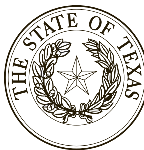
Workers' Compensation Health Care Networks



Published by the
Texas Department of Insurance
May 2009

TEXAS EMPLOYERS may provide workers' compensation coverage for their employees by participating in workers' compensation health care networks that provide cost-effective care for work-related injuries and illnesses. The networks specialize in treating injured workers and can help workers return to the job quickly and safely.

Overview

Insurance companies, certified self-insured employers, groups of certified self-insured employers, and political subdivisions can either operate networks directly or contract with an independent network.

Both types of networks must be certified by the Texas Department of Insurance (TDI). TDI also sets minimum financial standards and requirements for access and availability of care. TDI issues an annual report card rating all certified networks in areas such as return-to-work outcomes for injured workers, treatment outcomes, and employee satisfaction.

Workers' compensation health care 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 groups of physicians, hospitals, and other providers who work cooperatively to provide patient care.

Managed care plans control costs by contracting with providers to perform services at prenegotiated rates and by closely supervising patient care and treatment progress. Workers' compensation networks also use 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 that requires the use of a network, the network generally provides all the health care associated with any work-related injuries or illnesses. 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.

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 providers. The treating doctor takes the lead role in supervising the patient's workers' compensation-related care. HMOs use doctors called "primary care physicians" in a similar capacity. The treating doctor provides treatment for the patient's work injury and makes referrals to specialists. An HMO primary care physician may also be a treating doctor if the physician agrees to the network's terms.

Generally, patients are not allowed to see specialists without their treating doctor's approval. For certain types of care, a network may require the treating doctor to obtain "preauthorization" for proposed treatments and referrals to determine if they are medically necessary. A similar process, called "concurrent 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. Networks are required to have a process to allow patients and doctors to appeal any adverse decisions regarding medical necessity.

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 nonnetwork provider.

Information for Workers

If you have a work-related injury or illness, you must report your injury to your employer, file a claim with TDI's Division of Workers' Compensation, and select a treating doctor from the network's approved provider list. The treating doctor will supervise your treatment and make referrals to other providers if needed. The insurance company will provide your employer with a list of participating treating doctors updated at least quarterly.

Workers' compensation insurance companies are generally responsible for 100 percent of the treatment cost of covered work-related injuries and illnesses. An insurance company 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 a provider outside the network without receiving prior approval.

Notification Requirements

An employer must notify its current employees when it begins participating in a network and notify each new employee no later than the third day after the employee is hired. The notice must include information about the network's procedures for complaints and appeals of the network's treatment decisions, its service area, and a complete list of network service providers.

You'll be asked to sign and return a form acknowledging that you received the rules. Failure to return the form will not exempt you from the provider network's rules if you have a future claim

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 carrier will assume that you live at the address you provided to your employer.

Employees of the same company can have different requirements for their workers' compensation claims if some of the workers live outside the network's service area. Never misrepresent your primary living address to avoid a network's rules or to transfer to another network. If the insurer learns of the misrepresentation, it may deny coverage for the cost of any treatment associated with your workers' compensation claim.

Using Services in the Network

If you live within a network's service area, you must use network providers for most routine treatment of your workers' compensation claim. An insurance company can deny payment for care provided by nonnetwork providers without the network's prior approval. Exceptions are made for medical emergencies and certain other situations.

Networks operate in defined geographic service areas and must prove that they can provide sufficient medical services to meet workers' needs within that area. Certified networks are required to

- 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.
- provide an adequate number of doctors and hospitals within 30 miles of the homes of all workers living within the urban service area, and all necessary specialty services within 75 miles of workers' homes.
- provide an adequate number of doctors and hospitals within 60 miles of the homes of all workers living within the rural service area, and all necessary specialty services within 75 miles of workers' homes.

TDI can grant exceptions if a network is unable to meet these service guidelines but can provide 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's service area.

Employees living outside a network's service area are generally exempt from the network's rules and requirements. An employee living within a network's service area may also 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 nonnetwork provider.
- If you have been receiving your care from 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 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 nonroutine medical care, your treating doctor's treatment recommendations may also require prior approval from the network to ensure the care is medically necessary.

Your Rights

If you or your treating doctor disagrees with any medical necessity decision made by either the network or the insurance company, you or your doctor has 30 days to file an appeal for reconsideration by an alternate qualified doctor. The 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 30 days after receiving your appeal.

If it is not a life-threatening condition and you or your doctor disagrees with the decision, you or your doctor may file for an independent review by an independent review organization. In the case of a life-threatening condition, you have the right to request immediate review by an independent review organization.

Employees who receive medical care through a network have the following additional rights:

- You may select an alternate doctor from the network's list of treating doctors if you are not satisfied with your treating doctor. You must notify the network and 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.
- 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.
- 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 resolve your complaint within 30 days.
- 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***

  1-800-252-3439
  463-3515 in Austin

Information for Employers

When deciding whether to participate in a certified network, an employer should consider where employees live. If they live in different areas in the state, or even in several adjacent counties, some may reside outside the service area of any available network. Out-of-area employees are not required to use the network.

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 certified networks is available on the TDI website.

Required Notice

If you decide to participate in a network, you must provide your employees with written notice of the network's rules and requirements. Your insurer will provide the notice to you. 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 list of network providers.

The notice must be provided in English, Spanish, and any language common to 10 percent or more of your employees. You are required to provide this notice to existing employees at the time coverage takes effect and to all new employees no later than the third day of hire. You must also provide the notice again when an employee reports a work-related injury or illness.

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 exempt the employee.

You are required to maintain a complete record of all acknowledgment forms and document the method of delivery. This is not only required but is important, as it can help support your case in the event an employee disputes whether you provided the notice required.

All employers are also required to maintain a list of all participating network providers. You must provide copies when an employee requests it. You insurance company must update the list at least quarterly. You are also required to post notices about network coverage prominently in the workplace.

Information for Health Care Providers

Any licensed health care professional may apply to become a participating provider within one or more networks. Each network has its own credentialing process and may set its own minimum standards for participating providers.

Texas is not an "any willing provider" state. This means a network may decline your application if it has already contracted with a sufficient number of providers to meet the needs of injured employees. It may also decline your application if it does not credential providers in your particular medical specialty.

Your Requirements and Rights

As a network provider, you will be required to adhere to its policies, procedures, treatment guidelines, and return-to-work guidelines for all patients that are referred. Providers may not bill an injured employee 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 provider, the network may not offer you any financial incentives to limit medically necessary services. You are also required to post the toll-free number prominently in your office for anyone who wants to file a complaint about a certified network's operations.

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

- You may appeal any adverse determination for pre-authorization, concurrent review, retrospective review, or other network coverage decisions, on behalf of a patient. A certified 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's credentialing process, correct any errors, and learn the status of any pending application.

Leaving the Network

Except in cases of fraud, suspension of a medical license, or possible "imminent harm" to a patient, the certified 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 request to leave the network, the network must continue to reimburse you for care your provide to patients with an acute or life-threatening condition for up to 90 days, but you must show that disruption of care could potentially harm the patient.

For More Information or Assistance

For answers to general insurance questions or for information on filing an insurance-related complaint, call the ***Consumer Help Line*** between 8 a.m. and 5 p.m., Central time, Monday-Friday, or visit our website

1-800-252-3439
463-6515 in Austin
www.tdi.state.tx.us

For printed copies of consumer publications, call the 24-hour ***Publications Order Line***

1-800-599-SHOP (7467)
305-7211 in Austin

Help us prevent insurance fraud. To report suspected fraud, call our toll-free ***Fraud Hot Line***

1-888-327-8818

To report suspected arson or suspicious activity involving fires, call the State Fire Marshal's 24-hour ***Arson Hot Line***

1-877-4FIRE45 (434-7345)

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