Garza/Gonzalez & Associates, LLC
CERTIFIED PUBLIC ACCOUNTANTS

TEXAS MEDICAL BOARD

Austin, Texas

INTERNAL AUDIT ANNUAL REPORT

Fiscal Year 2025

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TEXAS MEDICAL BOARD
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Internal Audit Annual Report
Fiscal Year 2025

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Garza/Gonzalez & Associates, LLC
CERTIFIED PUBLIC ACCOUNTANTS

Board Members and
Executive Committee Members
Texas Medical Board
Austin, Texas

We performed procedures to assess the effectiveness and efficiency of the Texas Medical Board's (TMB) internal control structure of the Compliance Monitoring Area (the Area) and its compliance with the applicable chapters of the Texas Occupations Code, relevant rules of the Texas Administrative Code, and the Area's policies and procedures, for the nine months ended May 31, 2025.

Our audit procedures determined that TMB's internal control structure over the Area was adequate, and no material instances of noncompliance were noted. However, we did identify certain matters, detailed in this report, that present opportunities to strengthen internal controls and enhance compliance with TMB's policies and procedures. Based on their degree of risk or effect in relation to the audit objective, these matters were rated as Priority, High, Medium, or Low, as described in the "Summary and Related Rating of Observations/Findings and Recommendations" section of this report.

We also conducted follow-up procedures on a finding and recommendation from a prior internal audit report that was not fully implemented. This report reflects the results and implementation status of our follow-up procedures, and includes all information required for compliance with State of Texas Internal Audit Annual Report requirements.

We have discussed the audit comments and recommendations for the Area, as well as the follow-up results, with various TMB personnel. We are available to provide additional information if needed.

This report was prepared by Garza/Gonzalez & Associates, LLC, an independent Certified Public Accounting firm, following Generally Accepted Government Auditing Standards, International Standards for the Professional Practice of Internal Auditing, and the Institute of Internal Auditors' Code of Ethics contained in the Professional Practices Framework.

Garza/Gonzalez
& Associates, LLC

July 25, 2025

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INTRODUCTION

The Texas Medical Board (TMB) is an agency statutorily empowered to regulate the practice of medicine in Texas to protect the public's safety and welfare. TMB carries out this duty primarily through the licensure and discipline of physicians and other allied health care providers as mandated by law.

"Texas Medical Board" is both the official name of the agency and the name of its governing board (Board). The Board consists of 19 members, as follows:

- 9 physicians with a degree of doctor of medicine (M.D.), who have been licensed to practice medicine in Texas for at least 3 years.
- 3 physicians with a degree of doctor of osteopathic medicine (D.O.), who have been licensed to practice medicine in Texas for at least 3 years.
- 7 members who represent the public.

Board members serve staggered 6-year terms and are appointed by the Texas Governor with the advice and consent of the Texas Senate. Many of the Board's duties are carried out in the Board's 4 standing committees: Executive, Finance, Disciplinary Process Review, and Licensure. Recommendations made in the standing committees are then accepted, modified, or rejected by the full board. The Board also provides oversight and support for the following 4 other boards and 2 advisory committees:

- Texas Physician Assistant Board
- Texas State Board of Acupuncture Examiners
- Texas Board of Medical Radiologic Technology
- Texas Board of Respiratory Care
- Medical Physicists Licensure Advisory Committee
- Perfusionist Licensure Advisory Committee

2025 Internal Audit Plan

Following are the internal audit functions performed, as identified in TMB's 2025 Internal Audit Plan (Plan), dated February 7, 2025, and approved by the Board on March 21, 2025:

- Risk Assessment & Preparation of the 2025 Internal Audit Plan
- Compliance Monitoring Audit
- Follow-up of the Prior Year Internal Audit
- Preparation of the 2025 Internal Audit Annual Report
- Other Tasks

This report contains the results of the Compliance Monitoring Audit, reflects the results of the follow-up procedures performed this year on a finding from a prior year internal audit report, and complies with the State of Texas Internal Audit Annual Report requirements.

I. Compliance with Texas Government Code 2102.015: Required Posting of Internal Audit Information

To comply with the provisions of Texas Government Code, Section 2102.015 and the State Auditor's Office guidelines, within 30 days of approval by the Board, TMB will post the following information on its website:

- An approved fiscal year 2026 audit plan, as provided by Texas Government Code, Section 2102.008.
- A fiscal year 2025 internal audit annual report, as required by Texas Government Code, Section 2102.009.

The internal audit annual report includes any identified weaknesses, deficiencies, wrongdoings, or other concerns raised by internal audits and other functions performed by the internal auditor, as well as a summary of the actions taken by TMB to address such concerns.

II. Consulting and Nonaudit Services Completed

The internal auditor did not perform any consulting services, as defined in the Institute of Internal Audit Auditors' *International Standards for the Professional Practice of Internal Auditing* or any non-audit services, as defined in the *Government Auditing Standards,* 2018 Revision, Technical Update April 2021, Sections 3.64-3.106.

III. External Quality Assurance Review

The internal audit department's most recent *Peer Review Report*, dated January 20, 2025, indicates that its system of quality control has been suitably designed and conforms to applicable professional standards in all material respects.

IV. Internal Audit Plan for Fiscal Year 2025

The approved Internal Audit Plan (Plan) included one audit to be performed during fiscal year 2025. The Plan also included a follow-up on a prior year internal audit recommendation that had not been fully implemented as of fiscal year 2024, other tasks as assigned by the Executive Committee or the Board, and preparation of the 2025 Internal Audit Annual Report.

Note: The Texas Physician Health Program (TPHP) is subject to a periodic internal audit every third year. Although the audit was scheduled for fiscal year 2025, the Board directed that it be postponed to fiscal year 2026.

Risk Assessment

Utilizing information obtained through the completed questionnaires received and background information reviewed, 11 potential audit topics[1] were identified. A risk analysis utilizing 8 risk factors was completed for each individual audit topic and then compiled to develop an overall risk assessment.

[1] Excludes the TPHP, as it requires a periodic audit every third year.

Following are the results of the risk assessment performed for the 11 potential audit topics identified:

HIGH RISK	MODERATE RISK	LOW RISK
Litigation & ISC Compliance Monitoring	Information Technology Revenue (includes Cash Receipts Processing) Complaint Intake & Investigation	Accounting (includes disbursements& asset management) Records Management Registration Human Resources & Payroll (includes Travel) Procurement/Contract Management/HUB Licensure

In the prior 3 years, the following audits and functions were performed by the internal auditor:

Fiscal Year 2024:

- Risk Assessment & Preparation of the Internal Audit Plan
- Licensure Audit
- Follow-Up of the Prior Year Internal Audits
- Preparation of the Internal Audit Annual Report

Fiscal Year 2023 (performed by the predecessor internal auditor):

- Risk Assessment & Preparation of the Internal Audit Plan
- Enforcement Audit
- Follow-Up of the Prior Year Internal Audits
- Preparation of the Internal Audit Annual Report

Fiscal Year 2022 (performed by the predecessor internal auditor):

- Risk Assessment & Preparation of the Internal Audit Plan
- Texas Physician Health Program Audit
- Follow-Up of the Prior Year Internal Audits
- Preparation of the Internal Audit Annual Report

The internal audit and other tasks performed for fiscal year 2025 were as follows:

Report No.	Audits/Report Titles	Report Date
1.	Compliance Monitoring *Objective:* To assess whether TMB's policies, procedures, and internal controls over the Compliance Monitoring Area are adequately designed and operating effectively to ensure the proper monitoring of licensees' compliance with board orders and remedial plans.	7/25/2025
1.	Internal Audit Annual Report – Follow-up on a finding and recommendation that was presented in the Prior Year Internal Audit Report. *Includes all reported audit results for Fiscal Year 2025.*	7/25/2025
-	Other Tasks Assigned by the Executive Committee or the Board	None

V. Executive Summary

Compliance Monitoring

Background

The Compliance Department (Department) is responsible for monitoring licensees (formerly probationers) who are under a board order or remedial plan (collectively referred to as an order) to ensure compliance, in accordance with Texas Occupations Code (TOC) Chapter 164 and Texas Administrative Code (TAC) Chapter 181.

Board orders are generally disciplinary unless specifically designated as non-disciplinary. Remedial plans are non-disciplinary settlement agreements issued by the Board.

Organizational Structure

The Department is managed by the Director of Compliance (DOC), who reports to the Deputy Executive Director of Operations.

Key Roles

- **Supervisor of Compliance (SOC)**: Supervises Compliance Officers (COs) and conducts compliance monitoring.
- **Compliance Specialist**: Monitors compliance with drug and alcohol testing requirements.
- **Operations Officer**: Primarily conducts compliance monitoring for out-of-state and tolled licensees.
- **Compliance Officers (COs)**: Located throughout Texas, responsible for compliance monitoring activities.

Assignment of Orders

When an order takes effect, the Enforcement Support team notifies the DOC via email. The DOC assigns the order to a CO, who monitors the licensee's compliance with all terms of the order. If the licensee is already under monitoring for another order, the new order is assigned to the same CO.

Orders requiring in-person contact are typically assigned based on the CO's location; all other orders are assigned based on CO caseload. After assignment, a transmittal letter is sent to the licensee, notifying them of the CO assignment and requesting completion of the Licensee Information and Email Requirements forms.

Between September 1, 2024, and May 31, 2025, 306 orders were assigned to COs.

Compliance Monitoring

COs maintain periodic contact with their assigned licensees using the method (e.g., in-person, video, phone, email) and frequency (e.g., initial, quarterly, semi-annually) specified in the Department's Contact Standards. These standards vary based on the specific compliance requirements of each order.

Common compliance requirements, with specific deadlines, include:

- Completion of approved continuing education in specified hours and subject areas.
- Passing the Jurisprudence Examination within three attempts.
- Payment of assessed penalties or fees.
- Enrollment in drug and alcohol testing programs.

Initial contact with the licensee must occur within 30 days of the CO receiving the order. Following each contact, the CO prepares a Compliance Report (CR) summarizing the licensee's compliance status, using a template tailored to the order type. The licensee reviews and initials each outstanding or ongoing requirement, then signs the CR to confirm agreement.

The CR, signed by both parties, is reviewed by the SOC before being filed in the licensee's order file. Standardized CRs help the Department track progress efficiently and identify potential compliance issues.

As of May 31, 2025, approximately 380 orders were actively monitored.

Noncompliance

When noncompliance is identified, the CO immediately addresses or escalates the matter. Serious violations trigger automatic noncompliance processing ("FO4").

For other violations, the CO issues a compliance deficiency notice or warning letter, allowing the licensee 24 hours to respond. For minor violations, such as late submissions, the CO may request an FO4 waiver. FO4 waivers for requirements up to 90 days late are approved by the DOC; all other FO4 waivers require approval from the Executive Director.

If a waiver is not granted or available, the CO prepares an FO4 packet, which is reviewed and approved by the DOC before submission to the Quality Assurance (QA) Panel. An Informal Settlement Conference (ISC) then determines recommendations for Board action.

Order Termination or Modification

Orders may be terminated or modified in the following ways:

- **License Cancellation:** Terminated when the individual is no longer licensed (e.g., due to death, cancellation, non-payment, retirement, or by order). The CO verifies that the individual is not practicing medicine.

- **Automatic Termination**: Many orders automatically terminate once all terms are fulfilled. The CO confirms completion of requirements, prepares the Final CR and termination letter, and notifies the DOC for approval.

- **Modification or Termination Request**: Eligible licensees in full compliance may request modification or termination at the time specified in the disciplinary order. Remedial plans cannot be modified; they terminate automatically upon completion. The CO verifies eligibility, prepares a documentation packet, and obtains DOC or SOC approval before submission to the QA Panel for ISC review and Board recommendation.

Oversight

The SOC oversees licensee compliance and CO performance at the Department level. A Case Log spreadsheet tracks past-due CRs and other key data, such as virtual meeting approvals. The Case Log is periodically reconciled with the Compliance information in SQL Tracer (TMB's license management system) to ensure accuracy and completeness.

Audit Objective, Scope, and Methodology

Objective

The objective of this audit was to assess whether TMB's policies, procedures, and internal controls over the Compliance Monitoring Area are adequately designed and operating effectively to ensure the proper monitoring of licensees' compliance with board orders and remedial plans.

Scope

The audit scope included selected Department activities and functions during the 9-month period from September 1, 2024 to May 31, 2025 (audit period).

Methodology

The audit included reviewing applicable laws and regulations, the Area's policies and procedures, and other relevant documentation. Remote interviews and walkthroughs were also conducted with TMB staff to gain an understanding of the Department's current operations and control activities.

We performed procedures to achieve the audit objective, including the following:

1. Reviewed TOC Chapter 164, *Disciplinary Actions and Procedures*, and TAC Chapter 181, *Compliance Program*.
2. Reviewed the Department's written procedures and supplemental documents such as logs and templates, and conducted remote interviews and walkthroughs, to assess internal controls, processes, and current practices.
3. Selected a sample of 20 orders from the audit period and tested for:
    - **Compliance with TAC Chapter 181**
        a. Adherence to TAC §181.3 (Compliance Process).
        b. Documentation of verification under TAC §181.7 (Automatic Termination).
        c. Documentation supporting eligibility under TAC §181.6 (Modification and Termination).
    - **Compliance with Department procedures and CR Templates**
        a. Required documents obtained from the licensee or documentation of the CO's attempts to obtain:
            - Signed Order/Plan Acknowledgement Form.
            - Completed Licensee Information and Email Requirements forms.
            - Signed Continuing Medical Education (CME) Protocol.
        b. Contact frequency and method met Department Contact Standards; exceptions documented.
        c. CR Completion and Signatures:
            - Initial and periodic CRs: Signed by CO, licensee, and SOC/ DOC.
            - Final CR: Signed by CO and DOC.

d. Current version of CR template used and maintained in file until order termination.

e. CME requests processed within 15 business days.

f. Timely completion of initial (2-day) and 31-day compliance verification for Suspension, Surrender, and Revocation (SSR) orders.

g. Timely processing of Modification and Termination requests.

h. FO4 waiver requests properly documented and approved by the correct authority.

i. Effective termination dates accurately recorded.

j. Automatic termination documentation initiated by CO and approved by DOC.

k. Consistent adherence to document naming conventions by COs.

l. Updates reflected in TMB's online healthcare provider profile.

4. Obtained user account lists for SharePoint, SQL Tracer, and Laserfiche Compliance modules, and verified users were current TMB employees and only assigned to appropriate user groups/roles.

VI. Observations/Findings and Recommendations

SUMMARY AND RELATED RATING OF
OBSERVATIONS/FINDINGS AND RECOMMENDATIONS

As TMB's internal auditors, we exercised our professional judgment in rating the audit findings identified in this report. The rating system used was developed by the Texas State Auditor's Office and is based on the degree of risk or impact of the findings in relation to the audit objective(s). The table below presents a summary of the observations/findings in this report and their corresponding ratings.

Summary of Observations/Findings & Recommendations and Related Ratings		
Finding No.	**Title**	**Rating**
1.	Patient Charts Submission Method	Priority
2.	Inconsistent Adherence to Compliance Monitoring Procedures	Medium
3.	Policies Requiring Update	Low
Observation No.		
1.	Compliance Program Reporting	--

Description of Rating

A finding is rated *Priority* if the issues identified present risks or effects that if not addressed could critically affect the audited entity's ability to effectively administer the programs(s)/function(s) audited. Immediate action is required to address the noted concern(s) and reduce risks to the audited entity.

A finding is rated *High* if the issues identified present risks or effects that if not addressed could substantially affect the audited entity's ability to effectively administer the programs(s)/function(s) audited. Prompt action is essential to address the noted concern(s) and reduce risks to the audited entity.

A finding is rated *Medium* if the issues identified present risks or effects that if not addressed could moderately affect the audited entity's ability to effectively administer programs(s)/function(s) audited. Action is needed to address the noted concern(s) and reduce risks to a more desirable level.

A finding is rated *Low* if the audit identified strengths that support the audited entity's ability to administer the programs(s)/function(s) audited or the issues identified do not present significant risks or effects that would negatively affect the audited entity's ability to effectively administer the programs(s)/function(s) audited.

OBSERVATIONS/FINDINGS AND RECOMMENDATIONS

Report No.	Report Date	Name of Report	Observations/ Findings and Recommendations
1	7/25/25	Compliance Monitoring	**1. Patient Charts Submission Method** As part of its oversight responsibilities, the Department requires certain licensees to submit patient charts for monitoring reviews. While the HIPAA permits disclosures of protected health information (PHI) for health oversight activities, TMB is required to implement reasonable safeguards to protect electronic PHI (ePHI) transmitted over electronic communication networks. The Department's current process allows licensees to email patient charts without specifying technical security requirements for transmission. As a result, some licensees submit patient charts using personal or free email services (e.g., Gmail, Yahoo) that may not provide end-to-end encryption or HIPAA-compliant server storage. This practice increases the risk of unauthorized access to ePHI. **Recommendation** We recommend that TMB explore options and implement a secure method for licensees to submit patient charts. Until a secure method is in place, TMB should establish and communicate minimum security requirements for transmitting patient charts. These requirements should be practical, low-cost, and straight-forward for licensees to follow. **Management's Response** The TMB has a method of sending a secure link for uploading confidential documentation. The Compliance department will update its policies to include implementation of this process and will begin this practice as soon as possible. This will require training all compliance officers and compliance support staff by IT. This will require a reasonable timeline. There will also need to be materials for training of probationers to utilize this process. Implementation goal: begin 10/1/25 and full implementation by 4/1/2026. In the interim, Compliance Department management has implemented the recommendation made by the auditor to have the probationer delete the email after receiving confirmation of receipt of delivery by the Compliance Department. **2. Inconsistent Adherence to Compliance Monitoring Procedures** We tested a non-statistical sample of 20 board orders monitored by the Department between September 1, 2024, and May 31, 2025, to assess whether COs adhered to established monitoring procedures. Our review identified multiple deviations from standard requirements, indicating inconsistent application of monitoring controls. The deviations observed included: • Missing or incomplete compliance documentation from licensees without documented follow-up efforts. • Late preparation of required compliance reports without documented justification. • Lack of documentation for required activities, such as field visits or anonymous calls. • Insufficient records to verify timely processing of CME requests. • Missing documentation of automatic termination request emails, preventing validation of required content. • Failure to use the current CR template. • Noncompliance with file naming conventions.

Report No.	Report Date	Name of Report	Observations/ Findings and Recommendations
1	7/25/25	Compliance Monitoring	**Recommendation** We recommend that the Compliance Department ensure internal case audits, resumed in July 2025, are consistently conducted. These audits should confirm the timeliness and completeness of compliance activities and reinforce documentation standards. **Management's Response** Compliance management has been aware that there were issues in this area, but not to the extent uncovered in the audit. Prior to the auditor's findings, Compliance management had reintroduced case audits to locate and correct issues, as well as looking for trends in different Compliance Officers that would indicate a need for retraining, closer supervision, or disciplinary actions. Compliance management had also implemented the use of a "living" log that provides a look at the contact standards compliance at a quick glance. These tools are now used daily to try and limit or eliminate the oversights that are sometimes inherent in case work. The Compliance Department will continue to use these and any new tools we can implement to improve in this area. Implementation has already begun and will be fully implemented by 10/31/2025. **3. Policies Requiring Update** TMB Policies 13.01 – 13.10, which govern the Compliance Program, were last updated in fiscal year 2015 and are inconsistent with the Compliance Department Operations Manual (Manual), which reflects current practices. Examples of inconsistencies include: • Authority to Approve FO4 Waivers: Policies require all FO4 waivers to be approved by the Executive Director, whereas the Manual authorizes the DOC to approve late submissions up to 90 days. • Follow-up Verification for Suspension, Surrender, and Revocation (SSR) Orders: Policies require a 6-month follow-up, while the Manual requires follow-up within 31 days. • Contact Standards: Policies define five levels of contact, whereas the Manual defines four levels with different methods. While staff primarily rely on the Manual for daily operations, outdated and conflicting policies may present legal and compliance risks for the agency. **Recommendation** We recommend that TMB: • Review and update its Compliance Program policies to align with the current Manual, and • Establish a policy review cycle to ensure policies remain current with operational practices and statutory requirements. **Management's Response** Compliance management has been made aware that some policies and procedures are outdated or have contradicting steps. We have been made aware that procedures are located at different places such as SharePoint, the operations manual, and on the actual forms used. Both the Director of Compliance and Supervisor of Compliance have agreed that we will need to audit the policies to ensure that the policies are current and complete and all located in the same area. Full implementation anticipated by 8/31/26. Additionally, a biannual policy review cycle will be implemented to ensure policies remain current with operational practices and statutory requirements.

Report No.	Report Date	Name of Report	Observations/ Findings and Recommendations
1	7/25/25	Compliance Monitoring	**OBSERVATION** **1. Compliance Program Reporting** The Department's quarterly Compliance Section Activity Report to the Board's Disciplinary Process Review Committee (DPRC) includes the reported number of "current probationers" (a term no longer used in Board Rules and now refers to licensees under active orders), This figure is significantly higher than the number of licensees actively monitored by the Department because it includes active orders for inactive licenses that are not subject to compliance monitoring. For example, as of May 31, 2025, the report showed 698 current probationers, while the number of licensees actively monitored was 377. This reporting approach may result in a misunderstanding of the Department's actual monitoring workload and activities. **Recommendation** We recommend that the Department consider disclosing in the quarterly report how the number of current probationers (licensees) differs from the number actively monitored, or otherwise provide context to ensure accurate interpretation. **Management's Response** The Compliance Department will address how the number of current licenses differs from the number actively monitored within the board report beginning at the October 2025 Medical Board meeting. The Compliance Department has researched the number of cases being followed for compliance and the number being reported to the Board. The numbers sent to the Board are gathered from SQL and include all open orders. These include orders for surrender, C&D orders, Revocation Orders and cancellations, which have historically been left open as an active order to prevent accidental reissuance of a license. Over the past few months, we have begun closing these orders as the historical activity of the licensee is documented in the NPDB. This project is ongoing. While the goal is implementation by the October 2025 Board meeting – the current case activity tracking in the database may require coding from IT – which may delay the finalization of improved tracking. Regardless, the October 2025 Board reports will include an update.

Report No.	Report Date	Name of Report	Observations/Findings and Recommendations	Status (Fully Implemented, Substantially Implemented, Incomplete/Ongoing, or Not Implemented) with explanation if not yet fully implemented
1	7/25/25	2025 Follow-Up	**Follow-Up of Prior Year Internal Audits** Following is the status of a recommendation made in fiscal year 2024 by TMB's predecessor auditor that had not been fully implemented. Enforcement (Report Date 4/18/2023) 1. **SQL Tracer User Access** The Board should develop an agency-wide procedure over conducting user access reviews for SQL Tracer. The procedure should require department heads to review user access permissions on a periodic basis to ensure current roles and responsibilities align with job duties. The procedure should also include specific requirements for removing application-level user access for terminated users on the date of termination. ***Management's Explanation for FY25 Status*** TMB has assessed the risk and will accept it until legislative appropriation is received to replace SQL Tracer, which will support enhanced user access management.	**Not Implemented**

VII. External Audit Services Procured in Fiscal Year 2025

TMB procured the internal audit services documented in the approved Internal Audit Plan for fiscal year 2025. No other external audit services were performed.

VIII. Reporting Suspected Fraud and Abuse

TMB has provided information on their website home page on how to report suspected fraud, waste, and abuse to the State Auditor's Office (SAO) by posting a link to the SAO's fraud hotline. TMB has also developed a Fraud Reporting Policy that provides information on how to report suspected fraud, waste, and abuse to the SAO.

IX. Proposed Internal Audit Plan for Fiscal Year 2026

The risk assessment performed during fiscal year 2025 was used to identify the following *proposed* area that is recommended for internal audit and other tasks to be performed for fiscal year 2026. The 2026 Internal Audit Plan will be developed and presented to the Executive Committee and the Board, for acceptance and approval, at a meeting to be determined at a later date.

- Texas Physician Health Program Audit
- Follow-up of Prior Year Internal Audits
- Other Tasks Assigned by the Executive Committee or the Board