity if necessary.

TDI also agrees that a denial notification should include a description of how to appeal the denial using an issuer's complaints and appeals processes and information on how to file a complaint with TDI. Section 19.1732(b) has been modified accordingly.

TDI disagrees that the contents of the rescission notice required under §19.1732(d) are too burdensome or inconsistent with statute. Insurance Code §4201.655(a)(3) requires an

issuer to include on a rescission notice "the sample information used to make the determination" that less than 90% of the claims met the medical necessity criteria. Insurance Code §4201.655(b) requires a rescission determination to be made by a Texas-licensed physician, and for a rescission of a physician's exemption, the physician must have the same or similar specialty. The contents of the rescission notice required under §19.1732(d) are simply designed to inform the provider why the exemption is being rescinded, who made that decision, and what the provider can do about it.

TDI declines to remove the requirement that issuers provide denial notices. Insurance Code §4201.653 broadly requires issuers to conduct exemption evaluations without the physician's or provider's request, and Insurance Code §4201.655(c) requires denial notices. However, consistent with changes to the initial threshold under §19.1731(b), TDI modifies §19.1732(c) to clarify that notice is provided only when at least five eligible preauthorization requests are available for an initial evaluation.

With respect to the date a rescission notice is provided and the date it is effective, TDI declines to make a change; Insurance Code §4201.654 makes clear that an exemption remains in effect until the 30th day after the date the issuer notifies the physician or provider of the issuer's determination to rescind the exemption. TDI agrees to clarify the language in the Form LHL011 notice by adding "Unless you request an appeal to an independent dispute resolution organization as set forth below," before the statement of the effective date of the rescission. TDI expects issuers to use timely methods to transmit notices so providers receive the notices on the same day they are sent electronically, or typically within five calendar days of mailing.

TDI also modifies Form LHL011 to add the clarifying text "at no cost to you" within the explanation of the right to appeal the rescission and clarifies that the appeal request form may be sent electronically. TDI modifies §19.1732(d)(1) to clarify that the rescission notice must include the date the notice is issued, consistent with the example form LHL011 as proposed. TDI modifies §19.1732(d)(2) to clarify that the issuer must provide contact information for returning the appeal form "by paper or electronic means."

Comment. Several commenters jointly recommend the addition of a new subsection requiring issuers to solicit from physicians and providers their preferred contact method and preferred contact information, and to use the preferred method and information to provide required notices. A separate commenter also recommends that physicians and providers should be permitted to designate their notification address. The joint commenters suggest that TDI add language that if an issuer notifies a physician or provider via any other method, any rescission notice would be defective, and the exemption would continue. The commenters also suggest that TDI require issuers to retain records to show they provided timely and effective notice through the preferred method and contact information, and that failure to retain records would make rescission ineffective. In addition, the commenters recommend that TDI modify the rule to provide that if an issuer fails to retain a record of notice of granting a preauthorization exemption, then the six-month period before an exemption may be rescinded is extended to be counted from the date the issuer provides effective notice.

Agency Response. TDI agrees that physicians and providers should be able to designate their preferred contact information and has added new subsection (e) to §19.1732 to clarify that issuers must allow physicians and providers to choose whether to receive communications regarding preauthorization exemptions electronically or by mail and provide a method for updating contact information. New §19.1732(e) also requires issuers to include instructions for updating contact preferences on the website required under §19.1718(j) and in all communications issued under §19.1732. TDI disagrees that additional requirements are necessary; it will monitor this issue through complaints, but expects issuers and providers to work in good faith to establish practical and effective communication methods. TDI declines to modify the rule to add extensive record retention requirements for issuers. The statute and rule provide sufficient clarity regarding the notification requirements, minimum period for an exemption, and requirements for rescissions. Consistent with Insurance Code §4201.654, a rescission is not effective until at least 30 days after notice is issued.

Comment. One commenter recommends modifying the threshold percentage and timeframe to require providers to submit proof to a health plan 30 days before the end of an exemption period that they have maintained an 80% compliance rate with evidence-based guidelines for a particular medical service.

Agency Response. TDI declines to make a change. The statutory criteria for exemptions require a provider to meet the medical guidelines in 90% of cases. With respect to the timeframe, the statute requires a six-month evaluation period. This could not be achieved if the exemption determination is made before the end of the six-month period. While the 90-day period following the initial evaluation period does delay the effective date of exemptions, TDI believes this is necessary for the health plans to operationalize the rules. Once an exemption is granted, it will be in effect until it is rescinded.

Comment. One commenter states that the October 1 deadline for initial notification of preauthorizing exemptions is too delayed. The commenter states that if the data necessary to evaluate is readily available, then there should be no reason that this excessive amount of time is necessary.

Several commenters jointly state they oppose the October 1 deadline. They state that Insurance Code §4201.659(d) suggests that the law would technically require issuers to provide initial notices granting or denying exemptions no later than five days after the physician or provider qualifies for the exemption. They also recognize that the timing of the rule adoption may inhibit compliance with this timeframe for the initial grant or denial of a preauthorization exemption. They recommend that if TDI intends to move forward with a longer period for the initial notice granting or denying a preauthorization exemption to account for the adoption of final rules, then TDI should require the notice of the initial granting or denial to be provided no later than August 1, 2022. The commenters also state that for subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption no later than five days following the day after the end of the evaluation period, rather than the two-month period in proposed §19.1730(4)(C), redesignated as §19.1730(5)(C).

Noting the initial exemption notification date, another commenter asks whether providers can count on all aspects of this law to be operationalized by October 1, 2022, or whether there is another date for implementation.

Agency Response. TDI understands the commenters' concerns regarding the five-day notice following the end of the evalua-

tion period and modifies §19.1732(c) to clarify that, consistent with Insurance Code §4201.659(d), an issuer must provide a notice granting or denying a preauthorization exemption within five days of completing an evaluation. This clarifies that issuers should issue notices timely, following the completion of an evaluation, rather than waiting until the specified deadline. However, TDI declines to modify the proposed deadlines for issuing notices. Issuers must make substantial operational changes to implement the requirements of the statute and rule, and the flexibility provided in the timeframes should support issuers' ability to implement the statute as intended, with minimal impact on the physicians and providers who qualify for exemptions. TDI expects that as time goes on, issuers will develop systems that allow evaluations to be completed and communicated faster than the maximum amount of time provided by the rules. TDI will monitor the issue to determine whether future changes are needed.

This rule takes effect 20 days after the date it is submitted to the *Texas Register.* October 1, 2022, represents the deadline for issuers to provide initial notifications of preauthorizing exemptions.

Comment. One commenter states that a provider should be notified by May 15 or December 15 of the notice to rescind an exemption. The commenter states that providers need notification early enough to make sure they have the processes in place before rescission.

Agency Response. TDI disagrees that providers should be notified by May 15 or December 15 of the notice to rescind an exemption. Insurance Code §4201.654(a) requires notice 30 days before a rescission is effective. Insurance Code §4201.655 permits rescissions to occur only during January or June of each year. Given that an appeal would likely modify the actual effective date of a rescission, for consistency, TDI modifies §19.1732(d) to clarify that the January and June dates specified by statute apply with respect to the timing of the notice, rather than with respect to the timing of the rescission effective date.

*Comments on §19.1733*

Comment. One commenter notes that the proposed rules contain no mechanism to challenge the initial denial of a preauthorization exemption. The commenter recommends that an appeal process should include the initial evaluation period.

One commenter supports limiting the IRO review to the rescission evaluation.

Other commenters request clarification that the right to appeal to an IRO exists for initial exemptions. They state that the legislative intent was to allow physicians and providers the opportunity to appeal in the event they do not receive an exemption for a particular health care service as expected.

Agency Response. TDI declines to make a change to §19.1733 but does modify §19.1732(b) to require denial notices to describe how to appeal using the issuer's complaints and appeals processes and how to file a complaint with TDI. An initial denial of a preauthorization exemption is issued on the basis of the total rate of approvals and adverse determinations of preauthorization requests during the evaluation period, and under Insurance Code Chapter 4201, providers have the right to appeal each adverse determination of a preauthorization request on which an exemption denial is based. The calculation of the approval rate that determines whether an exemption is granted or denied does not involve the use of medical judgment.

Insurance Code §4201.656 provides for an independent review of an adverse determination regarding a preauthorization exemption. The term "adverse determination regarding a preauthorization exemption" is not defined in the Insurance Code, but TDI interprets it in §19.1730(1) as "a decision by an issuer that one or more claims retrospectively reviewed as part of an evaluation as defined in §19.1730(4)(B) . . . , with respect to a particular health care service for which the physician or provider has a preauthorization exemption, did not meet the issuer's screening criteria[.]" This interpretation is informed by the definition of "independent review" in 28 TAC §12.5 ("Independent review" means a "system for final administrative review by a designated IRO of an adverse determination regarding the *medical necessity and appropriateness or the experimental or investigational nature of health care services."*) (emphasis added); the definition of "adverse determination" in Insurance Code §4201.002 ("Adverse determination" means "a determination by a utilization review agent that health care services provided or proposed to be provided to a patient *are not medically necessary or are experimental or investigational.* ") (emphasis added); and the references to a "rescission review" in Insurance Code §4201.656(b)(2), "claims" in Insurance Code §4201.656(d), and "determination . . . to rescind" in Insurance Code §4201.657.

Comment. One commenter states that §19.1733(b) requires that up to 20 medical records requests per particular health care service, per individual plan per provider, would need to be submitted to the insurance carrier during the evaluation period. The commenter states that this could effectively require the provider to submit almost all patient medical record files to each insurance carrier during the review period. This would cause an extreme burden on the practice, increasing--not reducing--the administrative burden this legislation intended to relieve responsible providers of.

Several commenters jointly suggest alternate language for proposed §19.1733(b). They suggest language that would, (1) add a reference to proposed §19.1730(3)(B) (redesignated as §19.1730(4)(B)), (2) specify that the request for documents be "as minimally necessary," and (3) clarify that medical records may not be requested and a retrospective review may not be conducted for any claims that are outside the original random sample of five to 20 claims, unless a provider agrees. The commenters also recommend that the rules require the issuer to provide a physician or provider with a reminder request for any outstanding records needed for the assessment at least 15 days before the end of the deadline; require the issuer's notice to have enough specificity that a reasonable physician could identify the needed records; require the issuer to inform the physician or provider of the effect of a failure to provide records in the reminder request; and expressly make it a violation to request more information than is needed, fail to provide a request with sufficient specificity, or fail to provide the follow-up request.

Agency Response. TDI declines to restrict an issuer's ability to determine the size of the random sample (and by extension, the number of medical records requested for each particular health care service) beyond the statutory constraint. The statute requires a rescission to be based on a review of at least five and no more than 20 claims.

TDI recognizes these concerns related to potential additional specificity and clarification of the review procedures. However, TDI does not agree that substantive changes to the rule text are necessary. TDI declines to add language that medical record re-

quests must be "as minimally necessary" and include sufficient specificity, because §19.1707, as referenced, already provides standards for requesting medical records. To add clarity, TDI modifies §19.1733(b) to add a reference to the definition of an applicable evaluation under §19.1730(4)(B). TDI also clarifies that medical records requested in connection with a retrospective review of a random sample of claims as authorized under Insurance Code §4201.659(b)(1) should be limited to no more than 20 claims.

TDI declines to add a new requirement for issuers to provide a reminder request or warn physicians or providers of the consequences of failing to respond to a request for medical records because physicians and providers should already have systems in place to be responsive to such requests. However, issuers are not precluded from providing such reminders or warnings.

TDI will monitor compliance with the provisions of HB 3459 and other insurance laws and may take further regulatory action as necessary, including amendments to these rules. TDI wishes to balance the efficacy of the rules while remaining mindful of the potential unforeseen consequences of prescribing overly detailed and inflexible procedures. TDI will use market conduct examinations, complaint information, and targeted data collections where necessary to follow implementation of HB 3459 and these rules. In addition, TDI will closely observe implementation and be ready to provide additional guidance as needed.

Comment. One commenter recommends changing the time limit for providers to submit medical records from 30 to 15 days. The commenter argues that there is a built-in incentive for providers to appeal every rescission determination and it could give providers months of additional time under an exemption that should be rescinded. In addition, the commenter suggests that an independent review should not be available for a rescission that is based on a provider's failure to provide medical records. The commenter argues that allowing a provider to submit supporting records for the first time as part of an independent review would add substantial additional costs.

Another commenter states support for the need for a time limit for providers to submit requested records in proposed §19.1733(b), but states the language is not sufficiently clear as to require submission of records in a timely manner. The commenter recommends that a physician's or provider's timeframe to submit records be capped at 30 days to ensure that the reviewing organization has adequate time to conduct the evaluation.

Agency Response. TDI declines to change the time limit for providers to submit medical records from 30 to 15 days because the definition of evaluation periods under §19.1730(5)(C) provides sufficient time and flexibility for issuers to complete evaluations, taking into account the 30-day period. TDI disagrees that the language is not sufficiently clear. Under §19.1733(b), issuers must provide at least 30 days for medical records to be provided and specifies the consequence if medical records are not provided.

TDI agrees that issuers may face costs in the form of IRO fees if providers habitually fail to submit medical records and then appeal rescissions to IROs. If issuers are unable to review the medical records, this could lead to more proposed rescissions and more appeals, when the issuer would not have proposed to rescind the exemption had they been able to review the medical records. Nevertheless, Insurance Code §4201.656(a) provides a clear right to providers to have a recission reviewed by an IRO, and the statute does not limit that right based on the issuer's reason for a recission. But because of the potential costs to issuers noted above, TDI will monitor the issue to determine whether future changes are needed.

TDI also agrees that it would be impractical for an IRO to request medical records for the first time in cases where the provider has failed to provide them during the issuer's initial review. Insurance Code §4201.656(c) requires an IRO to complete its review not later than the 30th day after the physician or provider requests a review and does not provide for this timeframe to be extended while records are being requested. Therefore, to address this concern, TDI does modify §19.1733(d) to clarify that in order to request an appeal for a determination that was based on a failure to provide medical records, the physician or provider must include the applicable records in conjunction with their request for an independent review. Conforming changes are made to §19.1732(d)(3)(C)(i) and §19.1732(d)(5) to ensure that issuers specify when a determination is based on lack of medical records and instruct providers to include the records with the request for an independent review.

TDI also changes the last sentence in §19.1733(d) to clarify that the requirement for the issuer to submit the request for independent review applies only if the issuer seeks to proceed with the proposed rescission. This should mitigate the risk of unnecessary IRO appeals when the issuer is able to review records and determine that the provider continues to qualify for an exemption.

Comment. One commenter states that proposed §19.1733(b) should require issuers to send a medical records request via certified mail and that the request be made within 30 days following the end of the evaluation period, rather than 90 days as proposed. The commenter expresses concern that issuers could receive a negative determination due to lack of medical records where the request was not received because it was not sent via certified mail.

Agency Response. TDI declines to require issuers to send requests via certified mail because this would significantly increase costs. This should not be necessary since issuers will allow providers to designate their preferred contact method and address. Issuers will need to make timely requests for medical records, either during or shortly after an evaluation period, in order to meet the timeframe for rescissions specified in §19.1732(c). TDI declines to change the 90-day timeframe for medical record requests because an issuer or IRO may need to request additional records during an evaluation or appeal.

Comment. A commenter requests clarification of §19.1733(b) to avoid ambiguity or interpretation by the carriers that would cause claims already submitted and paid during the exemption period to be retrospectively denied if the provider fails to submit medical records.

Agency Response. TDI declines to make a change. In response to the commenter's clarification request, an issuer would not be allowed to request repayment of claims paid while an exemption was in effect, even if the exemption was subsequently rescinded. Insurance Code §4201.657(b) makes clear that an issuer is not permitted to retroactively deny a claim.

Comment. Several commenters jointly express concern with the reference to "additional claims that were not included in the random sample." They contend that the statute does not give issuers authority to choose to review claims that are not part of the operative sample. The commenters suggest that when a provider requests review of "another random sample," as permit-

ted under Insurance Code §4201.656(d), the IRO should perform a first-time review and not a re-review of claims reviewed by the issuer.

One commenter states that proposed §19.1733(e) introduces ambiguity that can be read as allowing the provider to request a second random sample. The commenter requests that TDI change the provision to confirm that the only reason a physician or provider may request a new sample for the IRO is if the issuer based the rescission on cases that were outside the random sample, and that the physician or provider cannot request review of a second random sample without reason.

Another commenter objects to an IRO reviewing only the claims in a second random sample, arguing that Insurance Code §4201.656(d) requires that if another random sample is requested, the IRO must base its determination on both the original random sample and the second random sample.

Agency Response. TDI agrees that an issuer may conduct a retrospective review of a health care service subject to an exemption only as provided in Insurance Code §4201.659(b)(1) and (2) and modifies §19.1733(d)(3)(A) to remove the reference to retrospective review of additional claims that were not included in the random sample.

TDI agrees that Insurance Code §4201.656(d) permits an IRO to review claims for the first time that were not first reviewed by the issuer and modifies §19.1733(e), as proposed, to permit a provider to request that an IRO review another random sample of claims if the issuer identifies on the rescission form that at least five additional claims were eligible for review but not included in the original random sample. In the case that fewer than five additional claims were eligible for review, it would not be possible to select another random sample that did not duplicate claims from the original sample. If a second random sample is requested, the issuer must, when submitting the request for independent review to the department, provide a listing of all payable claims that were eligible to be evaluated but that were not included in the original random sample. The listing must be sufficiently detailed to allow the IRO to identify each claim when selecting an additional random sample. Conforming changes were made to §12.601(e), which are discussed in a separate adoption.

To support the changes made in §19.1733(e), TDI modifies §19.1732(d)(3) to require issuers to include on the rescission notice the total number of payable claims that were eligible to be evaluated with respect to the health care service subject to rescission and the number of claims included in the random sample. This makes clear whether the physician or provider may request another random sample.

Comment. A commenter suggests clarifying that the response time for an insurer to communicate the determination of a review by the IRO to the physician or provider under §19.1733(f) is five business days.

Two commenters request clarification on the length of time an IRO has to process a review and return the determination to the issuer. The commenters note that proposed §19.1733(f) states that the issuer has five days to give an IRO determination to a physician. The commenters also note that there is no clarification for how long the IRO has to perform and complete the review before returning a verdict to the issuer, and that the general IRO notice requirements within 28 TAC §12.206 do not apply. One commenter recommends a requirement for a timely IRO notice to the issuer. The other commenter recommends adding a 30-day limitation on the length of time an IRO has to process an appeal. The commenter says this would ensure that a physician denied an exemption experiences no delay in his or her appeal process.

Agency Response. TDI declines to change §19.1733(f) in response to comment. The five-day requirement is based on the provision in Insurance Code §4201.654(a)(2) that a preauthorization exemption remains in effect until the fifth day after the date the IRO affirms the issuer's determination to rescind the exemption. The five days provided is consistent with Government Code §311.014, which requires that if the last day occurs on a Saturday, Sunday, or legal holiday, the period is extended to include the next business day. TDI also declines to amend §19.1733(f) to specify how long the IRO has to complete its review because Insurance Code §4201.656(c) clearly states that an IRO must complete its review not later than the 30th day after the physician or provider files the request for a review.

Comment. Several commenters jointly recommend that TDI clarify proposed §19.1733(g) to be limited to requiring the maintenance of medical records only with respect to claims eligible to be evaluated under the rules. Since the independent review is limited to claims that the issuer determined did not meet the screening criteria, the commenters ask TDI to clarify that the other reviewed claims be deemed to have met screening criteria and not be subsequently challenged on the basis of a lack of medical necessity or a failure to maintain medical records.

Agency Response. TDI disagrees that clarification is needed and declines to make a change. The requirement to maintain medical records clearly applies only in the context of the retention of a preauthorization exemption and the obligation of a physician or provider to cooperate with an evaluation and an appeal, which can be conducted and result in a favorable outcome only if the physician or provider provides the necessary records.

## SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY

## DIVISION 1. UTILIZATION REVIEWS

### 28 TAC §19.1710

STATUTORY AUTHORITY. The Commissioner adopts amended §19.1710 under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

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 August 12, 2022.

TRD-202203025
James Person
General Counsel
Texas Department of Insurance
Effective date: September 1, 2022
Proposal publication date: April 8, 2022
For further information, please call: (512) 676-6584

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## DIVISION 2. PREAUTHORIZATION EXEMPTIONS

**28 TAC §§19.1730 - 19.1733**

STATUTORY AUTHORITY. The Commissioner adopts new Division 2, §§19.1730 - 19.1733, under Insurance Code §4201.003 and §36.001.

Insurance Code §4201.003 authorizes the Commissioner to adopt rules to implement Insurance Code Chapter 4201.

Insurance Code §36.001 provides that the Commissioner may adopt any rules necessary and appropriate to implement the powers and duties of TDI under the Insurance Code and other laws of this state.

*§19.1730. Definitions.*

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

(1) Adverse determination regarding a preauthorization exemption--A decision by an issuer that one or more claims retrospectively reviewed as part of an evaluation as defined in paragraph (4)(B) of this section, with respect to a particular health care service for which the physician or provider has a preauthorization exemption, did not meet the issuer's screening criteria, and leads to an issuer's decision to rescind a preauthorization exemption. An adverse determination regarding a preauthorization exemption is not an adverse determination as defined under §19.1703 of this title (relating to Definitions).

(2) Denial of preauthorization exemption--A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation, as defined in paragraph (4)(A) of this section, of eligible preauthorization requests and demonstrating that the physician or provider received approval for fewer than 90% of the eligible preauthorization requests made for a particular health care service during the most recent evaluation period.

(3) Eligible preauthorization request--A preauthorization request for a particular health care service is eligible for the purposes of an evaluation under paragraph (4)(A) of this section if it is submitted by the physician or provider and finalized by the health plan during the evaluation period, is not pending appeal, and has an outcome of either approving the particular health care service or issuing an adverse determination for the particular health care service. A preauthorization request that is modified with the acceptance of the physician or provider and approved by the plan as modified is an eligible preauthorization request for the purpose of conducting an evaluation under this section, with respect to the particular health care service that was approved. If a preauthorization request includes more than one particular health care service, the outcome for each service must be counted separately for the purposes of an evaluation.

(4) Evaluation--

(A) with respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, a review of the outcomes of eligible preauthorization requests submitted by the physician or provider during the most recent evaluation period to determine the percentage of requests that were approved, which is conducted for the purpose of evaluating whether to grant or deny a preauthorization exemption; or

(B) with respect to a particular health care service for which a physician or provider has a preauthorization exemption, a retrospective review of a random sample of payable claims submitted by or in connection with the physician or provider during the most recent evaluation period to determine the percentage of claims that would have been approved, based on meeting the issuer's applicable medical necessity criteria at the time the service was provided, which is conducted for the purpose of evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption.

(5) Evaluation period--The six-month period preceding an evaluation. The evaluation periods are as follows:

(A) for an initial determination of a preauthorization exemption grant or denial, the evaluation period is the six-month period that begins on January 1, 2022, or the subsequent six-month periods of July 1 - December 31 and January 1 - June 30 that follow each year;

(B) after a denial or rescission of a preauthorization exemption for a particular health care service, the subsequent six-month evaluation period begins on the first day following the end of the evaluation period that formed the basis of the denial or rescission; and

(C) for a notification of a preauthorization exemption rescission as provided in Insurance Code §4201.655(a), the evaluation period is the six-month period an issuer determines or the subsequent six-month periods that follow, but there may not be more than two months between an evaluation period ending and the provision of notice under §19.1732 of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions).

(6) Issuer--A health maintenance organization or insurer that is subject to Insurance Code Chapter 4201, Subchapter N, including a URA or a person who contracts with an issuer to issue a preauthorization determination, or performs the functions described in this division.

(7) Particular health care service--A health care service, including a prescription drug, that is subject to preauthorization as listed on the issuer's website under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans).

(8) Physician--Has the meaning assigned by Insurance Code §843.002, concerning Definitions.

(9) Preauthorization--Has the meaning assigned in Insurance Code §4201.651, concerning Definitions. "Preauthorization" under this division does not include concurrent utilization review.

(10) Preauthorization exemption--A privilege obtained under this division in which a physician or provider is not subject to a preauthorization requirement that otherwise applies with respect to a particular health care service. The preauthorization exemption applies both to care rendered by a treating physician or provider and to care ordered by a physician or provider who is acting in his or her capacity as a treating physician or provider.

(11) Provider--Has the meaning assigned by Insurance Code §843.002.

(12) Random sample--A collection of at least five but no more than 20 claims for a particular health care service, selected without method or conscious decision, for the purpose of evaluating a physician's or provider's continued eligibility for a preauthorization exemption.

(13) Rescission of preauthorization exemption--An adverse determination regarding a preauthorization exemption based on an evaluation, as defined in paragraph (4)(B) of this section and consistent with Insurance Code §4201.655(b), in which the issuer

would have fully approved fewer than 90% of claims for a particular health care service.

(14) Treating physician or provider--The physician or other provider who is primarily responsible for a patient's health and medical care. A "treating physician or provider" can include a rendering physician or provider or a referring or ordering physician or provider.

*§19.1731. Preauthorization Exemption.*

(a) For the purposes of this division, a physician or provider should be identified using the National Provider Identifier (NPI) under which a physician or provider makes preauthorization requests.

(b) With respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, an issuer must conduct an evaluation of all preauthorization requests submitted by the physician or provider during the most recent evaluation period that were finalized prior to the evaluation and may not include a request that is pending appeal at the time the data is analyzed. The evaluation must be based on no fewer than five eligible preauthorization requests.

(c) With respect to a particular health care service for which a physician or provider has a preauthorization exemption, an issuer may conduct an evaluation, as defined in §19.1730(4)(B) of this title (relating to Definitions), to determine whether to rescind a preauthorization exemption consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption. In order to determine whether to rescind an exemption, the issuer must conduct a retrospective review of a random sample of at least five and no more than 20 claims submitted during the most recent evaluation period.

(d) Other than care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, a treating physician or provider may not rely on another physician's or provider's preauthorization exemption. If a treating physician or provider does not have a preauthorization exemption and relies on another physician's or provider's preauthorization exemption in violation of this subsection, an issuer may consider the physician or provider who has qualified for the preauthorization exemption as failing to substantially perform the health care service under Insurance Code §4201.659, concerning Effect of Preauthorization Exemption, and may reduce or deny payment for that service on that basis. It is not a violation of this subsection for a provider, such as a nurse or physician's assistant, who practices under the supervision of a physician, to rely on the supervising physician's exemption, if the provider appropriately orders care and requests preauthorization under the supervising physician's NPI.

(e) For care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, the treating physician or provider must include the name and NPI of the ordering physician or provider on the claim in fields 17 and 17B of CMS Form 1500, in fields 76 - 79 or another appropriate field in Form UB-04, or in the corresponding fields for electronic claims using the ASC X12N 837 format. The issuer may provide coding guidance to physicians and providers to ensure that this information is appropriately captured on the claim. If this information is not included, the issuer may treat the claim as subject to an otherwise applicable preauthorization requirement.

*§19.1732. Notice of Preauthorization Exemption Grants, Denials, or Rescissions.*

(a) When granting a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.659(d), concerning Effect of Preauthorization Exemption. The notice must include a plain language explanation of the effect of the preauthorization exemption and any claim coding guidance needed to document the preauthorization exemption, consistent with §19.1731(e) of this title (relating to Preauthorization Exemption). The exemption begins on the date the notice is issued and must be in place for at least six months before it may be rescinded. If an issuer subsequently receives a preauthorization request from the physician or provider for a particular health care service for which an exemption has been granted, the issuer must provide a notice consistent with Insurance Code §4201.659(e).

(b) When denying a preauthorization exemption, an issuer must provide notice to the physician or provider that demonstrates that the physician or provider does not meet the criteria for a preauthorization exemption, consistent with Insurance Code §4201.655(c)(2), concerning Denial or Rescission of Preauthorization Exemption; a description of how to appeal the denial using the issuer's complaints and appeals processes; and information on how to file a complaint with the department.

(c) After completing an evaluation as defined under §19.1730(4)(A) of this title (relating to Definitions), an issuer must provide a notice granting or denying a preauthorization exemption within five days. For the initial evaluation period of January 1 through June 30, 2022, an issuer must provide notice granting or denying a preauthorization exemption no later than October 1, 2022. For subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption no later than two months following the day after the end of the evaluation period. Notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least five eligible preauthorization requests, as provided in §19.1731(b) of this title.

(d) When rescinding a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.655(a)(3). Notice of the rescission must be provided during the months specified in Insurance Code §4201.655(a)(1). The notice must include the following (a sample form LHL011 is available on TDI's website):

(1) an identification of the health care service for which a preauthorization exemption is being rescinded, the date the notice is issued, and the date the rescission is effective, consistent with Insurance Code §4201.654, concerning Duration of Preauthorization Exemption;

(2) a plain language explanation of how the physician or provider may appeal and seek an independent review of the determination, the date the notice is issued, and the company's address and contact information for returning the form by mail or electronic means to request an appeal;

(3) a statement of the total number of payable claims submitted by or in connection with the physician or provider during the most recent evaluation period that were eligible to be evaluated with respect to the health care service subject to rescission, the number of claims included in the random sample, and the sample information used to make the determination, including:

(A) identification of each claim included in the random sample;

(B) the issuer's determination of whether each claim met the issuer's screening criteria; and

(C) for any claim determined to not have met the issuer's screening criteria:

*(i)* the principal reasons for the determination that the claim did not meet the issuer's screening criteria, including, if applicable, a statement that the determination was based on a failure to submit specified medical records;

*(ii)* the clinical basis for the determination that the claim did not meet the issuer's screening criteria;

*(iii)* a description of the sources of the screening criteria that were used as guidelines in making the determination; and

*(iv)* the professional specialty of the physician, doctor, or other health care provider who made the determination;

(4) a space to be filled out by the physician or provider that includes:

(A) the name, address, contact information, and identification number of the physician or provider requesting an independent review;

(B) an indication of whether the physician or provider is requesting that the independent review organization review the same random sample or a different random sample of claims, if available; and

(C) the date the appeal is being requested; and

(5) an instruction for the physician or provider to return the form to the issuer before the date the rescission becomes effective and to include applicable medical records for any determination that was based on a failure to provide medical records.

(e) An issuer must allow physicians and providers to designate an email address or a mailing address for communications regarding preauthorization exemptions, denials, and rescissions. An issuer must provide an option for physicians and providers to submit a request for appeal by mail or by email or other electronic method. Issuers must include an explanation of how the physician or provider may update their preferred contact information and delivery method on all communications issued under this section and on the website required under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans).

*§19.1733. Retrospective Reviews and Appeals of Preauthorization Exemption Rescissions.*

(a) For a retrospective review that is conducted under Insurance Code §4201.659(b)(1), concerning Effect of Preauthorization Exemption, to determine whether the physician or provider still qualifies for an exemption, Insurance Code §4201.305, concerning Notice of Adverse Determination for Retrospective Utilization Review, does not apply.

(b) An issuer that is conducting an evaluation as defined in §19.1730(4)(B) of this title (relating to Definitions) to determine whether a physician or provider still qualifies for a preauthorization exemption may request medical records or other documents, consistent with §19.1707 of this title (relating to URA Contact with and Receipt of Information from Health Care Providers), and must provide at least 30 days for a physician or provider to provide the records. Medical records requested in connection with a retrospective review of a random sample of claims as authorized under Insurance Code §4201.659(b)(1) should be limited to no more than 20 claims for a particular health care service and may be requested only during an evaluation period or within 90 days following the end of an evaluation period. If the physician or provider fails to provide the records necessary for the issuer to make a determination, the issuer may determine that the claim would not have met the screening criteria.

(c) After receiving a notice of rescission, a physician or provider may request an independent review of the adverse determination regarding a preauthorization exemption at any time before the rescission becomes effective. The date of the request must be documented on the form, and the form must be sent electronically or postmarked before the date the rescission becomes effective.

(d) In order to request an independent review of a rescission of a preauthorization exemption, a physician or provider must submit the form provided by the issuer under §19.1732(c) of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions). If one or more determinations subject to review were based on a failure to provide specified medical records, the physician or provider must include the applicable records with the request for an independent review. Upon receipt, if the issuer seeks to proceed with the proposed rescission, the issuer must submit the request for independent review to the department, consistent with §12.601 of this title (relating to Preauthorization Exemptions), and §19.1717(c) of this title (relating to Independent Review of Adverse Determinations), and provide information to the IRO consistent with Insurance Code §4201.402.

(e) If the notice of rescission of preauthorization exemption identified that at least five additional claims were eligible for review but not included in the original random sample, the physician or provider may request review of another random sample of claims, as authorized under Insurance Code §4201.656(d). If this request is made, the issuer must, when submitting the request for independent review to the department, provide a listing of all payable claims for the same health care service submitted by or in connection with the physician or provider during the most recent evaluation period that were eligible to be evaluated but that were not included in the original random sample. The listing must be sufficiently detailed to allow the IRO to identify each payable claim to be used in an additional random sample, as provided by §12.601(e) of this title.

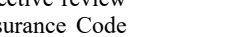
(f) An issuer must communicate the determination of a review by an independent review organization under §12.601 of this title to the physician or provider within five days.

(g) In order to retain a preauthorization exemption, a physician or provider must continue to maintain medical records adequate to demonstrate that health care services meet medical guidelines. In the absence of adequate records during an evaluation or appeal, an exemption may be rescinded.

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 August 12, 2022.

TRD-202203026
James Person
General Counsel
Texas Department of Insurance
Effective date: September 1, 2022
Proposal publication date: April 8, 2022
For further information, please call: (512) 676-6584



# PART 4. STATE OFFICE OF RISK MANAGEMENT

## CHAPTER 251. STATE EMPLOYEES - WORKERS' COMPENSATION

## SUBCHAPTER E. RISK ALLOCATION PROGRAM

### 28 TAC §251.503

The State Office of Risk Management (Office) adopts amended rules in Title 28, Part 4, Chapter 251, Subchapter E, Risk Allocation Program, §251.503, without changes to the proposed text as published in the May 27, 2022, issue of the *Texas Register* (47 TexReg 3104). The name referenced currently is the Risk Management for Texas State Agencies (RMTSA). The Office has renamed the guidelines to the Texas Enterprise Risk Management (TERM) Guidelines. The rules will not be republished.

Specifically, §§251.503 renames the guidelines to the Texas Enterprise Risk Management (TERM) Guidelines to ensure consistency with current policy and the proposed rules.

REASONED JUSTIFICATION: The Office adopts this name change to ensure consistency with current policy and the published rules. In addition, the Office adopts other changes for the purpose of simplification and administrative convenience.

SUMMARY OF COMMENTS AND RESPONSES: The public comment period on the proposal began May 27, 2022, and ended at 5:00 p.m. on June 27, 2022. No public comments were received.

STATUTORY AUTHORITY. The amendment is adopted under: Texas Labor Code §412.031 which requires the Office board to adopt rules as necessary to implement this chapter and Chapter 501; §412.041(c)(3) requiring the SORM director to prepare and recommend to the board plans and procedures necessary to implement the purposes and objectives of this chapter and Chapter 501, including rules and proposals for administrative procedures consistent with this chapter and Chapter 501; and under Texas Labor Code §412.0125(b)(3) which requires the Office to adopt, as part of return-to-work coordination services, rules that set standards and provide guidance to a state agency interacting with an injured employee.

CROSS REFERENCE TO STATUTES AFFECTED. Texas Labor Code §§412.031 and 412.0125(b)(3).

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 August 15, 2022.

TRD-202203032
Deea Western
Chief and General Counsel
State Office of Risk Management
Effective date: September 4, 2022
Proposal publication date: May 27, 2022
For further information, please call: (512) 936-1462

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## CHAPTER 252. STATE RISK MANAGEMENT
## SUBCHAPTER B. RISK MANAGEMENT

### 28 TAC §252.201

The State Office of Risk Management (Office) adopts amended rules in Title 28, Part 4, Chapter 252, Subchapter B, Risk Management, §252.201, without changes to the proposed text as published in the May 27, 2022, issue of the *Texas Register* (47 TexReg 3105). The rules will not be republished.

Specifically, §252.201 renames the guidelines to the Texas Enterprise Risk Management (TERM) Guidelines.

REASONED JUSTIFICATION: The Office adopts this name change to ensure consistency with current policy and the published rules. In addition, the Office adopts other changes for the purpose of simplification and administrative convenience.

SUMMARY OF COMMENTS AND RESPONSES: The public comment period on the proposal began May 27, 2022, and ended at 5:00 p.m. on June 27, 2022. No public comments were received.

STATUTORY AUTHORITY. The amendment is adopted under: Texas Labor Code §412.031 which requires the Office board to adopt rules as necessary to implement this chapter and Chapter 501; §412.041(c)(3) requiring the SORM director to prepare and recommend to the board plans and procedures necessary to implement the purposes and objectives of this chapter and Chapter 501, including rules and proposals for administrative procedures consistent with this chapter and Chapter 501; and under Texas Labor Code §412.0125(b)(3) which requires the Office to adopt, as part of return-to-work coordination services, rules that set standards and provide guidance to a state agency interacting with an injured employee.

CROSS REFERENCE TO STATUTES AFFECTED. Texas Labor Code §§412.031 and 412.0125(b)(3).

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 August 15, 2022.

TRD-202203033
Deea Western
Chief and General Counsel
State Office of Risk Management
Effective date: September 4, 2022
Proposal publication date: May 27, 2022
For further information, please call: (512) 936-1462

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# TITLE 43. TRANSPORTATION

## PART 10. TEXAS DEPARTMENT OF MOTOR VEHICLES

## CHAPTER 217. VEHICLE TITLES AND REGISTRATION
## SUBCHAPTER A. MOTOR VEHICLE TITLES

### 43 TAC §217.5

INTRODUCTION. The Texas Department of Motor Vehicles (department) adopts amendments to 43 Texas Administrative Code, Subchapter A, §217.5 concerning motor vehicle titles. These amendments are necessary to expand the definition of evidence of ownership to provide an alternative to filing lawsuits to satisfy evidence of ownership requirements under Transportation Code §501.033(b). The department adopts the amendments to §217.5 without changes to the proposed text as published in the Febru-

ary 25. 2022, issue of the *Texas Register* (47 TexReg 896). The rule will not be republished.

REASONED JUSTIFICATION. The amendments to §217.5 are necessary to remove unnecessary costs and burdens imposed by requiring a court order as evidence of ownership for identification number assignments and reassignments. The amendments provide for an alternative form of evidence of ownership for identification number assignments and reassignments in the form of a surety bond, while retaining the option of seeking a court order. The department's experience has shown that requiring court orders to serve as evidence of ownership is impractical and imposes significant costs on applicants, the court system, and the department. To pursue a court order, applicants must pay filing fees and the cost of service of process and may also incur costs associated with legal representation. The legal system is designed to handle genuine disputes as to ownership between parties, rather than issues as to lost ownership evidence. In most identification number assignment cases, there is no genuine dispute as to ownership; and pro se litigants, attorneys, and judges are uncertain as to who should be added as a party and how to structure a legitimate lawsuit declaring ownership.

The department has determined that a surety bond will eliminate these issues, while providing adequate evidence of ownership. An interested person damaged by the issuance of title on a motor vehicle will be protected under Transportation Code §501.053(c), which affords a right of action to recover on the bond. The department's proposed process will allow applicants with vehicles needing an identification number to have a surety bond serve as evidence of ownership which will allow for the assignment or reassignment of an identification number and the issuance of title.

SUMMARY OF COMMENTS.

The department received six written comments on the proposal from the Texas Association of Vehicle Theft Investigators, the Panhandle Auto Burglary and Theft Unit, the National Insurance Crime Bureau, the Lubbock County Tax Assessor-Collector, the Laredo Police Department Auto Theft Task Force, and the Tax Assessor-Collectors Association of Texas.

Comment:

A commenter expressed concern that law enforcement was not consulted during the development of the amendments because the amendments would have an impact on law enforcement personnel qualified to perform identification number inspections.

Agency Response:

The department did not consult law enforcement personnel prior to drafting the amendments because the amendments do not change how or when law enforcement personnel conduct identification number inspections. Instead, the changes deal with evidence of ownership presented to the department as part of an application for an identification number assignment or reassignment under Transportation Code §501.033(b). However, after seeing the concerns expressed by law enforcement personnel and tax assessor-collectors, the department reached out to each of the commenters to clarify the intent and purpose of the amendments and to address the concerns raised in their comments. These discussions were fruitful and helped to clear up misunderstandings regarding the purpose and implementation of the amendments.

No change has been made in response to this comment.

Comment:

The commenter also stated allowing a bond to serve as valid evidence of ownership would allow criminals to apply for an identification number and receive a title to a stolen vehicle without a judicial review of evidence of ownership.

Agency Response:

The department disagrees with this comment. Any application for an identification number assignment or reassignment requires an identification number inspection under Transportation Code §501.0321. If during an identification number inspection, a law enforcement inspector develops probable cause that a vehicle or part is stolen, or has had the serial number removed, altered, or obliterated, the law enforcement inspector may seize the vehicle or part and treat it as stolen property for purposes of custody and disposition of the vehicle under the authority of Transportation Code §501.158. The amendments do not remove the requirement to obtain an identification number inspection nor the authority of law enforcement to seize stolen vehicles.

Therefore, any applicant for an identification number assignment or reassignment will have already obtained an identification number inspection during which trained and qualified law enforcement inspectors determined the vehicle was not stolen. Only then will an applicant have the option of obtaining a bond or court order declaring that the applicant is the owner of the vehicle to serve as evidence of ownership for purposes of Transportation Code §501.033(b). The department believes that well-trained, experienced law enforcement inspectors will continue to detect and seize stolen vehicles they inspect, so the department may be confident that applicants for identification number assignment or reassignment do not possess stolen vehicles.

The amendments do not eliminate the option of obtaining a court order declaring that the applicant seeking an identification number assignment or reassignment for a vehicle is the owner of the vehicle in question, but only creates a streamlined alternative in the form of a surety bond that will serve to protect any party damaged by the assignment or reassignment of an identification number and issuance of a title.

No change has been made in response to this comment.

Comment

A commenter expressed support for the amendments and stated that "it seems surety bonds will help streamline the process for our customers."

Agency Response:

The department appreciates the support and agrees with the commenter that allowing surety bonds as evidence of ownership for the purposes of Transportation Code §501.033(b) will streamline the process for customers.

Comment:

The commenter stated that the proposal to eliminate inspections in order to streamline the process of getting a number assigned while keeping courts out of the process will lead to stolen property being assigned an identifying number.

Agency Response:

The department disagrees with the comment that keeping courts out of the process will lead to stolen property being assigned an identifying number. The department believes that well-trained,

experienced law enforcement inspectors will continue to detect and seize stolen vehicles they inspect, so the department may be confident that applicants for identification number assignment or reassignment do not possess stolen vehicles.

Courts are not in a strong position to assess whether a vehicle may be stolen based on the pleadings in court cases related to identification number assignments or reassignments.

Unlike proceedings under Chapter 47 of the Code of Criminal Procedure, where law enforcement officers are necessary parties, lawsuits brought to establish ownership of a vehicle to obtain an identification number assignment or reassignment most often do not involve testimony by law enforcement officers or parties disputing ownership. It is often unclear who should be named as a party in these cases as most of these cases do not involve disputes over ownership, but rather deal with lost ownership evidence. The Transportation Code, other statutes, and case law, provide little or no guidance or standards for courts to determine who is the owner of a vehicle in the absence of a title or vehicle identification number. Evidence presented is generally limited to a bill of sale, a completed identification number inspection, and testimony by the applicant.

The legislature provided the option of obtaining a title by filing a bond in Transportation Code §501.053 to address situations in which an applicant for title is not able to produce evidence of ownership in the form of a title. The surety bond purchased under §501.053 is intended to provide a recovery for any person damaged because of the issuance of a title to a vehicle or for a defect in or undisclosed security interest on the right, title, or interest of the applicant to the vehicle.

Transportation Code §501.074 only addresses court orders, which require the department to issue a new title for a motor vehicle registered in this state when ownership is transferred by operation of law or other involuntary divestiture of ownership. This section is intended mainly to cover transfers of title through operation of law by death, divorce decrees, judicial sales, non-judicial foreclosures, and foreclosures of constitutional or statutory liens. Section 501.074 does not squarely address situations where there is no dispute as to a sale and ownership of a motor vehicle and offers no standards for a court to use in evaluating cases in the absence of evidence of ownership in the form of a title.

No change has been made in response to this comment.

Comment:

The commenter requested that language be inserted into new proposed subsection (a)(3) allowing an applicant for assignment or reassignment of an identification number under Transportation Code §501.033 to use a tax assessor-collector hearing order under Transportation Code §501.052 as evidence of ownership for the purposes of §501.033(b).

Agency Response:

The Transportation Code does not authorize tax assessor-collector hearings under §501.052 for denials of applications for identification number assignments or reassignments. Transportation Code §501.052(a) authorizes persons aggrieved by a refusal, rescission, or cancellation, of a title under §501.051 to apply for a tax assessor-collector hearing. Section 501.051 applies to department action related to titles, and does not apply to actions related to applications for identification number assignments and reassignments under Transportation Code §501.033. If a tax assessor-collector hearing identifies that an applicant meets requirements under Transportation Code, Chapter 501, then a hearing would be acceptable for an applicant to obtain an identification number assignment or reassignment using the ownership evidence the applicant provided. The department will not be incorporating the proposed language allowing a tax assessor-collector hearing as evidence of ownership for an identification number assignment or reassignment under Transportation Code §501.033.

No change has been made in response to this comment.

Comment:

The commenter recommends that the department delay adoption of the amendments to consult with law enforcement, the National Insurance Crime Bureau (NICB), and tax assessor-collectors to allow law enforcement teams to determine what impact these amendments have on operations.

Agency Response:

The department will not delay the adoption of the amendments as all commenters have been contacted since the publication of the proposed amendments and positive discussions were had regarding the amendments. The department is also responding in detail to all written comments received.

No change has been made in response to this comment.

Comment:

The commenter disagrees with the impact assessment and states that the amendments, as posted, will result in using governmental processes to convert stolen property "into their own property." The commenter opines this will create liability for the state and local agencies conducting identification number inspections.

Agency Response:

The department disagrees that the amendments will create any liability for government actors. Law enforcement inspectors and the department are protected by the doctrine of sovereign immunity when acting under lawfully promulgated statutes and rules. The department does not agree that the amendments as posted will be used to convert stolen property into personal property as the department is confident that well-trained law enforcement inspectors will continue to detect stolen vehicles during the inspection process.

Comment:

The commenter expresses concern that the amendments remove qualified courts from making determinations of evidence of ownership. The commenter stated that judicial review allows for a controlled setting where all evidence of ownership can be presented.

Agency Response:

The department disagrees with this comment. As described in detail in responses above, courts are not in a good position to determine ownership of a vehicle where there is no active dispute of ownership between two parties. Further, the amendments do not eliminate the option of obtaining a court order to serve as evidence of ownership for the purpose of an identification number assignment or reassignment.

Comment:

The commenter states that proposed amendments to §217.5 would allow applicants to file a bond without any other evidence in order to prove ownership, where no title exists.

Agency Response:

The department disagrees with this comment. Applicants must complete an identification number inspection before they may apply for an identification number assignment or reassignment and bond to serve as evidence of ownership. Additionally, in drafting Transportation Code §501.053, the legislature understood that applicants applying for a bonded title will not have evidence of ownership in the form of a title, and the surety bond backing the title will provide a means of recovery for any person damaged by the issuance of the title.

STATUTORY AUTHORITY. The department adopts amendments to §217.5 under Transportation Code §501.0041 and §1002.001.

--Transportation Code §501.0041 authorizes the department to adopt rules to administer Chapter 501.

--Transportation Code §1002.001 authorizes the board to adopt rules that are necessary and appropriate to implement the powers and the duties of the department.

CROSS REFERENCE TO STATUTE. Transportation Code §501.033 and §501.053.

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 August 11, 2022.

TRD-202203000
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General Counsel
Texas Department of Motor Vehicles
Effective date: August 31, 2022
Proposal publication date: February 25, 2022
For further information, please call: (512) 465-4160

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**43 TAC §217.9**

INTRODUCTION. The Texas Department of Motor Vehicles (department) adopts amendments to 43 TAC §217.9 concerning Bonded Titles. The department adopts §217.9 with changes to the proposed text as published in the February 25, 2022, issue of the *Texas Register* (47 TexReg 900). The amendments to §217.9 are necessary to clarify portions of §217.9, remove duplicative information, and provide a lower-cost alternative to an appraisal for owners of trailers and semitrailers. The rule will be republished.

In response to comments, the department adopts nonsubstantive changes to renumbered §217.9(e)(6) to clarify the text regarding a weight certificate.

REASONED JUSTIFICATION.

The department adopts substantive and nonsubstantive changes to §217.9. The substantive changes to §217.9(c) clarify that the standard presumptive value (SPV) under existing Tax Code §152.0412 is the department's existing resource to determine the value of a motor vehicle. Amendments to §217.9(c) also provide an additional option for a person to determine the value of a motor vehicle that is 25 years old or older for purposes of applying for a bond. Amendments to §217.9(c) are necessary to ensure a person may use a valuation method that accurately reflects the value of their motor vehicle in its current condition. The option to use an appraisal instead of a national reference guide is at the person's discretion at the time of application for bond.

Amendments to §217.9(c)(4) provide a standard value for certain trailers whose value cannot be determined by SPV or a national reference guide. These amendments are necessary to provide a person with an alternative to determining the value of trailers and semitrailers from an appraisal by establishing a uniform value for trailers under 20 feet in length and another value for trailers 20 feet in length or greater. Subsection (e) is amended to clarify the language, including the language in renumbered subsection (e)(6), that says a weight certificate is required only if the department is unable to determine the weight using standard department resources. Nonsubstantive amendments to subsection (e)(1) delete existing duplicative requirements found in renumbered subsection (e)(5).

SUMMARY OF COMMENTS.

The department received six written comments on the proposal from the Texas Association of Vehicle Theft Investigators, the Panhandle Auto Burglary and Theft Unit, the National Insurance Crime Bureau, the Lubbock County Tax Assessor-Collector, the Laredo Police Department Auto Theft Task Force, and the Tax Assessor-Collector's Association of Texas.

Comment:

A commenter expressed concern that law enforcement was not consulted during the development of the amendments because the amendments would have an impact on law enforcement personnel qualified to perform identification number inspections.

Agency Response:

The department did not consult law enforcement personnel prior to drafting the proposed amendments because the amendments do not change how or when law enforcement personnel conduct identification number inspections. Instead, the changes deal with evidence of ownership presented to the department as part of an application for an identification number assignment or reassignment under Transportation Code §501.033(b). However, after seeing the concerns expressed by law enforcement personnel and tax assessor-collectors, the department reached out to each of the commenters to clarify the intent and purpose of the proposed amendments and to address the concerns raised in their comments. These discussions were fruitful and helped to clear up misunderstandings regarding the purpose and implementation of the proposed amendments.

No change has been made in response to this comment.

Comment:

Two commenters opposed deleting the requirement to produce a weight certificate and another commenter asked whether a weight certificate would still be required.

Agency Response:

The department appreciates the comments and will not delete renumbered subsection (e)(6) in its entirety as originally proposed. The department changed the language to make it clear that a weight certificate will be required only if the weight of the vehicle cannot be determined by the department through stan-

dard department resources. Most motor vehicles have a standard weight associated with them that the department can determine through various national reference guides if a weight is not already established on the department's motor vehicle record. However, in the case of trailers, trucks with added modifications, and some commercial vehicles, the department will not be able to determine the weight using a national reference guide. In these cases, the department will require a weight certificate.

The changes to the rule will eliminate the cost and expense of obtaining a weight certificate for customers with standard vehicles whose weights can easily be determined, while making certain that owners of trailers weighing over 4,000 pounds register and title their trailers as required.

The rule text has been changed in response to the comments as described above.

Comment:

The commenter states that the proposed new language in subsection (c), will not be sufficient for victims to recover damages through an action against a bond. Subsection (c) allows a bond amount to be based on the length of the trailers and semitrailers, as an alternative to an appraisal.

Agency Response:

The department disagrees with this comment. Proposed new subsection (c)(4) is intended to address assembled trailers under Chapter 217, Subchapter L. The value of most motor vehicles, including manufactured trailers, will be determined by the department's SPV resources or national reference guides, without issue, even if a motor vehicle lacks an identification number. This would not be the case for assembled trailers that would otherwise need an appraisal. Subsection (c)(4) eliminates the cost and expense of seeking an appraisal when a customer is pursuing a bonded title. The owner of a high value trailer or semitrailer, such as a dump trailer, livestock trailer, or custom barbecue pit trailer, who is applying for a bonded title continues to retain the option of using an appraisal to determine the value of the vehicle in place of the standard amounts in subsection (c)(4).

No change has been made in response to this comment.

Comment:

The commenter is not in favor of the proposed deletion of language stating that SPV can be determined using the department's internet website, and prefers that this language be retained.

Agency Response:

The deletion of language regarding the determination of SPV through the department's internet website and substitution of the language "under Tax Code §152.0412," does not eliminate the authority to determine SPV using the department's internet website, and instead includes SPV resources available on desktop applications currently utilized by the department.

No change has been made in response to this comment.

Comment:

The commenter recommends that the department delay adoption of the amendments to consult with law enforcement, the National Insurance Crime Bureau (NICB), and tax assessor-collectors to allow law enforcement teams to determine what impact these amendments have on operations.

Agency Response:

The department will not delay the adoption of the amendments as all commenters have been contacted since the publication of the proposed amendments, and positive discussions were had regarding the amendments. The department is also responding in detail to all written comments received.

No change has been made in response to this comment.

Comment:

The commenter disagrees with the impact assessment and states that the amendments, as posted, will result in using governmental processes to convert stolen property "into their own property." The commenter opines this will create liability for the state and local agencies conducting identification number inspections.

Agency Response:

The department disagrees with the comment that the amendments will create any liability for government actors. As government actors, law enforcement inspectors and department staff are protected by the doctrine of sovereign immunity when acting under lawfully promulgated statutes and rules such as Transportation Code §501.053 and §217.9. The department does not agree that the amendments will be used to convert stolen property into personal property as the department is confident that well-trained law enforcement inspectors will continue to detect stolen vehicles during the inspection process. No change has been made in response to this comment.

Comment:

The commenter also states that the proposed amendments to §217.9 would allow persons to use an appraisal to determine the value for vehicles 25 years or older, and for trailer or semitrailers, use set values in lieu of appraisals. The commenter proposes that the department not adopt the proposed amendment until the department can engage in substantive consultation with Texas law enforcement, NICB, property-casualty insurers, and Texas tax assessor-collectors.

Agency Response:

The department agrees that the proposed amendments would allow persons to use an appraisal in lieu of using a national reference guide for a vehicle 25 years or older, which will result in a more accurate evaluation of a vehicle's value, particularly when a vehicle is not in pristine or even operable condition and not worth the value identified by the national reference guide. The department also agrees the amendments provide for the use of predetermined values for trailers or semitrailers, based on the length of the trailer, but only in situations where the value of the trailer or semitrailer may not be determined using SPV or national reference guides. In those situations, a person is still allowed to use an appraisal if they believed an appraisal would provide a more accurate determination of the value of the trailer.

No change has been made in response to this comment.

Comment:

The commenter states that the proposed amendments strike the requirement "to present the inspection to be submitted as part of the bonded title process."

Agency Response:

The department proposes to delete subsection (e)(1), which requires verification of the vehicle identification number on a form specified by the department and replaces the verification

requirement with language in subsection (d) which states, "the vehicle identification number must be verified by an inspection under Transportation Code §501.0321." Transportation Code §501.0321 describes all the requirements of an identification number inspection, including the requirement that the department prescribe a form on which the inspection is to be recorded. The rule still requires proof of a completed identification number inspection as part of the bonded title process, as indicated in subsection (e)(5), and the deleted language is being eliminated as duplicative.

No change has been made in response to this comment.

STATUTORY AUTHORITY. The department adopts amendments to §217.9 under Transportation Code §501.0041 and §1002.001

Transportation Code §501.0041 authorizes the department to adopt rules to administer Chapter 501.

Transportation Code §1002.001 authorizes the board to adopt rules that are necessary and appropriate to implement the powers and the duties of the department.

CROSS REFERENCE TO STATUTE. Transportation Code §501.053.

*§217.9. Bonded Titles.*

(a) Who may file. A person who has an interest in a motor vehicle to which the department has refused to issue a title or has suspended or revoked a title may request issuance of a title from the department on a prescribed form if the vehicle is in the possession of the applicant; and

(1) there is a record that indicates a lien that is less than ten years old and the surety bonding company ensures lien satisfaction or release of lien;

(2) there is a record that indicates there is not a lien or the lien is ten or more years old; or

(3) the department has no previous motor vehicle record.

(b) Administrative fee. The applicant must pay the department a $15 administrative fee in addition to any other required fees.

(c) Value. The amount of the bond must be equal to one and one-half times the value of the vehicle as determined under Tax Code §152.0412 regarding Standard Presumptive Value (SPV). If the SPV is not available, then a national reference guide will be used. If the value cannot be determined by the department through either source, then the person may obtain an appraisal. If a motor vehicle is 25 years or older, a person may obtain an appraisal to determine the value instead of using a national reference guide.

(1) The appraisal must be on a form specified by the department from a Texas licensed motor vehicle dealer for the categories of motor vehicles that the dealer is licensed to sell or a Texas licensed insurance adjuster who may appraise any type of motor vehicle.

(2) The appraisal must be dated and be submitted to the department within 30 days of the appraisal.

(3) If the motor vehicle is 25 years or older and the appraised value of the vehicle is less than $4,000, the bond amount will be established from a value of $4,000.

(4) If the motor vehicle is a trailer or semitrailer, the person may, as an alternative to an appraisal, have the bond amount established from a value of:

(A) $4,000, if under 20 feet in length, or

(B) $7,000, if 20 or more feet in length.

(d) Vehicle identification number inspection. If the department has no motor vehicle record for the vehicle, the vehicle identification number must be verified by an inspection under Transportation Code §501.0321.

(e) Required documentation. An applicant may apply for a bonded title if the applicant submits:

(1) any evidence of ownership;

(2) the original bond within 30 days of issuance;

(3) the notice of determination within one year of issuance and the receipt for $15 paid to the department;

(4) the documentation determining the value of the vehicle;

(5) proof of the vehicle identification number inspection, as described in subsection (d) of this section, if the department has no motor vehicle record for the vehicle;

(6) a weight certificate if the weight cannot otherwise be determined;

(7) a certification of lien satisfaction by the surety bonding company, or a release of lien, if the notice of determination letter states that there may be a lien less than ten years old; and

(8) any other required documentation and fees.

(f) Report of Judgment. The bond must require that the surety report payment of any judgment to the department within 30 days.

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 August 11, 2022.

TRD-202202999
Elizabeth Brown Fore
General Counsel
Texas Department of Motor Vehicles
Effective date: August 31, 2022
Proposal publication date: February 25, 2022
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