Workers' Compensation Health Care Networks

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Texas employers may provide workers' compensation coverage for their employees by participating in "workers compensation health care networks" certified by the Texas Department of Insurance (TDI). These networks provide cost-effective care for work-related injuries and illnesses. Because the networks specialize in treating injured workers, they also can provide better access to appropriate medical care and help injured workers get back on the job quickly and safely.

This publication explains important aspects of workers' compensation health care networks as a means of providing health care services to injured employees. It specifically focuses on how these networks might impact employees, employers, and health care providers.

An Overview of Workers' Compensation Health Care Networks

Insurance carriers may establish or contract with workers' compensation health care networks certified by TDI to provide health care for injured workers. (Insurance carriers include insurance companies, political subdivisions, individual certified self-insured employers, or groups of certified self-insured employers). Workers' compensation networks are similar to "managed care" plans offered by health maintenance organizations (HMOs) and preferred provider organizations (PPOs). The central component of these plans is the use of a provider network – an association of physicians, hospitals, and other providers who work cooperatively to provide patient care. The plans control costs by contracting with health care providers to perform health services at pre-negotiated rates and by closely supervising patient care and progress under treatment. Workers' compensation health care networks also incorporate the use of return-to-work guidelines to monitor an employee's medical progress and ability to return to the job, and a quality improvement program to evaluate the network's overall effectiveness.

If an employer purchases a workers' compensation insurance policy from an insurance company that has established or contracted with a network, the network generally provides all the health care associated with any work-related injuries or illnesses suffered by the employer's workers. The insurance company pays for the cost of health care and any income benefits due to the worker for lost wages or permanent physical impairment.

Insurance companies may either operate networks directly or contract with independent networks to provide health care services to their policyholders' injured workers. Certified self-insured employers, groups of self-insured employers, and political subdivisions also may contract directly with a network or establish their own networks to treat their injured workers.

TDI sets minimum financial standards and requirements for access and availability of care. In addition, TDI issues an annual "report card" rating all certified networks in such areas as return-to-work outcomes for injured employees, treatment outcomes, and employee satisfaction.

How Workers' Compensation Health Care Networks Work

When a worker covered by a network suffers a work-related injury or illness, the worker selects a "treating doctor" from the network's list of participating health providers. The treating doctor takes the lead role in supervising the patient's workers' compensation-related care. (HMOs use physicians called "gatekeeper doctors" or "primary care physicians" in essentially the same capacity). The treating doctor provides treatment for the patient's work injury and, in the event that more extensive care is required, makes referrals to specialists.

Generally, patients are not allowed to see specialists without their treating doctor's approval. For certain types of care, a workers' compensation network may also require the treating doctor to obtain "preauthorization" for proposed treatments and referrals. The preauthorization process determines whether treatments and referrals are medically necessary before they are provided. A similar process, called "utilization review" or "retrospective review," determines whether treatment is medically necessary as it is being provided, or after it has been provided.

In most cases, an insurance carrier will only pay for health care deemed medically necessary. State law requires networks to have a process to allow patients and doctors to appeal any adverse decisions regarding medical necessity. In addition, a network's treatment guidelines must be sufficient to provide necessary care and flexible enough to allow deviations from normal rules when justified.

All employees living within a network's service area are generally required to obtain treatment through the network for work-related injuries or illnesses. Except in certain circumstances, such as emergencies and authorized out-of-network care, an insurance carrier may deny payment for care provided by a non-network provider.

Workers' Compensation Health Care Networks: Information for Employees

If your employer participates in a workers' compensation health care network, the employer is required by law to notify you in writing of the network's rules and procedures. This notice must include information about the network's procedures for complaints and appeals of network treatment decisions, its service area, and a complete listing of network service providers. Upon notification, you must return a signed form acknowledging your receipt of the rules. Failure to return the form will not exempt you from the provider network's rules in the event of a future claim – only an employer's failure to provide notification will do so. If you do not live in the network's service area, you must tell the insurance carrier immediately. If you do not tell the insurance carrier that you live outside the network area, the insurance carrier will assume that you live at the address you provided to your employer.

Workers' compensation insurance carriers are generally responsible for 100 percent of the treatment costs of covered work-related injuries and illnesses. An insurance carrier or health care provider may not bill you for any treatment or services related to care for a covered work-related injury or illness. However, you may be billed if you receive non-emergency care from outside the network without receiving prior network approval.

Workers' compensation health care networks operate in defined geographic service areas, within which the network has demonstrated to TDI that it provides sufficient medical services to meet workers' needs.

- All networks must contract with an adequate number of providers to treat workers 24 hours a day, seven days a week, and provide all necessary hospital, psychiatric, and physical therapy services.
- Networks in urban areas must provide an adequate number of treating doctors and general hospitals within 30 miles of the homes of all workers living within the service area, and all necessary specialty services within 75 miles of workers' homes.
- Networks in rural areas must provide an adequate number of treating doctors and general hospitals within 60 miles of the homes of all workers living within the service area, and all necessary specialty services within 75 miles of workers' homes.
- If a network is unable to meet these service guidelines, exceptions may be granted by TDI. However, a network must provide TDI with a plan to meet the requirements in the future. In addition, the network must have an interim plan to make services available to all employees currently within the network service area.

If you live within a network's service area, it is important to understand that, except under rare circumstances, you must use the network for treatment related to a workers' compensation claim. If you suffer a work-related injury or illness, your first step will be to select a treating doctor from the network's approved provider list. The treating doctor will supervise your treatment and be your liaison with any other providers in the network. The insurance company is required to provide your employer with a contact list of participating treating doctors updated at least quarterly.

An insurance carrier can deny payment for care provided by non-network providers without the network's prior approval. Exceptions are made for medical emergencies and certain other situations. This means that you will probably not be able to go to your regular family doctor for treatment of your work-related injury unless your doctor belongs to the workers' compensation network.

Employees living outside a network's service area are generally exempt from the network's rules and requirements. You may choose any doctor willing to treat you as long as the doctor is on TDI's approved doctor list.

Employees of the same company can have different requirements for their workers' compensation claims if some of the workers live outside the network service area. An employee should never misrepresent his or her primary living address in an attempt to avoid a network's rules or to transfer to another network. By law, if the insurer learns of the misrepresentation, it may deny coverage for the cost of any treatment associated with your workers' compensation claim.

An employee living within a network's service area also may be exempted from some or all of the network's requirements under certain specific circumstances:

- If you require emergency care, the network must cover the cost of treatment from any health care provider, regardless of network status. However, you are required to change to a network-approved provider once your condition has stabilized.
- If there is no network provider qualified to deliver the care you need, the network must approve your use of a non-network provider.
- If you have an HMO primary care doctor through your personal health plan, you may ask that the network allow this provider to serve as your treating doctor for your workers' compensation claim. However, to be approved, your HMO doctor must agree to abide by the workers' compensation network's rules, treatment guidelines, and return-to-work guidelines.

Your treating doctor is required to provide care in accordance with the network's rules, treatment guidelines, and return-to-work guidelines. In the event that you require expensive or non-routine medical care, your treating doctor's treatment recommendations may also require prior approval from the network to ensure the care is medically necessary.

However, in the event that you or your treating doctor disagrees with any medical necessity treatment decision made by either the network or the insurance carrier, you or your doctor has 30 days to file an appeal for reconsideration by an alternate qualified doctor. An entity that issued the medical necessity denial is required by law to complete your review as soon as reasonably possible, and generally not more than 35 days after receiving your appeal. However, in the case of a life-threatening condition, you have the right to request immediate review by an independent review organization. If it is not a life-threatening condition and you or your doctor disagrees with the reconsideration decision, you or your doctor may then file for independent review by an independent review organization.

Employees who receive medical care through a workers' compensation health care network have the following additional rights:

- If you are not satisfied with your treating doctor, you may select an alternate doctor from the network's list of treating doctors. You must notify the network. The network may not deny your request. However, if you are not satisfied with the alternate doctor, you may be required to obtain network approval for any subsequent change of treating doctor.

- A network must arrange for medical services, including referrals to specialists, on a timely basis, and never more than 21 days after the request for services.
- You have the right to file a complaint if you believe a network has acted improperly. The network must provide written acknowledgment of your complaint within seven days of receipt, and must generally resolve it within 30 days. Keep in mind that disagreements about the medical necessity of treatment provided by a network generally must be resolved through the network's appeals process, not its complaint process.
- If your complaint is not resolved, you have the right to file a complaint with TDI. Complaints may be filed online through the TDI website or by calling the Consumer Help Line
  www.tdi.state.tx.us
  1-800-252-3439
- An employer or network may never retaliate for appeals or complaints. If you believe your employer or the network has acted improperly, you should file a complaint with TDI.

Workers' Compensation Health Care Networks: Information for Employers

When deciding whether to participate in a workers' compensation health care network, an employer should consider the geographic distribution of its employees. If you have employees in many areas of the state, or even widely distributed across a single metropolitan area, some workers may reside outside the service area of an available network. Out-of-area employees will have different rules for their workers' compensation coverage. These employees generally may receive treatment for their work-related injuries from any doctor on TDI's approved doctor list.

To legally operate in Texas, a workers' compensation health care network must be approved by TDI as meeting the minimum coverage and service standards required by law. A list of approved networks is available on the TDI website.

If you decide to participate in a workers' compensation health care network, you must provide your employees with written notice of the network's rules and requirements. You are required to provide this notice to existing employees at the time coverage takes effect, and to all new employees at the time of hire. You must also provide the notice again when an employee reports a work-related injury or illness. The notice must include a list of any health care services for which the network requires preauthorization or utilization review, descriptions of all network processes, information on the network's service area, and a complete listing of network providers. Your insurer will provide the notice to you. The notice must be provided in English, Spanish, and any language common to 10 percent or more of your employees. By law, if you fail to provide notice to an employee, the employee is not required to adhere to the network's treatment rules.

At the time notice is delivered, employees must sign a form acknowledging receipt of the network rules. An employee's failure to submit the form will not exempt the employee from the network rules – only your failure to provide notice will do so. Therefore, maintaining a complete record of all acknowledgment forms is important, as it can help support your case in the event an employee disputes whether you provided the notice required.

In addition, all employers are required to maintain a contact list of all participating network providers, updated at least quarterly, as supplied by your insurer. You are also required to post notices about network coverage prominently in the workplace.

Workers' Compensation Health Care Networks: Information for Health Care Providers

Any licensed health care professional may apply to become a participating provider within one or more workers' compensation networks. A workers' compensation network must be certified by TDI in order to legally operate in the state.

Unlike providers who treat employees covered by traditional workers' compensation insurance policies, network providers are not required to obtain approved doctor list certification from TDI's Division of Workers' Compensation. However, each network will have its own credentialing process and may set its own minimum standards for participating providers.

A network may decline to review your application if the network has already contracted with a sufficient number of providers to meet the needs of injured workers. It may also decline to review your application if it does not include in its network providers in your particular medical specialty.

As a network provider, you will be required to adhere to the network's policies, procedures, treatment guidelines, and return-to-work guidelines for all patients that are referred to you through the network. Providers may not legally bill an injured worker for any costs related to treatment of compensable work-related injuries or illnesses, including copays or "balance billing" amounts for additional payment beyond the network's contract rate. All payment for services must come either from the insurance company or a third party acting on behalf of the insurance company.

If you are accepted as a participating network provider, the network may not offer you any financial incentives to limit medically necessary services. You are also required to post prominently in your office the toll-free number for anyone who wants to file a complaint about any aspect of a network's operations.

In addition, you have the following rights and protections under state law:

- You may appeal any utilization review or retrospective review determination, or other network coverage decisions, on behalf of a patient. A network may never terminate or nonrenew your contract or otherwise retaliate against you for filing an appeal or a complaint.

- The network must give you written notice before conducting any economic profiling or utilization review studies comparing your history of care to any other provider's.
- It is your right to review any information used in the network credentialing process, correct any errors, and learn the status of any pending application.

Except in cases of fraud, suspension of a medical license, or possible "imminent harm" to a patient, the network must provide 90 days' notice of termination of your network contract. Within 30 days of receiving notice, you may appeal the termination.

You may leave the network for any reason after providing 90 days' advance written notice. If you leave the network at your request, the network must continue to reimburse you for care to any worker with an acute or life-threatening condition for up to 90 days, provided that you can show that disruption of care could potentially harm the patient.

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