Texas Department of Insurance
WCNetNews
a publication of the Health and Workers' Compensation Networks Division
Volume 1 Number 3 Spring 2007

HWCN Division Toll-Free Phone Number

The Health and Workers' Compensation Quality Assurance and Network Certification Division (HWCN) now has a toll-free number for direct access to staff for questions related to Workers' Compensation Health Care Networks. The new number is **1-866-554-HWCN** (4926).

Network Applicant Open Conference Calls

TDI holds monthly conference calls with network applicants to discuss issues related to Certified Workers' Compensation Health Care Network applications. Please see the calendar of events at the end of this newsletter for specific details.

The minutes and agenda of previous Network Applicant Conference Calls can be accessed on the Workers' Compensation Networks page of the TDI Web site.

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Certified Workers' Compensation Health Care Networks

The list of Certified Workers' Compensation Health Care Networks is available on the TDI Web page. This list is updated as additional networks are certified and as service areas are modified. Currently the following workers' compensation health care networks have been certified:

Aetna Workers' Comp Access (AWCA)

Argus Provider Network

Bunch and Associates Inc, Texas HCN

CMI Barron Risk Management, Inc./Southwest Medical Provider Network

Concentra HCN

Corvel Healthcare Corporation/Corcare

First Health/AIGCS TX HCN

First Health HCN

First Health/Travelers HCN

Forte Inc./Compkey/First Health

Genex Services, Inc/Genex Care for Texas' Comp Access (AWCA)

Genex Services Inc./Genex Health Care Network

The Hartford Workers' Compensation Health Care Network – FH

IMO Med-Select Network/Injury Management Organization, Inc.

International Rehabilitation Associates Inc./IntraCorp.

Interplan Health Group, Inc./Zenith Health Care Network (ZHCN)

Intracorp/Lockheed Martin Aero Employee Select Network

Liberty Health Care Network

Memorial Hermann Health Network Providers, Inc./Worklink

National ChoiceCare, NCC ChoiceNet

North Texas Innovative Health Care Network, Inc.

Physician's Cooperative of Texas

SHA, LLC./FirstCare Network

Specialty Risk Services Texas Workers' Compensation Health Care Network (First Health)

Texas Star Network/Concentra

Zurich Services Corporation Health Care Network

Zurich Services Corporation Health Care Network/Corvel

Texas Department of Insurance WCNetNews

Certification Requirements for Workers' Compensation Health Care Networks

In Issue 2 the Department provided information on the Background, General Filing Requirements and Exhibits 1-9 of an application for a Certified Workers' Compensation Network. This issue will cover Exhibits 10-21.

Exhibit 10

Chapter 1305 of the *Texas Insurance Code* (TIC) requires a workers' compensation network applicant to submit policies and procedures for the following processes:

Complaints: The applicant must demonstrate that it has established reasonable procedures for the resolution of an oral or written complaint. For a complete list of requirements, please see TIC §§1305.401-405 and 28 Texas Administrative Code (TAC) §§10.120-122.

Quality Improvement: The applicant must have a governing body to develop and maintain an ongoing quality improvement program designed to:

- objectively and systematically monitor; as well as, evaluate the quality and appropriateness of care; and
- pursue opportunities for improvement.

Please see 28 TAC §10.81 for additional information and a complete list of requirements.

Credentialing: The network is responsible for implementing a documented process for selection and retention of contracted providers; i.e.; credentialing the provider. Although network applicants are not required to use the form, the applicant may refer to the Texas Standardized Credentialing Form posted on the TDIs website as an example of an application form. Please see 28 TAC §10.82 for a complete list of requirements.

Treating doctor selection/changes: The applicant must provide policies and procedures that describe how it will provide a list of contracted treating doctors from which the injured employee may initially choose the treating doctor. An employee that is dissatisfied with the initial choice of a treating doctor is entitled to select an alternate treating doctor from the network's list by notifying the network in the manner prescribed in the policies and procedures. Please see 28 TAC §10.85 for additional information.

Emergency care and referrals to out of network providers: The applicant must demonstrate that emergency care is available and accessible 24 hours a day, 7 days a week without restrictions as to where the services are rendered as required by TIC §1305.302(e).

Referrals to out-of-network providers must be approved by the network as described by TIC §1305.103(e), and applicants must submit policies and procedures to demonstrate this process.

All requirements are outlined in 28 TAC §10.22 and reflected in the exhibits attached to the application.

Certification Requirements for Workers' Compensation Health Care Networks

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Exhibit 11

Chapter §§1305.301-304 of the TIC requires a workers' compensation network applicant to submit a description of the network configuration. This description must demonstrate that health care services are sufficient in number to serve the population, within the service area, as well as, maps to demonstrate compliance for accessibility and availability for the injured employee. For detailed information please see TIC Chapter §§1305.053(9) and 28 TAC §§10.22(11) and 10.80.

Exhibit 12

The location of the network entity's books and records is primarily needed for examination purposes, as may be performed under TIC §1305.251. If different records are maintained at separate locations, then all locations must be identified relative to those books and records. Also, if certain functions are delegated to others, any records that are maintained by the delegated party are also subject to examination and the location of those records must also be identified.

Exhibit 13

The business plan and projections included in Exhibit 13 allow the analyst to assess the near future outlook for the applicant. The primary concern of the analyst is that the applicant will be able to meet its ongoing obligations. Exhibit 13 requires a business plan that describes the applicant's intended operations in Texas, including both a narrative description and projections related to anticipated revenue and profitability for the first two years of operation after certification.

Below are the minimum business plan guidelines:

- Narrative description of intended operations in Texas, as indicated by the Service Arrangements listed in Section IV of the application.
- Financial projections for the first two years of operations in Texas to include an income statement, balance sheet and statement of cash flows.
- The income statement projections shall provide detail of revenue and expense components of each service arrangement listed in Section IV of the application.
- A description of the methods of compensation by which any contracted insurance carrier(s) shall reimburse the WCN applicant for contracted services to be provided by applicant. Any capitation arrangement or any other method by which risk would be transferred from any carrier to applicant is not allowed.

Exhibit 14

The authorization form for bank account and bank loan information are required for audit purposes to confirm financial information disclosed within the network entity's financial statements submitted within Exhibit 7. The confirmation procedure requires that bank balances, plus any hypothecations and outstanding loans be disclosed as of the financial statement date as is filed in Exhibit 7. This means that the cash and cash equivalent amount reported in the financial statement will be compared to the total of the confirmed cash balances reported directly to the Texas Department of Insurance by the banks. Therefore, it is imperative that authorizations to confirm all bank accounts, certificates of deposit, and other bank issues, such as money market accounts, be included.

Questions on Certified Networks

The TDI Certified Workers' Compensation Health Care Network Web page contains a wealth of information on certified networks, including Frequently Asked Questions (FAQs) for health care providers, carriers, employers and employees. The FAQ section can be accessed by scrolling down to the FAQ heading and selecting the appropriate category.

If your question is not addressed in the information on the TDI Web page or FAQ call TDI toll free at 1-800-252-3439 or submit your question to the Health and WC Network Certification and Quality Assurance Division by email to wcnet@tdi.state.tx.us.

Certification Requirements for Workers' Compensation Health Care Networks

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Exhibit 15

Each network application must include a description of the applicant's plan for providing care to injured employees who live temporarily outside the service area, as required under 28 TAC §10.22(15).

Exhibit 16

Each network application must include a detailed plan which assures health care providers trained in Maximum Medical Improvement (MMI) determinations and Impairment Rating (IR) assignments are available to assess injured employees. Network health care providers that perform MMI and IR services must complete the appropriate training and testing requirement described in the Labor Code §408.023 and offered by the Division of Workers' Compensation (DWC).

Exhibit 17

Each network application must include a description of the applicant's plan for obtaining certification by doctors and health care practitioners of filing the required financial disclosure with the DWC under Labor Code §§408.023, 413.041 and 28 TAC §10.22(17).

Exhibit 18

Exhibit 18, also known as the "Notice of Network Requirements" (Notice), is a vital part of a Workers' Compensation Health Care Network application as well as the network's operation. An employer must inform an employee of its participation in a certified network by providing a copy of the Notice no later than the third day of hire and upon notification of a compensable injury. The employer is also required to post the Notice in the workplace. (TIC §1305.005(d)-(g)).

The Notice must contain all components specified by 28 TAC §10.60 and TIC §§ 1305.005 and 1305.451. For example, the Notice must contain language that is compliant with 28 TAC §10.60(g)(15), which requires "a statement that, except for emergencies, the network must arrange for services, including referrals to specialists, to be accessible to an employee on a timely basis on request and within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 days after the date of the request."

In some instances, a network seeking certification that modifies certain required TIC and TAC language in their Notice may be non-compliant, thus risking delayed certification.

Three Common Errors in Exhibit 18:

1. Non-compliant "Continuity of Care" language as required by 28 TAC §§10.42(b)(5) and 10.60 (g)(11):
   - 28 TAC §10.42(b)(5)(A) states "if a provider leaves the network, upon the provider's request, the insurance carrier or network is obligated to continue to reimburse the provider for a period not to exceed 90 days at the contracted rate for care of an employee with a life-threatening condition or an acute condition for which disruption of care would harm the employee;"

Certification Requirements for Workers' Compensation Health Care Networks

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- In some instances, the applicant will omit the "Continuity of Care" language in its entirety or provide language that omits "upon the provider's request", thus the Notice is not compliant.

2. Non-compliant 28 TAC §10.60 (g)(14) and TIC §1305.451(12) language:
   - 28 TAC §10.60(g)(14) and TIC §1305.451(12) requires and states " a list of network providers updated at least quarterly, including":
     – the names and addresses of network providers grouped by specialty. Treating doctors shall be identified and listed separately from specialists. Providers who are authorized to assess maximum medical improvement and render impairment ratings shall be clearly identified;
     – a statement of limitations of accessibility and referrals to specialists;
     – and a disclosure of which providers are accepting new patients."
   - In some instances applicants omit all of the above referenced requirements or do not include all required statements.

3. Non-compliant 28 TAC §10.60 (g)(15):
   - Applicant states "except for emergencies, the network must arrange for services, including referrals to specialists the last day of the third week following the request". Depending on the number of days in the month the last day of the third week following the request could exceed 21 days thus the statement is not compliant.
   - Applicant states "except for emergencies, referrals to specialists will not exceed 21 days". While the this language is partially compliant, it does not indicate the network will arrange for all services appropriate to the circumstances and conditions of the injured employee, but not later than 21 days after the date of the request; thus the Notice is not compliant.
   - Applicant states "except for emergencies, the network should arrange for services, including referrals to specialists, to be accessible to an employee on a timely basis on request and within the time appropriate to the circumstances and condition of the injured employee, and should be arranged no later than 21 days." "If you are not able to receive services within 21 days please call the network. This language appears to indicate the requirement of "no later than 21 days" is flexible, thus the Notice is not compliant. 28 TAC §10.60(g)(15), states "except for emergencies, the network must arrange for services, including referrals to , to be accessible to an employee on a timely basis on request and within the time appropriate to the circumstances and condition of the injured employee, but not later than 21 days after the date of the request."

Exhibit 19

Each Network must include a plan for monitoring whether providers have received and are following treatment guidelines, return-to-work guidelines, and individual treatment protocols. Guidelines and protocols must be evidence-based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary health care while safeguarding access to necessary care as required under TIC §1305.304 and 28 TAC §§10.22(19) and 10.83.

Certification Requirements for Workers' Compensation Health Care Networks

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Exhibit 20

A workers' compensation network applicant must submit the name of its treatment guidelines , return to work guidelines, and individual treatment protocols. These guidelines must be certified by the medical director to be evidenced based, scientifically valid and outcome focused, and designed to reduce inappropriate or unnecessary health care while safeguarding necessary care. For detailed information refer to TIC §1305.304 and 28 TAC §§10.83 and 10.22(20).

Exhibit 21

Each workers' compensation network applicant must have a medical director that is a fully licensed occupational medicine specialist or must employ or contract with an occupational medicine specialist who is licensed to practice medicine in the United States. Refer to TIC §1305.301(c) and 28 TAC §10.22(21).

The IRO Process in Relation to Workers' Compensation Networks

The information below applies to the independent review of requests for medical necessity disputes filed on or after January 15, 2007, in the Workers' Compensation Health Care Network system. As of January 15, 2007, all independent review assignments will be made by the HWCN Division of TDI.

Upon notice of an initial adverse determination and a denial of reconsideration, a utilization review agent (URA) is required to allow an injured employee, the employee's representative, or requesting provider to seek review of the determination by an independent review organization (TIC § 1305.355(a)).

What is an Independent Review Organization?

An Independent Review Organization (IRO), as defined in TIC § 1305.004(11), is an entity certified by the Texas Department of Insurance to conduct independent review of the medical necessity and appropriateness of health care services requested for an injured employee. At the time of the review, the health care services are either being provided (concurrent), proposed to be provided (preauthorization), or have already been provided (retrospective) (TIC § 1305.004(10)).

When and how is an IRO review requested?

No later than the 45th calendar day after the date the denial of reconsideration is received, the requesting party must complete Form LHL009 (Request For A Review By An Independent Review Organization) and return it to the carrier or the carrier's URA (28 TAC § 133.308(g)).

The IRO request form may be provided by the carrier/URA, or it can be obtained from the HWCN Division website: http://www.tdi.state.tx.us/company/iro_requests.html .

An employee with a life-threatening condition is entitled to an immediate review by an IRO and is not required to request reconsideration after receiving an adverse determination (TIC§1305.354(c)).

The IRO Process in Relation to Workers' Compensation Networks

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Upon receipt of the completed IRO request form (LHL009), the carrier or the URA will immediately notify the HWCN Division of the request via the online IRO request system (28 TAC § 133.308(f)).

What happens after the IRO request is submitted?

In accordance with 28 TAC § 133.308(i), after reviewing the request for IRO review, the HWCN Division will randomly assign an IRO and notify the following parties of the assignment:

- IRO
- URA
- Insurance Carrier (if different from the URA)
- Adverse Determination Provider (the provider that received the denial)
- Injured employee (or person acting on the employee's behalf)

As outlined in 28 TAC § 133.308(h), the Department may dismiss a request for medical necessity dispute resolution if:

- the requestor informs the Department, or the Department otherwise determines that the dispute no longer exists;
- the individual or entity requesting medical necessity dispute resolution is not a proper party to the dispute;
- the Department determines that the dispute involving a non-life threatening condition has not been submitted to the carrier for reconsideration;
- the Department has previously resolved the dispute for the date(s) of health care in question;
- the request for dispute resolution is untimely pursuant to subsection (g) of this section;
- the request was not submitted in compliance with the provisions of this subchapter; or
- the Department determines that good cause otherwise exists to dismiss the dispute.

No later than the third business day after receiving the notice of IRO assignment, the carrier/URA must submit to the assigned IRO the required documentation, including request forms, medical records that are relevant to the review, guidelines, protocols or criteria used to make the adverse determinations, and copies of adverse determination notices. Specific descriptions of the required documentation are outlined in 28 TAC § 133.308(j)).

* The IRO may request additional information from either party or from other providers whose records are relevant to the review (28 TAC §133.308(k)).

- IROs may request DWC to assign a designated doctor examination as part of the medical necessity review. The required timelines for the IRO review will change if this examination is requested. See 28 TAC § 133.308(l) pertaining to the IRO's right to request a designated doctor examination (DDE).

The IRO Process in Relation to Workers' Compensation Networks

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When and how will the parties be notified of the IRO decision?

In accordance with 28 TAC 133.308(m), the IRO will render a decision as follows:

- for life-threatening conditions, no later than eight days after the IRO receives of the dispute;
- for preauthorization and concurrent medical necessity disputes, no later than the 20th day after the IRO receives of the dispute;
- for retrospective medical necessity disputes, no later than the 30th day after the IRO receives payment; and
- If a designated doctor examination has been requested by the IRO, the above time frames begin on the date the IRO receives the designated doctor report.

The IRO decision will be mailed or otherwise transmitted to the parties and to representatives of record for the parties and transmitted in the form and manner prescribed by the Department (28 TAC § 133.308(n).

Who pays for the IRO review?

The carrier pays for the independent review for certified network requests, and must remit payment to the assigned IRO within 15 days after receipt of an invoice from the IRO (28 TAC §133.308(1)).

Can the IRO decision be appealed?

Yes. TIC § 1305.355(e), allows a party to a medical dispute to seek judicial review if the dispute remains unresolved; however the HWCN Division and the Department are not considered to be parties to the medical dispute.

In a preauthorization and concurrent review, the IRO determination is binding while the appeal is pending; therefore the carrier and the network are required to abide by the determination
(TIC § 1305.355(f)).

If judicial review is not requested, the carrier and network are required to comply with IRO's determination (TIC§ 1305.355(g)).

IRO decisions related to workers' compensation medical necessity disputes will be posted on the TDI website at www.tdi.state.tx.us/company/iro_requests.html.

Workers' Compensation Network Report Cards

Background

TIC §1305.502 requires the TDI Workers' Compensation Research and Evaluation Group (REG) to publish an annual consumer report card comparing the quality and cost of medical care provided to injured workers in certified workers' compensation networks with each other and with medical care provided outside of certified networks. Additionally, Texas Labor Code, §504.053 requires political subdivisions and intergovernmental risk pools who elect to provide medical benefits outside of certified networks by directly contracting with health care providers to also be included in the network report card.

Workers' Compensation Network Report Cards

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When will the report card be issued?

In accordance with House Bill (HB) 7 (79th Legislature, Regular Session, 2005), the first report card is due no later than eighteen months from the date the first workers' compensation network is certified by the Department. Since the Department certified the first workers' compensation network at the end of March, 2006, the REG will issue the first network report card in September, 2007.

What will the report card include?

By statute, the report card must include an evaluation of each certified network's performance on issues such as:

- Patient satisfaction;
- Access to care;
- Return-to-work outcomes;
- Health-related outcomes; and
- Medical costs and utilization of care.

During the past few months the REG has been examining possible measures to be included in the first report card, as well as determining sources of data for these measures. As a starting point, the REG looked at data measures used in the HMO report card published by the Office of Public Insurance Counsel (OPIC) (see http://www1.outerscape.net/opic/page.php?p_sub_page_id=56), measures recommended by the former Workers' Compensation Health Care Network Advisory Committee (HNAC) (see http://www.tdi.state.tx.us/wc/information/events/reports/feas-appendixf.pdf) and workers' compensation managed care performance measures developed by URAC (see http://www.urac.org/savedfiles/WorkersCompPerformanceMeasures.pdf).

Using these sources as well as information from the REG's previous injured worker surveys, the REG developed a set of proposed workers' compensation network report card measures and presented these measures at the June 14, 2006 meeting of the Workers' Compensation Working Group. A copy of these proposed measures can be viewed at http://www.tdi.state.tx.us/consumer/documents/wcwg614rptcard.rtf.

Next steps

Starting in late January, the REG has been working closely with a select group of system stakeholders to fine tune the set of proposed measures for the first network report card and to finalize the methodology for calculating these measures. Since a number of networks certified in late 2006 may not be actively treating a significant number of injured workers at the time the first report card is developed, it is likely that the number of networks compared in the first report card will be limited to those who were certified earlier in 2006. Future report cards will include an expanded list of certified networks as well as an expanded list of measures. As the date for the publication of the first report card draws near, the REG will provide updates on the status of the report card in future editions of WCNet News. Questions about the report card should be directed to Amy Lee at WCResearch@tdi.state.tx.us.

Service Area Expansions

After receiving certification, a network may seek to expand, eliminate or reduce its existing service area or to add a new service area. If so, the network must file an application for TDI's approval to modify its service area at least 30 days before implementation of the modification. The network must complete the application form (available on TDI's web site at http://www.tdi.state.tx.us/forms/form19.html) and submit the form to TDI along with all documentation required by 28 TAC §10.26. A filing fee is not required. TDI staff will review the application and documentation under the same standards that apply to a network's application for certification. Upon receipt of TDI's approval, the network may implement the requested modification.

Changes Made to Previously Approved Documents

From time to time changes may need to be made to documents previously approved by TDI as part of the certification process or for business reasons. Frequently this occurs during the submission of an SAE, where for example, the network's service area has been altered, thereby necessitating the updating of Exhibit 18 (among others). To expedite review of the changed documents the network must include:

- An attestation from an officer of the certified network confirming that no information other than those highlighted, underlined or identified in some fashion has changed.
- A "redlined" version of the document.

Due to technological limitations "redlines" may not be readily visible to TDI staff reviewing the documents. To ensure the review is completed as quickly and as accurately as possible any changes should be outlined in the attestation and the changes clearly identified or marked in the document.

Both the attestation and the redlined version of the document are required in order to expedite the review process. If either the attestation or redlined version is not included TDI will review the document in its entirety as if it is a new document that has been submitted as a replacement for a previously submitted document.

As part of the division's due diligence procedures, an audit process for reviewing the redlined documents is being started in April 2007. A sample of documents will be selected and reviewed in its entirety as if it were a new document. If noncompliant features are identified or if changes from the original approved document in addition to the highlighted changes are found, the network will be notified of the deficiencies and requested to submit corrections.

Frequently Asked Questions (FAQ's)

In each issue of WC Net News we will include FAQ's for one of the segments of our audience. In this issue we focus on FAQ's for employees.

Q. What is a workers' compensation network?

A. A network is an organization formed as a health care provider network to provide health care services to injured workers and is certified by the Texas Department of Insurance. The network must be certified in accordance with Chapter 1305, Texas Insurance Code, and 28 TAC §§10.20 -10.27 and established by, or operating under contract with, an insurance carrier.

Q. How will I know whether I'm required to get care from a network provider for an injury on the job?

A. If your employer has elected to contract with a workers' compensation health care network, you are required to obtain medical treatment for a work-related injury through the workers' compensation health care network if you live within the network's service area. Your employer is required to give you notice that describes the network's requirements, including a list of network providers. You will be asked to sign an acknowledgment form stating that you have received the notice. Even if you do not sign and return the form, you will be required to use network providers in the event of a work-related injury if you live within the network's service area. If you require emergency treatment for the injury, you may go to any hospital for the emergency care. After the emergency situation has passed, you will be required to seek any additional care for the injury from network providers. If you do not go to network providers after you have received the notice from your employer, you may have to pay for your care.

Q. What if my employer's carrier has a network, but I live a long way away from where network services are available?

A. If you do not live in the workers' compensation health care network's service area, you will not be required to receive health care from the workers' compensation network providers. Where an employee lives includes: a) the employee's principal residence for legal purposes, including the physical address that the employee represented to the employer as the employee's address; b) a temporary residence necessitated by employement; or c) a temporary residence taken by the employee primarily for the purpose of receiveing necessary assistance with routine daily activities because of a compensable work-related injury.

Q. I have health insurance through my job. If I am injured on the job, can I go to my primary care physician for my health insurance instead of a network doctor?

A. If your health insurance is health maintenance organization (HMO) coverage and you are required to receive health care services within a workers' compensation health care network, you may request that the network allow your primary care physician (PCP), who you selected prior to your injury, to be your treating doctor. In order to receive care from your PCP, he or she must agree to follow all the terms and conditions of the network's contract and comply with the Workers' Compensation Health Care Network Act (Chapter 1305, Insurance Code) and applicable rules.

Q. Do I still get to choose my own treating doctor if I am in a workers' compensation network?

A. Yes, but you must choose a treating doctor from the list of primary treating doctors

FAQ's *continued from page 11*

provided by your workers' compensation health care network. You will receive a copy of the network's list of providers when you receive the notice of network requirements from either your employer or the insurance carrier. The exception to this is, if you are already a member of an HMO plan, you may request that your HMO primary care physician (PCP), if selected prior to your injury, be your workers' compensation treating doctor. Your HMO primary care physician (PCP) must agree to be your workers' compensation treating doctor and agree to the terms and conditions of your workers' compensation network's contract.

Q. Does a treating doctor in a network have to be a particular type of provider? Can a chiropractor be my treating doctor?

A. The workers' compensation health care network decides the specialty or specialties of doctors who may serve as treating doctors; therefore, the network will decide whether a chiropractor may be a treating doctor in the network.

Q. I chose a treating doctor from the network and I am dissatisfied. Can I change treating doctors?

A. Yes. An employee who is dissatisfied with his or her initial choice of a treating doctor has the right to select an alternate treating doctor from the workers' compensation health care network's list of treating doctors who provide services in the network's service area. The employee must notify the network in the manner prescribed by the network. The network may not deny the selection of an alternate treating doctor who is within the network. An employee must get approval from the network to make a second or additional treating doctor change.

Q. I have been receiving medical treatment for my workers' compensation claim, but my employer just gave me a form to sign and said that I have to change to a doctor under a workers' compensation health care network plan or I have to pay the bills myself. Can they do this?

A. Yes. Your employer's insurance carrier is liable for payment of out-of-network medical care until the employee receives notice of workers' compensation health care network requirements. An injured worker who lives within the network's service area and has received the notice is required to obtain medical treatment within the network for a compensable work-related injury. A workers' compensation insurance carrier must pay for out-of-network care that is provided to an injured worker who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract.

Q. When I select my treating doctor and I decide I want it to be my HMO PCP, does the PCP have to agree to all the terms of the network contract?

A. Yes. The provider must agree to abide by the terms of the network's contract and comply with Insurance Code Chapter 1305, Subchapters D through I and applicable adopted rules.

Q. My employer has selected a network. If I live outside the network service area and I select a treating doctor, does the treating doctor have to be on the ADL?

A. An employee who lives outside the service area may choose to participate in a network established by the carriers or with which the carrier has a contract upon mutual agreement between the employee and the carrier. If the employee is not willing to

FAQ's *continued from page 12*

participate in a network, and does live outside of the service area, the care would default to the non-network workers' compensation and the treating provider would need to be on the ADL.

Q. What if I go to a network doctor and have a complaint about the care I received?

A. You may file a complaint with the workers' compensation health care network about any care you receive from network providers. You should have received a notice from your employer or the carrier that will explain how you can file the complaint. You may also contact the Texas Department of Insurance to file a complaint if you are dissatisifed with the workers' compensation network's resolution of your complaint. You may obtain a complaint form on the Department's website at: www.tdi.state.tx.us. You may also call toll-free 1-800-252-3439 or mail a complaint to:

Texas Department of Insurance
HMO Division, Mail Code 103-6A
P.O. Box 149104
Austin, TX 78714-9104

Previous Issues of WCNet News

Previous issues of WCNet News are located on the TDI Workers' Compensation Health Care Network Web page under "Publications".

Calendar of Events

Network Applicant Conference Call – 1-888-387-8235 - passcode 5751967

Thursday, April 12,	2:00-3:00 p.m. CST
Thursday, May 10,	2:00-3:00 p.m. CST
Thursday, June 14,	2:00-3:00 p.m. CST
Thursday, July 12,	2:00-3:00 p.m. CST

Provider/Office Manager Conference Call – 1-888-387-8235 - passcode 5751967

Tuesday, April 10,	2:00-3:00 p.m. CST
Tuesday, May 8,	2:00-3:00 p.m. CST
Tuesday, June 12,	2:00-3:00 p.m. CST
Tuesday, July 10,	2:00-3:00 p.m. CST