TDI HWCN Division

HWCN News

A publication of the Health and Workers' Compensation Networks Division

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HWCN News and *WCNet News* to be merged

Beginning in July 2008, HWCN News and WCNet News will be merged into a single newsletter covering all functions performed by the HWCN Division of TDI. HWCN News will be published quarterly. Though some areas, such as IROs and URAs, overlap it is our intent to divide the newsletter into sections representing each functional area (HMOs, Workers' Compensation Networks, URAs and IROs) when possible to facilitate locating articles that may be of interest to a specific reader.

By combing the two newsletters and teams that are responsible for their content the HWCN Division's goal is to make the most efficient use of resources and create a more streamlined production schedule while continuing to provide news and information that is both timely and relevant to our audience.

2008 Life, Health and Licensing Compliance Conference

The Texas Department of Insurance (TDI) strives to be the best insurance regulatory agency in the nation. To assist life, accident and health insurers, health maintenance organizations (HMOs), and agents in understanding and meeting Texas' regulatory requirements, TDI will host the 2008 Life, Health and Licensing Compliance Conference.
The conference will last 1 1/2 days and will be held June 23 and June 24 until Noon.

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Hotel Reservations: The Compliance Conference will be held at the Doubletree Hotel, 6505 I.H. 35N, Austin, Texas 78752. The Doubletree Hotel is offering a special rate of $85/single and $135/double for attendees of the compliance conference. Please call the hotel directly at 1-800-347-0330 to make your reservations. Refer to the TDI Compliance Conference to get the special rate.

Detailed information regarding registration for the conferences is available on the TDI Web site at https://wwwapps.tdi.state.tx.us/inter/asproot/consumer/lhlcompliance/registration.asp.

HMO Audit Tools Available on Web

After many months of hard work, the staff in TDI's HWCN Division has completed making necessary changes to the HMO Audit Tools. The current HMO Audit Tools have been posted on TDI's Internet Homepage and are available for use by HMOs and their delegated entities, as applicable.

- Updated HMO Access Plan Checklist, LHL 398
- HMO Claims Tool P & Ps Checklist, LHL 432
- HMO Complaints P & Ps Checklist, LHL 433
- HMO Credentialing P & Ps Checklist, LHL 434
- HMO Delegated Entities File Review Checklist, LHL 435
- HMO Plan Operations Checklist, LHL 436
- HMO Network Adequacy Checklist, LHL 437
- HMO Provider Manual Checklist, LHL 438
- HMO Quality Improvement Program Checklist, LHL 439
- HMO Single Service Quality Improvement Prog. Checklist, LHL 440
- HMO Single Service Accessibility & Availability Checklist, LHL 441

You may send your HMO-related questions via e-mail to **HMOGrp@tdi.state.tx.us** or your URA/IRO-related questions to **URAGrp@tdi.state. tx.us**. You may also contact the HWCN Division by telephone, toll-free at 1-866-554-4926.

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HMO Complaint and Appeal Process

An HMO is required to have a Quality Improvement Program, which requires each entity to monitor multiple aspects of its operation. While there are many operations and/or functions within an HMO that must comply with the TIC and TAC, this article will discuss the Complaint and Appeal Process.

An HMO must implement and maintain a complaint system as required by TIC §843.251. HMOs have detailed requirements for complaint handling that are monitored by the Department by way of triennial exams. Some of the requirements for complaint handling are as follows, an HMO must:

- Send a letter to the complainant acknowledging their complaint, no later than the 5th business day after the date the complaint was received.
- Acknowledge, investigate and resolve a complaint not later than 30 calendar days from the receipt date.
- An HMO must send a resolution letter that explains its resolution, state specific medical/contractual reasons for the resolution and provide the specialization of any provider consulted. TIC §843.252

An HMO must also provide an appeals process. Some of the requirements for the appeals process are as follows, and HMO must:

- Send a letter to the complainant acknowledging their appeal, no later than the 5th business day after the date the request for an appeal was received.
- Complete the appeals process not later than 30 calendar days from the receipt date of appeal request.
- Give a complainant the right to appear in person before its complaint appeal panel.
- Inform its enrollees of the right to an Independent Review by an Independent Review Organization for cases involving medical necessity. TIC §843.254

An HMO must keep records of complaints and appeals logs until the third anniversary from the complaint receive date. For more information on the complaint and appeals process see TIC Chapter 843.

URA Renewal Process

Utilization Review Agents (URA) must apply for renewal every two years from the date of the original certification. The following items are required for renewal.

- The URA application form (LHL005) and applicable checklist(s) (see bottom of page 5 of application form for details on which checklist to use).
- The filing fee of $545.00 made payable to The Texas Department of Insurance.
- A summary of the current screening criteria.
- A statement signed by an authorized representative of the company certifying that all information previously submitted is true and correct and that all changes have been previously filed to the application certified by the department.
- If there are updates/changes, to previously filed documents, the URA must submit the information for review and approval using the applicable checklist(s). The renewal fee is not refundable.

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URA Renewal Process *continued from page 2*

A utilization review agent may continue to operate under its certificate of registration until the renewal is finally denied or issued by the department, if the URA application form and filing fee is received by the department on or before the renewal date.

If the required information and fee is not received prior to the deadline for renewal of the certificate of registration the certificate of registration will automatically expire and the utilization review agent must complete and submit a new application form and a new fee of $2,150.00 with all required information.

For more Information regarding URA certification and renewals you may refer to 28 TAC §19.1704.

HMO Advertising

The Department occasionally receives questions about the requirements that apply to advertising/marketing materials used by a Texas-licensed HMO. Here's some useful information:

- All HMO advertising/marketing materials must be approved by the HMO's Home Office before being used by the sales force/agents.
- Except for Medicare Cost advertising which is filed with TDI "for acceptance", HMO advertising does not have to be filed with TDI.
- All Medicare Advantage advertising materials must be filed with the Centers for Medicare & Medicaid Services (CMS) – for more information, visit the Medicare Web site.
- An HMO is prohibited from using advertising which is untrue or misleading. (§843.204(a)(2)(A), TIC)
- TDI's Advertising Unit reviews advertising submitted by an HMO "for acceptance" to the Department.

You may send your HMO advertising-related questions via e-mail to **Advertising@tdi.state.tx.us** or you may contact the staff in TDI's Advertising Section by telephone at 1-512-475-1949.

Meet TDI staff member Charles Reyna

Charles Reyna joined TDI (formerly known as the State Board of Insurance - SBI) in March, 1988 and has been with TDI's HWCN Division (formerly known as the HMO Division) since August 1993. Charles' first HMO-related assignment was to assist in developing rules for Dental HMOs, now known as Chapter 11, Subchapter W, Single Service HMOs.

Charles reviews various types of HMO form filings, including Certificate of Authority (COA) applications, Service Area Expansion Requests and HMO Form Filings submitted to TDI subsequent to issuance of the HMO's COA. Charles is a member of the HMO Examinations team and participates in the performance of TDI's triennial HMO Quality of Care examinations.

Charles also reviews Certification applications and Certification renewals submitted by utilization review agents (URAs) and Independent Review Organizations (IROs).

You may send your HMO-related questions via e-mail to **HMOGrp@tdi.state.tx.us** or your URA/IRO-related questions to **URAGrp@tdi.state.tx.us**.

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Got an idea for an article or a "Did You Know"?

The HWCN Division would like to hear from you! Is there a subject you would like more information on or that needs additional clarification? Please email your ideas for articles to **HMOGrp@tdi.state.tx.us**.

Real or Rumor?

Q. Have the prompt payment statutes changed?

A. Yes. Effective September 1, 2007 Senate Bill (SB) 1884 made a change to TIC §843.342 Section 1, Subsections (g) and (h). SB 1884 amends the TIC to change the calculation of an underpaid claim paid by a HMO to a physician or provider or by an insurer to a preferred provider benefit plan from the billed charges submitted on the claim to that amount minus the contracted rate. For the HMO or insurer to avoid liability for an underpayment penalty, the physician or provider must notify the HMO or the plan must notify the insurer of such a claim within 270 days, rather than 180 days, after the underpayment was received. The HMO or insurer must correct the underpaid claim within 30 days, rather than 45 days, after receiving the notification.

Credentialing

Health Maintenance Organizations (HMOs), including single-service HMOs, are required to credential and re-credential network participating physicians and other providers in accordance with several requirements, some of which are discussed below. TDI recognizes the enormity of, and the effort needed for, accomplishing this requirement and wants to acknowledge the HMOs' hard work in this area of regulation. With that in mind, the purpose of this article is to discuss, and perhaps clarify, some credentialing requirements and to also provide guidance in several areas that TDI believes are obstacles to full compliance.

Texas Standardized Credentialing Application. The Texas Standardized Credentialing Application (Application) must be used by HMOs for credentialing and recredentialing physicians, advanced practice nurses and physician assistants. TDI receives numerous questions about the Application. Since TDI makes the application form available to the public, TDI unavoidably gets numerous calls and emails from health care providers about how to fill out the Application and about whether a particular field applies to their particular circumstances or profession. For the most part, TDI can only refer them back to the HMOs. However, judging from the many calls TDI gets about the Application, TDI believes that HMOs may need to provide more information and instruction to their participating providers about the Application. The benefit to the HMO is receipt of a complete and timely Application, which are important credentialing requirements.

NCQA Standards-Do They Apply? The answer may be both "yes" and "no." TIC §1452.006 provides that an HMO must credential its physicians and other providers in accordance with standards adopted by the National Committee for Quality Assurance (NCQA), to the extent those standards do not conflict with other Texas laws. See also 28 TAC §11.1902(4). However, NCQA standards do not "reach" non-physicians such as dentists and optometrists. Thus, if the HMO

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Credentialing *continued from page 4*

has both physicians and non-physicians, the HMO would be required to credential physicians in accordance with NCQA standards but not be required to do so for non-physicians. The question then becomes: What standards can or should be utilized for credentialing non-physicians? The best way to answer this question is by addressing the standards TDI uses for single-service HMOs that typically contract with, for the most part, providers who are not physicians.

Credentialing of Single-Service HMO (Dental and Vision) Non-Physician Providers: Even if a single-service HMO uses NCQA standards for credentialing non-physicians, TDI will apply the HMO's own credentialing process (typically described in policies and procedures) when reviewing credentialing files. In other words, even if the policies describe NCQA standards word for word, TDI will still apply the HMO's written policies rather than apply the NCQA standards straight out TDI's NCQA checklist. In sum, an HMO could have other than NCQA standards for credentialing non-physicians and TDI will apply those non-NCQA standards when reviewing non-physician credentialing files.

Obstacles to Complete Compliance: TDI staff reviews numerous credentialing files during examinations of HMOs. Below is a list of common (and easily avoidable) errors or omissions that result in failure to accomplish full compliance with credentialing requirements:

- Credentialing file does not include all necessary documentation. For example, although the HMO may have verified specifically required information such as licensure, the file does not contain documented evidence of the verification. Until the HMO submits such evidence, TDI will mark the element as noncompliant.
- Credentialing file checklist does not include the signature/initials of the person verifying specific information.
- Credentialing file does not include dates such as: (a) date information was verified; (b) date the applicable committee (QI committee or governing board) approved the application; and (c) date the provider was recredentialed. These dates are necessary to determine whether the HMO met certain required deadlines for completing the credentialing process.
- HMO's policies conflict with the actual process followed when credentialing a provider. This error will be typically evident in non-physician credentialing files. For example, the HMO's policy requires a 5-year work history but the credentialing application form only requires a 3-year history. If the HMO fails to apply its own documented standard, then this element would be marked as non-compliant.

Tips For Avoiding Common Errors and Omissions:

- Take advantage of the TDI tools and checklists that are available in TDI's Web site. TDI has developed tools and checklists regarding credentialing requirements. One such checklist has all the NCQA requirements that TDI applies when reviewing physician credentialing files. This checklist can be found at http://www.tdi.state.tx.us/forms/lhlhmo/lhl443rev0108.xls.
- Compare the HMO's documented policies with the actual credentialing process being followed. As stated above (in the case of non-physicians, for example), if the HMO fails to apply its own documented standard, then the standard would be marked as non-compliant. *Continued on page 6*

Credentialing *continued from page 5*

- Perform Self-Audits. Do what TDI does. Randomly select credentialing files and put them to the test. A self-audit is particularly critical if the time for the HMO's next triennial exam is imminent.

You may send your credentialing related questions to TDI at **HMOGrp@tdi.state.tx.us** or contact the HWCN Division by phone at 1-866-554-4926. As a reminder, in most instances questions regarding the Texas Standardized Credentialing Application should be directed to the HMOs.

Web site Resources

The information below was originally published in Issue 1 of the *HWCN News*. It is being republished here as a service to our audience.

Though the TDI Web site is going through a redesign there is still valuable information, resources and tools currently available.

The HMO page includes links to HMO forms and checklists, HMO company profiles, HMO Financial Reports, and the ability to search for HMOs by county, among other information.

The IRO page includes forms for requesting a review by an IRO, a listing of currently certified IROs, application and attachments, applicable law and rules, and IRO decision templates.

The URA page includes the ability to search for a specific URA by name or download the complete list of URAs. This page also includes information and forms for certification and renewal, applicable laws and rules, and reporting requirements.

The Workers' Compensation Health Care Networks page includes a section on the latest news, a listing of certified workers' compensation networks, applicable rules and regulations, open conference call agendas and minutes, frequently asked questions (FAQs) and links to each edition of the WCNet News newsletter.

The above is just a sample of information on the TDI Web site. We invite you to explore the Web site to find information that may be useful to you. We appreciate your patience while the Web site is being revamped to become a more effective tool for everyone.

If you are unable to find the information you need on the TDI site or have questions about information on the TDI Web site please feel free to contact us toll-free at 1-866-554-4926, locally at (512)322-4266 or via email at **HMOGrp@tdi.state.tx.us**.

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Compliance Resources

The information below was originally published in Issue 1 of the *HWCN News*. It is being republished here as a service to our audience.

Primary HMO Requirements*

The laws that primarily provide for the licensing and operation of HMOs in Texas are codified in the Texas Insurance Code (TIC), Chapter 843.

The rules which primarily provide for the licensing and operation of an HMO in Texas are designated under Chapter 11, Texas Administrative Code (TAC).

***COMPLIANCE NOTE:** *While the laws in Ch. 843, TIC and the rules in Ch. 11, TAC, primarily apply to a Texas-licensed HMO, there are other laws and rules that also apply to a Texas-licensed HMO. For example, to see a list of all of the requirements that apply to an HMO Provider contract, an HMO evidence of coverage (EOC), an HMO Delegated Entity/Delegation Agreement and an HMO Access Plan, you may use the following link to access each checklist: http://www.tdi.state.tx.us/forms/form9hmo_filings.html.*

Checklists

The HWCN Division staff use checklists as tools when reviewing HMO filings to determine if the HMO form filings comply with applicable requirements.

Depending on the type of EOC the HMO offers, a Texas-licensed HMO is required to cover certain services and benefits:

- basic service (a medical HMO plan); OR
- limited service (a mental health/chemical dependency/long term care HMO plan); OR
- single service (a dental or vision HMO plan).

An HMO plan may cover:

- an individual; or
- a small employer group (between 2 and 50 employees); or
- a large employer group (51 or more employees).

For a complete listing of all of the requirements that apply to each type of EOC, you may refer to the applicable EOC checklist and to the "Mandated Benefits Chart for an HMO," at the end of this listing of checklists. All of TDI's HMO checklists are available on-line at the following links:

HMO Evidence Of Coverage (EOC) Checklists

Individual EOC – LHL 011
Small Employer EOC – LHL 380
Large Employer EOC – LHL 381

Consumer Choice Benefit Plan (CCBP) Checklists

Individual CCBP – LHL 359
Small Employer CCBP – LHL 358
Large Employer CCBP – LHL 360

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HMO-Physician/Provider contract

An HMO-Physician/Provider contract must include certain mandatory provisions and may not include certain prohibited provisions. The HMO Physician/Provider Contract Checklist can be found at this link:

HMO-Physician/Provider Contract Checklist - LHL 012

HMO Access Plan Checklist

An HMO is required to provide an adequate network for its entire service area. This means that all of the HMO's covered services must be accessible and available so that travel distances for an enrollee from any point in the HMO' s service area to a point of service are no greater than 30 miles for primary care and general hospital care; and 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.

If any covered health care service or a participating physician and provider is not available to an enrollee within the required distances, the HMO must submit an access plan to TDI for approval. To view the checklist please click on the link below:

HMO Access Plan Checklist – LHL 398

HMO Delegated Entities/Delegated Third Parties Checklist

When an HMO delegates certain functions to another entity, such as contracting with physicians/providers, handling complaints or performing utilization review to another party (a Delegated Entity) the delegation must be in writing and the delegation agreement must include certain mandatory provisions. (Source Chapter 1272, TIC)

The Delegated Entities & Delegated Third Parties checklist can be found at:

Delegated Entities/Delegated Third Parties – LHL 385

Mandated Benefits Chart for an HMO Plan

An HMO that covers basic health care services must also cover other additional benefits, which are generally referred to as "mandated benefits." These two checklists can be found at::

Mandated Benefits Chart for an HMO Plan PDF Format
Mandated Benefits Chart for an HMO Plan MS Word Format

Know a friend or colleague who may be interested in the HWCN News?

If you know a friend or colleague who may be interested in the HWCN News please forward them the link to our current issue and let them know how simple it is to join our mailing list. To be added all that is needed is a quick email to **HMOGrp@tdi.state.tx.us** titled "Subscribe HWCN News". Please include the email address that you wish to be subscribed under.