WC HCN Workshop Questions & Answers

1. Q: Who completes the online Independent Review Organization (IRO) form if the claim involves regular healthcare insurance? Who completes the IRO form for workers' compensation?

A: In all instances the online IRO assignment request form must be completed by the URA or the carrier. This had been the process for health, and pursuant to House Bill 7, IROs for workers' compensation must follow the same process. The URA or carrier is asked to complete the online request for IRO assignment because pursuant to Chapter 4201 of the Texas Insurance Code the request for an IRO goes to the URA or carrier and pursuant to 28 TAC§133.308 of the Texas Administrative Code the URA or carrier must notify the Department of the request for IRO and request IRO assignment. Use of the online request form is the most expeditious way for a URA or carrier to provide the required information to the Department.

2. Q: Does the new IRO form need to be attached to the adverse determination in both English and Spanish?

A: The English version of the IRO form needs to be attached to the notice of adverse determination. However, upon request, the Spanish version will need to be made available.

3. Q: Will the Division of Workers' Compensation (DWC) staff continue to process the backlog of retrospective medical necessity disputes under the new medical dispute resolution IRO rules or the rules that were in effect at the time the dispute was originally received?

A: The DWC staff will continue to process the backlog of retrospective medical necessity disputes that were received prior to the transition date of January 15, 2007, under the rules that were in effect at the time the dispute was originally received.

4. Q: Has the Texas Department of Insurance (the Department) reviewed the issue of applying a new rule to a dispute resolution filed prior to the effective date of the rule?

A: The new rule is not applicable to dispute resolutions filed prior to the rule's effective date. DWC will continue to process disputes that were received prior to the effective date of the rule in accordance with rules that were applicable at the time of the receipt of the fee dispute. Both §§133.307(a) and 133.308 (a) state that they apply to a request for medical fee ore medical dispute resolution filed on or after January 15, 2007.

5. Q: What data calls can be expected for 2007?

A: In preparation for the network report card and to assist the DWC with fee guideline development, the Department has currently asked for information on the number of injured employees being treated in a workers' compensation health care network (network), the carriers that have contracted with networks, and aggregate information on the types of fees that are paid to network providers. In addition, the Department will likely request an update of projections in early 2007 regarding the number of employers and employees that will participate in networks similar to the information the Department previously requested in September, 2006 from select workers' compensation insurance carriers.

6. Q: When will the criteria for the network report card survey be finalized?

A: A draft of the injured employee survey was posted on the Department's website. The deadline for comments on that survey expired on February 28, 2007. The Workers' Compensation Research and Evaluation Group (REG) is currently reviewing those comments and will finalize the survey instrument for the first network report card sometime in March. The REG anticipates continuously evaluating the various network report card measures and requesting public input on any major proposed changed to those measures prior to their incorporation in the network report card.

7. Q: Will individual physicians have a report card, and if so, will they be made public?

A: No, individual health care providers will not have their own "report card" produced in the same way as the network report card requirements of Chapter 1305, Insurance Code. However, the Division of Workers' Compensation is currently required under Labor Code §402.075, to develop and implement a performance-based oversight program, which includes a biennial assessment of individual health care providers and insurance carriers on a variety of compliance measures. The Division has already held several stakeholder meetings to discuss possible health care provider and insurance carrier measures and will be initiating rule proposals, as required by statute, to identify key regulatory goals for the performance-based oversight program sometime late Spring/early Summer 2007. Additionally, certified networks are required as part of their quality improvement programs to monitor the quality and utilization of care by their contracted providers and may produce reports as part of this monitoring.

8. Q: If a complaint is referred to Legal & Compliance Division, in what time frame will they contact us, and what penalties can be expected?

A: The time frames will vary depending on the type of violation reported. When a complaint is referred to the Legal & Compliance Division for further action, there are

several disciplinary options available, including administrative penalties up to, and including, revocation of licensure or certification.

9. Q: Will network related administrative violations be levied against the certified network or the carrier?

A: Depending on the type of administrative violation, the penalties could be levied against either the carrier or the network. A network could be assessed administrative penalties if it violated applicable statutes or rules.

10. Q: When will electronic billing be enacted?

A: The rules concerning electronic medical billing, reimbursement and documentation were adopted July 21, 2006. Please refer to 28 TAC Chapter 133, Subchapter G. §133.500 and §133.501 for the specific requirements of the rule. Pursuant to §133.501(a), all entities must be able to exchange electronic data by January 1, 2008, unless they are excepted from the process.

11. Q: How often are networks required to re-certify?

A: Currently, networks are not required to re-certify. Pursuant to Insurance Code §1305.054(e), a certificate issued under Chapter 1305, Subchapter B is valid until revoked or suspended. However, a network must receive Department approval when it plans to make changes to management contracts or information regarding fidelity bonds; change the physical location of books and records; make a material modification of network configuration; or implement an expansion, elimination, or reduction of existing service areas or an addition of new service areas. Request for approval must be made a minimum of 30 days before the planned change. A network must also give the Department 30 days notice before it makes any changes to any other information required as part of the information originally submitted in the network's application for certification.

12. Q: Will your website list the employers who have elected to contract with or establish a certified network? If so, how often will the website be updated? How can I find data that displays how many WC policy holders have chosen to use a WC network?

A: Carriers and certified networks are not required to report the names of the employers who contract with them. Thus, the Department is unable to list the employers who have elected to use a network.

13. Q: Why doesn't the Department publish a current list of in-network doctors?

A: A network enters into a separate written contract with each provider or group of providers that wish to participate in the network. The networks are required to maintain current provider lists and many of them make the information available on their websites. Because of frequent changes in these lists due to the addition and removal of providers, it is not practical for the Department to maintain such a list. The Department's website does contain contact information concerning all networks to assist in obtaining information about the networks.

14. Q: In a network for each county, how do we find the available providers on the Department or network website?

A: Many of the networks have provider directories available on their websites. You may contact each individual network to determine which providers are available for that network and where the providers are located.

15. Q: Is there a quick and easy way for providers to locate networks in the provider's geographical location?

A: The link to workers' compensation network information on the Department's website is available at: hhtp://tdi.state.tx.us/wc/wcnet/index.html. It contains a page that includes maps for each network that indicate what geographical service areas have been certified for each network. In addition, there is also a listing of corresponding counties for each network map. There is also a new search feature on the website that allows you to enter a particular county and discover all the networks that are certified in that county.

16. Q: Is there a search tool for providers to search which network an employer is in by employer name?

A: Because the Department cannot capture this information, there is currently no search tool available for providers to search for networks by an employer's name. *See question #12.*

17. Q: Does TDI have a master file of all the networks, with which any particular provider is contracted, or is that information with the network only?

A: No. The HWCN Division does not have a listing of contracted network providers. However, the website, located at www.tdi.state.tx.us. , contains a listing of all certified workers' compensation networks

18. Q: Once an employer has elected to use a certified network, how long are they locked into that network? How often can they change?

A: Once an employer has elected a certified network, the length of time the employer is required to retain that network is determined by the contract between the employer and the carrier. If the contract contains a "cancellation provision", the employer and/or carrier would have to request cancellation accordingly. Additionally, the employer must also comply with the provisions of Labor Code, §406.007, which prescribes detailed procedures with which an employer must comply to request cancellation. Labor Code §406.005 also requires the employer to give notice to employees of a cancellation or change in coverage no later than the 15th day after the effective date.

19. Q: How will physician providers be compensated when they treat an employee in an emergency situation that is a member of an outlying network of which the physician is not a member? Will 125% of Medicare fees remain in effect as required compensation, and for how long?

A: Providers who are not contracted with a network, but provide emergency care to injured employees or provide care subject to a referral from an in-network provider, will be compensated at the rate assigned in the current fee schedule promulgated by the DWC. The fee schedule is currently undergoing a review process, but the current fee schedule will control until a new fee schedule, if any, is adopted by the Division. The review of the fee schedule does not change the schedule that providers are currently being paid under.

20. Q: What is the mandatory composition of medical specialists in a certified network and the geographic requirements (i.e. distance)? More specifically, is a pain management specialty a requirement?

A: Neither the statute (Insurance Code §1305.302) nor the rule (28 TAC§10.80) requires a specific type of provider to be included in the networks, other than requirements to have chiropractors, physical therapists, and occupational therapists. However, each network is required to have sufficient numbers and types of health care providers to ensure choice, access, and quality of care to injured employees. If a network does not have available within its network a particular specialty that would reasonably be required for injured employee care, then the network is required to approve an out-of-network referral so that the employee may receive the necessary care.

21. Q: Labor Code §413.021 (amended by Section 3.243 of House Bill7 from the 2005 Regular Legislative session); states that evidence of case management is required on all lost time claims as early as practicable. Does this requirement apply to both network and out of network claims? When will specific guidelines be adopted for this?

A: Many network functions are regulated by the Insurance Code rather than the Labor Code, and under Chapter 1305 of the Insurance Code, case management is a required component of a certified network's quality improvement Program. The requirements for

in-network case management are available in 28 TAC §10.81(f). Please check the DWC website for details regarding specific guidelines for medical case management for non-network claims. The website is: http://www.tdi.state.tx.us/wc/indexwc.html

22. Q: If a practice has an in-house pharmacy and is in a network, can it still prescribe or fill workers' compensation medications? If it is not in a network, would the answer change?

A: Assuming that the in-house pharmacy has met the appropriate licensing requirements of the Board of Pharmacy in Texas, the pharmacy may deliver prescription services as a non-network provider. Insurance Code 1305.101(c), prohibits the delivery of prescription medication or services, as defined by Labor Code§401.011 9 (19) (E), from being delivered through a workers' compensation health care network. Thus, the practice may not deliver pharmacy services as part of the network services. However, the pharmacy may deliver prescription services as a non-network provider. Doctors in the practice may prescribe medications regardless of whether they are included in a network.

23 Q: Can a network choose to work with a specific pharmacy for workers' compensation?

A: No. As explained in the previous answer, prescription medication and services may not be delivered through a certified workers' compensation health care network, pursuant to Insurance Code §1305.101(c).

24. Q: Can an employer or carrier (prospective user of a network) obtain financial information regarding certified workers' compensation health care networks from the Department?

A: Some financial information that may have been filed with TDI by a certified network as part of an application or as an annual filing would be subject to the requirements of the Texas Public Information Act. However, information that discloses provider discounts or differentials between payments and billed charges for individual providers or networks is considered to be confidential and is not subject to disclosure as stated under §1305.503(b)(2), Texas Insurance Code.

25. Q: Can a carrier use both a certified network for in-network services and a separate secondary certified network for out-of-network services in which providers contract at a discounted rate?

A: A network is required to provide all of the services required for the medical care of injured employees. If the network does not have the appropriate contracted providers, the network will need to seek care for injured employees through out-of-network providers. There is no requirement for the network to use another certified network's providers.

26. Q: Can a carrier use discounted fee arrangements for out-of-network services if the arrangements do not constitute a "network"?

A: Carriers are not prohibited from directly contracting with providers for services rendered to injured employees that are not subject to a certified network. The fee arrangements would be governed by the contract between the two parties.

27. Q: Will the payor be allowed to "reprice" claims for the lowest contracted rate if I am contracted with multiple PPO networks?

A: If the provider is contracted with a certified workers' compensation network, the payment must be in accordance with that contract. If a carrier uses a third party as its authorized agent to obtain a contractual fee arrangement with a provider, there should be: (1) a contract between the carrier and the third party that authorizes the third party to contract with health care providers on the carrier's behalf; and (2) a contract or contract amendment between the third party, as authorized agent for the carrier, and the provider that names the carrier and clearly states the fee arrangement is between the health care provider and the third party, as authorized agent of the carrier. You may find additional information on this issue in the Commissioner's Bulletin #B-0005-06 located on the website at: http://www.tdi.state.tx.us/bulletins/2006/b-0005-06.html

28. Q: As Return-to-Work was a strong focus under HB 7, how are providers held accountable to follow Return-to-Work guidelines?

A: 28 TAC §§10.83(a) requires that each network shall adopt treatment guidelines, return-to-work guidelines, and individual treatment protocols which must be evidence-based, scientifically valid, outcome-focused, and designed to reduce inappropriate or unnecessary health care while safeguarding access to necessary care.
Additionally, §10.83(c) provides that a network, through its quality improvement program under §10.81, shall assure that all treatment guidelines, return-to-work guidelines, and individual treatment protocols are made accessible to all network providers. The network shall contractually require providers to follow its treatment guidelines, return-to-work guidelines, and individual treatment protocols pursuant to §10.42(b) (2).

29. Q: When are the guidelines for medical case management coming out in rules? What role is case management playing in treatment guidelines and return to work with employers?

A: DWC anticipates conducting training for the Disability Management rules soon. Please check the website for additional details. The Disability Management rules, 28 TAC Chapter 137, Subchapters A, B, C, and D (§§ 1371.1, 137.10, 137.100, and 137.300) are effective May 1, 2007. Rules for case management are scheduled to be adopted at a later date.

30. Q: How will hospitals and Independent Radiology Facilities be able to identify the network for an employee at the time of admission so that the patient can be booked to the right contract reimbursement?

A: An injured employee should be provided a notice of network requirements at the time the employer elects network coverage or when the employee is hired, and again at the time of injury. If the injured employee is unable to provide that information to the hospital or IRF, the facility may contact the employer to obtain it.

31. Q: Is it legal for networks to ask or insist that providers agree to provide services for less than the Medicare rates used in the industry?

A: Networks have the ability to offer contracts at, above, or below the Medicare rates for the industry. No restrictions were placed on the networks regarding contracted rates, other than what the contracting parties agree to. If the provider is not happy with the offered rates, he or she may negotiate for a higher rate or may choose not to contract with that network.

32. Q: What does an employer need to look for in choosing a network?

A: An employer may choose to consider the following: schedule of rates, discounts, types of providers, locations of providers, and availability and accessibility of network providers. A network that has been providing services over a period of time should be able to provide an employer with information about the quality and utilization of services by its providers. Additionally, beginning late 2007, the Department will make available a report card on networks.

33. Q: How are networks being priced to employer groups?

A: Some carriers have begun offering discounted premium rates to employers that choose to use a network in conjunction with worker's compensation coverage. The discount varies from carrier to carrier. An employer should check with its current carrier concerning discounted rates.

34. Q: In networks, do providers have a dispute resolution process through TDI or DWC?

A: In a network, a provider may file a complaint under 28 TAC §10.22 to seek dispute resolution under 28 TAC§§133.305, 133.307 and 133.308. For medical necessity disputes, a network provider may access the IRO process by requesting an IRO review using the LHL009 form and returning it to the URA or carrier that denied the services. The URA or carrier will then submit an online form to TDI to request assignment of an IRO. For fee disputes, the provider should file a complaint with the certified network. The network should then resolve the complaint. If the provider is still unsatisfied after

this process, he or she may file a complaint with TDI. The fee dispute process available through DWC does not apply to network providers. Required forms and further information regarding this issue is available on the TDI website at http://www.tdi.state.tx.us/company/iro_requests.html.

35. Q: How does a third party administrator (TPA) contract with a network for its self-insured clients?

A: Because the statute requires the carrier (in this case, the certified self-insured employer) to contract with a network, a TPA may not unilaterally contract with a certified network. A TPA may file an application to become a certified network in order to provide a network for its self-insured clients. You may also want to consult with a private attorney to discuss alternative, appropriate methods of contracting.

36. Q: In a provider to carrier communication, is an automated fax confirmation page considered adequate proof of timely filing?

A: It would be a prudent business decision to maintain a copy of the fax confirmation page and to be able to determine which injured employee and what services were included in the fax. You may wish to refer to your contract with the carrier to ensure that the carrier has no other contractual requirements that must be followed in order to allow for prompt payment when a claim is submitted via facsimile.

37. Q: Is a computer log of claims filed considered adequate proof of timely filing for the 95-day rule for filing a provider claim with a carrier?

A: You may wish to refer to your contract with the carrier to ensure that the carrier has no other contractual requirements to be followed in order to allow for prompt payment when a claim is submitted. The computer log would also need to be specific enough to demonstrate which injured employee the claim was for and all of the services included with that claim filing.

38. Q: Is there a plan to provide a workshop geared towards employees, employers, and providers?

A: The Department is planning several other workshops directed primarily towards employers, providers, and employees in the near future. Currently, plans are being developed for workshops in Dallas and Houston, in August and October, 2007. Notice will be provided on the Department website, through the WCNet Newsletter, and directed emails.

39. Q: Where are you in your decision to move legacy claims with date of injury January 1, 1991 to August 31, 2005 into the network?

A: A carrier may move a legacy claim into its network at their discretion if the injury occurred between January 1, 1991 and August 31, 2005.

40. Q: Can TDI or the network do anything to help a provider get in a network if the network gets full or closes?

A: Networks are not required to contract with "any willing provider", thus, a network or insurer may deny a provider's application for inclusion in the network. As a state agency, the Department of Insurance is not able to assist a provider in securing a contract. Networks may accept nominations from injured employees, employers, and providers to join the network. Please contact the network you wish to contract with to discuss their network participation requirements. You may locate the contact information for the carriers on the Department's website at: http://www.tdi.state.tx.us/wc/wcnet/wcnetworks.html.

41. Q: Does the Medical Fee Dispute Resolution (MFDR) Section handle fee disputes if the paid amount is zero?

A If the paid amount is zero, and there are no compensability, extent, liability, medical necessity, or contract issues, MFDR would review the dispute as a fee dispute.

42. Q: If our office submits a medical claim by standard mail (non-certified/return receipt) and it is denied for timely filing, our standard procedure is to submit an appeal to the workers' compensation carrier with a system-generated print-out that is created when the paper claim is submitted. The purpose of that print out is to serve as proof of timely filing. If the carrier refuses to accept our print-out as proof of timely filing and upholds their denial, what recourse do we have as a medical provider?

A: The providers have the right to file a complaint with the Department or file a Medical Fee Dispute with the (MFDR) Division at the DWC.

43. Q: Is there an established rule or law regarding what is acceptable as proof of timely filing? Or is it left up to the workers' compensation carrier to determine what is acceptable?

A: There is currently not a standard devised specifically for network or non-network workers' compensation for proof of timely filing. It would be a prudent business decision to review the contract between the carrier and provider or the network and the provider to determine what acceptable proof of timely filing has been outlined in the contract.

44. Q: We have a specific situation in which the carrier approved medical branch facet block. We submitted the claim, using Current Procedural Terminology (CPT) code(s) 64475 and 64476. The carrier denied our claim stating, "Per documentation, facet injections were performed, however, unilateral medial branch blocks were authorized". We submitted an appeal explaining that medial branch blocks and lumbar facet injections are the same procedure and are billed under the same CPT codes. The carrier denied our appeal, because the dictation did not reflect *their* terminology. Should our next step be medical dispute resolution?

A: Medical Fee Dispute Resolution is available to providers to utilize whenever they feel their services have not been paid appropriately and there is no contract.

45. Q: Can a carrier be contracted with more than one network?

A: A carrier may choose to contract with more than one network if it wishes. The carrier would then have the ability to allow an employer the choice of several networks.

46. Q: Do you have an ombudsman (OMB) for the provider and if so, what is the email/phone number for that department? Is an OMB for a patient different from an OMB for the provider?

A: The Department does have an ombudsman for group health and workers' compensation network providers. You may contact the provider ombudsman at WCNet@tdi.state.tx.us. for group health and WC networks. The ombudsman in the field offices will be happy to assist providers. Please call your local field office and request assistance. The same field office staff acts as ombudsman for both injured employees and providers.

47. Q: Why are the CPT codes for work conditioning/work hardening not included in the 97000 series codes in the network fee schedules?

A: The networks may include their own fee schedules in their contracts and those fee schedules are not reviewed by TDI.

48. Q: How is the Department handling those carriers who are putting providers in network without their approval or knowledge? Providers don't know they are in that network until they receive an Explanation of Benefits (EOB) showing the reason for the reduction in the reimbursement.

A: If the Department becomes aware that a provider has not signed a contract to participate in a certified workers' compensation network, and the network has the

provider listed as a contracted provider, then that potential violation by the network could be referred to the Department's Enforcement Division for administrative action. If a carrier or other party has put a provider in a fee-for-service network (non-certified), and a discount has been taken, the provider may request a fee dispute with MFDR.

49. Q: Are providers generally contracting with networks outside of the provider's county? If so, what is the advantage of such?

A: The Department does not have any knowledge of this practice at this time.

50. Q: Are patients within a network restricted (geographically) to which providers the patient may see?

A: Yes. An employee who has workers' compensation coverage through his or her employer and who lives in the network's service area is required to obtain health care services for a compensable injury within the network's service area. The network is required to have accessible and available treating doctors and hospitals within a distance of no greater than 30 miles in non-rural areas, 60 miles in rural areas, and no greater than 75 miles for specialty care.

51. Q: When a patient has a workers' compensation claim that is being denied and disputed by the carrier and the patient wants to file medical services on their group insurance, what are the patient's or provider's responsibilities and where can a provider refer a patient for help?

A: If the injury was work-related, the injured employee or the provider should not file on his or her own group insurance. The injured employee should continue to follow the appeal processes available through the worker's compensation system if he feels his claim was denied incorrectly. For more information, the injured employee can call the Department's toll free number at 1-800-252-3439 or visit the website available at http://www.tdi.state.tx.us.

52. Q: When the provider's claims continue to go unpaid, what can the provider do to expedite adjudication?

A: If a carrier does not meet the 45-day deadline set forth in Labor Code 7408.027, the provider can file a complaint with the Department. Complaint forms are available on the website at http://www.tdi.state.tx.us/consumer/complfrm.html.